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Science and Technology Committee

Drug classification: making a hash of it?

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Report, together with formal minutes, oral and written evidence

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Report

Summary

This Report is the second of three case studies under the Committee's over-arching inquiry into the Government's handling of scientific advice, risk and evidence in policy making. It addresses the relationship between scientific advice and evidence and the classification of illegal drugs.

In the course of this case study, we have looked in detail at the role played by, and workings of, the Government's scientific advisory committee on drug classification and policy, the Advisory Council on the Misuse of Drugs (ACMD). We have identified a number of serious flaws in the way the Council conducts its business. Although the Council has produced useful reports explaining the rationale behind its recommendations on drug classification decisions, we found a lack of transparency in other areas of its work and a disconcerting degree of confusion over its remit. We also note that the ACMD has failed to adhere to key elements of the Government's Code of Practice for Scientific Advisory Committees. In response to these and other concerns about the Council's operations, we have called for the Home Office to ensure that there is, in future, independent oversight of the Council's workings. We have also highlighted the need for the ACMD to play a far more a proactive role in supporting the work of the Department of Health and Department for Education and Skills: the Government's approach to drug education and treatment must be informed by scientific advice and stronger cross-departmental coordination will be vital if the Public Service Agreement targets on drugs policy are to be met.

With respect to the ABC classification system, we have identified significant anomalies in the classification of individual drugs and a regrettable lack of consistency in the rationale used to make classification decisions. In addition, we have expressed concern at the Government's proclivity for using the classification system as a means of 'sending out signals' to potential users and society at large—it is at odds with the stated objective of classifying drugs on the basis of harm and the Government has not made any attempt to develop an evidence base on which to draw in determining the 'signal' being sent out.

We have found no convincing evidence for the deterrent effect, which is widely seen as underpinning the Government's classification policy, and have criticised the Government for failing to meet its commitments to evidence based policy making in this area. More generally, the weakness of the evidence base on addiction and drug abuse is a severe hindrance to effective policy making and we have therefore urged the Government to increase significantly its investment in research.

Finally, we have concluded that the current classification system is not fit for purpose and should be replaced with a more scientifically based scale of harm, decoupled from penalties for possession and trafficking. In light of the serious failings of the ABC classification system that we have identified, we urge the Home Secretary to honour his predecessor's commitment to review the current system, and to do so without further delay.

1 Introduction

1. On 9 November 2005 the Committee launched a major inquiry into the Government's handling of scientific advice, risk and evidence in policy making.[1] We decided that, in addition to collecting evidence on the over-arching terms of reference, we would undertake three case studies to enable us to examine the Government's policy making processes in greater detail. The Report of the first of these case studies, addressing the UK's involvement with, and response to, the EU Physical Agents (Electromagnetic Fields) Directive, was published on 29 June 2006.[2] In this case study, we have looked at the relationship between scientific advice and evidence and UK policy on the classification of the illegal drugs. The Report of the remaining case study, which explores the technologies supporting the Government's policy on ID cards, will be published in August 2006.

2. There were a number of factors that influenced our decision to pursue this case study. The misuse of illegal drugs is a major public health, criminal and social problem. The UK's drug market is estimated to be worth around £6.6 billion, with drug-related economic costs to the UK estimated at approximately double this.[3] The classification system plays a key role in directing the resources devoted by Government to tackling illegal drugs, with around 75% of this expenditure spent on enforcing drug laws.[4] The classification of illegal drugs is also a matter of significant public concern and recent decisions regarding changes in classification, most notably the reclassification of cannabis from Class B to Class C, have been the subject of intense media debate. Perhaps the strongest indicator of discontent over the current ABC classification system came in January 2006, when the then Home Secretary, Rt. Hon. Charles Clarke, announced that he would be undertaking a root and branch review of the ABC system.[5]

3. We held three evidence sessions in conjunction with this case study, during which we heard from:

- The Chairman of the Advisory Council on the Misuse of Drugs (ACMD) and Chairman of the ACMD Technical Committee;
- The Chief Executive of the Medical Research Council (MRC), Chairman of the Association of Chief Police Officers' (ACPO) Drugs Committee, Director of the National Addiction Centre and NGOs; and
- The Parliamentary Under-Secretary of State for policing, security and community safety.

1 www.parliament.uk/parliamentary_committees/science_and_technology_committee/scitech091105.cfm.

2 Science and Technology Committee, Fourth Report of Session 2005-06, *Watching the Directives: Scientific Advice on the EU Physical Agents (Electromagnetic Fields) Directive*, HC 1030

3 Ruth Levitt, Edward Nason, Michael Hallsworth, *The evidence base for the classification of drugs*, Technical Report, RAND Europe, March 2006, para 31, combined figures, www .rand.org/pubs/technical_reports/TR362/

4 RAND Report, para 31

5 HC Deb, 19 Jan 2006, col 983

4. The transcripts of these sessions are published with this Report, together with the 14 written submissions received in response to our call for evidence and requests for supplementary information. In addition, we undertook a visit to the United States as part of our over-arching inquiry, where we met, amongst others, representatives from the Department of Health and Human Services, National Institute on Drug Abuse, RAND Drug Policy Research Centre, White House Office of Drug Control Policy, UN Office of Drugs Policy and New York Police Department. We are grateful to all those who helped organise the visit and contributed evidence to this inquiry. We would also like to place on record our thanks to our specialist adviser, Professor Michael Gossop, Head of Research in the Addictions Directorate at the Maudsley Hospital in London.

2 Background

ABC classification system

5. The ABC classification system "was designed to make it possible to control particular drugs according to their comparative harmfulness either to individuals or to society at large when they were misused".[6] The ABC system has its origins in the Misuse of Drugs Act (MDA) 1971, which introduced the concept of 'controlled drugs' and (as amended) constitutes the main piece of legislation regulating the availability and use of these drugs. The purpose of the Act was to provide a coherent framework for drug regulation which, until then, had been covered by the Drugs (Regulation of Misuse) Act 1964 and the Dangerous Drugs Acts of 1965 and 1967.

6. The United Nations' Single Convention on Narcotic Drugs 1961 and its attempts to establish a Convention on Psychotropic Substances (eventually ratified in 1971) formed an important backdrop to the UK's efforts to rationalise its legislation in this area. James Callaghan, the then Home Secretary, told Parliament in 1970 that in developing the ABC classification system the Government had used the UN Single Convention and guidance provided by the World Health Organisation to place drugs "in the order in which we think they should be classified of harmfulness and danger".[7] Even at that early stage, the Government said that drugs would be classified "according to the accepted dangers and harmfulness in light of current knowledge", with provision "for changes to be made in […] the light of scientific knowledge".[8]

7. The Misuse of Drugs Act did not specify why particular drugs were placed in Class A, B or C but did create an Advisory Council on the Misuse of Drugs (ACMD) to keep the classification of drugs under review. The role and workings of the ACMD are discussed in detail in Chapter 3. The classifications of a selection of controlled drugs are listed in Table 1.[9] Since the introduction of the Act, the Government has made a number of changes to the Class of drugs, the most prominent of which was the decision in 2002 to move cannabis from Class B to Class C. Various drugs which were not originally regulated under the Act have also become classified—ketamine, gamma-hydroxy butyrate (GHB) and steroids have all been placed in Class C. Chapter 4 discusses the role played by scientific advice and evidence in determining the Class of cannabis, amphetamines—including ecstasy and methylamphetamine—and magic mushrooms.

6 Ev 53

7 HC Deb, 25 March 1970, col 1453. This was the Government's first attempt to introduce an ABC classification system – the Misuse of Drugs Bill 1970 was not passed but the classification system was eventually introduced under the Misuse of Drugs Act 1971.

8 HC Deb, 25 March 1970, col 1453

9 Correct as of March 2006.

Table 1: Classification of illegal drugs

Classification	Drugs	Maximum penalties
Class A	Heroin, LSD, ecstasy, amphetamines (prepared for injection), cocaine and crack cocaine, magic mushrooms.	For possession: 7 years' imprisonment and/or fine. For supply: life imprisonment and/or fine.
Class B	Amphetamines, methylamphetamine, barbiturates, codeine.	For possession: 5 years' imprisonment and/or fine. For supply: 14 years' imprisonment and/or a fine.
Class C	Cannabis, temazepam, anabolic steroids, valium, ketamine, methylphenidate (Ritalin), gamma-hydroxy butyrate (GHB).	For possession: 2 years' imprisonment and/or fine. For supply: 14 years' imprisonment and/or fine.

8. Under the Misuse of Drugs Act, it is an offence to possess a controlled drug unlawfully; to possess with intent to supply; to supply or offer to supply a controlled drug (even where no charge is made); to allow premises to be used for the purpose of drug taking; and to traffic in drugs.[10] While the Act specifies the penalties attracted by offences associated with drugs of different categories, the police and courts retain a degree of discretion in policing and sentencing. The RAND report on the evidence base for the classification system for illegal drugs (see paragraph 10) points out that "in 2004 under 10,000 of the 70,000 drug offences coming before the courts attracted any custodial sentence" and that "In the first three years' operation of the Crime (Sentences) Act 1997, which introduced minimum sentences for those caught dealing in Class A drugs for the third time, only three people were actually sentenced in accordance with the powers of the act".[11] We return to the relationship between the classification system and penalties for possession and supply of controlled drugs in Chapter 7.

Misuse of Drugs Regulations

9. The Misuse of Drugs Regulations 2001 are concerned with the therapeutic use of drugs. They define the classes of persons who are authorised to supply and possess controlled drugs while acting in their professional capacities and lay down conditions under which these activities must be carried out. Under the Regulations, drugs are categorised in five schedules which govern import, export, production, supply, possession, prescribing and record keeping. According to the Advisory Council on the Misuse of Drugs:

- Schedule 1 includes substances such as LSD and cannabis that are not available for medical purposes. Possession and supply are prohibited without specific Home Office approval.
- Schedule 2 includes prescription drugs such as morphine and diamorphine that, because of their harmfulness, are subject to special requirements relating to their safe

10 RAND Report, para 2

11 As above, Addendum, section 1.2

custody, prescription, and the need to maintain registers relating to their acquisition and use.

- Schedule 3 drugs include barbiturates and are subject to special prescription, though not safe custody, requirements.
- Schedule 4 drugs include benzodiazepines and are subject neither to special prescribing arrangements, nor to safe custody requirements.
- Schedule 5 includes preparations that, because of their low strength, are exempt from most of the controlled drug requirements.[12]

Commissioned research

10. As part of this inquiry, the Committee commissioned RAND Europe, a not-for-profit policy research consultancy, to provide an independent review of the evidence base for developing policy on the classification of illegal drugs. The research looked at the evidence for physical and social harm associated with specific drugs, evidence of the impact of classification and international differences in the interpretation of the existing evidence. The research looked at drugs in all three classifications. For Class A it examined cocaine, magic mushrooms and ecstasy. In Class B it covered amphetamines. In Class C it investigated the most commonly used illegal drug, cannabis, which was reclassified in 2002 and considered again by the Home Secretary in January 2006. The research also looked at the classification systems used in three other countries to provide evidence for comparative purposes. The report, referred to here as the 'RAND report', was published on 1 March 2006 and an addendum issued shortly thereafter.[13]

11. We commissioned this research with the objective of obtaining an impartial assessment of the relationship between UK policy on drug classification and the international, publicly-available evidence base to underpin it. In so doing, we sought to complement our own evidence-gathering processes undertaken during the inquiry, in which we have heard directly from the key players involved in the provision of advice and development of policy, as well as looking in greater detail at the workings of the Government's major source of scientific advice in this area, the Advisory Council on the Misuse of Drugs.

International comparisons

12. We asked RAND to undertake a comparison of the UK, US, Dutch and Swedish approaches to drug legislation as part of its research. These countries were selected in order to provide a range of different policy contexts, with the Netherlands having adopted an approach to drugs legislation which is generally considered to be 'liberal' and Sweden following a comparatively conservative system. The US is often considered to share similarities in politics and values with the UK and was one of the countries examined by the influential Runciman inquiry into drugs and the law (see paragraph 18). We also visited the US to examine its approach to policy making in respect of drugs in greater depth.

12 Ev 96

13 RAND Report

US

13. The focus of drug legislation in the US is on reducing the number of drug misusers in the country. The Controlled Substances Act, title II of the Comprehensive Drug Abuse Prevention and Control Act (1970), divides drugs into five schedules, based on their potential for abuse, potential for creating dependence and accepted medical use. Schedule I contains drugs with the highest potential for abuse and the lowest medical use and Schedule V contains those with low potential for abuse and high medical use.[14] For those drugs in higher Schedules, punishments can vary depending on the amount of drug a person is caught in possession of. Different States have their own legislation for scheduling drugs and for punishments. Hence, while ecstasy is a Schedule I drug in Florida, attracting a maximum penalty of 30 years in prison for selling, California has not scheduled ecstasy and does not, therefore, have specified penalties for its sale and possession.[15] The US spends large sums on research to provide evidence regarding drug abuse and the effectiveness of treatment and punishment regimes via the National Institutes of Health, the National Institute on Drug Abuse and the White House Office for National Drug Control Policy.

Netherlands

14. The overall objective of drugs policy in the Netherlands is to reduce the harm caused by drugs, both to individuals and to society. Policy is based on the premises that education, prevention and treatment are more effective than punishing users; that interventions should focus on the most harmful drugs; and that drug addiction is a 'normal social problem'.[16] Under the 1976 revision of the Dutch Opium Act, drugs are divided into two schedules: Schedule I drugs, such as heroin, present an unacceptable health risk while Schedule II drugs are associated with a negligible or acceptable health risk. Cannabis is a Schedule II drug. The intention behind creating these two Schedules was to separate the markets for 'hard' and 'soft' drugs and to thus prevent users moving from 'soft' to 'hard' drugs.[17]

Sweden

15. Swedish drug legislation aims to produce a drug free state by reducing the availability of drugs to potential users. The 1968 Narcotics Drugs Act categorised drugs according to five lists: List I is for drugs with no medical use; Lists II-IV are for narcotic substances with medical use and List V deals with narcotic substances not subject to international controls. Classification of drugs is on the basis of their effects, rather than the punishments they attract for possession and supply. Drug policy research focuses primarily on efficacy of treatment and punishment regimes.

14 RAND Report, para 182

15 As above, para 212

16 As above, para 222-225

17 As above, paras 222-226

Obligations under UN treaties

16. The key features of the UK, US, Dutch and Swedish drug policy regimes are described in Table 2. It is clear that despite the fact that the UK, US, Netherlands and Sweden are all signatories to the UN drug control treaties, their drug legislation policies differ significantly. This is important since some have argued that scope for reform of the UK classification system is constrained by its commitments under the UN conventions. **We conclude that the UN drug control treaties do not pose a major barrier to reform of the UK system of drug classification.** This is in accordance with the observation made in the Runciman report *Drugs and the Law* that "although they rule out the legalisation of any prohibited drug other than for medical, scientific or limited industrial purposes, the conventions allow more room for manoeuvre than is generally understood".[18]

Other reports and sources of information

17. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised agency of the European Union. It describes itself as "the central source of comprehensive information on drugs and drug addiction in Europe" and aims to provide the EU and its Member States with objective, reliable information on drugs and drug addiction.[19]

18. Additional sources of advice available to the Government include the Forensic Science Service and the police, both of which are represented on the ACMD (see ANNEX). The annual British Crime Survey is also frequently cited as a source of evidence for making drugs policy. Other key reports of relevance to this inquiry include the Home Affairs Select Committee 2002 Report, *The Government's Drug Policy: Is It Working?*,[20] and the so-called 'Runciman report'—the Report of the Independent Inquiry into the Misuse of Drugs Act 1971, *Drugs and the Law*, published by the Police Foundation in 2000.[21] Both of these recommended that changes be made to the classification of drugs under the ABC system, including the reclassification of cannabis from B to C and ecstasy from A to B. We discuss the Government's decision to reclassify cannabis in paragraph 43 and refusal to reconsider the Class of ecstasy in paragraph 61.

18 The Police Foundation, *DRUGS AND THE LAW: Report into the Independent Inquiry into the Misuse of Drugs Act 1971*, March 2000, para 12

19 http://www.emcdda.europa.eu/

20 Home Affairs Committee, Third Report of Session 2001-02, *The Government's Drug Policy: Is It Working?*, HC 318-I

21 Runciman Report

Table 2: Comparison of drug legislation policies and use: UK, USA, the Netherlands and Sweden

	UK	USA	Netherlands	Sweden
Aim of drug legislation	To reduce supply, prevent uptake, reduce crime and increase treatment uptake	To cut off supply of drugs to users	To reduce harm to individuals and society	To create a drug free state
Drug Classes	Classes A-C; based on the relative harm of drugs. Class A is the most harmful, Class C the least harmful	Five schedules (I to V): based on abuse, dependence and medical use	Two schedules: I for drugs with unacceptable health risk; II for negligible risk drugs	Five lists; list I is narcotics with no medical use; list V is drugs that lie outside international conventions
Different penalties for Classes	Yes	Yes	Yes	No
Punishment scales	Maximum penalties depend on the nature of the offence (supply or possession)	Maximum penalties depend on amount of drug possessed. Different penalties in different States. Penalties increase with the number of offences	Maximum penalties depend on amount of drug possessed. Penalties increase with the number of offences	Maximum penalties depend on the amount of drug possessed
Maximum imprisonment for possession	Up to 7 years for Class A drugs	Up to life for large quantities	Up to 2 years	Up to 10 years for large quantities
Treatment regime	Opportunities for offenders to take treatment rather than fines or cautions	Drug courts recommend treatment regimes rather than prison sentences	Can be enforced for addicts with drug crime history	Mandatory for offenders who are a danger to themselves or society
Use of scientific evidence in policy making?	Evidence on medical and social harm, punishment and treatment may be considered.	Large budget for research. Specific scientific criteria for scheduling drugs	Government commissions research into drug harm and facilitates meetings between scientists and policy makers	Scientific evidence on treatment is used, but not on drug harm
Drugs in top class/schedule/list identified as a policy concern	cocaine ecstasy	crack methamphetamine	cocaine	heroin amphetamines
% population using any drug in the last 12 months	12.2	14.5	5 (for cannabis alone)[22]	10.2
Education	National Curriculum guidelines on teaching about drug issues	Government funded programme for drug free schools	No legal requirement to teach drug issues but there are state guidelines	All years in school have drug teaching; involves parents and pupils
Street price (US$ per gram; 2004)	• Cocaine – 0.97 • Cannabis – 4.40 • amphetamine – 14.70	• cocaine – 0.77 • cannabis – 11.40 • methamphetamine – 96.50	• cocaine – 0.50 • cannabis – 6.90 • amphetamine – 8.00	• cocaine – 0.86 • cannabis – 5.90 • amphetamine – 33.90

Source: RAND report

22 Figures for any drug use in the last 12 months are not available for the Netherlands.

3 Sources of advice

Advisory Council on the Misuse of Drugs

Role

19. The Advisory Council on the Misuse of Drugs (ACMD) was established by the Misuse of Drugs Act (MDA) 1971. It is a non-departmental public body (NDPB) and its terms of reference, as set out by the Act, are as follows:

> "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 aftercare 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."[23]

The Act also requires the ACMD to consider any matter relating to drug dependence, or the misuse of drugs, which may be referred to it by Ministers. The Home Secretary is obliged to consult the ACMD prior to making any amendments to the Regulations to the MDA (including changing the classification of any drug), although he is under no obligation to follow its advice.

20. The Government's evidence during this inquiry made clear the pivotal role played by the ACMD in the provision of scientific advice on drugs policy. The Government told us

that alternative sources of advice included "other published research, consultations with key stakeholders, and the advice and experiences of practitioners within the drugs field upon whom the issue of classification has a direct effect", but acknowledged the ACMD provided "the key advice on classification of drugs".[24] Furthermore, in oral evidence, the Home Office Minister, Vernon Coaker, repeatedly implied that the very fact that the Government sought advice from the ACMD ensured that its policy in this area was evidence based. **The Government's total reliance on the ACMD for provision of scientific advice on drugs policy gives the Council a critical role to play in ensuring that policy in this area is evidence based. It is, therefore, vital that the Council is fit for purpose and functioning effectively.**

Agenda

21. The Government memorandum stated that there were two ways in which the ACMD's agenda was determined: "Firstly, the ACMD is statutorily obliged to consider any relevant issue referred to them by the Government […] Secondly, the ACMD is at liberty to set its own agenda (in addition to any tasks requested of it by Government) in response to the concerns or issues it is made aware of, either through the professional experience of its members or any other means".[25] Evidence submitted to this inquiry revealed a perception that the ACMD tended to operate primarily in reactive mode. Transform Drug Policy Foundation was of the view that the ACMD was "essentially a reactive body—the Minister dictates its agenda and the scope and remit of its inquiries".[26] We put this point to the Chairman of the ACMD, who vigorously disagreed, telling us that "approximately 40% of the Council's work is initiated by the Council".[27]

22. We also heard conflicting accounts regarding the remit of the ACMD. Transform Drug Policy Foundation asserted that because the ACMD operates as part of the Misuse of Drugs Act 1971, "it can make recommendations for minor tweaks to the policy of prohibition but cannot challenge its basic tenets".[28] Lesley King-Lewis, Chief Executive of Action on Addiction, was also under the impression that "prevention does not come within the remit of the ACMD or the Drugs Misuse Act".[29] This was refuted by Martin Barnes, Chief Executive of DrugScope and a member of the ACMD. In addition, the ACMD told us that some of the work carried out by its Prevention Working Group addressed primary prevention.[30,31] **The apparent confusion in the drug policy community over the remit of the ACMD suggests that the Council needs to give more attention to communicating with its external stakeholders.**

24 Ev 55

25 As above

26 Ev 65

27 Ev 105

28 Ev 65

29 Q 459

30 As above

31 Ev 95

Consideration of harm

23. The ACMD is required to examine harm associated with the drugs that it considers but, as DrugScope pointed out, there is no definition of harm provided in the Misuse of Drugs Act 1971.[32] In addition, some have argued that the debate around harm too frequently focuses on the inherent harmfulness of the drug itself, rather than on the wider question of harm associated with misuse of the drug. For example, the risk of HIV or hepatitis infection is linked to drug injecting, as opposed to the abuse of a specific drug. Similarly, criminal behaviour may be driven by the need to maintain a supply of drugs to feed an addiction rather than to the misuse of any particular drug.

24. We were surprised to discover a marked divergence of views between the then Home Secretary and the Chairman of the ACMD on the extent to which consideration of social harm fell within the Council's remit. During exchanges following his statement on the classification of cannabis on 19 January 2006, the then Home Secretary Charles Clarke repeatedly asserted that "clinical, medical harm is the advisory council's predominant consideration".[33] Andy Hayman, Chairman of the Association of Chief Police Officers (ACPO) Drugs Committee and member of the ACMD, reinforced this view, telling us: "What is directing what classification a drug goes into is the scientific and medical harm. It has no relationship with the crime that might be associated with it".[34] However, in evidence to this inquiry, Sir Michael Rawlins, Chairman of the Council, directly contradicted this, telling us that social harms (including association with crime) were given "equal weight" in the ACMD's deliberations.[35] **The fact that the Chairman of the ACMD and the Home Secretary have publicly expressed contradictory views about the remit of the Council is perturbing.** Home Office Minister Vernon Coaker's attempts to reconcile these diametrically opposed positions in evidence to us were not entirely successful but the Minister at least appeared to recognise that social harm should be taken into account by the Council in developing its recommendations.[36] **The ACMD must look at social harm in its considerations—it is impossible to assess accurately the harm associated with a drug without taking into account the social dimensions of harm arising from its misuse.** We address specifically the apparent misunderstanding on the part of the ACPO representative in the section on the role of ACPO (paragraphs 35-37).

Cross-departmental remit

25. The terms of reference of the ACMD enable it to provide advice to any Minister, not just the Home Secretary. In practice, this facility appears to have been little used. Sir Michael Rawlins told us: "I do not think in my time in office we have been approached by other Government ministers outside the Home Office. The Act would allow any secretary of state to ask for our views, but that has not happened".[37] Sir Michael nevertheless argued that the Council had "very close relationships with the Department of Health" and

32 Ev 91

33 HC Deb, 19 Jan 2006, col 988

34 Q 388

35 Q 260

36 Qq 1241-45

37 Q 137

"relations" with the Department for Education and Skills, Department of Trade and Industry and the police.[38] Officials from the Department of Health and Department for Education and Skills, as well as the devolved administrations and any other relevant agencies, are represented at meetings of the Council and its sub-committees as observers and/or advisers.[39]

26. The importance of effective coordination between departments in this policy area is underlined by the fact that responsibility for delivery of the Public Service Agreement Targets associated with the Government's Drug Strategy straddles three departments: the Home Office, Department of Health and Department for Education and Skills. The relevant Targets are as follows:

i. To reduce the harm caused by illegal drugs […] including substantially increasing the number of drug misusing offenders entering treatment through the Criminal Justice System.

ii. To increase the participation of problem drug users in drug treatment programmes by 100% by 2008 and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

iii. To reduce the use of Class A drugs and the frequent use of any illicit drug among all young people under the age of 25, especially by the most vulnerable young people.[40]

The Home Secretary is charged with taking the lead on Target 1, the Secretary of State for Health has lead responsibility for Target 2 and the Secretary of State for Education and Skills leads on the delivery of Target 3.[41] Clearly, delivery of each of these Targets requires a sound knowledge and understanding of the relevant evidence base and access to authoritative scientific advice. It is, therefore, a serious concern that the ACMD devotes the vast majority of its time and resources to providing advice to the Home Office. We further emphasise the importance of an evidence based approach to drugs education in paragraphs104–105.

27. **We acknowledge that some provision has been made to enable departments other than the Home Office to benefit from the ACMD's expertise but the current levels of coordination appear to be entirely inadequate.** The division of responsibility for delivery of the Government's PSA targets on drugs policy between the Departments of Health and for Education and Skills and the Home Office highlights both the fact that all three have key roles to play, and the need for robust and effective links between these departments at Ministerial level. **The ACMD must be much more proactive in ensuring that it provides and promotes scientific advice to underpin drugs policy in the Department for Education and Skills and Department for Health.**

38 Q 137

39 Ev 54

40 HM Treasury, *2004 Spending Review Public Service Agreements 2005–2008* , 12 July 2004

41 www.drugs.gov.uk/drug-strategy/psa-targets/

Membership

28. The Government memorandum lays out the criteria governing appointments to the ACMD:

> "Members of the ACMD, of whom there should be not less than 20, are appointed by the Secretary of State for a term of 3 years and in accordance with the guidance issued by the Office of the Commissioner for Public Appointments. Nominations come from a wide range of sources including relevant professional bodies, Public Appointments Unit of the Cabinet Office and self-nomination. Under the terms of the MDA 1971 the ACMD is required to include representatives of the practices of medicine, dentistry, veterinary medicine and pharmacy, the pharmaceutical industry, and chemistry (other than pharmaceutical chemistry); and members who have a wide and relevant experience of social problems connected with the misuse of drugs."[42]

Sir Michael told us that, beyond this, "Successive Home Secretaries have permitted me, as chairman, to identify those areas in which I consider the Council needs expertise".[43] The shortlisting process and interviews for candidates are chaired by the ACMD Chairman. A Home Office representative and independent assessor approved by the Public Appointments Commissioner participate throughout, but are not required to have a scientific background or technical expertise in drugs policy. Of the 38 current members of the ACMD, 17 have professional expertise in a science subject.[44] Scientists and other experts may also be co-opted onto ACMD sub-committees as necessary.

29. Several of the witnesses queried the balance of expertise on the Council, with particular concern being expressed over the composition of the Council during its considerations of cannabis in 2001–2 and 2005. The campaigning organisation Rethink argued that there was too much emphasis on professionals as opposed to service users: "To our knowledge, there is no-one with personal experience of using drug or mental health services involved in making cannabis policy. This seems a significant omission especially in the make-up of ACMD". [45] Rethink suggested that "Including people with mental illness and/or substance use problems on such bodies could help ensure that they are more in touch with current issues for people and that views are grounded in experience, rather than preconceived ideas".[46] Mary Brett, retired biology teacher and UK representative on the board of Europe Against Drugs (Eurad) said of the membership of the ACMD: "Where are the biologists, the neurologists […], the toxicologists […], or experts on psychosis and schizophrenia?". She also argued that there was a bias on the Council towards proponents of a more 'liberal' stance: "there is not a single member of an anti-drugs charity, […] one that advocates Prevention over Harm Reduction. Why? There is certainly a preponderance of the other viewpoint […] This committee lacks any sort of balance".[47]

42 Ev 54

43 Ev 107

44 Ev 106

45 Ev 74

46 As above

47 Not published

30. In response to these criticisms, Sir Michael told us: "I cannot answer the question as to either whether the membership is liberal or how other people would view it",[48] although he did say that the Council might benefit from having "a few younger people".[49] We note that the Government Chief Scientific Adviser's Guidelines on Scientific Analysis in Policy Making state that "Departments should ensure that their selection of advisers matches the nature of the issue and the breadth of judgement required and is sufficiently balanced to reflect the diversity of opinion amongst experts".[50] **We are not in a position to judge whether the current membership is appropriately balanced but emphasise the importance of having a diversity of views represented amongst the experts appointed to reflect the range of views typically held by experts in the wider community.** In light of the unusually large size of the Council, we would in any case oppose further expansion of the membership for fear of it becoming unwieldy and unmanageable. Instead, **the ACMD's current policy of co-opting experts onto working groups and sub-committees in order to expand access to specific areas of expertise seems eminently sensible.**

31. Although the Home Secretary is officially responsible for the appointment of members of the Council, the ACMD Chairman himself conceded that he plays a major role in advising the Minister on the selection of members. On the one hand, it is natural that the Minister should make use of the Chairman's expertise in determining the membership of the Council; on the other, it highlights the potential for the Chairman to exert a very powerful influence over the Council's composition. The presence of an independent assessor ensures that due process is followed during the appointment of individual members, but an independent assessor with no scientific expertise is unlikely to be in a position to make a judgement about the overall balance of scientific and technical expertise represented on the Council.

32. Caroline Flint, then Home Office Minister, told the House in June 2005: "Professor Sir Michael Rawlins was first appointed to the chair of the ACMD in October 1998 for a period of four years. His tenure was extended to a second term, which is due to expire in December 2005".[51] In fact, Sir Michael's term of office has now been extended until 30 September 2008, when he will have completed the maximum term allowed (ten years) under guidance from the Office of the Commissioner for Public Appointments. The Minister went on to say: "Sir Michael is an effective and respected chairman", as well as noting that he was also the Chair of the National Institute for Clinical Excellence.[52] We do not wish to dispute that Sir Michael has been an effective and respected Chairman but we are also not convinced that it is good practice for an individual to occupy such an influential position for such a long time. **We recommend that the term of office for the Chairman of the ACMD be limited to a maximum of five years.** After this, the individual should, if re-appointed, be permitted to continue to serve on the Council as an ordinary member up to the maximum of ten years.

48 Q 164

49 Q 158

50 Chief Scientific Adviser, Office of Science and Innovation, *Guidelines on Scientific Analysis in Policy Making*, October 2005, para 13

51 HC Deb, 7 Apr 2005, col 1781W

52 As above

33. We also note that communication between the Council and the Home Secretary is generally conducted through the Chairman. In our view, the interests of the Council would be better served by the introduction of safeguards to ensure that the Chair is not given inappropriate opportunity to exert his preferences, whether in terms of the appointment of members of the Council or in dealings with Ministers on behalf of the Council. In the final evidence session of the over-arching inquiry, Professor Sir David King, the Government Chief Scientific Adviser, made it clear that departmental Chief Scientific Advisers should be ensuring that advisory committees were adhering to the Code of Practice for Scientific Advisory Committees and included an appropriate balance of expertise.[53]

34. We will consider the functioning of scientific advisory committees in detail in the over-arching Report on the Government's handling of scientific advice, risk and evidence but, in keeping with the Government Chief Scientific Adviser's recommendation, **the Home Office Chief Scientific Adviser should be tasked with overseeing the appointment of members to the Council.** An example of a departmental Chief Scientific Adviser fulfilling a similar role is provided by the involvement of the Department for Environment, Food and Rural Affairs (DEFRA) CSA in overseeing the work of the Committee on Radioactive Waste Management—a DEFRA advisory Committee.[54] **We also recommend that the Chairman always be accompanied by another member of the Council—preferably the Chair of the Technical Committee or the relevant working group—in meetings with Ministers.** It should not be inferred from this that we believe the current Chairman to have acted improperly. We will return to the role of the Home Office Chief Scientific Adviser in paragraph 33.

Role of ACPO

35. ACPO has two seats on the ACMD, reflecting the key role played by the police in enforcing the Government's drug strategy. We were concerned to discover a distinct lack of clarity about their role on the Council. In oral evidence, Andy Hayman, Chair of the ACPO Drugs Committee and member of the ACMD, told us: "we have two seats on the ACMD and we will make a contribution to it" but suggested that his contribution did not carry the same weight as that of other Council members: "It has to be said that the input from the police is going to be very narrow compared with other colleagues on ACMD because the main rationale as to why something goes into a different classification is based on medical and scientific evidence, not necessarily on what the police would bring to the party".[55] Andy Hayman suggested that ACPO's role on the Council was essentially passive, arguing that it was not for the police to comment on the appropriateness of the classification of particular drugs: "We do not have a view on what classification is; that is not our job. It is for experts to determine what classification drugs go into and once that is then linked to legislation and police powers and priorities we would then implement that."[56]

53 HC 900-xii, (to be published in HC 900-II, Session 2005-06).

54 House of Lords, *Radioactive Waste Management: Government Response*, Second Report of the Select Committee on Science and Technology, Session 2004-05, HL Paper 89, para 22

55 Q 398

56 Q 390

36. By contrast, the Home Office has categorically stated on more than one occasion that it expects ACPO to play a full and active part in the ACMD's deliberations. The then Home Office Minister Paul Goggins, for example, said that "Two representatives of the Association of Chief Police Officers (ACPO) are full members of the Advisory Council on the Misuse of Drugs and contribute their expertise and knowledge of policing issues to the council".[57] In evidence to this inquiry, the Home Office Minister Vernon Coaker also told us: "You would expect and hope that the police are bringing that knowledge and experience of dealing with these issues to the committee. In my view, that would be why they are there: to bring that experience, knowledge and understanding to the committee".[58]

37. We have already highlighted the confusion over whether the ACMD should consider social harms alongside clinical and medical harm in its assessments. It is both worrying and perplexing that, in light of the assertion of the ACMD Chairman that the Council gives these two types of harm equal weight, the ACPO representative—a key member of the Council—should still be under the impression that this was not the case, despite having been on the Council since January 2002. It is also extremely regrettable that this apparent misunderstanding has caused the ACPO representatives on the Council to play a less than full part in proceedings. Professor Colin Blakemore, Chief Executive of the MRC and Professor of Physiology at the University of Oxford, correctly pointed out that the police were "in the best possible position" to provide evidence about the relationship between drug use and its social impact.[59] The police are also exceptionally well placed to gather data on, and bring to the Council's attention, trends such that should be informing the Council's work, such as the impact of a change in classification on crime. **There is no point ACPO having a seat on the ACMD if its representatives do not bring their expertise to bear on the problems under discussion. The ACPO representatives have as much relevant experience as do other practitioners and academics on the ACMD and they must play a full and active role in developing the ACMD's position. It is highly disconcerting that the Chair of the ACPO Drugs Committee appears to be labouring under a misapprehension about his role on the ACMD more than four years into his term of office.**

Role of Home Office

38. The ACMD has no staff or budget of its own and its secretariat comprises four staff from the Drug Legislation and Enforcement Unit of the Home Office's Drug Strategy Directorate. One argument in favour of this arrangement is that it ensures robust links between the Council and the Home Office, potentially strengthening the role played by the Council's input in policy development within the department. However, critics have suggested that this arrangement also has the potential to compromise the Council's independence. In oral evidence, Professor John Strang, Director of the National Addiction Centre and former member of the ACMD, expressed this very concern, suggesting to us that the ACMD was not sufficiently independent of the Home Office.[60] Whilst not

57 HC Deb, 8 Feb 2006, col 1275W

58 Q 1249

59 Q 400

60 Q 413

necessarily supporting Professor Strang's view, Mr Hayman, Chair of the ACPO Drugs Committee, did not enhance our confidence by saying he did "not have a clue what the secretariat [provided by] the Home Office does".[61] Although we see the merits of the current arrangement whereby the Home Office provides the secretariat to the ACMD, we acknowledge concerns that this may pose a risk to the independence of the Council. We also note that, in contravention of the Code of Practice for Scientific Advisory Committees, the Home Office secretariat does not possess any scientific or technical expertise of relevance to the ACMD's work.[62]

39. Whilst we fully recognise the importance of preserving the ACMD's independence, there must be mechanisms in place to allow the Home Office to ensure that the Council is functioning properly and providing advice of the highest quality. Rethink has called for "the advice given by Government-appointed bodies such as ACMD and Government policy to be regularly evaluated by external organisations".[63] Nevertheless, in response to a Parliamentary Question asking whether the Home Secretary would make provision for independent testing of the validity of the review process used by the ACMD, the then Home Office Minister Caroline Flint stated that the Government had "no intention" of doing so. Her explanation for this was that the Government "believe in the integrity of the council and its individual members, and are confident that the advice we receive from them is of the highest quality".[64] She also stated that she was "content that the range of professions, and levels of expertise on the ACMD is suitable".[65] **It is difficult to understand how the Government can be so confident in the composition and workings of the Council without having sought any expert or independent assessment, and disappointing that it takes such a dismissive view of the need to do so.**

40. The ACMD has a critical role to play in provision of advice underpinning a key strand of Government policy. There must be independent oversight of its workings. **We recommend that the Home Office commission independent reviews to examine the operation of the ACMD not less than every five years. The first such review should be commissioned as soon as possible to enable the outcome to feed into the current re-examination of the classification system. This review should also address the relationship between the Home Office and ACMD and whether the current secretariat arrangements are working in a satisfactory manner.** We will consider the broader issues relating to best practice in scrutinising the work of scientific advisory committees in our over-arching Report. In the meantime, we propose that the Home Office Chief Scientific Adviser take the lead in commissioning a review of the ACMD.

61 Q 415

62 Office of Science and Technology, *Code of Practice for Scientific Advisory Committees*, December 2001, para 38

63 Ev 74

64 HC Deb, 7 Apr 2005, col 1783W

65 HC Deb, 7 Apr 2005, col 1782W

4 Incorporation of advice into policy

41. As noted above, the ACMD makes recommendations to the Home Secretary regarding the appropriate classification for individual drugs but although the Minister must seek the Council's views prior to making any changes, he is under no obligation to implement its recommendations. In order to illustrate the way in which the Government has used the Council's advice in developing its policies, we examined the classification of three types of drugs—cannabis, magic mushrooms and amphetamines, including ecstasy and methylamphetamine. In each case, our primary interests were the processes used for, and the role of scientific advice and evidence in, decisions regarding classification.

Cannabis

42. Cannabis comes from *Cannabis sativa*, a plant which is found growing wild in many parts of the world and readily cultivated in the UK. The three main forms of cannabis are: resin, which is scraped and compressed from dried plants; herbal cannabis, comprising chopped dried leaves; and cannabis oil, made by percolating solvent through the resin.[66] Cannabis is mainly used as resin or in herbal form in the UK, with cannabis oil accounting for less than 1% of usage.[67] Herbal cannabis is available in two forms. 'Traditional' herbal cannabis imported from overseas comprises a mixture of leaf, flowering tops and seeds. 'Sinsemilla' is a higher potency preparation, either imported or home-grown, made from the flowering tops of unfertilised female cannabis plants.[68] The primary psychoactive agent in cannabis is delta 9-tetrahydrocannabinol (THC). Preparations of cannabis vary considerably in their potency and there may be wide variation between different plant varieties in the amount of THC that can be derived from them.

43. There has been a long running debate over the appropriate classification for cannabis. The ACMD recommended that cannabis should be reclassified from Class B to Class C as early as 1979, on the grounds that cannabis was less harmful than other drugs in Class B and police resources could be deployed more effectively.[69] This view was endorsed by the Runciman report in 2000.[70] In October 2001, the then Home Secretary David Blunkett asked the ACMD to provide advice on the appropriate classification for cannabis. In March 2002, the ACMD presented its report to the Home Secretary, recommending that all cannabis products be reclassified as Class C. The report made reference to concerns about a possible link between chronic use of cannabis and mental illness, but concluded that "no clear causal link has been demonstrated". It also acknowledged that "cannabis use can unquestionably worsen schizophrenia (and other mental illnesses) and lead to relapse in some patients". The report did not address possible increases in cannabis potency.[71] The

66 RAND Report, para 90

67 As above, para 2.1

68 ACMD, *Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971*, December 2005, para 2.2

69 RAND Report, para 98

70 Runciman Report

71 ACMD, *The Classification of Cannabis under the Misuse of Drugs Act 1971*, 2002

Government indicated that the recommendations of both the ACMD and the Home Affairs Committee had influenced its decision to support the reclassification of cannabis.[72]

44. Although the Home Office announced the decision to reclassify cannabis as Class C in July 2002, the change did not come into effect until January 2004. In the meantime, three new studies were published which examined the link between cannabis use and mental illness. The charity Rethink expressed concern about the time lag between the start of the ACMD review in 2001 and the implementation of reclassification in 2004: "In this period, a significant amount of new evidence emerged about cannabis and mental illness, but the cannabis decision was not revisited in the light of this".[73]

45. The weeks leading up to and following the implementation of reclassification saw a media maelstrom of reporting about cannabis. Many argued that the changes had caused widespread confusion about the legal status of cannabis and there were reports that this was being exacerbated by the fact that different approaches were being adopted by police in different areas.[74] Sir John Stevens, the then Metropolitan Police Commissioner, was quoted as saying: "We do need to clarify where we are in terms of drugs law", adding that junior officers in his force had told him they were "muddled" about the drug's status.[75] The Government defended its actions, saying that it had initiated a £1 million advertising campaign targeted at teenagers and later arguing that survey results indicated that the message had been widely understood by young people.[76, 77] However, the mental health charity Rethink criticised the fact that "the public health campaign that accompanied reclassification did not mention the possible mental health effects of cannabis, but instead concentrated solely on the physical health effects of use and its continued illegality".[78]

46. Moreover, Charles Clarke, who succeeded David Blunkett as Home Secretary in December 2004, deviated from the Government line and, in an implicit criticism of his predecessor's actions, said: "The thing that worries me most [about the decision to move cannabis to Class C] is confusion among the punters about what the legal status of cannabis is".[79] He also said he was "very worried" about emerging evidence suggesting a possible link between cannabis use and mental illness.[80] **Changes in drug policy, especially classification decisions, must be accompanied by a comprehensive information campaign. We recognise that the Government did undertake a campaign when the reclassification of cannabis came into effect but in view of the subsequent confusion, which was publicly acknowledged by the Home Secretary, we can only conclude that these efforts were insufficient.**

72 Home Office, *The Government Reply to the Third Report from the Home Affairs Committee, The Government's Drug Policy: Is it working?*, Cm 5573, July 2002, p 12

73 Ev 74

74 e.g. Law: Keep off the grass?, *The Independent*, 16 August 2004

75 Cloud of confusion over cannabis law, *The Daily Telegraph*, 23 January 2004

76 Home Office press notice 020/2004, 17 January 2004

77 Home Office press notice 183/2004, 17 May 2004

78 Ev 72

79 We misled public over downgrading cannabis, *The Times*, 5 January 2006

80 As above

47. In March 2005, Charles Clarke asked the ACMD to revisit the classification of cannabis, also asking for advice on the extent to which the potency of cannabis products had increased—a response to anecdotal evidence that higher potency cannabis was being used more frequently. The ACMD reported its findings to the Home Secretary in December 2005, making a number of recommendations but not advocating any change in the classification of cannabis. The Council found that although cannabis had "real and significant" effects on mental health, "the consumption of cannabis is neither a necessary, nor a sufficient, cause for the development of schizophrenia".[81] The Council was not able to reach a definitive conclusion on the extent to which the potency of cannabis products had increased in recent years but noted that material seized by law enforcement officers suggested that while the potency of 'traditional' herbal cannabis and cannabis resin had stayed the same, the average potency of the less widely used sinsemilla had more than doubled.[82] The Home Secretary accepted the ACMD's recommendations in full in January 2006, simultaneously launching a fundamental review of the classification system itself. **We recognise that the Home Secretary followed due process in asking the ACMD to review the classification of cannabis in response to concerns about the link between cannabis use and mental illness and perceptions that cannabis was becoming more potent. However, the timing of the second review against a backdrop of intense media hype and so soon after the change in cannabis classification had come into effect gave the impression that a media outcry was sufficient to trigger a review.**

48. The Government has argued that the reclassification of cannabis has had the desired effect, with arrests for cannabis possession falling by one third in the first year since re-classification, saving an estimated 199,000 police hours.[83] Furthermore, British Crime Survey data suggest that reclassification has not led to an increase in the use of cannabis: the use of cannabis in the general population (16–59 year olds) has remained stable since 1998 while cannabis use among young people (16–24 year olds) has gradually declined since 1998.[84]

49. Nonetheless, the decision remains controversial. The 2006 *World Drug Report* published by the UN Office on Drugs and Crime (UNODC) devoted particular attention to cannabis. The report stated that it was used by an estimated 162 million people at least once in 2004, equivalent to 4% of the global population aged 15–64, making it the world's most abused illicit drug. UNODC Director, Antonio Maria Costa, speaking at the launch of the report, made a number of comments, including the assertion that "Many countries have the drug problem they deserve", which were widely interpreted as criticism of the UK stance on cannabis. He also argued that "the harmful characteristics of cannabis are no longer that different from those of other plant-based drugs such as cocaine and heroin" and that "Policy reversals leave young people confused as to just how dangerous cannabis is".[85]

81 ACMD, *Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971*, December 2005, para 6.2-6.4

82 As above, letter from Sir Michael Rawlins to the Home Secretary

83 *Cannabis Reclassification*, Home Office press release, 28 January 2005

84 As above

85 *UN drugs chief sounds warning about Afghan opium production, cocaine consumption in Europe*, UNODC press release, 29 July 2006

50. Recent media reports have suggested that the Home Office is to drastically reduce the quantities of drugs that people can carry before the charge of possession is upgraded to the charge of possession with intent to supply. In evidence to this inquiry, Home Office Minister Vernon Coaker confirmed that the Government was reviewing this but said that no decisions had yet been taken regarding the limits to be set. According to The Guardian, the draft regulations would put the threshold for cannabis at 5g: "a sharp reversal from David Blunkett's decision 18 months ago to ensure that cannabis possession was normally to be dealt with by confiscation and an informal warning".[86] Jan Berry, Chair of the Police Federation, said in response: "The constant changes only add to public confusion".[87] **Having already caused confusion by failing to adequately communicate the implications of the reclassification of cannabis to the public, the Government must be careful that any additional changes to policy relating to cannabis do not further cloud the picture.**

Gateway theory

51. The 'gateway theory' refers to the concept that cannabis use in some way predisposes individuals—and is therefore a gateway—to subsequent use of 'harder' drugs. The theory is predicated on the observation that many users of Class A drugs have used cannabis before moving onto these drugs. Professor John Strang, Director of the National Addiction Centre, emphasised the importance of establishing whether the relationship between cannabis use and Class A drug use was causal. He told us: "It is a correct observation that people who are using heroin went through gates on the way to where they are now. The crucial question is: if you had had the power to stop them going through that gate would it have altered their subsequent journey?". He pointed out that "going to primary school is a gateway to being a heroin addict but you are not implying there is a causal relationship between the one and the other".

52. Professor Blakemore, MRC Chief Executive and Professor of Physiology at the University of Oxford, said he could not "think of a chemical or physiological basis" for a causal relationship. He also dismissed the idea that "If you are buying your first drug from a person who then tries to persuade you to use a 'better' one and a stronger one then there is a causal relationship which is determined by the supplier" on the grounds that "cannabis supply is, to a large extent, rather different from the supply of harder drugs". In addition, Professor Blakemore noted that in the Netherlands, while "the attitude to cannabis use is even more relaxed than it is in this country and […] cannabis use amongst the population is a little less than it is in this country", "hard drug use is about one third of the rate in this country".[88]

53. The ACMD considered the gateway theory in its 2002 report on cannabis. The report concluded that proving any causal relationship between cannabis use and later use of Class A drugs was "very difficult due to the many confounding factors that might also act as gateways", including the individual's personality and their environment and peer group.[89]

86 Revealed: how 10 joints could lead to 14 years for dealing, *The Guardian*, 7 June 2006

87 Plans to toughen drugs law 'only sow confusion', *The Times*, 8 June 2006

88 Q 435

89 ACMD, *The classification of cannabis under the Misuse of Drugs Act 1971*, 2002, para 4.6.1-4.6.3

The report also stated that "Even if the gateway theory is correct, it cannot be a very wide gate as the majority of cannabis users never move on to Class A drugs".[90] In addition, Sir Michael Rawlins, Chairman of the ACMD, commented in evidence to us that "the early use […] of nicotine and alcohol is a much wider gateway to subsequent misuse of drugs than cannabis or anything like that".[91] The RAND report also concluded that "the gateway theory has little evidence to support it despite copious research".[92] We note that recent results from animal models have suggested a possible biological mechanism for a gateway effect, at least in rats,[93] but in the course of this inquiry **we have found no conclusive evidence to support the gateway theory.**

Magic mushrooms

54. Magic mushrooms contain psilocin and psilocybin, naturally-occurring compounds with hallucinogenic properties. Psilocin and psilocybin were designated Class A drugs under the Misuse of Drugs Act 1971, apparently on account of their hallucinogenic properties. Psilocin is also listed under Schedule I, the highest level of prohibition, under the UN's Convention on Psychotropic Substances 1971.[94] Sir Michael Rawlins, Chairman of the ACMD, told us: "I have no idea what was going through the minds of the group who put it in Class A in 1970 and 1971 […]It is there because it is there".[95] The Home Office has admitted that it has never conducted any research into psilocin use and that there is "no clear evidence of a link between psilocin use and acquisitive or other crime".[96]

55. In the past a legal loophole meant that fresh magic mushrooms were not treated as controlled drugs, providing that they had not been 'prepared' (i.e. dried, packaged, cooked etc.). Section 21 of the Drugs Act 2005, which came into force on 18 July 2005, makes it an offence to import, export, produce, supply and possess with intent to supply magic mushrooms in any form.[97] Because the decision to place magic mushrooms in Class A was a clarification of the law rather than a reclassification decision, the Government was not obliged to seek the advice of the ACMD in the usual manner. Nevertheless, the Government told us that it "did write to the ACMD, and ask for its views on [its] proposals before the Drugs Bill was introduced". [98] The ACMD endorsed the move, telling us: "in March 2004 the Technical Committee heard that, over recent years, there had been a substantial increase in the number of retail outlets selling 'fresh' magic mushrooms. In fact HM Customs and Excise estimated the importation of 8,000–16,000 kgs during 2004".[99] However, the ACMD did not conduct a full review of the evidence in arriving at its decision. **The Government's use of a clarification of the law to put fresh magic**

90 As above, para 4.6.2

91 Q 128

92 RAND Report, Executive Summary

93 Ellgren M., Spano S.M. and Hurd Y.L., Adolescent cannabis exposure alters opiate intake and opioid limbic neuronal populations in adult rats, *Journal of Neuropsychopharmacology*, doi:10.1038/sj.npp.1301127,July 2006

94 RAND Report, para 137

95 Qq 223-24

96 HC Deb, 24 Jan 2005, col 130W

97 Ev 56

98 As above

99 Ev 99

mushrooms in Class A contravened the spirit of the Misuse of Drugs Act and meant that the ACMD was not given the chance to consider the evidence properly before responding. We also note the admission by the Home Office Minister Paul Goggins that "the Home Office received no submissions in favour of the clarification of the law in respect of magic mushrooms prior to the Drugs Act 2005 being granted Royal Assent on seven April and four submissions against".[100]

56. In fact, we encountered a widespread view that the Class A status of magic mushrooms does not reflect the harms associated with their misuse. The RAND report concluded that the Government's decision "was not based on scientific evidence", noting that "the positioning of them in Class A does not seem to reflect any scientific evidence that they are of equivalent harm to other Class A drugs".[101] The RAND report pointed out that "National Statistics show that for deaths in which drug poisoning (listed on the death certificate) was the underlying cause of death, between 1993 and 2000 there was one death from magic mushrooms and 5,737 from heroin" and that "The lethal dose for humans is about one's own body weight in mushrooms".[102] Professor Blakemore was also of the view that "if one could look at all the evidence for harm available now, including social harms, one would say [the classification of magic mushrooms] is wrong".[103] The Government's own 'Talk to Frank' drug information website states that "Magic Mushrooms are not addictive in any way".[104] The drugs charity Release told us that "There was little transparency as to the reasoning behind this policy", describing it as "an unacceptable situation".[105] Paul Flynn MP was also of the view that "The policy appears to have been driven by something other than evidence" and warned that "other more dangerous mushrooms, not covered by the current law, could be substituted for those that are prohibited".[106] Recent press reports, and data from the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA), suggest that substitution with legal hallucinogens – including potentially lethal mushrooms of the Amanita family – is already happening.[107,108]

57. We were, therefore, surprised and disappointed to hear Sir Michael Rawlins, Chairman of the ACMD, tell us that "it was not a big issue" whether magic mushrooms were in the right Class. In Sir Michael's view: "there are bigger, more important issues to worry about than whether fresh mushrooms join the rest of the other things in Class A".[109] **The Chairman of the ACMD's attitude towards the decision to place magic mushrooms in Class A indicates a degree of complacency that can only serve to damage the reputation of the Council.** Martin Barnes, Chief Executive of DrugScope and a member of the

100 HC Deb, 20 Oct 2005, col 1144W

101 RAND Report

102 As above, para 136

103 Q 428

104 www.talktofrank.com

105 Ev 89

106 Ev 75

107 *Magic mushroom users turn to exotic alternatives to get high without breaking law*, The Independent, 30 May 2006

108 EMCDDA, *Hallucinogenic mushrooms: an emerging trend case study*, June 2006, p17

109 Q 255

ACMD, did not share Sir Michael's nonchalance. He told us that he was "not aware that the full council were asked to deliberate on this" and that "it was wrong for the Home Secretary to seek to enact [the change] in primary legislation without properly consulting the ACMD and giving it time to deliberate on it".[110] Mr Barnes was also of the view that "the evidence has indicated that [magic mushrooms are] in the wrong classification".[111] **The ACMD should have spoken out against the Government's proposal to place magic mushrooms in Class A. Its failure to do so has undermined its credibility and made it look as though it fully endorsed the Home Office's decision, despite the striking lack of evidence to suggest that the Class A status of magic mushrooms was merited on the basis of the harm associated with their misuse.**

Ecstasy and amphetamines

58. Amphetamines fall into Class A or B according to their method of preparation. Ecstasy or MDMA (3,4-methylenedioxymethamphetamine) is a so-called 'substituted amphetamine' and, along with the other substituted amphetamine MDA (3,4–methylenedioxyamphetamine), is a Class A drug. Amphetamine and its derivatives are collectively known as 'phenylamphetamines' and include methylamphetamine, also known as methamphetamine. Phenylamphetamines have common properties but can also differ in their effects. Amphetamines are classified in Class B if orally administered, but Class A if injected, on the grounds that intravenous administration produces a more pronounced effect and carries additional risks (e.g. through needle sharing).

59. Professor Nutt, Chairman of the ACMD Technical Committee, was adamant that it was appropriate to make this distinction for amphetamines because "The method of administration clearly determines the risk to the individual and to society".[112] However, Transform Drug Policy Foundation pointed out that "the classification system makes no distinction between coca leaf chewing and smoking crack, because they are both cocaine use", despite the fact that "coca chewing is low dose and slow release and is not associated with significant health harms".[113] When we asked the ACMD why this was the case, Professor Nutt told us: "That is a very good question" and reflected the fact that "We are not as sophisticated with cocaine in terms of the law as we are with amphetamines".[114] **We see the logic behind the differential classification of amphetamines depending on the method of administration but regret the fact that the same rationale has not been applied, where appropriate, to other drugs. We recommend that a consistent policy be developed as part of the forthcoming review of the classification system.**

Ecstasy

60. A number of commentators have called into question whether the Class A status of ecstasy is warranted on the basis of the harm caused by its misuse. The RAND report cited

110 Q 468

111 As above

112 Q 234

113 Ev 64

114 Qq 235-36

evidence suggesting that "ecstasy may be several thousand times less dangerous than heroin, although both are in Class A, as the percentage of deaths among users is very small and there is little evidence that ecstasy users exhibit withdrawal symptoms, with far more evidence suggesting there are no withdrawal symptoms".[115] It also noted that "Recent figures show that there were about 13.5 times more ecstasy users than heroin users in 2004, and deaths caused by ecstasy were around 3% of the number caused by heroin".[116] In oral evidence to this inquiry, Professor Colin Blakemore, MRC Chief Executive, told us that ecstasy was "at the bottom of the scale of harm" and "on the basis of present evidence […] should not be a Class A drug".[117]

61. According to DrugScope, the ACMD was not consulted prior to classification of ecstasy as a Class A drug in 1977 and the Government has resisted more recent calls to refer the matter to the ACMD.[118] David Blunkett, then Home Secretary, rejected the recommendation of both the Runciman report in 2000 and the Home Affairs Committee in 2002 that ecstasy should be reclassified from Class A to Class B, in the latter case on the grounds that reclassification would be "irresponsible".[119] The Government's response to the Runciman report stated: "In the absence of any clear recommendation from the Advisory Council to the contrary, the Government believes that ecstasy should remain a Class A drug", but Mr Blunkett subsequently refused to ask the ACMD to conduct a review of the evidence.[120,121] The Home Office Minister Vernon Coaker told us categorically in evidence to this inquiry that the Government still had "no plans" to refer the classification of ecstasy to the ACMD.[122]

62. What is perhaps more surprising is that the ACMD has not "presented any recommendations on [ecstasy] to the Government of its own volition".[123] Sir Michael gave the following explanation for this in evidence to us: "The difficulty is it is one of these other areas where there is very little research done on it […] Frankly, I do not think we would get anywhere by a review at the present time. This may change. There may be better evidence that comes forward but it is vague and imprecise and I do not think we would get very far".[124] We are not convinced by this explanation and note that there is a substantial body of scientific literature on ecstasy, much of which has been published in recent years. **In view of the high-profile nature of the drug and its apparent widespread usage amongst certain groups, it is surprising and disappointing that the ACMD has never chosen to review the evidence for ecstasy's Class A status. This, in turn, highlights the lack of**

115 RAND Report, para 53

116 As above

117 Q 434

118 Ev 92

119 Home Office, *The Government Reply to the Third Report from the Home Affairs Committee, The Government's Drug Policy: Is it working?*, Cm 5573, July 2002, p 15

120 Home Affairs Committee, Second Special Report of Session 2000–01, *Government Response to the Police Foundation's Independent Inquiry into the Misuse of Drugs Act 1971*, HC 226, para 13

121 RAND Report, para 61

122 Q 1267

123 Ev 56

124 Q 257

clarity regarding the way the ACMD determines its work programme. We recommend that the ACMD carries out an urgent review of the classification of ecstasy.

Methylamphetamine

63. Methylamphetamine (also called methamphetamine) is a derivative of amphetamine which is both produced for medicinal purposes and manufactured illicitly. Methylamphetamine can be produced as a tablet, powder or in a crystalline form commonly known as 'ice'. The latter form tends to be extremely potent and, unlike other types of amphetamines, can be smoked in a similar way to crack cocaine.[125] In addition to the harms associated with methylamphetamine misuse, the toxic chemicals and risky procedures involved in the illicit manufacture of the drug can pose a danger to those who live in the vicinity of clandestine laboratories and to others who enter the premises, including law enforcement officers. Methylamphetamine is the most widely produced illicit synthetic drug in the world.[126]

64. The ACMD recently reviewed methylamphetamine following a request from the Home Office. The Council told us that the request had been prompted by a visit to the US, in late 2003, by the Permanent Secretary for Crime, Policing, Counter-Terrorism and Delivery at the Home Office.[127] We also heard on our visit to the US about the scale and severity of the problems associated with methylamphetamine abuse there. Most memorably, a senior officer from the New York Police Department told us that the highly potent crystalline form of methylamphetamine "makes crack cocaine look like a Hershey bar". According to the World Drug Report 2006, the US dismantles the largest number of methylamphetamine laboratories worldwide—17,199 in 2004 alone.[128]

65. The ACMD report found that methylamphetamine was nearly twice as potent as other amphetamines and although the majority of symptoms were the same as for other amphetamines, the level of dependence was higher and was reached more quickly. However, the ACMD concluded that "there does not appear to be evidence in the UK that [methylamphetamine] is present in the drugs scene to any appreciable extent" and "There does not, therefore, appear to be a firm foundation and rationale for reclassifying [methylamphetamine] under the Misuse of Drugs Act 1971, at least at the present time".[129] Furthermore, the ACMD suggested that "reclassification could have the unintended consequence of increasing interest in the drug amongst potential users".[130] Professor Nutt, Chair of the ACMD Technical Committee, made it clear in evidence to us that this was the driver for the Council's decision not to recommend a change in classification: "The reason I believe we did not recommend it at the time was mostly because there could be a perverse effect. If people saw methylamphetamine as a more dangerous drug, a more Class A amphetamine, we might well have begun to see importation".[131] We put this suggestion to

125 Q 257

126 ACMD, *Methylamphetamine review*, 2005, para 1.4

127 Ev 98

128 As above

129 ACMD, Methylamphetamine Review, November 2005, Executive Summary, para 9.1

130 ACMD, Methylamphetamine Review, November 2005, para 14.1

131 Q 237

experts and officials involved in drugs policy in the US, all of whom told us they were not aware of any evidence to support this view.

66. Sir Michael Rawlins, Chairman of the ACMD, acknowledged that in developing its position the Council had made "a judgment […] as to which would be the least damaging thing to do", but argued that it was a "misunderstanding" to think "that scientific advisory committees just make their decisions purely on the science".[132, 133] **The recommendation by the ACMD that methylamphetamine should stay in Class B because of the signal that reclassification might send to potential users has given us serious cause for concern. We recognise that the Council often has to make recommendations on the basis of weak or limited evidence, but invoking this non-scientific judgement call as the primary justification for its position has muddied the water with respect to its role.** The ACMD acknowledged that there was clear-cut evidence that the harmfulness of methylamphetamine misuse justified a Class A status.[134] It should therefore have conveyed this to the Home Secretary with the caveat that he should consider any unintended consequences of a change in classification. **It is highly regrettable that the ACMD took it upon itself to make what should have been a political judgement.**

67. The ACMD presented its recommendations on methylamphetamine to the Home Secretary in November 2005. He accepted their recommendations in full, but "given the nature of the drug, and the risk of the prevalence in the UK increasing", asked the ACMD to keep a "watching brief" and provide further advice in 12 months.[135] Following a flurry of media reports about the dangers of methylamphetamine and warnings from the UN, the ACMD decided to reconsider its position on methylamphetamine on 25 May 2006, just six months after the publication of its original advice. Further to these discussions the ACMD recommended to the Home Secretary "that methylamphetamine (and its salts) be re-classified as a Class A substance".[136] The Home Office Minister Vernon Coaker confirmed in evidence to us that the Government would be accepting this recommendation.[137]

68. The ACMD said in its letter to the Home Secretary that it was submitting further advice on methylamphetamine in advance of the 12 month deadline "because of the threat potentially posed by this substance".[138] The letter cited four main reasons for the change in recommendation. Firstly, "there are indications that the use of methylamphetamine is now starting to become more widespread"; secondly, "the police have become aware of the existence of a small number of illicit laboratories synthesising the substance"; thirdly, "over the past 6 to 9 months, there has been considerable media interest in the properties and use of methylamphetamine"; and fourthly, reclassification as a Class A drug would give police "powers to close down 'ice houses' as they currently do with 'crack houses'".[139] All of these

132 Q 239

133 Q 241

134 Q 237

135 Ev 56

136 Letter from ACMD to Home Secretary on Methylamphetamine, 5 June 2006, www.drugs.gov.uk/publication-search/acmd/ACMDFurtherMethylamphetamine

137 As above

138 As above

139 Letter from ACMD to Home Secretary on Methylamphetamine, 5 June 2006, www.drugs.gov.uk/publication-search/acmd/ACMDFurtherMethylamphetamine

could have been predicted and, indeed, were by various observers. **The ACMD's decision to revise its position and recommend that methylamphetamine become a Class A substance will be welcomed by many. However, the fact that the ACMD changed its mind so quickly makes it look like the Council either realised that it had made a mistake, or had succumbed to outside pressure.**

69. Overall, our examination of the processes used by the ACMD and Home Office to make, respectively, recommendations and decisions regarding the classification of drugs has revealed a disconcertingly *ad hoc* approach to determining when reviews should be undertaken and a worrying lack of transparency in how classification decisions are made. We address these concerns in the following Chapter.

5 Transparency

ACMD

70. Transparency is crucial to building confidence in scientific advice and policy making. This is recognised in the Code of Practice for Scientific Advisory Committees published by the Office of Science and Innovation, which states:

> "Committees should operate from a presumption of openness. The proceedings of the committee should be as open as is compatible with the requirements of confidentiality. […] The committee should maintain high levels of transparency during routine business."[140]

We have been impressed by the transparency and clarity of ACMD reports explaining the methodology and rationale underlying its recommendations on drug classification decisions. However, we received evidence to suggest that the Council was not complying with this guidance in other aspects of its operations. Transform Drug Policy Foundation, for example, told us: "The ACMD lacks transparency—Its deliberations are not open to the public, are unpublished and are unavailable for independent comment or scrutiny".[141]

71. The Code of Practice for Scientific Advisory Committees explicitly states that committees should publish meeting agendas and minutes and, "unless there are particular reasons to the contrary", supporting papers, none of which the ACMD currently does.[142] We asked the Chairman, Sir Michael Rawlins, why the Council did not publish minutes of its meetings. He told us that "anyone who asks would get a version of it" but warned that "there is sometimes material in the minutes that we would need to remove because they are based on intelligence that would not be appropriate in the public domain".[143] When pressed, Sir Michael conceded that "it would not be a major issue" to remove this information since it only amounted to "a couple of lines, that is all".[144] The ACMD provided to us, at our request, copies of the minutes of meetings of the full Council, Technical Committee and methylamphetamine working group on a confidential basis. Having reviewed these documents, **we do not accept that the majority of the Council's work requires the level of confidentiality currently being exercised. The ACMD should, in keeping with the Code of Practice for Scientific Advisory Committees, routinely publish the agendas and minutes for its meetings, removing as necessary any particularly sensitive information.**

72. In taking evidence on the terms of reference for the over-arching inquiry on the Government's handling of scientific advice, risk and evidence, we were struck by the extent to which the Food Standards Agency had placed transparency at the heart of its operations. We will address this topic more fully in the over-arching Report but were interested to

140 Office of Science and Technology, *Code of Practice for Scientific Advisory Committees*, December 2001, para 46

141 Ev 65

142 Office of Science and Technology, *Code of Practice for Scientific Advisory Committees*, December 2001, para 65

143 Q 165

144 Q 170

know, in view of the fact that the Food Standards Agency routinely holds board meetings in public, whether the ACMD ever held open meetings to enable the public to observe its deliberations. The Council told us that it had not and again invoked the argument that to do so would cause "a particular problem for ACMD because it is sometimes provided with police or enforcement agency intelligence which cannot be disclosed to the public (at the present time)".[145] The Council further argued that "Although it might appear to be possible to exclude the public from those agenda items that include sensitive material of this nature, members might wish to raise such matters during the discussion of other agenda items".[146] According to the Council, "Failure to do so could place the Council at a serious disadvantage and impair the quality of its advice".[147] **Holding open meetings where the public could witness the processes used by the ACMD in developing its recommendations could have enormous benefits in terms of strengthening public confidence in the scientific advisory process. We do not believe that the need for confidentiality in discussion of certain topics is an insurmountable obstacle to holding occasional, if not routine, meetings of this nature.**

73. The measures that we have proposed here to improve the openness of the ACMD are not radical – they simply reflect best practice, as outlined in the Code of Practice for Scientific Advisory Committees. **It is extremely disappointing that the Council has not taken any steps to increase the transparency of its operations and, moreover, that the Chairman displayed so little interest in improving the Council's approach** in evidence to us. It is incumbent upon the Chairman to ensure that the ACMD follows the spirit of openness prescribed by the Code of Practice.

Home Office

74. Advice from the ACMD forms just one input to decisions about classification taken by Ministers. It is inevitable that in this sensitive and high profile policy area, these decisions will be susceptible to influence by factors such as media pressure and perceptions of public opinion, as well as harm. Martin Barnes, Chief Executive of DrugScope and member of the ACMD, emphasised the importance of "the political context, the way the media covers these issues and the fact that when we deal with the issue of drugs and drugs policy it is very difficult on almost any level to have an informed, objective, evidence based discussion".[148] He argued that "politicians are nervous about drugs policy; they are nervous about being seen to make changes", citing the example of the reclassification of cannabis: "in terms of the system overall it is not that big [a change], but that was not the way it was reacted to politically or in the media".[149]

75. In view of the political sensitivities associated with policy making on topics relating to drug abuse, it is particularly important that Government decision making processes are as transparent as possible. Parents Against Lethal Addictive Drugs argued that this was not happening at present: "There is no transparency concerning which types of scientific and

145 Ev 108

146 As above

147 As above

148 Q 439

149 As above

non-scientific evidence have been considered relevant, how this has influenced policy making and how conflicting rights and responsibilities of stakeholders have been balanced during policy making".[150] As discussed in paragraph 81, the Home Office also has a tendency to see classification decisions as vehicles for 'sending signals' to the public. **We acknowledge that in this sensitive policy area scientific advice is just one input to decision making, The Home Office should be more transparent about the various factors influencing its decisions.**

The need for a systematic approach

76. We were also concerned by the evident lack of a systematic approach to determining when reviews of classifications were needed. As discussed in Chapter 4, we have been left with the impression that media responses have been influential in triggering at least one of the Home Secretary's referrals to the ACMD. It is perfectly reasonable for the Government to seek to take into account public opinion in determining its policy on classification, but in the absence of any research or empirical data on this subject, we can only assume that the Government is using the media response as a proxy. We tried to ask the Minister whether this was indeed the case, but did not find his response – "We are not driven by headlines; we are driven by what is best for the people that we seek to do our best for"—terribly illuminating.[151] **If the Government wishes to take into account public opinion in making its decisions about classification it should adopt a more empirical approach to assessing it. The Government's current approach is opaque and leaves itself open to the interpretation that reviews are being launched as knee-jerk responses to media storms.**

77. **More generally, we have identified a pressing need for both the Home Office and ACMD to institute a more systematic approach to reviewing the classification of individual drugs. We recommend that the Home Office and ACMD draw up a list of criteria to be taken into account in determining whether a review of a particular drug is required.** Ministers and the ACMD would still be free to exercise their judgement in deciding when reviews should be undertaken but would do so within a more transparent framework.

150 Ev 60

151 Q 1225

6 Evidence base for classification

Evidence for deterrent effect

78. The stated purpose of the classification system is to classify harmfulness so that the penalties for possession and trafficking are proportionate to the harm associated with a particular drug.[152] Although it is implicit in this policy that placing drugs in a higher Class has some kind of deterrent effect, we found little evidence to support this. Transform Drug Policy Foundation asserted that the ABC classification system was "based upon the false assumptions underlying historical prohibition of specific drugs".[153] Steve Rolles, information officer for Transform, also told us: "there is no research at all—not a single piece of research ever done by the Home Office that I am aware of—into the effectiveness of the classification system as a deterrent and the independent research that we do have—what little there is—suggests that at best it is a marginal impact on drug taking decisions".[154] The Home Office Minister Vernon Coaker was unable to provide us with any specific evidence to the contrary.

79. In oral evidence, Professor David Nutt, Chairman of the ACMD Technical Committee also said: "I think the evidence base for classification producing a deterrent is not strong",[155] while Andy Hayman, Chair of the ACPO Drugs Committee, told us: "I cannot envisage any user – a dependent user, that is – having any kind of thought as to whether it was a Class A, B or C drug they were consuming".[156] The Runciman report concluded that "such evidence as we have assembled about the current situation and the changes that have taken place in the last 30 years all point to the conclusion that the deterrent effect of the law has been very limited".[157] Charles Clarke, the then Home Secretary, appeared to acknowledge this problem in the exchanges following his statement regarding the classification of cannabis in January 2006. He said: "The key question is how best to reduce the use of cannabis. The subsidiary question is: what role does classification, as opposed to education, health and policing campaigns and so on, play in that?".[158] However, the mental health charity Rethink pointed out that even at a global level there was "very little knowledge […] on the relative effectiveness of legal status, drugs education and information campaigns on reducing usage levels".[159]

80. The penalties associated with classification can have serious consequences for users in terms of sentencing. As noted above, the classification system also plays a significant role in directing expenditure of the £1.5 billion that the Government spends annually on tackling drugs. **We have found no solid evidence to support the existence of a deterrent effect, despite the fact that it appears to underpin the Government's policy on classification.**

152 Q 109

153 Ev 58

154 Q 447

155 Q 130

156 Q 387

157 Runciman Report, para 4

158 HC Deb, 19 Jan 2006, col 994

159 Ev 71

In view of the importance of drugs policy and the amount spent on enforcing the penalties associated with the classification system, it is highly unsatisfactory that there is so little knowledge about the system's effectiveness.

Sending out signals

81. The lack of evidence of a deterrent effect is particularly significant in view of the Government's eagerness to use the classification system to 'send out signals'. As Lesley King-Lewis, Chief Executive of Action on Addiction, pointed out: "We do not even know if the public see that if a drug is in Class A is that more of a deterrent or is it actually an attraction?".[160] Nevertheless, the then Home Secretary cited as justification for the review of the classification system announced in January 2006 the fact that "Decisions on classification often address different or conflicting purposes, and too often send strong but confusing signals to users and others about the harms and consequences of using a particular drug".[161] Home Office Minister Vernon Coaker also insisted that although the purpose of classification was to "categorise drugs according to harm", it "does send out messages; it does send out signals to people, in a way which people understand".[162] Mr Coaker further posed the question: "is not part of any system with respect to drugs […] not only trying to send messages out to people who misuse drugs but also about trying to send messages out to people out there in the community?".[163]

82. Transform Drug Policy Foundation was of the view that "Criminal law is supposed to prevent crime, not 'send out' public health messages" and warned that it could backfire by "fostering distrust of police and public health messages amongst young people".[164] We are inclined to agree. **The Government's desire to use the Class of a particular drug to send out a signal to potential users or dealers does not sit comfortably with the claim that the primary objective of the classification system is to categorise drugs according to the comparative harm associated with their misuse. It is also incompatible with the Government's stated commitment to evidence based policy making since it has never undertaken research to establish the relationship between the Class of a drug and the signal sent out and there is, therefore, no evidence base on which to draw in making these policy decisions.**

Evidence base for classification decisions

Sources of evidence

83. The ACMD told us that it makes use of a variety of sources and types of evidence in its deliberations over control of substances under the MDA. These include:

- formal surveys undertaken for, or on behalf of, Government including the British Crime Survey, the Forensic Science Service statistics, general population surveys, school

160 Q 440

161 HC Deb, 19 Jan 2006, col 983

162 Q 1228

163 Q 1229

164 Ev 64

surveys as well as international/European surveys such as European School Survey Project on Alcohol and other drugs;

- the law enforcement agencies;
- voluntary sector organisations with concerns and responsibilities for those who misuse drugs;
- professional bodies;
- published and unpublished scientific literature;
- submissions from special interest groups and the general public.[165]

84. The ACMD told us that the evidence base available for making decisions about classification was often inadequate. For example, Sir Michael, ACMD Chairman, said of the decision to clarify the law resulting in fresh magic mushrooms being placed in Class A: "It may be better in B rather than A. The trouble is that the evidence now is so old. It all dates back to the 1960s and there was not very much evidence then".[166] On the matter of why psilocin, one of the hallucinogenic compounds found in magic mushrooms, was in Class A, Sir Michael told us: "it is there because it is there […] there have been very few publications on psilocin. It has hardly been investigated at all".[167] Nevertheless, as Martin Barnes, Chief Executive of DrugScope and a member of the ACMD also pointed out, when the ACMD has called for more investment in research, the Government has not always responded positively. He told us that the Government had taken two years to publish its response to the ACMD's *Hidden Harm* report which recommended more research into the issue of the effects of drug use amongst parents of young people, ultimately concluding "that we have enough research on that issue".[168]

85. Whilst physical harmfulness can usually be assessed on the basis of existing pharmacological, clinical and epidemiological literature, the ACMD warned that it could be more difficult to establish the dependence-producing potential of a substance on the basis of such sources. The ACMD further told us that evidence about social harms tended to be "the weakest data-set because of the inherent problems in gathering relevant information". For example, there is often little reliable evidence "about the quality and potency of material used by consumers, their pattern of consumption, and the social consequences of their use".[169] The ACMD explained that while "in some instances the Council has commissioned primary research into areas of particular significance", in other cases it "has had to rely on anecdotal evidence provided by individual Council members or others with expertise in the particular field".[170] We note that, despite the difficulties of conducting such research, there are a substantial number of publications focussing on social harms carried out under the auspices of bodies such as the National Addiction

165 Ev 96

166 Q 230

167 Q 224

168 Q 451

169 Ev 97

170 As above

Centre and EMCDDA. **If, as the ACMD Chairman indicated to us, the Council's work has been seriously hindered by the lack of evidence, the ACMD should have been far more vocal in pressing Ministers to ensure that more research was commissioned to fill the key gaps in the evidence base.**

UK investment in research

86. Charles Clarke, the then Home Secretary, stated in January 2006 following the announcement that he would be launching a review of the classification system: "I want to emphasise to the House the importance of evidence and research on this subject".[171] However, Professor Strang, Director of the National Addiction Centre, described UK expenditure on addiction research as "an embarrassment" which caused "people like myself and my colleagues [to] get lured away" to the US and Australia, where investment was "orders of magnitude greater".[172] Professor Blakemore confirmed this:

> "In 2003 to 2004 [the MRC] spent £2 million in total out of a £450 million budget on addiction research. The total budget of the three NIH [US National Institutes of Health] institutes that work in this area is $2.9 billion so even if one takes a conservative estimate of how much of that is actually devoted to addiction research it comes out to about five hundred times higher than in the UK—in other words about a hundred times more per head of the population."[173]

Professor Nutt, Chair of the ACMD Technical Committee, had previously estimated that there was a "1000 fold differential" between UK and US public expenditure on addiction research.[174]

87. Professor Strang emphasised that this had serious consequences for the UK: "The lack of policy related research severely handicaps the ACMD and it severely handicaps government's process of making decisions".[175] Indeed, Paul Flynn MP described Government policy decisions on illegal drugs as "largely evidence free".[176] The charity Rethink told us: "The government has singularly failed to commission [research] looking at the impact of cannabis on mental health. No major study so far on this issue has hence originated from the UK. This seems a significant failure on the part of the Government".[177] The observation that the UK does not invest sufficient amounts in research is not new. Authors of the Runciman report published in 2000 were similarly forthright about the UK's failure to invest in research and evaluation, saying: "we have been forcibly struck by the lack of research and the weakness of the information base about drug use in the UK […] Equally striking is the anomaly that the largest part of the drugs budget is spent on enforcement without the necessary resources being applied to the proper evaluation of its

171 HC Deb, 19 Jan 2006, col 996

172 Q 400

173 Q 417

174 Not published

175 Q 411

176 Ev 75

177 Ev 71

success or failure".[178] **UK investment in addiction research is woefully inadequate. The Government's failure to ensure that sufficient resources are devoted to building the evidence base to underpin drugs policy is at odds with its commitment to adopt an evidence based approach.** We were pleased to hear the Minister agree in evidence to us that addiction research was "something we should look at" and encourage him to do so as soon as possible.[179]

Monitoring and evaluation

88. In light of the weakness of the evidence base, it was disappointing to hear that opportunities were being missed to gather data to evaluate the effect of changes in drug-related policies. Professor John Strang, Director of the National Addiction Centre, told us: "we are ill informed about whether the changes [in drug classifications] have made [the situation] better or worse", particularly with respect to cannabis.[180] He argued that, although "the political process sometimes needs to make decisions with a pace that does not fit science and the gathering of evidence […] when a decision is made I would expect to know three years down the line had the trajectory carried on going up or had it taken off".[181] DrugScope cited another missed opportunity: "A case in point might be ketamine, controlled in January 2006 as a Class C drug, but with no prevalence data against which to track the impact of control".[182] **The Government has been remiss in failing to conduct a proper evaluation of the impact of its policy decisions in this area and has, as a result, missed out on opportunities to gather valuable data to improve policy making in the future.**

Role of ACMD

89. The then Home Office Minister Caroline Flint stated in response to a question asking what research had been promoted by the ACMD in recent years that the Council "does not actively promote any external research" but "does commission its own research".[183] Professor Nutt, Chairman of the ACMD Technical Committee told us, however, that the Council did "not have the resources to do extensive novel research". Professor Nutt also suggested that one reason for the "mismatch between research needs in addiction and research outcomes" was the fact that "the ACMD is embedded in the Home Office and the Home Office does not have any particular representation at the MRC [Medical Research Council]".[184] When questioned on this, Sir Michael admitted that the Council had been "remiss" in not building better links with the Research Councils, telling us "we probably should and try to ensure that there are some formal channels of communication between the ACMD, the MRC and the ESRC [Economic and Social Research Council]".[185] The

178 Runciman Report, para 4

179 Q 1218

180 Q 376

181 Q 377

182 Ev 91

183 HC Deb, 24 Jun 2004, col 1503W

184 Q 172

185 Q 221

ACMD also told us that links with the Department of Health had been important in facilitating the promotion of research of relevance to drugs policy. We note that the proposed merger of the NHS research and MRC budgets provides an opportunity to strengthen these relations further.

90. The need to stimulate investment in research to support policy development has been a recurring theme in each of the case studies. We will therefore consider it in more detail in the over-arching Report on the Government's handling of scientific advice, risk and evidence. In respect of this case study, **it is essential that the ACMD and Home Office develop better relationships with the Research Councils, particularly the Medical Research Council and the Economic and Social Research Council, and further improve relations with the Department of Health. The fact that the Council has not devoted much effort to this in the past has been a contributing factor to the weakness of the UK evidence base on drugs policy and addiction.**

91. Finally, we note that Sir Michael argued strongly that we should take into account the fact that "This is an area in which it is extraordinarily difficult to do research", giving the example of the ethical and practical problems posed by volunteer studies involving ecstasy.[186] We do not dispute that research of that nature would present significant challenges but we also note that other methodologies have been successfully employed which do not entail such ethical difficulties. There are, for example, large numbers of publications based on observational studies of patterns of use among existing users, prospective studies of patterns of use or harm, policy change studies and clinical intervention studies. **We do not underestimate the challenges involved in undertaking scientific studies concerning the misuse of illegal drugs, but the Government must not use this as an excuse for not fulfilling its obligations to undertake proper evaluations of the impacts of its policies and to fund research for the public good.**

186 Q 242

7 A scientifically based scale of harm?

Assessment of harm

92. We were interested to find out the criteria used by the ACMD in making its assessments of harm. The ACMD told us that Professor Nutt and his colleagues on the ACMD Technical Committee had developed a risk assessment matrix to evaluate the harms associated with different drugs (see Table 3). Professor Nutt said: "The matrix was developed when I was working on the Runciman Report because it became quite clear that we did not have any systematic way of conceptualising the range of harms and any way of properly categorising them and rating them […] When I became a member of the ACMD and Chairman of the Technical Committee, we set in process this procedure of getting all the members of the Technical Committee to work through in a systematic way the drugs".[187] The Minister, referring to the matrix, told us: "We have a scientific basis for determining harm. The ACMD refer to that when they classify drugs".[188]

Table 3: ACMD Risk Assessment Matrix

Category	Parameter
Physical harm	Acute
	Chronic
	Parenteral
Dependence	Intensity of pleasure
	Psychological dependence
	Physical dependence
Social harms	Intoxication
	Other social harms
	Healthcare costs

93. Professor Colin Blakemore pointed out, however, that it was not trivial to "decide what weighting to give to the different criteria for harm". We asked the ACMD to explain how it determined the weighting given to harm in each domain. In response, the ACMD stated: "using [the ACMD Risk Assessment] matrix, and assigning a score to each parameter (0 = no risk; 1 = some risk; 2 = moderate risk; 3 = extreme risk), Professor Nutt and his colleagues have developed an overall harm rating. They have not, as yet, attempted to weight individual parameters".[189] **We welcome the initiative taken by the ACMD Technical Committee to develop a standard framework for the assessment of harm but**

187 Q 174

188 Q 1201

189 Ev 103, 104

we also note that determining harm scores using the matrix is almost as much an art as a science.

Current classifications

94. It is important to note that most of the current classifications of drugs were not decided on the basis of the risk assessment process described above. This is reflected in the conclusion drawn by the RAND report that "classification is not based upon a set of standards for harm caused by a drug; it varies depending on the drug in question".[190] DrugScope also told us: "there is no standard assessment tool or set of criteria of harm against which to match the different drugs".[191]

95. Although we have only examined a small number of drugs in any detail, we have identified a multitude of anomalies in decisions about their classification. Fresh magic mushrooms were placed in Class A despite the lack of evidence that this reflected the harms associated with their misuse. They were put there because the chemicals which they contain, psilocin and psilocybin, were already there, but there was also a lack of evidence to justify these chemicals being placed in Class A. By contrast, the ACMD argued that it could not review the Class A status of ecstasy because there was insufficient evidence. In addition, while on the one hand psilocin and psilocybin appear to be used rarely (if ever) as hallucinogens, the ACMD argued, on the other, against the movement of methylamphetamine to Class A on the grounds that there was no evidence of widespread usage. In the case of methylamphetamine, the ACMD also suggested that moving it to Class A could increase its appeal—an argument which if invoked more widely could be used to counter any proposal to move a drug to a higher Class. It is perhaps not surprising that Professor Colin Blakemore's view of the classification system was that "It is antiquated and reflects the prejudice and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical, consequences".[192]

96. Furthermore, a paper authored by experts including Professor Nutt, Chairman of the ACMD Technical Committee, which we have seen in draft form, found no statistically significant correlation between the Class of a drug and its harm score as calculated by leading experts using the so-called Delphi method.[193,194] Astonishingly, despite the fact that Professor Nutt is the lead author, the paper asserted that "The current classification system has evolved in an unsystematic way from somewhat arbitrary foundations with seemingly little scientific basis".[195] The paper also found that the boundaries between the Classes were entirely arbitrary and the authors argued that the rigid nature of the classification system made it difficult to move substances between Classes as new evidence emerged.

190 RAND Report, Executive Summary

191 Ev 91

192 Professor Colin Blakemore, *A Scientifically Based Scale of Harm for All Social Drugs, An Interdisciplinary Perspective on Alcohol and Other Recreational Drugs: Conference Proceedings*, The Beckley Foundation, 2003

193 Draft provided in confidence by Professor Nutt on behalf of the authors.

194 The Delphi Method generally involves a structured process for collecting and distilling knowledge from a group of experts using of a series of questionnaires interspersed with controlled opinion feedback.

195 As above

97. Considering the fact that the Chair of the ACMD Technical Committee had started drafting the paper proposing an alternative to the ABC system of classification more than 18 months ago, we were very surprised to hear from the Chairman of the ACMD that the Council had "never formally discussed the case for reviewing the classification system".[196] We were also taken aback by Sir Michael's assertion that the Council did not possess "the necessary expertise" to provide advice on alternative approaches to the classification of drugs. In addition, confidential information we have obtained makes us somewhat suspicious of the reasons behind the delay in submission of the paper authored by Professor Nutt and his colleagues for publication. **We understand that the ACMD operates within the framework set by the Misuse of Drugs Act 1971 but, bearing in mind that the Council is the sole scientific advisory body on drugs policy, we consider the Council's failure to alert the Home Secretary to the serious doubts about the basis and effectiveness of the classification system at an earlier stage a dereliction of its duty.**

Review of the classification system

98. On 19 January 2006, following his statement on the classification of cannabis, the then Home Secretary Charles Clarke announced that he was initiating a review of the ABC classification system:

> "The more that I have considered these matters, the more concerned I have become about the limitations of our current system. […] I will in the next few weeks publish a consultation paper with suggestions for a review of the drug classification system, on the basis of which I will make proposals in due course."[197]

The decision to review the classification system was supported by the ACMD and others. Sir Michael Rawlins told us in oral evidence: "I think it right that the Home Secretary is relooking at it".[198] Martin Barnes, Chief Executive of DrugScope and member of the ACMD, also told us: "I think the fact that the Home Secretary has announced a review is very welcome" and argued that the review should be as wide ranging as possible: "obviously the wider, the more clean slate it starts the better".[199] Mr Barnes further noted that this provided "an opportunity […] to address those issues of over the counter medicines but also the substances that are not currently classified that can be bought on Camden High Street or on the Internet".[200]

99. Professor Blakemore, Chief Executive of the MRC, indicated that he supported the decision to undertake a review, suggesting that "the driver for the review was quite clearly the time, effort, deliberation and conflicting advice that impinged on the decision not to re-classify cannabis, and the realisation that the arbitrary (and I would defend that word) boundary between B and C was not easily defensible". Professor Blakemore asked: "If it took so much effort to consider one particular drug and whether it should be placed on one

196 Ev 104

197 HC Deb, 19 Jan 2006, col 983

198 Q 115

199 Q 440

200 As above

side or other of a boundary, does it not imply that the entire mechanism for classifying requires a new look?".[201]

100. We too welcomed the announcement by the then Home Secretary that he would be reviewing the entire classification system. However, we became concerned that the promised "few weeks" between the announcement and the publication of the consultation turned into several months. Furthermore, following the ministerial changes at the Home Office, Vernon Coaker told us: "with respect to the consultation document which is in draft form in the department, the view is that we will need to wait until such time as we decide how to proceed with respect to the review of the classification system and also, similarly, wait for the report of this Committee – which we want to take into account in determining the best way forward".[202] **We urge the new Home Secretary to honour his predecessor's promise to conduct the review—our findings suggest that it is much needed. Although we are, of course, pleased that the Home Office is placing such store by our recommendations, the long delay in publishing the consultation paper on the review of the classification system has been unfortunate and should be rectified immediately.**

Relationship between classification and penalties

101. We were interested to hear that the police only use the classification system as a rough guide in carrying out their duties. Andy Hayman, Chair of the ACPO Drugs Committee, was of the view that the anomalies in the classification system did not matter, asking: "why should we get too hot under the collar about it?". He argued that a classification system was useful "to direct effort" in health services and policing but since the police could use their discretion in determining their responses, it was not a problem that the classification system was "pretty crude".[203] Jan Berry, Chair of the Police Federation, has also commented: "We have repeatedly said you do not need to change classification to change the way drug issues are policed. It's important that police officers have discretion to take account of all individual circumstances".[204] In addition, we heard in the US that the lack of a direct link between Schedules and penalties gave the police the freedom to focus resources as they saw fit. Nevertheless, Professor Blakemore warned that "If the placement of the drug in [a specific] category is only rough and if it is not particularly rationally assessed then the attitudes to society and the media and politicians are misplaced".[205]

102. **The dismissive tone adopted by the Chair of the ACPO Drugs Committee in giving evidence to this inquiry was disappointing, but his lack of concern over the classification system was also revealing.** We have already noted that the purpose of the classification system is to ensure that the penalties for possession and trafficking are proportionate to the harmfulness of the particular substance (paragraph 78). **The fact that the classification system is of such minor importance to the police suggests that it is not fit for purpose.** This being the case, it also seems surprising that so much effort was made

201 Q 393

202 Q 1205

203 Q 380-1

204 Plans to toughen drugs law 'only sow confusion', *The Times*, 8 June 2006

205 Q 386

to get the classification of cannabis 'right'. **We recommend that the Government make this *de facto* relationship more explicit and decouple the ranking of drugs on the basis of harm from the penalties for possession and trafficking.**

103. It would clearly be impractical to have a classification system directly linked to penalties in which the ranking of drugs changed frequently in response to new evidence. **Decoupling penalties and the harm ranking would permit a more sophisticated and scientific approach to assessing harm, and the development of a scale which could be highly responsive to changes in the evidence base.** It is beyond the scope of this inquiry to recommend an alternative approach to determining penalties but we note that possibilities could involve a greater emphasis on the link between misuse of the drug and criminal activity or make a clearer distinction between possession and supply. It should also be noted that while it is certainly possible—and desirable—to take a more evidence based approach to ranking drugs according to harm associated with their misuse, as highlighted in paragraph 93, caution needs to be exercised in viewing the scale as 'scientific' when the evidence base available is so limited and, therefore, a significant part of the ranking comes down to judgement calls.

Benefits of a more scientifically based scale of harm

104. The caveats about the limitations of the evidence base notwithstanding, **a more scientifically based scale of harm than the current system would undoubtedly be a valuable tool to inform policy making and education.** Charles Clarke, the then Home Secretary, pointed out that: "One of the biggest criticisms of the current classification system is that it does not illuminate debate and understanding among the young people who are affected by it".[206] Lesley King-Lewis, Chief Executive of Action on Addiction, also called for "a much more rational debate" which would inform "young people in particular, of the different levels of drugs and the different and varying harms that they can do to themselves".[207] Sir Michael Rawlins, ACMD Chair, agreed, saying: "Where I think we are all at fault, not just the ACMD but all of us are at fault, is not being better at explaining to young people particularly the dangers of drugs".[208]

105. Professor Nutt, Chair of the ACMD Technical Committee, argued that a more scientifically based scale of harm would be of value in this situation: "in education the message has to be evidence based. If it is not evidence based, the people you are talking to say it is rubbish".[209] The Runciman report also noted that "The evidence that we have collected on public attitudes shows that the public sees the health-related dangers of drugs as much more of a deterrent to use than their illegality", emphasising the importance of conveying health risks and harms as clearly and accurately as possible.[210] **It is vital that the Government's approach to drugs education is evidence based. A more scientifically based scale of harm would have greater credibility than the current system where the placing of drugs in particular categories is ultimately a political decision.**

206 HC Deb, 19 Jan 2006, col 992

207 Q 465

208 Q 167

209 Q 197

210 Runciman Report, para 8

Tobacco and alcohol

106. One of the most striking findings highlighted in the paper drafted by Professor Nutt and his colleagues was that fact that, on the basis of their assessment of harm, tobacco and alcohol would be ranked as more harmful than LSD and ecstasy (both Class A drugs).[211] The Runciman report also stated that, on the basis of harm, "alcohol would be classed as B bordering on A, while cigarettes would probably be in the borderline between B and C".[212] Various memoranda argued that the exclusion of tobacco and alcohol from the classification system was an anomaly. Transform Drug Policy Foundation told us: "It is this omission from the classification system that, perhaps more than any other, truly lays bare its fundamental lack of consistency, reasoning or evidence base" on the grounds that together tobacco and alcohol cause "approximately 40 times the total number of deaths from all illegal drugs combined".[213] **In our view, it would be unfeasible to expect a penalty-linked classification system to include tobacco and alcohol but there would be merit in including them in a more scientific scale, decoupled from penalties, to give the public a better sense of the relative harms involved.**

211 Draft provided in confidence by Professor Nutt on behalf of the authors.

212 Runciman Report, para 40

213 Ev 64

8 Conclusion

107. In this case study, which forms part of our broader inquiry into how the Government handles scientific advice, risk and evidence, we examined the role that scientific advice and evidence have played in the classification of illegal drugs. The classification system purports to rank drugs on the basis of harm associated with their misuse but we have found glaring anomalies in the classification system as it stands and a wide consensus that the current system is not fit for purpose. We were also concerned and disappointed by the attitudes of the ACMD and the police towards the classification system. In addition, we identified a pressing need for greater transparency, both in terms of the workings of the ACMD and the role that scientific evidence plays in informing the Home Secretary's decisions about classification. We have recommended that the Home Office put in place mechanisms for independent oversight of the ACMD and suggest that the departmental Chief Scientific Adviser is best placed to initiate this process.

108. The problems we have identified highlight the fact that the promised review of the classification system is much needed and we urge the Government to proceed with the consultation with further delay. We have proposed that the Government should develop a more scientifically based scale of harm, decoupled from penalties for possession and trafficking. In addition, we have argued that there is an urgent need for greater investment in research to underpin policy development in this area. We conclude that, in respect of this case study, the Government has largely failed to meet its commitment to evidence based policy making.

Conclusions and recommendations

Background

International comparisons

1. We conclude that the UN drug control treaties do not pose a major barrier to reform of the UK system of drug classification. (Paragraph 16)

Sources of advice

Advisory Council on the Misuse of Drugs

2. The Government's total reliance on the ACMD for provision of scientific advice on drugs policy gives the Council a critical role to play in ensuring that policy in this area is evidence based. It is, therefore, vital that the Council is fit for purpose and functioning effectively. (Paragraph 20)

3. The apparent confusion in the drug policy community over the remit of the ACMD suggests that the Council needs to give more attention to communicating with its external stakeholders. (Paragraph 22)

4. The fact that the Chairman of the ACMD and the Home Secretary have publicly expressed contradictory views about the remit of the Council is perturbing. (Paragraph 24)

5. The ACMD must look at social harm in its considerations—it is impossible to assess accurately the harm associated with a drug without taking into account the social dimensions of harm arising from its misuse. (Paragraph 24)

6. We acknowledge that some provision has been made to enable departments other than the Home Office to benefit from the ACMD's expertise but the current levels of coordination appear to be entirely inadequate. (Paragraph 27)

7. The ACMD must be much more proactive in ensuring that it provides and promotes scientific advice to underpin drugs policy in the Department for Education and Skills and Department for Health. (Paragraph 27)

8. We are not in a position to judge whether the current membership is appropriately balanced but emphasise the importance of having a diversity of views represented amongst the experts appointed to reflect the range of views typically held by experts in the wider community. (Paragraph 30)

9. The ACMD's current policy of co-opting experts onto working groups and sub-committees in order to expand access to specific areas of expertise seems eminently sensible. (Paragraph 30)

10. We recommend that the term of office for the Chairman of the ACMD be limited to a maximum of five years. (Paragraph 32)

11. The Home Office Chief Scientific Adviser should be tasked with overseeing the appointment of members to the Council. (Paragraph 34)

12. We also recommend that the Chairman always be accompanied by another member of the Council—preferably the Chair of the Technical Committee or the relevant working group—in meetings with Ministers. (Paragraph 34)

13. There is no point ACPO having a seat on the ACMD if its representatives do not bring their expertise to bear on the problems under discussion. The ACPO representatives have as much relevant experience as do other practitioners and academics on the ACMD and they must play a full and active role in developing the ACMD's position. It is highly disconcerting that the Chair of the ACPO Drugs Committee appears to be labouring under a misapprehension about his role on the ACMD more than four years into his term of office. (Paragraph 37)

14. It is difficult to understand how the Government can be so confident in the composition and workings of the Council without having sought any expert or independent assessment, and disappointing that it takes such a dismissive view of the need to do so. (Paragraph 39)

15. We recommend that the Home Office commission independent reviews to examine the operation of the ACMD not less than every five years. The first such review should be commissioned as soon as possible to enable the outcome to feed into the current re-examination of the classification system. This review should also address the relationship between the Home Office and ACMD and whether the current secretariat arrangements are working in a satisfactory manner. (Paragraph 40)

Incorporation of advice into policy

Cannabis

16. Changes in drug policy, especially classification decisions, must be accompanied by a comprehensive information campaign. We recognise that the Government did undertake a campaign when the reclassification of cannabis came into effect but in view of the subsequent confusion, which was publicly acknowledged by the Home Secretary, we can only conclude that these efforts were insufficient. (Paragraph 46)

17. We recognise that the Home Secretary followed due process in asking the ACMD to review the classification of cannabis in response to concerns about the link between cannabis use and mental illness and perceptions that cannabis was becoming more potent. However, the timing of the second review against a backdrop of intense media hype and so soon after the change in cannabis classification had come into effect gave the impression that a media outcry was sufficient to trigger a review. (Paragraph 47)

18. Having already caused confusion by failing to adequately communicate the implications of the reclassification of cannabis to the public, the Government must be careful that any additional changes to policy relating to cannabis do not further cloud the picture. (Paragraph 50)

19. We have found no conclusive evidence to support the gateway theory. (Paragraph 53)

Magic mushrooms

20. The Government's use of a clarification of the law to put fresh magic mushrooms in Class A contravened the spirit of the Misuse of Drugs Act and meant that the ACMD was not given the chance to consider the evidence properly before responding. (Paragraph 55)

21. The Chairman of the ACMD's attitude towards the decision to place magic mushrooms in Class A indicates a degree of complacency that can only serve to damage the reputation of the Council. (Paragraph 57)

22. The ACMD should have spoken out against the Government's proposal to place magic mushrooms in Class A. Its failure to do so has undermined its credibility and made it look as though it fully endorsed the Home Office's decision, despite the striking lack of evidence to suggest that the Class A status of magic mushrooms was merited on the basis of the harm associated with their misuse. (Paragraph 57)

Ecstacy and amphetamines

23. We see the logic behind the differential classification of amphetamines depending on the method of administration but regret the fact that the same rationale has not been applied, where appropriate, to other drugs. We recommend that a consistent policy be developed as part of the forthcoming review of the classification system. (Paragraph 59)

24. In view of the high-profile nature of the drug and its apparent widespread usage amongst certain groups, it is surprising and disappointing that the ACMD has never chosen to review the evidence for ecstasy's Class A status. This, in turn, highlights the lack of clarity regarding the way the ACMD determines its work programme. We recommend that the ACMD carries out an urgent review of the classification of ecstasy. (Paragraph 62)

25. The recommendation by the ACMD that methylamphetamine should stay in Class B because of the signal that reclassification might send to potential users has given us serious cause for concern. We recognise that the Council often has to make recommendations on the basis of weak or limited evidence, but invoking this non-scientific judgement call as the primary justification for its position has muddied the water with respect to its role. (Paragraph 66)

26. It is highly regrettable that the ACMD took it upon itself to make what should have been a political judgement. (Paragraph 66)

27. The ACMD's decision to revise its position and recommend that methylamphetamine become a Class A substance will be welcomed by many. However, the fact that the ACMD changed its mind so quickly makes it look like the Council either realised that it had made a mistake, or had succumbed to outside pressure. (Paragraph 68)

Transparency

ACMD

28. We do not accept that the majority of the Council's work requires the level of confidentiality currently being exercised. The ACMD should, in keeping with the Code of Practice for Scientific Advisory Committees, routinely publish the agendas and minutes for its meetings, removing as necessary any particularly sensitive information. (Paragraph 71)

29. Holding open meetings where the public could witness the processes used by the ACMD in developing its recommendations could have enormous benefits in terms of strengthening public confidence in the scientific advisory process. We do not believe that the need for confidentiality in discussion of certain topics is an insurmountable obstacle to holding occasional, if not routine, meetings of this nature. (Paragraph 72)

30. It is extremely disappointing that the Council has not taken any steps to increase the transparency of its operations and, moreover, that the Chairman displayed so little interest in improving the Council's approach. (Paragraph 73)

Home Office

31. We acknowledge that in this sensitive policy area scientific advice is just one input to decision making, The Home Office should be more transparent about the various factors influencing its decisions. (Paragraph 75)

The need for a systematic approach

32. If the Government wishes to take into account public opinion in making its decisions about classification it should adopt a more empirical approach to assessing it. The Government's current approach is opaque and leaves itself open to the interpretation that reviews are being launched as knee-jerk responses to media storms. (Paragraph 76)

33. More generally, we have identified a pressing need for both the Home Office and ACMD to institute a more systematic approach to reviewing the classification of individual drugs. We recommend that the Home Office and ACMD draw up a list of criteria to be taken into account in determining whether a review of a particular drug is required. (Paragraph 77)

Evidence base for classification

Evidence for deterrent effect

34. We have found no solid evidence to support the existence of a deterrent effect, despite the fact that it appears to underpin the Government's policy on classification. In view of the importance of drugs policy and the amount spent on enforcing the

penalties associated with the classification system, it is highly unsatisfactory that there is so little knowledge about the system's effectiveness. (Paragraph 80)

35. The Government's desire to use the Class of a particular drug to send out a signal to potential users or dealers does not sit comfortably with the claim that the primary objective of the classification system is to categorise drugs according to the comparative harm associated with their misuse. It is also incompatible with the Government's stated commitment to evidence based policy making since it has never undertaken research to establish the relationship between the Class of a drug and the signal sent out and there is, therefore, no evidence base on which to draw in making these policy decisions. (Paragraph 82)

Evidence base for classification decisions

36. If, as the ACMD Chairman indicated to us, the Council's work has been seriously hindered by the lack of evidence, the ACMD should have been far more vocal in pressing Ministers to ensure that more research was commissioned to fill the key gaps in the evidence base. (Paragraph 85)

UK investment in research

37. UK investment in addiction research is woefully inadequate. The Government's failure to ensure that sufficient resources are devoted to building the evidence base to underpin drugs policy is at odds with its commitment to adopt an evidence based approach. (Paragraph 87)

38. The Government has been remiss in failing to conduct a proper evaluation of the impact of its policy decisions in this area and has, as a result, missed out on opportunities to gather valuable data to improve policy making in the future. (Paragraph 88)

39. It is essential that the ACMD and Home Office develop better relationships with the Research Councils, particularly the Medical Research Council and the Economic and Social Research Council, and further improve relations with the Department of Health. The fact that the Council has not devoted much effort to this in the past has been a contributing factor to the weakness of the UK evidence base on drugs policy and addiction. (Paragraph 90)

40. We do not underestimate the challenges involved in undertaking scientific studies concerning the misuse of illegal drugs, but the Government must not use this as an excuse for not fulfilling its obligations to undertake proper evaluations of the impacts of its policies and to fund research for the public good. (Paragraph 91)

A scientifically based scale of harm?

Assessment of harm

41. We welcome the initiative taken by the ACMD Technical Committee to develop a standard framework for the assessment of harm but we also note that determining harm scores using the matrix is almost as much an art as a science. (Paragraph 93)

Current classifications

42. We understand that the ACMD operates within the framework set by the Misuse of Drugs Act 1971 but, bearing in mind that the Council is the sole scientific advisory body on drugs policy, we consider the Council's failure to alert the Home Secretary to the serious doubts about the basis and effectiveness of the classification system at an earlier stage a dereliction of its duty. (Paragraph 97)

Review of classification system

43. We urge the new Home Secretary to honour his predecessor's promise to conduct the review—our findings suggest that it is much needed. Although we are, of course, pleased that the Home Office is placing such store by our recommendations, the long delay in publishing the consultation paper on the review of the classification system has been unfortunate and should be rectified immediately. (Paragraph 100)

Relationship between classification and penalties

44. The dismissive tone adopted by the Chair of the ACPO Drugs Committee in giving evidence to this inquiry was disappointing, but his lack of concern over the classification system was also revealing. (Paragraph 102)

45. The fact that the classification system is of such minor importance to the police suggests that it is not fit for purpose. (Paragraph 102)

46. We recommend that the Government make this *de facto* relationship more explicit and decouple the ranking of drugs on the basis of harm from the penalties for possession and trafficking. (Paragraph 102)

47. Decoupling penalties and the harm ranking would permit a more sophisticated and scientific approach to assessing harm, and the development of a scale which could be highly responsive to changes in the evidence base. (Paragraph 103)

Benefits of a more scientifically based scale of harm

48. A more scientifically based scale of harm than the current system would undoubtedly be a valuable tool to inform policy making and education. (Paragraph 104)

49. It is vital that the Government's approach to drugs education is evidence based. A more scientifically based scale of harm would have greater credibility than the

current system where the placing of drugs in particular categories is ultimately a political decision. (Paragraph 105)

50. In our view, it would be unfeasible to expect a penalty-linked classification system to include tobacco and alcohol but there would be merit in including them in a more scientific scale, decoupled from penalties, to give the public a better sense of the relative harms involved. (Paragraph 106)

9 ANNEX: Membership of the ACMD

Professor Sir Michael Rawlins (Chairman)	Professor of Clinical Pharmacology, University of Newcastle upon Tyne
Dr Dima Abdulrahim	Briefings Manager, National Treatment Agency
Lord Victor Adebowale	Chief Executive, Turning Point
Mr Martin Barnes	Chief Executive, Drugscope
Dr Margaret Birtwistle	Specialist General Practitioner, Senior Tutor – Education and Training Unit, St. George's Hospital & Forensic Medical Examiner
Reverend Martin Blakebrough	Director, Kaleidoscope Drugs Project, Kingston upon Thames
Dr Cecilia Bottomley	Specialist Registrar in Obstetrics and Gynaecology
Ms Carmel Clancy	Principal Lecturer (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 & Service Director Substance Misuse, CNWL Mental Health Trust
Ms Dianne Draper	Public Health Policy Support Officer, Leeds
Mr Robert Eschle	School Teacher and Magistrate
Ms Vivienne Evans	Chief Executive, ADFAM
Professor C Robin Ganellin FRS	Emeritus Professor of Medicinal Chemistry
Dr Clare Gerada	General Practitioner, London; Primary Care lead for Drug Misuse
Mr Patrick Hargreaves	Adviser (Drugs and Alcohol), Durham County Council Education Department.
Mr Paul Hayes	Chief Executive, National Treatment Agency
Mr Andrew Hayman	Assistant Commissioner, Metropolitan Police, Chair of the Association of Chief Police Officers Drugs Committee
Mr Russell Hayton	Clinical Nurse Specialist & Clinical and Services Governance Manager, Plymouth Drug and Alcohol Action Team
Ms Caroline Healy	Director of Childline
Dr Matthew Hickman	Deputy Director, Centre for Research on Drugs & Health Behaviour, Senior Lecturer in Public Health
Mr Alan Hunter	Director – Law Regulatory & Intellectual Property and Secretary to the Association of British Pharmaceutical Industry.
Professor Leslie Iversen FRS	Professor of Pharmacology, University of Oxford

His Honour Judge Thomas Joseph	Resident Judge, Croydon Crown Court
Professor Michael Lewis	Professor of Oral Medicine, Cardiff University
Dr John Marsden	Research Psychologist, Institute of Psychiatry
Mr Peter Martin	Former Chief Executive, Addaction
Mrs Samantha Mortimer	Head of PSHE and Citizenship, St Paul's Catholic High School, Manchester
Professor David Nutt	Director of Psychopharmacology Unit, University of Bristol
Dr Richard Pates	Consultant Clinical Psychologist & Clinical Director Community Addiction Unit, Cardiff
Mr Trevor Pearce	Acting Director General, National Crime Squad
DCC Howard Roberts	Deputy Chief Constable, Nottinghamshire Police
Mrs Kay Roberts	Pharmacist, Glasgow
Dr Mary Rowlands	Consultant Psychiatrist in Substance Misuse, Exeter
Dr Polly Taylor	Veterinary Surgeon
Ms Monique Tomlinson	Freelance Consultant in Drug Misuse
Mr Arthur Wing	Assistant Chief Officer, Sussex Probation Area

Formal minutes

Tuesday 18 July 2006

Members present:

Mr Phil Willis, in the Chair

Adam Afriyie
Dr Evan Harris
Dr Brian Iddon

Draft Report, Drug classification: making a hash of it?, proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 108 read and agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 19 July at nine o'clock.

Witnesses

Wednesday 1 March 2006 **Page**

Wednesday 26 April 2006

Wednesday 14 June

Written evidence

Reports from the Science and Technology Committee

Session 2005–06

First Report	Meeting UK Energy and Climate Needs: The Role of Carbon Capture and Storage	HC 578–I
Second Report	Strategic Science Provision in English Universities: A Follow–up	HC 1011
Third Report	Research Council Support for Knowledge Transfer	HC 995–I
Fourth Report	Watching the Directives: Scientific Advice on the EU Physical Agents (Electromagnetic Fields) Directive	HC 1030
First Special Report	Forensic Science on Trial: Government Response to the Committee's Seventh Report of Session 2004–05	HC 427
Second Special Report	Strategic Science Provision in English Universities: Government Response to the Committee's Eighth Report of Session 2004–05	HC 428
Third Special Report	Meeting UK Energy and Climate Needs: The Role of Carbon Capture and Storage: Government Response to the Committee's First Report of Session 2005–06	HC 1036
Fourth Special Report	Strategic Science Provision in English Universities: A Follow-up: Government Response to the Committee's Second Report of Session 2005–06	HC 1382

Oral evidence

Taken before the Science and Technology Committee

on Wednesday 1 March 2006

Members present:

Mr Phil Willis, in the Chair

Adam Afriyie
Mr Jim Devine
Dr Evan Harris
Mr Robert Flello
Dr Brian Iddon
Margaret Moran
Mr Brooks Newmark
Bob Spink
Dr Desmond Turner

Witnesses: **Professor Sir Michael Rawlins,** Chairman of the Advisory Council, and **Professor David Nutt,** Member of the Advisory Council and Chairman of the Technical Committee, Advisory Council on the Misuse of Drugs, gave evidence.

Q107 Chairman: Good morning everybody, and could I make an especial welcome to Professor Sir Michael Rawlins and Professor David Nutt. You are very, very welcome this morning. Could I remind everyone that this session is being televised and, as with the *Big Brother* house, we want to make sure that all actions and words are commensurate with broadcasting licence agreements. This is the first case study in an over-arching inquiry into scientific evidence which the Government uses to inform policy. It is a particularly important area in terms of drug classification. I have to say that we are focusing specifically on the process and we are not making any judgments about drugs policy. We are very interested to make sure that the classification process is something that stands up to scrutiny. I shall start by asking our two eminent witnesses, beginning with you Sir Michael, to spend no more than one minute introducing themselves and say what their role is within their organisation.
Professor Sir Michael Rawlins: Thank you very much. I am Chairman of the Advisory Council on the Misuse of Drugs (the ACMD) and I am Professor of Clinical Pharmacology at the University of Newcastle. I have been Chairman of the ACMD since 1998 and I have been in Newcastle since 1973.

Q108 Chairman: Thank you very much indeed.
Professor Nutt: I am David Nutt. I am a psychopharmacologist at the University of Bristol. That means I am a medical doctor, a psychiatrist, who is interested in drugs and the brain. I have been Chair of the Technical Committee of the ACMD for the last five years and have a research track record in the field of drugs of addiction and mental processes. I spent two years working in the National Institute of Health in the States in the 1980s so I have some experience of the US system as well.

Q109 Chairman: Thank you very much indeed. I wonder if I could start by asking you, Professor Rawlins, what is the purpose of the ABC drug classification system that we have got at the moment?
Professor Sir Michael Rawlins: The purpose is to classify the harmfulness of drugs so that the penalties for possession and trafficking should be proportionate to the harmfulness of the particular substance.

Q110 Chairman: Harmfulness to whom?
Professor Sir Michael Rawlins: Harmfulness to the individual and harmfulness to society.

Q111 Chairman: Which is the balance between the two?
Professor Sir Michael Rawlins: We take both of them into account, both the individual and the individual's family and society, and one does not overrule the other.

Q112 Chairman: Do you feel you have been proactive in achieving that objective and that the ABC classification has done what it has set out to do?
Professor Sir Michael Rawlins: I think in terms of what it was intended to do, that is to say to try and make the penalties proportionate to the harmfulness of the substances that were being used or traded, yes. Of course, in the United Kingdom over the last 30 years the use of these substances has increased dramatically, not just in Britain but in most other countries as well, so in another sense one can say that we need more than that. I think one of the important things about drugs misuse is that it is not just a criminal justice problem, it is also a public health problem and one has to be certain that one is looking at it from both angles.

Q113 Chairman: We did not know when we started this inquiry what the priority of the Government is in terms of those two angles; public health and law enforcement.
Professor Sir Michael Rawlins: My view is that it is both a criminal justice problem and a public health problem, and a social problem as well.

Q114 Chairman: Yes, but when somebody like Professor Colin Blakemore, Chief Executive of the Medical Research Council, says this about the ABC classification system: "It is antiquated and reflects the prejudice and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical, consequences", this is a man who has got a certain reputation to uphold and he is saying really it is a bit of a waste of time.
Professor Sir Michael Rawlins: And he is a good friend of mine and a good friend of David's as well.

Q115 Chairman: So do you think it is a waste of time as well?
Professor Sir Michael Rawlins: No, I do not think it is a waste of time but I think it is right that the Home Secretary is relooking at it. There are various ways in which one could do this sort of thing. Different countries have different arrangements. The notion that the penalties for possession and supply should be proportionate, broadly speaking, to the harmfulness seems to me reasonable, but it does not necessarily have to be done that way, so I very much welcome the approach that the Home Secretary is taking, that he is reviewing it and is going to produce a consultation paper shortly. I am not sure how far away "shortly" is.

Q116 Chairman: What worries me here, and perhaps Professor Nutt you can comment on this as well, is that there does not seem to be a blind bit of evidence which your Committee uses to make any of the decisions on which you advise the Home Secretary. Indeed, Paul Flynn, the Minister responsible, one of our eminent MPs, described government policy decisions on illegal drugs as "largely evidence-free" in evidence to this Committee.
Professor Sir Michael Rawlins: I cannot answer for him but if you look at the way we examine the evidence, there is a lot of evidence that we are able to look at. It is not perfect by any manner or means. There are gaps and in some areas there are large gaps, but there is evidence and there is evidence that we can use.

Q117 Chairman: But have you then ever provided evidence to ministers which they have just disregarded?
Professor Sir Michael Rawlins: Not since I have been Chairman, no.

Q118 Chairman: Have you ever given them advice which they have disregarded?
Professor Sir Michael Rawlins: No.

Q119 Chairman: So in perfect harmony?
Professor Sir Michael Rawlins: In the past ministers have rejected the Council's advice but not during my tenure of office and David's.
Chairman: I will pass you on to my colleague.

Q120 Dr Iddon: Thank you, Chairman. Obviously the Home Secretary is looking at the reclassification of drugs at the moment. Was that an idea that came from your Committee? If not, where has the Home Secretary gained the idea that the present system needs looking at?
Professor Sir Michael Rawlins: Well, I think it is fair to say that I did have a discussion with him about it and I said that if he felt that he wished to re-examine the classification system the Council would welcome it.

Q121 Dr Iddon: Are you as a committee, Professor Rawlins, commissioning any research into this aspect?
Professor Sir Michael Rawlins: As to the question of the classification itself?

Q122 Dr Iddon: Yes.
Professor Sir Michael Rawlins: No, we are not. What we are doing is using the system that we are asked to use, and that is laid out in the Misuse of Drugs Act. We collect scientific evidence in relation to our responsibilities in that, but, no, we have not commissioned research into how one might classify them. I think that is a more appropriate thing to be done by the Government and the Home Office.

Q123 Dr Iddon: Because the classification is set out in the 1971 Misuse of Drugs Act, could I suggest that you are perhaps operating within a straitjacket and there is very little flexibility?
Professor Sir Michael Rawlins: There is some lack of flexibility and that is one of the reasons why we welcome the Home Secretary's decision to review the classification system and come out with a consultation paper.

Q124 Chairman: Why did you not suggest it?
Professor Sir Michael Rawlins: I did talk to him about it informally and I said if he felt that he wanted to do that it would be strongly supported by the Council.

Q125 Dr Iddon: Is it not a fact also that the United Nations Conventions—and there are more than one of them—severely constrain the debate anyhow because they lay out internationally how different countries classify drugs?
Professor Sir Michael Rawlins: Well, there is a wide range of ways in which the different countries do this and it is summarised quite nicely in the Runciman Report the various systems that are available, and I think it is a matter of what suits us rather than necessarily borrowing somebody else's, but obviously we can learn from their experience.

Q126 Dr Iddon: I agree that there are cultural aspects we have to take into consideration. Which countries would you advise the Government to look at in particular that might have different systems than ourselves?
Professor Sir Michael Rawlins: I am not an expert on the international dimension to this, but my advice would be to look at all the systems in developed countries in Europe and in North America and in Australia, look at their strengths and weaknesses, look at their own experience of it, and look at what

we ourselves need in this country, but I am not an expert in this area. Professor Nutt might have a comment.

Professor Nutt: I think we should look across a spectrum. Obviously we have in the past been very interested in the Dutch approach and, as shown in the RAND Report, the Swedish approach is almost diametrically opposite, and other European countries like Spain have gone through quite major changes in the way they regulate drugs in recent years, so there are lessons to be learnt there.

Q127 Chairman: Bearing in mind that alcohol probably kills directly or indirectly about 32,000 people a year, tobacco 130,000 people a year, and those deaths are far in excess of all the deaths caused by the use of all illicit drugs, why is your committee not enabled to look at tobacco and alcohol as well as all the other substances?

Professor Sir Michael Rawlins: I think the idea that we would control tobacco and alcohol in the form of the Misuse of Drugs Act (which would thereby render them illegal in terms of possession or supply) the Americans tried in this Prohibition days in the 1930s, and it was a disaster and just encouraged crime, and quite clearly it is not a practicable proposition.

Q128 Chairman: But, Professor Rawlins, that is exactly what has happened in terms of the drugs classification system. It is exactly what happened with the prohibition of alcohol in the States.

Professor Sir Michael Rawlins: I would not disagree with that. I think it is important that the Council does not exclude alcohol and nicotine entirely. One of the very important things the Council does—and it is nothing to do with classification—is it has a Prevention Working Group looking at prevention aspects of the misuse of drugs and its current programme, which is looking at the pathways to misuse of drugs by children and adolescents, is particularly also looking at nicotine and alcohol because we know that the early use—and Professor Nutt may want to talk about this—of nicotine and alcohol is a much wider gateway to subsequent misuse of drugs than cannabis or anything like that.

Professor Nutt: Yes, I think it is important for you to realise that we are aware of the harms of tobacco and alcohol and we do bear them in mind, both in terms of the issue, as Michael has said, of the gateway but also in terms of the interactions. There are some drugs which by themselves are not necessarily very dangerous or harmful but when used with alcohol can become very much so.

Q129 Dr Iddon: I am not asking for an ACMD view on this but a personal view. If you were to put alcohol and/or tobacco in one of the present classifications, bearing in mind the harm that they cause not only to individuals but also to society, which classes would you put them in?

Professor Sir Michael Rawlins: When the Runciman Committee looked at this it was very clear that alcohol was at the border of A and B and tobacco was at the border of B and C.

Q130 Dr Turner: Sir Michael, the point has already been made about the defects of prohibition and many senior police officers have told me that, in their view, the way in which we operate the Misuse of Drugs Act is actually counter-productive as far as dealing with drugs misuse is concerned, particularly with its emphasise on criminalising personal possession and use. Do you have a view on this?

Professor Sir Michael Rawlins: Yes, I think the question of possession versus trafficking is very much the criminal justice and the public health elements, and I think for possession the public health issue should be paramount, and I am particularly thinking of vulnerable sections of society. Professor Nutt is much more expert on this than me, but we are very conscious that people with schizophrenia may relapse very readily if they use cannabis, and that cannabis consumption amongst people with schizophrenia is extraordinarily high. The worst thing you can possibly do with somebody with schizophrenia is to send them to jail for two years or five years or any time, particularly in relation to something like possession of cannabis. It is totally inappropriate and I do not think that happens very much, but we want to be helping them not to use it rather than punishing them if they have a spliff in their pocket.

Professor Nutt: I have a lot of sympathy with your view. I think the evidence base for classification producing deterrence is not strong and we see that with a number of drugs.

Dr Turner: Do you agree that there is also a problem with the way in which we handle, for instance, heroin addicts in that the substitutes could be as bad if not worse than the primary product if they had access to a pure source?

Q131 Chairman: I would really like to move on if you do not mind, Des, on this. Could I just finalise with you, Sir Michael, you said you had an informal conversation with the Home Secretary so there has been no formal recommendation from your Committee that he should re-visit the classification at all?

Professor Sir Michael Rawlins: No.

Q132 Chairman: It was just an off-the-cuff conversation between yourself and the Home Secretary?

Professor Sir Michael Rawlins: It was.

Chairman: Margaret?

Q133 Margaret Moran: Can I pursue the issue of your work programme and how it is determined. What proportion of your work is in response to Home Office or government departments and what proportion is proactive from yourselves, and what processes do you use to decide what issues you will pursue proactively?

Professor Sir Michael Rawlins: I will start off and Professor Nutt will follow. I cannot give you a breakdown in quantitative terms. Occasionally it is the Home Secretary himself who asks us, but it has not happened very often. Sometimes it is officials in the Home Office who may propose things. Quite

often it is also intelligence that we gather through the Police or the Forensic Science Service that stimulates an inquiry or a serious examination, but David?

Professor Nutt: Yes, my Committee is called the Technical Committee and it incorporates individuals with an expertise and knowledge of drug toxicity but also people interested in the epidemiology, the natural history of drug use. In the last few years we have initiated reviews of drugs such as khat, based on, I suppose, public concern about sections of society being distorted by the use of khat. Ketamine was driven by concern from Customs & Excise about the very big increase in the importation of ketamine, which was certainly mislabelled as certain products. Basically we are reactive to social concerns, I suppose.

Q134 Margaret Moran: I do not think you clarified for me the exact process, so you are effectively saying there is an issue that comes from the media or from general public concern, and you think, "Okay, we should formulate that into an inquiry"?

Professor Nutt: That is what we have to do but we have also done other things. Systematically since I have been Chair of the Committee we have worked through two issues. One is how best to assess the harms and risks of drugs, and you have that report from Sir Michael in front of you. We have done that process; over a series of our meetings we have evaluated across the whole range almost every drug in the Act in a systematic way, given the current level of evidence. So we have set up a system where we can be proactive in terms of individual drugs and also we have reviewed the relative harms and risks of all the drugs.

Q135 Margaret Moran: That is my next question. Could you give us a couple of specific examples where you have come across something where you think policy practice needs to be changed?

Professor Nutt: I can give you a couple of good examples from the process that the Technical Committee has done. For instance, buprenorphine was Class C, and based on our harm assessment we thought it should be Class B. The same process was applied to cannabis back in 2002, where we thought it should go from Class B to Class C, so those are two examples of where we have used our expertise, applied the template of risk assessment and come up with what I think are quite sensible solutions, and from what we have seen at least one has been acted on.

Q136 Bob Spink: I just wondered how the ACMD actually assessed risk, what evidence it took, and how it did the work of collecting that evidence. For instance, on crystal methylamphetamine, did the ACMD go to see the devastating impact of that drug on society and individuals in Thailand or in America, and did it use the evidence that it gathered in that way, if indeed it did gather evidence in that way, in making its decision to hold it as a Class B drug rather than classifying it as an A?

Professor Sir Michael Rawlins: Can I in general terms answer on the approach we take. When we look into a particular area we usually set up a small working group. That small working group undertakes or usually commissions a systematic review of the public evidence, the chemical, the basic science and the social science evidence. That is supplemented by a search for unpublished material from all sorts of sources, not only from scientists we know are working in the field but through our national and international contacts, and then we interact with experts in the field, seeking their written evidence, seeking oral evidence from them and seeking their views on the systematic review and whether we have left anything out. That then forms the basis of a draft report which is looked at by the Technical Committee and then finally goes to the Council for further discussion and consideration and sometimes a bit of iteration between the Council and the Technical Committee. We have not paid visits to Thailand on the crystal meth business as a Council but Professor Nutt has visited.

Professor Nutt: The people we worked with to produce the scientific overview—Farrell and Marsden and colleagues—do research in Thailand on crystal meth, they are world experts on it, so we felt very comfortable with their expertise because they were part of our process.

Q137 Margaret Moran: Obviously your direct relationship is with the Home Office but how often are you consulted by other ministers or other departments or have a dialogue with them about some of the issues that need to be raised?

Professor Sir Michael Rawlins: I do not think in my time in office we have been approached by other government ministers outside the Home Office. The Act would allow any secretary of state to ask for our views, but that has not happened. We do have very close relationships with the Department of Health. That is obviously very, very important and during the time that I have been in the Chair our relations with the Department of Health have got better and better, and it is very collaborative and they are very, very supportive. We also have relations obviously with the Department for Education and Skills, to some extent with the Department of Trade and Industry, with the Foresight Programme in particular, and we obviously have relationships with the Police—ACPO, the Met, and so on.

Q138 Margaret Moran: When you say relationships, have you actively gone to discuss issues with ministers or representatives of those departments?

Professor Sir Michael Rawlins: Yes, ministers in the Department of Health have talked to me about misuse of drugs and the views of the Council in discussion. They have not referred a topic to us but we have had discussions about it, yes.

Q139 Margaret Moran: Just one quick one. When you are finalising your advice to ministers, for example anything about the reclassification of cannabis, how much has the opinion of that minister helped to form the final policy judgment?

Professor Sir Michael Rawlins: Not in the slightest. It is a very independent group. There is no way I could persuade them to put something in a report because the Home Secretary might like it. They are a very, very independent group. They would walk out of the room if I even thought about doing it.

Q140 Chairman: It is more likely if the *Daily Mail* wants it?
Professor Sir Michael Rawlins: Not the *Daily Mail*, sir!

Q141 Dr Harris: What is your relationship with the media and indeed other opposition politicians? I use the term other opposition politicians because clearly statements are made and demands are called for which influence ministers by these groups, and indeed opposition politicians, without the benefit of a formal relationship with you. Do you have any form of relationship with these groups so that you could let them know if some form of work is ongoing in particular spheres, particularly when they state something as fact which is not a fact? Do you do anything?
Professor Sir Michael Rawlins: No, to be honest.

Q142 Dr Harris: Do you think you should?
Professor Sir Michael Rawlins: Perhaps we should. Our role in the Act is to advise the secretaries of state, particularly the Home Secretary, but I think you are probably right, maybe we should talk more to parliamentarians and the opposition parties as well but we have not really done that in the past.
Professor Nutt: We did a presentation, to MPs a couple of years ago, I think you were present.

Q143 Dr Harris: The All-Party Group. If I am offered I pitch up but I think we are arguing for more than a meeting of an All-Party Group, to which I am sure you will be regularly invited. You just mentioned you did this thing on khat because of perceived public concern.
Professor Nutt: It was not just that.

Q144 Dr Harris: Did I mishear?
Professor Nutt: There was unquestionably public concern which came to us through people working in drug services but also through the Department of Health, which I believe had some ongoing research looking at the potential risks of khat use in certain communities.

Q145 Dr Harris: I do not know how you measure public concern. It is hard to measure. A good way is to talk to 2,000 people and ask them which of these they are most concerned about. Some form of large-scale survey is probably the best and only way. I do not know what you mean by public concern. Do you mean ministers saying we are concerned? Do you mean a newspaper headline?
Professor Nutt: I think it would be fair to say that we do try to be evidence-based. A simple newspaper headline would not drive us to do a major piece of work.

Q146 Dr Harris: Are you confident that what you have said was the basis of public concern about that particular substance was evidence-based or is that just your impression?
Professor Nutt: The concern was raised, as I say, through a number of sources—health sources, drug addiction workers—and based on that, and in parallel with ongoing research by the Department of Health, we did our report. I do not really quite understand what you are getting at.

Q147 Dr Harris: You said public concern and I am saying what is the evidence that there is broader public concern?
Professor Nutt: I was not talking about the general public, I suppose, so maybe I misunderstood you.

Q148 Chairman: You seem to be giving the impression—and I would not want the Committee to be unfair—that this is a very ad hoc sort of organisation, where there is a lack of transparency about where you get advice from. You have loose conversations with ministers which may or may not change policy. The *Daily Mail*, or some other organ, may exert undue influence. You may or may not have conversations with the Department for Education and Skills, even though drugs policy in schools is a massive issue. Are we being unfair here?
Professor Sir Michael Rawlins: Grossly unfair, yes. The way issues like this come through will be multiple routes and finding out about, for example, khat, which is used by a very small group of people, there is not a way in which one can have a routine mechanism for flagging up issues. Yes, I had the conversation with the Home Secretary, but that is about the only thing I can think of that I have ever talked to him in that way. We publish reports which are fully referenced and fully detailed. The methylamphetamine report and the khat report are all fully detailed with the sources of the evidence and the evidence base. As for being influenced by the *Daily Mail*, you have only got to read the *Daily Mail* and read what they say about me and Professor Nutt to realise we are not influenced by them.

Q149 Chairman: I am sure that will be reported tomorrow.
Professor Sir Michael Rawlins: I look forward to it.

Q150 Dr Harris: I want to ask you about this ability to do proactive work. You have not done Ecstasy—I could phrase that better!
Professor Sir Michael Rawlins: I know what you mean, Dr Harris!

Q151 Dr Harris: We are going to take ecstasy later in the question but the Runciman Report and these other reports stated clearly that they thought there was a case for reclassification, and indeed I think the Home Affairs Select Committee did as well. These were not trivial pieces of work. These were serious pieces of work, yet, remarkably, despite having the ability (although you have not been asked by the Government and in fact one might say because you have not been asked by the Government) and in the

face of these reports, you have not done a report following that up. That gives the appearance, would you not agree, that if ministers are not keen on something then you are not going to do it, even if other august bodies, who do not take perhaps as rigorous approach as you, have done it. It just seems odd.
Professor Sir Michael Rawlins: Yes, ecstasy was placed into Class A in 1977. Since that time—

Q152 Dr Harris: Without your being advised?
Professor Sir Michael Rawlins: 1977—that was when we were both medical students.

Q153 Dr Harris: Without the ACMD being advised?
Professor Sir Michael Rawlins: I do not know in 1977. I presume it was on the advice of the Council. I presume it would be then because the Act was already there. Since that time the amount of research on ecstasy is minute. There has hardly been any good scientific research at all on ecstasy. What has been done is a few animal studies and little bits of epidemiology on deaths which are very, very difficult to interpret and, frankly, if we keep on going back --- so there is no evidence base now to change the decision.

Q154 Bob Spink: Leah Betts' parents might challenge your assertion that there is no evidence base.
Professor Sir Michael Rawlins: There is no change in the evidence base; it is almost non-existent.

Q155 Dr Harris: So the limiting factor is not resources? You have enough resources to do proactive reviews?
Professor Sir Michael Rawlins: Absolutely.

Q156 Dr Harris: My last area of questioning is you said that you had said to ministers that if they were minded to look at the way the classification system worked then the ACMD would support that. Does that mean the ACMD discussed that?
Professor Sir Michael Rawlins: We did discuss it very briefly at the end of our meeting on cannabis.

Q157 Dr Harris: It is a bit peculiar because a lot of organisations do spend time thinking about it and in case they are asked by those who set their terms of reference, "It would be really good if the terms of reference could change . . . " they have a piece of work ready. Would you say that it is something that really ought to be done, that there ought to be serious consideration so that if someone says, "Shall we do this?" you can say, "Yes, and here is some work that we have done that would support the idea of a change from a rigid ABC"? Select committees do that. They are always looking at the way they work.
Professor Sir Michael Rawlins: Our terms of reference are independent of the classification system if you look at our terms of reference in the Act. This discussion came at the end of two days of very intense discussion on cannabis, and we had not actually discussed it previously and this was not a moment to start going into what might be, and anyway I think it is an issue that would be more appropriately done by Home Office officials and by government ministers and then followed by broad consultation. It was not appropriate at that stage, as I said, at the end of two days of very intense discussions to try and unpick it in any sense.
Chairman: I am going to try and change direction a little bit because I am very conscious of the need to move on. Des?

Q158 Dr Turner: Sir Michael, looking at the list of members of your Committee, there is quite an impressive breadth of expertise there and just about every stakeholder that I can think of that needs to be represented is there. Is this a function of your influence or is it decided by the Home Secretary? Who actually determines the membership?
Professor Sir Michael Rawlins: What happens now is that there is an advertisement to join, but I have also indicated that there are certain slots that we needed to have filled. We needed to have, for example, senior police officers. I was very keen on having a judge. I have been very anxious recently to have people with experience of teaching, particularly current, practical experience of teaching rather than, with great respect, directors of education, so real, actual working teachers. So I have influenced it and there has been no political suggestions at all as to the range of individuals. I have also been keen on trying to get a few younger people on it because most of us are my age or a bit younger, like Professor Nutt here, but we felt we needed some younger people who knew the culture and the environment rather better than fathers and grandfathers like me.

Q159 Dr Turner: Clearly your influence is very strong in this. The only thing of course is that although your minimum membership is 20, it has expanded to 38 members. Is it in danger of getting cumbersome?
Professor Sir Michael Rawlins: I would not want it to go any larger, but the breadth of expertise, knowledge and understanding is very important to the Council, and you will see from the membership that it includes very distinguished scientists who are Fellows of the Royal Society as well as people who have experience of looking after and helping individuals who misuse drugs, and their families, so it is a wide range, as you say.

Q160 Dr Turner: Of course one of the other facets of work of the Advisory Committee, or regulatory committees that we have come across before, is that sometimes decisions are not necessarily consistent because they depend on who is there on any given day, so out of your large membership what is the quorum, how many people are normally there, and do you take any steps to try and ensure consistency of approach?
Professor Sir Michael Rawlins: I think consistency is obviously something that I as Chairman and Professor Nutt as Chairman of the Technical Committee would want to make sure that we did not make inconsistent decisions. I quite agree with you,

that is very important. I cannot tell you what the average attendance is offhand but I can write to you afterwards and let you know, but it is 75% plus most of the time as far as I am conscious of it. There are a few critical people particularly on various discussions, but they all almost invariably attend and so it works reasonably well.

Q161 Bob Spink: And the quorum?
Professor Sir Michael Rawlins: Is seven.
Professor Nutt: I think the point you make is a very important one because when I joined the ACMD and took on the Chair of the Technical Committee, I was very exercised by the potential for random decision-making based on individuals being present or not. That is one of the reasons I have set up this system of a very systematic appraisal so that all drugs we appraise we do in the same way. We have the same parameters and we have the same process, where possible, of having a detailed up-to-date, scientific report, in order to try and even out some of the possible inconsistencies.

Q162 Bob Spink: Could I just come in here, Des. The ACMD is there to benefit society at large. What do you think society at large would think about the over-representation of liberal elements within the 38 people making up your body?
Professor Sir Michael Rawlins: People with liberal views towards drugs?

Q163 Chairman: It is an accusation that is often made against the Council that the Council has liberal views?
Professor Sir Michael Rawlins: By the *Daily Mail*.

Q164 Bob Spink: No, Chairman, could I just say that I am not talking about the *Daily Mail*, I am talking about the 90,000 people in Castle Point whom I am elected to represent, who take a very strong view about the liberal attitude towards the illegal use of drugs and the damage that it does to individuals and to society.
Professor Sir Michael Rawlins: I cannot answer the question as to either whether the membership is liberal or how other people would view it. We are basically a scientific advisory committee and we have to give advice on the basis of the science as we see it. I would hope that the 90,000 people you represent would understand, if they had the opportunity to sit there and listen, the reasons why we come to the conclusions that we do. I would accept that it is very difficult to produce in reports the flavour of the judgments that have to be made because although ACMD is a scientific body, all advisory scientific bodies have to make judgments, and those judgments are very difficult to explain in written words, but I would hope that if your constituents (some of them anyway) attended they would realise that the decisions we reached and the conclusions we reached were ones that they would understand why we reached them.

Q165 Bob Spink: It would perhaps help them to understand if the ACMD published the minutes of its meetings, for instance. Why do you not do that?
Professor Sir Michael Rawlins: We have not done it to date. Anyone who asks would get a version of it. There is sometimes material in the minutes that we would need to remove because they are based on intelligence that would not be appropriate in the public domain.

Q166 Bob Spink: Would my 90,000 constituents think it was perhaps a little loose that you had 38 members, that the membership of the your body was over-representative of the liberal attitude to drug-taking, and that you have a necessity of only seven people in a quorum to make decisions?
Professor Sir Michael Rawlins: Sorry, the quorum is laid out in our instruments and I do not think it has ever met with a small group like that. The other question was about the liberal elements. I do not know whether you would call them liberal or illiberal or whatever. What we have to do, though, is realise that over the last 30 years the use of drugs has dramatically increased in this country, and that the criminal justice system has not prevented that in any way.

Q167 Bob Spink: Nor has the ACMD.
Professor Sir Michael Rawlins: We do not know because we do not have a scientific basis to make that assessment, with great respect. We do not have a control trial of half the country with an ACMD and half the country without. We do not know what would have happened. All we do know is that in every Western society drug use has increased astronomically despite all sorts of different approaches. The Americans give 20 years minimum to life for a second offence of having cannabis in your pocket and that still has not made very much difference. Crack cocaine in America is widely used. Penalties and the criminal justice approach has not worked very well. It may have been worse if we had not got it. Where I think we are all at fault, not just the ACMD but all of us are at fault, is not being better at explaining to young people particularly the dangers of drugs.
Chairman: Which is what makes it even more surprising that there is not a stronger link between your organisation and the Department for Education and Skills.

Q168 Mr Flello: I just wanted to pick up on a point that was made. You have referred many times to the fact that it was a scientific committee and you are looking at the scientific base. With the greatest respect to the judges and senior police officers that are on there, do you feel you have got enough scientists?
Professor Sir Michael Rawlins: The Council itself is broadly based. The Technical Committee is much more focused on scientists, particularly clinical scientists and social scientists.

Q169 Mr Flello: How many scientists have you got on the Committee overall as a percentage?

Professor Sir Michael Rawlins: I will have to write to you with that. I have not got it on me.

Q170 Dr Turner: Coming back to the minutes, obviously if you did publish the minutes then any concerns that people have about the transparency of your operations would be greatly diminished. You said that you could not publish the full minutes because some of the information was not suitable for the public domain. The only circumstances I can think of for that is if it concerned specific individuals or named specific individuals. Is that the case? If so, can you not report it anonymously in the minutes?
Professor Sir Michael Rawlins: Yes, there are also some intelligence matters that would be inappropriate to be in the public domain, but it is a couple of lines, that is all. It would not be a major issue.
Chairman: Can I move on to you, Brooks.

Q171 Mr Newmark: An important part of everything that we are doing and that you are doing comes down to the evidence and hard evidence—and I will go into what I would define as hard evidence a bit later on. As a start, do you see the role of the ACMD to contribute to the evidence base or merely to review it?
Professor Sir Michael Rawlins: It is primarily to review the existing evidence base, although individual members professionally are involved in capturing information and data. Primarily we are there to examine the evidence that is available.

Q172 Mr Newmark: You are both intelligent individuals and you are clearly going to find gaps, I suspect, in that evidence. Do you have the power to commission any academic research or any study to fill that gap that you and your team might well identify?
Professor Sir Michael Rawlins: To some extent, yes.
Professor Nutt: We do not have the resources to do extensive novel research. I think the point you are hitting on is an important one and linking with organisations that might have those resources is, I think, something we should be looking to do. I am particularly concerned that the ACMD is embedded in the Home Office and the Home Office does not have any particular representation at the MRC. I have written to Colin Blakemore about that. Obviously the Department of Health has representation but the Home Office does not. I think that is a possible reason why there is a mismatch between research needs in addiction and research outcomes.

Q173 Mr Newmark: That is something you maybe could take away to your Committee and try and achieve that objective? It seems fairly common sense to me.
Professor Sir Michael Rawlins: We will also talk to Colin Blakemore about it and ESRC as well.

Q174 Mr Newmark: To Professor Nutt: when did you develop the risk assessment matrix and what role has it played in the ACMD's deliberations?
Professor Nutt: The matrix was developed when I was working on the Runciman Report because it became quite clear that we did not have any systematic way of conceptualising the range of harms and any way of properly categorising them and rating them, so that was very much a pilot. When I became a member of the ACMD and Chairman of the Technical Committee, we set in process this procedure of getting all the members of the Technical Committee to work through in a systematic way the drugs, doing about four or five drugs a meeting. We have two meetings a year and we slowly worked through the drugs in the Act.

Q175 Mr Newmark: Is there a direct relationship then between the scores given to a drug using your matrix and the recommendations made by the ACMD about respective classifications?
Professor Nutt: There are anomalies, there is no question about that. One of the anomalies is buprenorphine which we suggested was moved up. Another anomaly was cannabis which we suggested was moved down. As you almost certainly know, another anomaly was ecstasy. We have not progressed that at present because, as Sir Michael said, the evidence on which to do a systemic review in terms of the real harms of ecstasy has been a bit slow in coming.

Q176 Dr Harris: Is it possible to use a scientifically-based scale of harm to determine the illegal status of a drug? I notice your matrix has "other things" in there.
Professor Nutt: I think it can inform. It depends how you want to make laws. I suppose you could just add the numbers up and say that is how the law would be, but I suspect you would always want to look at other factors, particularly the prevalence of the drug in society, which obviously is major factor in terms of the harm.

Q177 Dr Harris: I was intrigued—and this maybe goes back to Dr Iddon's point—Professor Blakemore has argued for a scientifically-based scale of harm for all drugs with alcohol and tobacco included in some form of calibration. I am curious as to your thoughts on that.
Professor Nutt: I think it is a very sensible idea.
Professor Sir Michael Rawlins: I think inevitably, as David says, it will inform the decision but it will not determine it. These things cannot be entirely algebraic.

Q178 Dr Harris: You have not done that. You have got this matrix that you sent us, which you did not send us originally but you kindly supplied it later, which is very interesting and I think it is possibly among your interesting memorandum the most interesting. If you did this scale and you put in tobacco and alcohol then that would be a useful thing. I cannot understand, since you have agreed it would be useful, why you have not done it, unless it would show that the current ABC would not—
Professor Sir Michael Rawlins: We can send to you the paper that David has been preparing.

Professor Nutt: We have done this.

Q179 Dr Harris: Has it been published?
Professor Nutt: No, it has not but the plan is to send it to *The Lancet*, get it peer reviewed, and hopefully have it in the public domain.

Q180 Dr Harris: Has there been a delay? If you have done it, why not publish it?
Professor Nutt: Because it takes some time. It is an iterative process. There are four authors and it has taken some time. It is not trivial writing a quality paper for *The Lancet*.
Professor Sir Michael Rawlins: David is more than willing to share a draft (I have not been party to it) with the Committee.

Q181 Mr Newmark: Professor, you discussed the importance of science, yet to what extent can an assessment of the parameters that are used in the assessment matrix be objective and how much of it ends up being more a judgment call or subjective? I raise that question because the ACMD told us that social harms tended to be "the weakest data set because of the inherent problem of gathering relevant information." For example, there is often little reliable evidence—and again I quote here—"about the quality and potency of material used by consumers, their pattern consumption, and the social consequences of their use". That is not scientifically based. That comes down to as much to a judgment call or a subjective decision.
Professor Sir Michael Rawlins: Absolutely. I think it is very important that the Select Committee understands that scientific advisory committees look at science but they also have to make judgments. I have been on scientific advisory committees for 25 years and I have been very conscious that there are judgments that have to be made, and they really fall into two groups. There are scientific judgments that you have to make. There are judgments that you have to make about the reliability of the evidence, how generalisable it is, how good it is, is it flawed in some way, and so on, because the scientific evidence is never perfect, it has always got gaps it in. Bodies like the ACMD also have to make social judgments, and that is the difficult part in many respects. Many scientific committees have difficulties over this and over the years I have become more and more uneasy about social judgments because I am not sure that scientists are the right people to make them. The ACMD, I think, is very fortunate in having at least a broad range of views so that those sorts of judgments do have some sort of resonance, but I think it is an area which is not just confined to the ACMD because almost every scientific advisory committee that I have ever been on has had to make these social judgments too, and in another organisation called NICE we have set up a Citizens' Council to help us in getting that, but it is a difficult area and I am very grateful to you for raising the judgment bit.

Q182 Chairman: I think that is exactly what this inquiry is about—actually seeing in terms of making critical judgments (which in fact can take away somebody's liberty for a long period of time) that we have a situation as to where is the balance of evidence between, if you like, the scientific evidence, which I accept is always flawed at the margins at any rate and indeed the sociological evidence which you have got to make decisions on, and that is why we are having this inquiry because I think it is absolutely crucial that we get to that. In terms of the participatory committee which NICE have set up, why do you not do that yourselves?
Professor Sir Michael Rawlins: Maybe we should. The NICE Citizens' Council is very much an experiment. I do not think any other organisation in the country has done anything quite like this. Dr Harris is giving one of those old-fashioned looks.

Q183 Dr Harris: It is a focus group.
Professor Sir Michael Rawlins: It is not, no, it is much more than a focus group.

Q184 Dr Harris: Do you think that the people who make decisions like citizens' juries in the case of NICE, about whether you let older people die because you want to treat younger people first should be made by elected representatives who are accountable rather than, let me be more polite, a glorified focus group?
Professor Sir Michael Rawlins: Yes except, by and large, elected representatives find those sorts of decisions very difficult to take and over the years they have not really done it, with great respect.

Q185 Dr Harris: We can agree that it ought to be done and if they are cowards then you are forced to go down a less satisfactory path. On this issue of the social harms, let us just deal with this point about science. Is what you are saying because it is harder to measure social harms because social scientists would claim they are scientists it is a softer outcome?
Professor Sir Michael Rawlins: No, I am not saying that at all. I am saying the work has just not been done for all sorts of logistic reasons. This is a very difficult area. For example, on the strengths of tetrahydrocannabinol, THC, the main active ingredient of cannabis, the strengths that we know of is from that which has been seized by law enforcement officers. Whether that relates to what people are actually using is a different matter. We have no idea and collecting what people are using is not so easy. I have never bought cannabis so I do not know where you would buy it from, but you have really got to go to the consumers and find out what they are using, not what the law enforcement officers have seen. That is just an example.
Chairman: We are going to return to that when we are dealing with cannabis.

Q186 Dr Harris: You said you did not think scientists were best placed to measure social effects.
Professor Sir Michael Rawlins: No.

Q187 Dr Harris: I was not disagreeing with you. I just think what you are saying is that it is harder to measure and you would rather scientists did it than artists.
Professor Sir Michael Rawlins: There are two aspects. One is social sciences and the sociology and of course they can measure that. It is the values of a community and a society which are much more difficult to capture.

Q188 Dr Harris: In this matrix you include under "social harms" intoxication, health care costs, and other social harms. Included under "other social harms" do you include the harm that stems from criminalisation itself?
Professor Sir Michael Rawlins: Yes.

Q189 Dr Harris: You do not spell that out but that is understood?
Professor Sir Michael Rawlins: Yes and whether it leads to acquisitive crime.

Q190 Dr Harris: You think it should feature more highly in your parameters or not because it is not scientific?
Professor Sir Michael Rawlins: It is scientific. It is a matter of weighting.

Q191 Dr Harris: I am just asking the question.
Professor Sir Michael Rawlins: I know it is something that David has been thinking about. One of the reasons why they have not published their paper is whether one should weight certain aspects more than others in the matrix.
Bob Spink: I am becoming a little worried, Chairman, about the way in which the ACMD arrives at its decisions within this rather big body of 38 people. On crystal methylamphetamine, for instance, I notice that Judge Joseph felt that the evidence had grown since it had last been considered by the ACMD and yet Professor Nutt felt that nothing much had changed.
Chairman: We are coming back to that.

Q192 Bob Spink: On this particular point, the thing that worries me is whether in fact the members of the ACMD are able to withstand the pressure from strong individuals like, for instance, Professor Nutt, the Chairman of the Technical Committee, or whether certain key individuals are able to push through this action rather than the body taking the right action? How are they actually considering the evidence?
Professor Nutt: We are clearly not the right people to answer that question, that is all I can say.

Q193 Dr Harris: Can I come back to what is a key issue with the social harms thing and you will see where I am coming from in a minute because there are a couple of questions I want to go through. In this matrix you have got "other social harms", which I think contains a lot of stuff and I am somewhat surprised that it is not spelt out for our benefit, but is one of those the impact of criminalisation and acquisitive crime, and do you think that should be one-ninth, as it appears to be, or should it be of greater consequence than one-ninth? You have got three under "physical harm", three under "dependence" and three under "social harms". It seems to me for my constituents it matters hugely whether everyone is shoplifting because you cannot get it legally or the price has gone up because it is criminal.
Professor Nutt: This is a very fair point and we have discussed it a lot and we do not know what the appropriate weightings should be. What we have done is we have come up with probably the most sophisticated way of assessing drug harms that there is available in the world. What we would like to do is move to the next stage, get it published, then have informed feedback, but then modify it into an instrument that really does capture those sorts of concerns.

Q194 Dr Harris: I think if this had been published quickly the work you are doing would have been better. Were there any influences on deciding that it would be not be a good time to publish because of the Government's reaction to the paper you are talking about being published in *The Lancet?*
Professor Nutt: No specific restrictions but obviously the individuals who worked with us have had some concerns as you have raised. Some of the sociologists themselves have said, "We are not sure we fully can endorse that particular element of the social harm", for the reasons you have raised.

Q195 Dr Harris: Your recommendation recommending classification into a particular class creates social effects, does it not?
Professor Nutt: Indeed it does.

Q196 Dr Harris: Because obviously it brings criminal justice along with it and that affects the price and availability and so forth. Do you recognise that? Your own actions impact on the evidence. Did you feed that back in before you made the recommendation?
Professor Nutt: We know it might happen but you can never be sure how big an effect that might have. I suppose the best example we might have now is cannabis. The natural experiment is happening. Cannabis has been reclassified. We will be able in a few years' time to answer that question for cannabis because it has changed its classification.

Q197 Dr Harris: Do you see any tension between the government's desire to send out messages with its drugs policy and its aspiration to use an evidence-based approach to policy development? Brooks also was seeking to ask this question.
Professor Nutt: I very much support what you are trying to do because I have been trying with my colleagues on the ACMD to develop evidence based assessment for the last five years. I guess what you are trying to do today is help us do that. I believe the educationalists on our committee would say the same, that in education the message has to be evidence based. If it is not evidence based, the people you are talking to say it is rubbish.

Q198 Dr Harris: What if the government say that by changing its drugs policy—let us say, making it tougher—we are sending out a message and there is evidence that sending out a message is a good thing and, secondly, there is evidence that it works, do you get into that?
Professor Nutt: We would if the evidence was there, yes.
Dr Harris: I do not think you say in your report how strong the evidence is for any conclusion. Your report says there is evidence and you give a reference but you do not make a judgment, which you have done in your evidence today, about the relative strength of that evidence. Is that something you might consider doing?

Q199 Mr Newmark: Specifically with different categories of drugs. There is a linkage between evidence and the perceived strength of those drugs, but there seems to be no stronger message with what may be a stronger drug. The message seems to be a fairly blunt instrument at the moment.
Professor Sir Michael Rawlins: In our two cannabis reports we have indicated areas where the evidence was not strong or where it was strong, so we have given a view but again it is judgmental. Going back to what Dr Harris was saying about the scoring system, the things he is raising indicate the reasons why in the foreseeable future it will be informed decision making, but it is not just arithmetic and mathematical. The science has not developed that far.
Chairman: We will look at some of these issues now with specific drugs. You see the Committee is very excited at having you here today and they are becoming very unruly.

Q200 Adam Afriyie: You recently reviewed the link between cannabis and mental illness. How did you determine the weight of the new evidence compared to the original evidence that had informed your advice in 2002?
Professor Sir Michael Rawlins: The evidence base had changed. Between 2002 and last year, there was a very significant change in the evidence base.
Professor Nutt: As you may well know, a number of studies particularly from New Zealand, following groups of children who have now grown up into their 20s, and in Holland and Germany, raised more evidence that cannabis could potentially cause psychotic disorders. When you have four or five new papers suggesting that there is potentially quite a big mental health problem, a review seems reasonable—

Q201 Adam Afriyie: Did the strength of that new evidence warrant review, in your view?
Professor Nutt: After the 2002 report, we decided that cannabis would be a continual item on the Technical Committee's agenda. We did take evidence from one of the researchers, Stan Zanit, about a year before when he presented his new data on reassessing the Swedish conscript cohort study. We were always conscious of the ongoing research in cannabis. Then it got to the point that there were four or five papers that were pointing in the direction that there might be an increased risk.

Q202 Adam Afriyie: Is this what prompted your review? It was not the Home Secretary?
Professor Nutt: We have ongoing reviews but the big review that Michael chaired was prompted by the Home Secretary.

Q203 Adam Afriyie: You first published your advice in 2002 on cannabis and mental illness. You then needed to re-evaluate that evidence base. Does that show any weaknesses in the system because you had to review it so soon afterwards?
Professor Sir Michael Rawlins: No. It was an important area with more evidence about it. We did talk about it in 2002: could it precipitate or cause schizophrenia in vulnerable people?

Q204 Adam Afriyie: What changed? You alluded to this in the 2002 report. Were there no experts on schizophrenia on the panel? Are you saying the evidence just was not there?
Professor Sir Michael Rawlins: The evidence was not there. It was not a lack of experts. We had psychiatrists coming out of our ears. It was just the scientific evidence. This is a very tricky area and even now the epidemiologists that we recruited specially to advise us, on the balance of probabilities, think there is a causal link, but they are not 100% certain because there are all sorts of confounding issues that bedevil the interpretation of the evidence. One of the difficulties is, when you take the confounding issues into account, the relationship becomes smaller and smaller. Technically it is a very difficult area.

Q205 Adam Afriyie: It seems to imply that the classification of drugs that we all read about from yourselves is dependent on the timing of when you choose to undertake a review.
Professor Nutt: No. It is dependent on the evidence. If the evidence base changes dramatically as it did from 2002 to 2005—

Q206 Adam Afriyie: And do you make that judgment as to whether the evidence base has changed?
Professor Nutt: No. The evidence base did change because there were many papers published in this area. It was not a judgment call; it was a fact.

Q207 Adam Afriyie: There was clearly a lot of media concern and confusion when cannabis was reclassified from class B to class C. Did this in any way influence your decision to leave the classification the same when you looked at it recently?
Professor Sir Michael Rawlins: Although people say there was confusion, surveys amongst school children showed that there was not much confusion. 95 or 97% knew that it was illegal. The confusion, if anything, was in the newspapers.

Q208 Chairman: Or in the Home Secretary's mind because he was obviously confused as well.
Professor Sir Michael Rawlins: I could not possibly comment.

Q209 Adam Afriyie: You are saying you do not think there was much confusion. From my understanding, looking at the papers at the time and from people I spoke to at the time, there was a great deal of confusion. Some people thought it was legal to take cannabis. Why do you think there was such confusion?
Professor Sir Michael Rawlins: I do not know whether there really was that confusion. We have made it very clear in our second report that it is essential that people understand—particularly young people—that it is illegal. It was quite interesting, when we were having this discussion. One of our teachers on the Council said, "That in many ways is much more potent than you think. I am not sure whether I am speaking correctly or not but I say to them that if they have ever even been cautioned for possession they will not be allowed into America." She said that had much more impact than many other things that she teaches the children, the fact that they might not ever be able to visit America.

Q210 Dr Iddon: One of the things that irritates me about the cannabis debate is that if I go into a coffee shop, as I have done but not to buy cannabis, and I have questioned the owner of the coffee shop, he will lay out all his different species of cannabis and tell you exactly what the THC content is. We talk about cannabis in this country as if it is a single substance. The fact is that the THC content of the cannabis being sold on the street has changed. Therefore, why should we keep talking about cannabis as a single substance? It is not a single substance.
Professor Sir Michael Rawlins: No, and the strength there is 10 fold whenever it has been looked at in the material that is seized. What we do not know is what people are buying.

Q211 Mr Flello: There are reports in the media this morning that seem to suggest that the use of cannabis in the US has plateaued or is starting to plateau but, in mainland Europe, use is still on the increase. How do you feel, if at all, the reclassification to class C has made any difference whatsoever, given that it has continued to increase since it has been changed to a C?
Professor Sir Michael Rawlins: It has not increased. It has decreased. It has been decreasing in young people since about 1998 and it is falling at about 2% a year. That fall has continued.

Q212 Mr Flello: That is just young people or across the board?
Professor Sir Michael Rawlins: That is across the board, but with young people in particular it is falling at about 1% a year.

Q213 Mr Newmark: Is there substitution in there—ie, are they taking some other drug?
Professor Sir Michael Rawlins: Not that we are aware of. These are figures based on self-reporting behaviour, so we are reliant on that.

Q214 Mr Flello: Do you feel that the reclassification to class C has had an influence on that?
Professor Sir Michael Rawlins: If you look at the graph, we only have another year and the line is not a very steep curve but it is going the right way. It has not changed as a result of reclassification, but we do not know what is going to happen.

Q215 Mr Flello: In terms of the mental illness use of cannabis, if I may widen it slightly to all drug abuse, what is your view on people who suffer from mental illnesses because of drug use or people who use drugs because they have mental illnesses?
Professor Nutt: It is a big question. Some drugs cause mental illness. Many people with mental illness use drugs, even though it makes them worse, and we do not understand why. If we just focus for a minute on cannabis, the brain makes its own kind of cannabis. In the brain there are more cannabis receptors, targets for cannabis, than all the receptors like serotonin and adrenalin put together. There is some evidence that during the course of schizophrenia the brain's own natural cannabis substances change in relation to illness. It may be that what people are doing when they smoke cannabis is trying to restore some internal deficiency which may make some aspects of their mental state better, but in many cases it makes the psychosis worse. That is an example of the sort of complexity.

Q216 Mr Flello: In terms of the classification of drugs and cannabis as a particular example, to what extent do you take into account the impact of people with certain types of mental health disorders using those drugs?
Professor Nutt: It is a factor we consider when we look at all drugs because it comes into the personal life issue. Also it is a factor we look at in relation to the cost to the NHS. It is counted twice.

Q217 Mr Devine: You said the drugs make psychosis worse. Is that evidence based?
Professor Sir Michael Rawlins: Yes. There is very strong evidence and there is no argument amongst psychiatrists.
Professor Nutt: That is some drugs, not all drugs.
Professor Sir Michael Rawlins: I am talking about cannabis. In patients with schizophrenia who are in remission, cannabis will precipitate relapse. There is no doubt at all. Even I know that.

Q218 Mr Flello: When the ACMD met to discuss the reclassification, were the same people on from the 2002 ACMD meeting present at the more recent one? Were any measures taken to exclude them?
Professor Nutt: It was very different because we had to extend by a month the life of the previous committee to get the 2002 report fully approved. So many were coming off.

Professor Sir Michael Rawlins: There was a big turnover after the publication in 2002. It was a rather different group. I cannot tell you how many. I can certainly let you know.

Q219 Mr Flello: It was not ever an issue to consider about making sure there were different members on the committee?
Professor Sir Michael Rawlins: No. A proportion will have been there previously but a significant proportion was new members who had not been involved in the 2002 decision.
Professor Nutt: To reassure you on the *ad hoc* members, we brought in a number of external experts to bolster the committee. We really covered all the bases, particularly the psychiatric and the epidemiology bases.
Professor Sir Michael Rawlins: They had not been involved in the 2002 decision.

Q220 Mr Flello: There was no undue influence?
Professor Sir Michael Rawlins: I do not think so, apart from the chairman.

Q221 Chairman: What discussions have you had, if any, with the research councils to encourage them to look for the application of resources to research projects to support your work? Does that discussion take place?
Professor Sir Michael Rawlins: No. That is probably remiss of us and I think we probably should and try to ensure that there are some formal channels of communication between the ACMD, the MRC and the ESRC.

Q222 Dr Iddon: Psilocin and psilocybin, which are the psychoactive constituents of magic mushrooms, have been class A for a long time. You said drugs are in classes according to the harm they either cause to individuals or to society as a whole. I do not see psilocin or psilocybin being sold in the shops, synthesised by many people and for sale on the streets. How on earth did those two compounds get into class A?
Professor Sir Michael Rawlins: Psilocin and the esters were originally class A right from the beginning of the Medicines Act. Magic mushrooms were in class A right at the very beginning, before the ACMD had been formed. Psilocin is a hallucinogenic compound with properties similar to LSD. At the time the Misuse of Drugs Act went through Parliament it was class A, but only for products of mushrooms, dried mushroom extract. The issue about fresh mushrooms was very unclear in law.

Q223 Dr Iddon: I want to know what the evidence was that psilocin and psilocybin should be classed as A. I have never known anybody use them.
Professor Sir Michael Rawlins: I have no idea what was going through the minds of the group who put it in class A in 1970 and 1971.

Q224 Dr Iddon: It is there because it is there?
Professor Sir Michael Rawlins: It is there because it is there. However, since that time there have been very few publications on psilocin. It has hardly been investigated at all. It was looked at in the 1950s and 1960s at the time of Aldous Huxley, mescaline, LSD and those sorts of things. Since that time, there has been virtually no work done on it at all.

Q225 Dr Iddon: Could I suggest that there should be and that they are in the wrong classification because they are not causing great harm to any individuals I have ever known and certainly not to society at large.
Professor Sir Michael Rawlins: There is no doubt that people do still take magic mushrooms.

Q226 Dr Iddon: I am not talking about magic mushrooms; I am talking about psilocin and psilocybin as chemicals. I suggest that it was because psilocin and psilocybin were already there that magic mushrooms were completely put into the wrong classification, either by yourselves or by the government, because the two compounds were already contained in class A with no evidence for them to be there.
Professor Sir Michael Rawlins: The evidence that psilocin is a hallucinogen is very strong. There is no doubt about that and no argument about it. The evidence upon which one should change now is non-existent because there has been very little work done on it. To leave fresh magic mushrooms available when all the other forms of mushrooms were class A is causing grave difficulties. Although you may think that psilocin is pretty harmless, as a physician sometimes I get kids who have been eating fresh magic mushrooms grown on the Newcastle town moor, accidentally apparently.

Q227 Dr Iddon: Arsenic is very dangerous; so are a lot of other chemicals but they are not being widely used and neither are psilocin and psilocybin. What evidence was there to put magic mushrooms in class A?
Professor Sir Michael Rawlins: Magic mushrooms were being sold in farm shops and so on by the kilo. Very considerable quantities of magic mushrooms were being sold two or three years ago, fresh, which escaped the law. They do have an hallucinogenic effect. There is no question about it.

Q228 Dr Iddon: How many deaths have there been due to taking magic mushrooms?
Professor Sir Michael Rawlins: I do not know.

Q229 Dr Iddon: The figure I have seen is one.
Professor Sir Michael Rawlins: I do not know.

Q230 Chairman: We have had some research done for the Committee as a background piece of work by RAND. You have had a copy of it and that report made clear that the government's decision about class A was not based on scientific evidence, that the evidence on mushrooms is small with very little research on their effects and the positioning of them

in class A does not seem to reflect any scientific evidence that they are of equivalent harm to other class A drugs. Do you not think that brings into question the system that we have for classification, full stop?
Professor Sir Michael Rawlins: One has to be very careful about the issue of things like hallucinogens. They can cause serious problems. There is no benefit to anybody by taking hallucinogens in a medical sense. It is all down side. If one is operating something approaching a precautionary principle—and I hope you will not ask me to define it in the way you asked Sir David King to—it is frankly unwise to encourage in any way the use of this hallucinogen. It may be better in B rather than A. The trouble is that the evidence now is so old. It all dates back to the 1960s and there was not very much evidence then, but one does know anecdotally, if nothing more, that they are hallucinogenic. I have had kids in my ward who have needed antipsychotic drugs for 12 months.

Q231 Dr Iddon: Your committee was consulted by the government and asked to review magic mushrooms.
Professor Sir Michael Rawlins: It was slightly different. The government asked us about it but they did not have to because it was going into primary legislation in the last Drugs Bill.

Q232 Dr Iddon: I was on the Standing Committee for that Bill, the 2005 Drugs Act, and I had the impression that the whole thing was rushed through. My feeling was that the whole business was rushed through in 2005 because the election was coming and the Bill had to be on the statute book but, more importantly, because there were two court cases outstanding where the government were trying to prosecute shopkeepers for selling fresh mushrooms on the basis that they were not fresh mushrooms; they had been frozen in freezers and that fell into the law. It was illegal to prepare mushrooms in any way and the government was trying to prove that by freezing the mushrooms that was a kind of preparation of fresh magic mushrooms. I contested that when I was on the Standing Committee and I did not think it should have gone through the Standing Committee, frankly, because of those two very loose court cases that the government was in danger of losing. Have you or has the government ever classified a drug on grounds of clarification of the law, because that is what happened in my opinion.
Professor Sir Michael Rawlins: I cannot answer that question. I do not know what has happened over the last 35 years but since I have been on the ACMD I do not think it has happened. I cannot recall another case.

Q233 Mr Devine: Do you support the fact that amphetamines are classified as class A or B depending upon the method of preparation?
Professor Sir Michael Rawlins: It is really the method of administration.
Professor Nutt: I do, because there is undoubtedly much greater harm from amphetamines given intravenously than amphetamines taken orally.

Q234 Mr Devine: It is not the method of preparation?
Professor Nutt: The method of administration clearly determines the risk to the individual and to society.

Q235 Mr Devine: If the form of the drug can affect its status in this case, why is there no distinction made between, for example, cocaine prepared for snorting and coca leaves prepared for chewing?
Professor Nutt: That is a very good question.

Q236 Mr Devine: Is there any answer?
Professor Nutt: We are not as sophisticated with cocaine in terms of the law as we are with amphetamines.

Q237 Bob Spink: In the answer you have just given to Mr Devine about the way in which the drug is administered, you said intravenous is much more serious than taking it orally and yet methylamphetamine in its pure, crystal form can be smoked. In that circumstance, it is extremely dangerous because it is very highly addictive, like crack cocaine, and it has a massive psychotic impact on the individual and causes great harm in various societies like Thailand and the USA. Why should that particular drug be classified as a B rather than an A?
Professor Nutt: That is an extremely good point. There is no doubt that methylamphetamine, because it can be smoked, is more dangerous than traditional dexedrine (amphetamine sulphate). When we reviewed the whole issue of methylamphetamine, we clearly accepted that it was more dangerous than amphetamine sulphate. The issue is would you minimise risk to society by moving it into class A. The reason I believe we did not recommend it at the time was mostly because there could be a perverse effect. If people saw methylamphetamine as a more dangerous drug, a more class A amphetamine, we might well have begun to see importation. There is a peculiar phenomenon in the UK at present which is that we do not have very much methylamphetamine. That is based on a couple of historical facts which relate to precursors and also the preference of the population.
Bob Spink: Added to the dangers of the drug, we have the availability of the drug, which is something you said you take into account. This is changing in the UK, largely driven by the internet, but the precursor chemicals like red phosphorous, for instance, are increasingly available and people can make this drug in their kitchen and are doing that now. Given that and given the dangers, should we not take the precautionary principle and reclassify this drug before it becomes a major societal problem, as it has in other societies, in order to protect our children and young people; or should we just wait until a lot of them suffer from that and society gets a real pain in the butt on this and then reclassify?

Q238 Mr Devine: We are very pleased that you are not influenced by *The Daily Mail*, but I wonder if you are influenced by *The Metro,* which describes the drug as a dance and sex drug, more addictive than crack cocaine and as fast becoming a global problem, the United Nations has warned. It also makes reference in the article to sites being set up in Europe and in England for the making of this drug.
Professor Nutt: There is no question that methylamphetamine is a huge international problem. It has caused devastation in Thailand. It has caused an enormous amount of personal harm and social harm from the chemical factories in the USA. We do not have a big problem. We looked very hard when we did the methylamphetamine review to find evidence of its use in the UK and there is not a great deal of use. It is a very fine judgment as to whether moving it to class A because it is smokeable—and I think we could do that—would reduce the chances of it becoming popular in the UK or whether it would give a message that it is a better quality product. It might get people who import drugs to realise it would be extremely easy to import this from Holland particularly. At the time the decision was made that it was probably better to wait and see. With many drugs, these epidemics have cycles. They are fashion driven and it may be that we would get lucky and not get a wave of methylamphetamine here.

Q239 Bob Spink: Are you aware or is there any evidence that this particular drug is used by a certain sector of society—in particular, the homosexual groups—and that this drug encourages and promotes risky sexual behaviour which that particular section of society can least do with because it causes the spread of diseases? Is this a concern?
Professor Nutt: It was a great concern. If you read our report, which is a very systematic report, that is a big concern. One of the targets for monitoring the possible increasing use of methylamphetamine is to try to monitor clubs which are frequented by the gay community because we think that may well be the first sign of an upswing in use. If there was a serious change in the usage or a trend upwards, we would have to review the classification.
Professor Sir Michael Rawlins: The Council thought very long and hard about this and it was a judgment at the end of the day as to which would be the least damaging thing to do. When it took the decision to advise that it should not move, it also made sure that there were measures in place so that if there was any hint of a problem emerging we could have a meeting—that is why the quorum of seven was quite important—within hours to change our advice.

Q240 Bob Spink: This would not require waiting for one of your biannual meetings?
Professor Sir Michael Rawlins: No.

Q241 Mr Flello: Having listened to your evidence this morning, I am left with the impression that these things seem to be very *ad hoc*. You can have magic mushrooms where I understand there has been one death but fresh mushrooms were pushed into class A on a precautionary principle. On a similar precautionary principle cannabis is class C and on a similar precautionary principle some of the amphetamines are class A and some are class B. It seems complete nonsense, does it not?
Professor Sir Michael Rawlins: I have sat on government advisory committees for 25 years, mainly in terms of medicine but others as well. There is a misunderstanding around in the world that scientific advisory committees just make their decisions purely on the science. They have to take judgments too and judgments are very important in scientific advisory committee meetings. Sometimes people do not realise they are making judgments but they are. It is very important to realise that we all have to do it. I think your Committee also understands that scientific advisory committees look at the science and then they have to make a judgment.

Q242 Chairman: Our frustration this morning is that time and time again you seem to have responded to Members of the Committee that there is a lack of evidence or you have agreed that there is a lack of evidence to make certain decisions. We want to know why the ACMD has not done more to promote research in those areas where there is a lack of evidence. Do you think it is your job to do it or have we misjudged what the purpose of the committee is?
Professor Sir Michael Rawlins: It is arguable whether it is our job. This is an area in which it is extraordinarily difficult to do research, not just for legal reasons but for real reasons. Would I, for example, be prepared to do volunteer studies with Ecstasy? Would I be prepared to give volunteers Ecstasy? I could probably get the Home Secretary's approval. It is schedule one and it is possible. I am not sure I would. I do not know what an ethics committee would think about it but how would I think about it? We start getting into very real problems of doing research in this area. It is all very well people saying, "You should promote research" but you have to promote research that can be done, not research that we would just like to see.

Q243 Chairman: Could I ask whether the Council has ever formally asked the Home Secretary for permission to carry out research in any of the areas that we have talked about this morning?
Professor Sir Michael Rawlins: Yes, and it does commission research.

Q244 Chairman: You could give us some background?
Professor Sir Michael Rawlins: Yes. We can let you know of areas we have asked for research to be commissioned in.

Q245 Dr Turner: When questions fall outside the massive expertise you already have in the committee, who do you look to and how do you choose specific people to go to for advice?

Professor Nutt: Essentially in the scientific arena we look for people who publish in the field. The methylamphetamine review brought in people like Charles Marsden who is a world expert on the effects of amphetamines in the brain. We make searches of the published literature to find people.

Q246 Dr Turner: Do you ever set up sub-committees to pursue specific issues?
Professor Nutt: Sometimes.

Q247 Dr Turner: Do these report separately? Do those reports reach the public domain?
Professor Nutt: They come in through the committee structure with the technical committee.
Professor Sir Michael Rawlins: They form the report that goes to the Council and it is published on the internet.

Q248 Chairman: Do you mean original research, or is this a review of existing research?
Professor Nutt: The ACMD does not have a budget that could remotely fund proper research in the sense of original, primary research. The average research grant that the MRC funds now is about a third of a million and I think the whole ACMD is run on much less than that. It does not have any resources to commission primary research.

Q249 Chairman: It has no mechanism to ask somebody else to commission it?
Professor Nutt: We have worked with the Department of Health who do have a research budget.
Professor Sir Michael Rawlins: And the Home Office sometimes.

Q250 Chairman: When we are talking about magic mushrooms, could you say, as a simple yes or no, when the government decided to put magic mushrooms in class A, was that evidence based? Yes or no?
Professor Nutt: Magic mushrooms contain the active substances which are in class A.

Q251 Bob Spink: They are not in class A based on evidence. They are there because they were there.
Professor Nutt: That is exactly right.

Q252 Dr Harris: It is not evidence based; it is historic.
Professor Nutt: Historic evidence, yes.

Q253 Chairman: Was the Council split on that? Do you ever have disagreements about an issue like that?
Professor Nutt: It seemed somewhat illogical given the fact that we had not done a systematic review of psilocin et cetera, but we did understand that under the current Act it was a class A drug.
Professor Sir Michael Rawlins: The other thing the Council was particularly worried about was that people who had magic mushrooms perchance growing in their fields would suddenly be prosecuted. We made the point that in the fields belonging to the Duke of Northumberland if, by chance, there were some magic mushrooms growing he was not necessarily going to have to go to jail.

Q254 Dr Harris: I am very interested in this risk assessment approach, which is methodical. It is flawed.
Professor Sir Michael Rawlins: Flawed?

Q255 Dr Harris: It is not perfect because of the issue of the lack of evidence. I thought you did very well, Professor Rawlins, in setting that out. When it came to magic mushrooms where the government asked you in a rush what your view was, I had the perception that you did not have time to find an expert. Maybe there was not an expert. You did not have time to do a full technical review. You were asked for your opinion: shall we stick this in class A as well? You defended your decision not to object or to approve by starting in on the precautionary principle and historically hallucinogens had always been in class A. Feel free to write but would you consider, after a review of what you have said, that it might be an alternative approach to say, "On reflection, we did not really have time to do this properly and that is not our fault; it is just the timing. If the government are going to do this they can do it but we should not have given it the imprimatur to imply that a full risk assessment model had been given to it by the fact that we wrote to them saying, 'This is fine, people understand that we do these risk assessments and that might have been the impression they got'." Would that be a fair way of putting the situation?
Professor Sir Michael Rawlins: No. If we were to do a review of psilocin now, the evidence base upon which to make any sort of decision, bar knowledge of the fact that it is hallucinogenic and causes hallucinations when you take various preparations of vegetables that contain it, is about as far as we would ever get. Frankly, I do not think it is worth it. There are bigger, more important issues to worry about than whether fresh mushrooms join the rest of the other things in class A. It is not a big issue.

Q256 Dr Harris: If you get thrown into prison it is a big issue.
Professor Sir Michael Rawlins: That is only if you are supplying and trafficking.

Q257 Mr Devine: There have been recommendations that Ecstasy should be changed from class A to class B. I wonder if you have given the government any advice and, if you have not, why not? There have been various committees that have now made recommendations about the reclassification of Ecstacy.
Professor Sir Michael Rawlins: It is class A. The difficulty is it is one of these other areas where there is very little research done on it. We do not even understand how it kills people. It does. I am afraid the report from the RAND Corporation managed to

mangle up the mechanisms of its toxicity but perhaps I could write to you separately about that. The estimates of the mortality rates with it vary some ten to twenty fold, depending on certain assumptions that you have to make. They are either half as harmful as road traffic accidents or they are ten times as harmful. There is a huge, wide variation in the estimates. Frankly, I do not think we would get anywhere by a review at the present time. This may change. There may be better evidence that comes forward but it is vague and imprecise and I do not think we would get very far.

Q258 Mr Flello: Just to pick up on Dr Harris's point about it being an issue if you are caught supplying magic mushrooms and you get ten years, what is your view on perhaps having a twin track approach whereby perhaps all drugs are classified as class A if you are supplying them and dealing in them, but if you are using them for personal use it is in the existing category?

Professor Sir Michael Rawlins: There are various ways in which one could do this. One could change the whole pattern and disaggregate the supply. That is a very fair approach to it, to separate possession and supply from trafficking.

Q259 Chairman: When the Home Secretary made his statement on 19 January he stated that clinical medical harm is the Advisory Council's predominant consideration in terms of classification. Would you agree with that?
Professor Sir Michael Rawlins: We also look at social harms.

Q260 Chairman: So it is not predominant?
Professor Sir Michael Rawlins: It takes equal weight.

Q261 Chairman: The Home Secretary was wrong?
Professor Sir Michael Rawlins: I could not possibly say that.
Chairman: We thank you enormously for your contribution this morning. It has been thoroughly enjoyable. Thank you very much for coming along.

Wednesday 26 April 2006

Members present:

Mr Phil Willis, in the Chair

Mr Jim Devine
Dr Brian Iddon
Margaret Moran
Mr Brooks Newmark

Witnesses: **Professor Colin Blakemore,** Chief Executive, Medical Research Council and Professor of Physiology, University of Oxford, **Professor John Strang,** Professor in Addiction Research and Director of the National Addiction Centre and **Mr Andy Hayman,** Chair, Association of Chief Police Officers Drugs Committee, gave evidence.

Q372 Chairman: Good morning. Can I welcome everyone to this session which is looking at the classification of illegal drugs within an overall inquiry which is looking at scientific advice to government in terms of policy information. Can I particularly welcome our Panel One: Professor Colin Blakemore, the Chief Executive of the Medical Research Council and Professor of Physiology at Oxford University; Professor John Strang, Professor in Addiction Research and Director of the National Addiction Centre and Mr Andy Hayman, the Chair of the Association of Chief Police Officers Drugs Committee. Welcome to you all, thank you very much for giving us your time. Could I start by asking you, Professor Blakemore, you said in 2004 of the ABC classification system for illegal drugs: "It is antiquated and reflects the prejudices and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical, consequences". That was in 2004; do you stand by that comment?
Professor Blakemore: There are sometimes useful reasons for making what, with hindsight, might seem to be pejorative or hyperbolic statements, but I stand by much of what I said, although some of the adjectives could be attenuated. To call a system antiquated of course does not necessarily mean criticising it.

Q373 Chairman: But "illogical consequences" is pretty severe.
Professor Blakemore: The Monarchy, the House of Lords and Shakespeare's plays might be called antiquated by some people but they would not necessarily be dismissed by everybody. I think the logic on which the misuse of drugs classification is based is impeccable. The logic is that drugs should be classified according to their potential for harm and that classification should then guide particularly the judiciary in its attitude towards policing and sentencing.

Q374 Chairman: You no longer think it is illogical.
Professor Blakemore: I think the basis is logical, but I am not sure of the evidence on which drugs were placed in those arbitrary groups—they are essentially arbitrary; there is nothing that rationally could provide evidence of sharp boundaries in a scale of harm from drugs. I think that not all the evidence was taken into account in the initial classification and subsequent emergence of evidence has not easily been incorporated in re-classification.

Q375 Chairman: Professor Strang, do you accept Colin Blakemore's original hyperbole?
Professor Strang: It seems to me that people at a previous time have tried to place drugs in what they think is a ranking of the levels of concern which should be attached to them. Periodically it seems proper for us to re-visit that and decide whether the ranking is correct and also then the way in which we organise our responsibilities. Being concerned about the potential for harm we wanted to look at ways in which a harm that is otherwise going to hit individuals in society might be deflected by the system. I would have thought that in any system from yesteryear one is bound to see things that you want to change. Personally I was pleased to be reminded about your overall process, about looking at how science might or ought to be contributing to the process of government. I am not sure whether that is the correct terminology. It does seem to me that there are many examples where what you or me have is inherited and what we are wanting to know as well is a whether a move in one direction or another direction would bring benefit or more harm. That is a more urgent question, rather than whether people happened to get it right a number of years ago. What I crucially want to know is that when changes have occurred, when minor adjustments have been made to the classification—not just to the classification, to the way in which the law is applied, because the law may be an ass but it is a sometimes subtle ass—that it is not just what the documents say, it is the way in which is applied. We have lots of examples in the UK as well as overseas (but let us just stick with the UK) where we have changed the law or we have changed the way in which the law is applied. Examples in the last couple of decades would be that we have re-classified certain drugs.

Q376 Chairman: We will come onto that specifically; we want to know why we have done some of those things. The basic premise that I would like to start with this morning is: is the ABC category as exists now as illogical and is it as arbitrary as Professor Blakemore said. What is your opinion?
Professor Strang: I am being much more moderate about the view. I am not wishing to defend the precise drugs and I probably would not see it as my

area of expertise. What I would say is that I think we are ill informed about whether the changes make it better or worse. We have changed the detail of it and we do not actually know whether that has made the situation better or worse, so changes we have made, what I would expect of government in science, is to be able to tell me: So you have made that change five years ago . . .

Q377 Chairman: We would like to know why; what was the evidence on which it was based?
Professor Strang: Yes. Not only would we like to know the evidence of why but in particular did the effects that you expected happen? Even if your evidence base was rather weak and arbitrary, and it seems to me that the political process sometimes needs to make decisions with a pace that does not fit science and the gathering of evidence, but when a decision is made I would expect to know three years down the line had the trajectory carried on going up or had it taken off or had it got worse and for it to be sufficiently transparent that if it had got worse you would say that we made what we thought was a correct decision, we now see that it actually had a contrary effect.

Q378 Chairman: Mr Hayman, very briefly do you feel the current system of the ABC classification is antiquated?
Mr Hayman: If you want me to be very brief, no. If you want me to elaborate on that I don't actually know what the problem is in this discussion. Why do we have that classification? Is it because we want something very precise or is because we want something as a rough guide? If we want something very precise then it is a problem; if we want a rough guide it is not a problem.

Q379 Chairman: What do you think the purpose should be then?
Mr Hayman: From a police perspective it only does a couple of things really. It puts certain drugs in a category which then has certain powers associated to that category and also it gives a bit of a steer which normally comes from government or from the local policing priority as to what the priority would be for policing those particular drugs.

Q380 Chairman: Just to clarify that, from your point of view you think the classification is to deal with possession and trafficking and the penalties that follow from that. That is the main purpose. It is not about education; it is not about debate; it is not about the degree of harm; it is just about that.
Mr Hayman: Other people make the determination as to the degree of harm; we are not in a position to comment on that. What we do is that once those discussions have been held by the experts in that field they get put into those classifications and that will then direct police resources and priority. I think, on a really practical note here, even when you ask this question you need to have some kind of view as to what we would replace the system with if we were to rubbish it. I do not think there is an easy answer to that. You are going to have to have some kind of brackets, whether you call it A or 1 or any other division. What is going to direct you to put a certain drug into those categories? That goes back to my earlier point which is: why should we get too hot under the collar about it?

Q381 Chairman: Why bother having classifications at all?
Mr Hayman: Because then you will not be able to direct effort either in the health service or in policing or any other discipline to a given priority. They will all get given the same kind of even handed response. For me, as long as we all know that the determination is pretty crude, the way they go into these different categories, let us all go into it with our eyes open knowing it is crude. On the other hand, if you want it more precise then we will have to do some more thinking on it. I think, as ever, it is the middle ground. I think there is some decision there because it is directed by health and scientific experts; it is not as rough as some are making out but it is certainly not as precise as perhaps some of the other commentators would want.

Q382 Chairman: Would you be happy for it just to be left to the police to use their discretion?
Mr Hayman: We do anyway.

Q383 Chairman: So the classification is irrelevant to you.
Mr Hayman: No, it is not irrelevant. The discretion will be around the priorities that we give policing-wise to the different categories. Clearly a Class A drug is determined by the experts as being the most harmful and the criteria which is directed into that conclusion and therefore I think it would be illogical from the police perspective if we were putting a lot of effort into a Class C drug when actually Class A presents more harm. It is helpful in that regard.

Q384 Chairman: Alcohol, which is not in a classification at all, is a lot more harmful than most of the drugs that are in Class C.
Mr Hayman: I am not in a position to comment on that.

Q385 Chairman: Professor Blakemore, what do you feel should be the primary purpose of the classification?
Professor Blakemore: I would agree with Andy that the classification is intended as a useful guide to the direction of priorities for medical care, to policing operations and to the work of the judiciary in trying to deal with the problem of drug abuse. The question would be that if the system is acknowledged to be rough—I think Andy used that term, that it is only a rough guide—then where is the nuancing of the interpretation coming from and on the basis of what expertise is that nuancing occurring? Is it on the basis of some additional assessment of risk in the mind of a doctor treating someone with drug problems? Or a police officer considering whether to caution them or arrest them? Or the courts in dealing with the case? Is it an opportunity for the exercise of personal views and prejudices?

Q386 Chairman: Is the primary purpose then really, as Andy said, about helping in terms of policing and the judicial system? I am surprised, in your particular position, that you would not see it in terms of sort of degrees of harm and how we actually deal with it; a classification system which would actually support the work of the MRC and the health service.
Professor Blakemore: I am no expert on the law but I think primarily the classification is used to guide policing efforts. However, it also influences public and political reaction. The fact that a drug is classed in a category which is perceived as being especially risky influences the attitude of people, the media and politicians to that drug. If the placement of the drug in that category is only rough and if it not particularly rationally assessed then the attitudes to society and the media and politicians are misplaced.

Q387 Dr Iddon: I want to try to direct my questions to Mr Hayman, please. Do you think placing a drug in a higher category has any deterrent effect on the user at all?
Mr Hayman: You would have to ask a user that to get the best reply, but if you want my professional judgment based on my interaction with users I cannot envisage a user—a dependent user, that is—having any kind of thought as to whether it was a Class A, B or C drug they were consuming. They may know that but they may not; all they are worried about is the dependency that they suffer from. That is my professional take on it, but I think you would have to ask the users to get the most accurate reply.

Q388 Dr Iddon: Do you think there is any relationship between the classification of a drug and the amount of criminal activity? I put it to you that by placing a drug in a higher category with the higher risks involved of sentencing and the whole judiciary process, that puts a higher price on the drug so the criminals are more attracted to trading in those higher classification drugs.
Mr Hayman: It depends on what you are defining as the link with crime. We have to go back to first base. What is directing what classification of drug goes into is the scientific and medical harm. It has no relationship with the crime that might be associated with it. It would be a very interesting research project I am sure (which Colin would jump at) to try to determine whether there is a relationship as you have tried to suggest. For me there is well recorded academic research which shows that certain drugs have certain linkages with certain crimes. Some are violent; some are acquisitive, but to start making those links in with the classification I think we are going to mix up loads of different methodologies. For me it is very clear; there is a clear thought process as to why a drug goes into a different classification. Certain drugs have certain relationships with certain crimes.

Q389 Dr Iddon: Has ACPO ever discussed the classification of drugs, even before the home secretary decided to look at the system?
Mr Hayman: Yes.

Q390 Dr Iddon: What conclusions did you come to?
Mr Hayman: I think it was in 2001/02 when we wrote the ACPO policy statement right across the whole agenda of drugs which included classification. In fact at the moment we are just reviewing that for an update. You may see our position as a bit of a cop-out but I think it is a professionally reliable position. We do not have a view on what classification is; that is not our job. It is for experts to determine what classification drugs go into and once that is then linked to legislation and police powers and priorities we would then implement that. Our position on the re-classification on cannabis was that we all stand ready for the experts to express their opinion and then we will operate guidelines to implement that on the street.

Q391 Dr Iddon: We will be coming to cannabis shortly so I will not pursue that now. To any member of the panel, do we have the best practice operating in Britain regarding our classification system or is there a better one somewhere else in another country?
Mr Hayman: I have probably already shown my hand in the earlier questions, I really do not think we should get too hot under the collar around this classification. It is there to guide and it is as simple as that. If we get too sophisticated around that process we will be strangled by the sophistication of classifying a drug rather than getting on and doing the job both from a medical perspective and from a law enforcement perspective and for the greater good of the community. It might be very interesting to travel to other countries but actually we are in this country now and we have a job to do and I think we should just roll our sleeves up and get on with it.

Q392 Dr Iddon: In this early part of this evidence session I am getting the feeling that perhaps the home secretary is misguided by reviewing the system because everybody here seems quite happy about it. Why is the home secretary calling for a review of the system? Does anybody know?
Mr Hayman: He is the person to ask.
Dr Iddon: We will, of course.

Q393 Chairman: Can you hazard a guess, Colin?
Professor Blakemore: I think that the driver for the review was quite clearly the time, effort, deliberation and conflicting advice that impinged on the decision not to re-classify cannabis, and the realisation that the arbitrary (and I would defend that word) boundary between B and C was not easily defensible. If it took so much effort to consider one particular drug and whether it should be placed on one side or other of a boundary, does it not imply that the entire mechanism for classifying requires a new look? There are other issues too and I suspect that the Advisory Council pointed these out—that some drugs might simply have become lodged in categories on the basis of historical allocation, which might have seemed very reasonable at the time but the present position cannot easily be defended on the

basis of present evidence. I point particularly to the hallucinogens in category A and also perhaps to ecstasy.

Mr Hayman: I think another interesting question to pose here is that, let us say this is such a grim situation that we are facing here and we have it all badly wrong. I do not mean this in a flippant way but, so what? What is the consequence of getting it so badly wrong and how much effect does that really have on the medical and law enforcement functions? I actually cannot see that there are major consequences.

Q394 Mr Devine: Surely if I had that Class A drug I would go to jail but if I had a Class C drug you would let me go.

Mr Hayman: Not necessarily, no.

Q395 Chairman: If you were caught selling magic mushrooms which are in Class A you would go to prison.

Mr Hayman: On the current classification and the current penalty.

Q396 Chairman: You have been arguing that one of the major reasons for the ABC classification is its links in terms with crime and punishment.

Mr Hayman: Having been classified the punishment is then linked to that.

Q397 Chairman: You are splitting hairs.

Mr Hayman: That is what I am saying. Exactly. I think the whole debate is very interesting but it does not take us anywhere at all. If we got members of the public in here now, even with the layman's understanding of it, and if we put all the different types of drugs on the table I bet they would be able to determine which were more serious than the others.

Q398 Mr Newmark: I am interesting in what you are saying here, Andy. On the one hand you are saying that you play a very passive role in this whole process of classification and that at the end of the day it does not matter because frankly if you see kids dealing in something in a playground in a village in Essex—where I am from—you will deal with it anyway, whether it is magic mushrooms or acid or heroin or whatever. You are just going to go there and do it. That is what you are saying. You say it helps guide your priorities, but you have not talked at all about what input you have in this process. You must have, as the police, some input because it is your resources that you are allocating at the end of the day. You are at the sharp end in seeing what is going on on the ground. I am really curious; you must have some input as a police force in determining what this classification is.

Mr Hayman: We do; we have two seats on the ACMD and we will make a contribution to it. When we had the re-classification of cannabis debate I was part of that discussion. It has to be said that the input from the police is going to be very narrow compared with other colleagues on ACMD because the main rationale as to why something goes into a different classification is based on medical and scientific evidence, not necessarily on what the police would bring to the party. I am not saying it is ignored because it is not and the chair of the ACMD is very inclusive, but I am not in a position to be able to offer that kind of technical advice. What I can offer are some of the points that I was asked before about the impact that certain drugs have on crime on the street and on the fabric of the community, and the consequence of drug misuse or dependency in the community under controlled circumstances.

Q399 Mr Newmark: Also the proliferation of drugs and therefore if you are seeing far more on the ground, ie people are using a particular drug far more, I have to believe that as a police force you then have input on determining what the classification or the re-classification of that drug should be. If something is something is suddenly Class C—hypothetically—and you are spending ten times your resources now dealing with that Class C drug, surely you are going to go back and say that this needs to be re-classified.

Mr Hayman: My understanding—and I might be wrong on it—is that that would not be a strong weighting or indeed a current criteria as to why something goes into A, B or C. It is very relevant material but it is not a show stopper for it.

Professor Strang: You asked a little while ago about what functions the classification system served. The other one that I hope you would consider is the way in which it shapes the general public's views on drugs. There is something about the way in which government and the public perception of drugs are portrayed which influences those early stages of drug use that I do not see any involvement in in my clinical work. In that regard it is strange that we do not peep over the garden fence at the alcohol and tobacco fields to try to learn lessons where you would presume there were generaliseable findings. The presumption would be that those observations would be generalised.

Q400 Chairman: When Brian Iddon raised this issue of the connect between a particular drug and crime the answer was that there is not a research base on which we can deliver the evidence in order to reform policy, and yet you have responsibility in many ways of delivering that research.

Professor Blakemore: I think there are some correlations between drug use and behaviours and their social impact which are very well documented. I think the police are in the best possible position to provide evidence about those relationships. For instance, the effect of alcohol and its impact on families, the tendency to produce aggression and violence; the same with crack cocaine—the link between violent behaviour and crack cocaine is very well established. I think when we talk about assessing drugs according to their harm it is very important to emphasise that we should not just be talking about medical harm—toxicity, damage to the body and the user—but the general impact on society. I think if we look at the impact of drugs in the last forty or fifty years the biggest effect has been on society rather than users. We know that 90% of

drug related deaths are attributable to alcohol and tobacco, and much of the remainder to methadone (prescribed methadone, at least initially prescribed and then illegally available methadone). We have to take into account the social impact of drugs when considering their harms.

Professor Strang: One of the reasons you do not have answers to your questions is that the UK does not invest in getting the answers. We are junior players when it comes to funding research that studies impact. If you look at the US and Australia they are orders of magnitude greater in investment. Our investment of our expenditure is about 0.1%; they operate at between 1 to 4%. I am not just saying there should be a little bit more. It is an embarrassment and it means that people like myself and my colleagues get lured away. Australia is populated by ex-pat addictions researchers who created a critical mass because of a better research funding environment. Supporting Andy Hayman's point, it may seem strange that people this side of the table are saying that it has less significance than perhaps your attention to it, but our interest is in the law as it is applied; it is not the same as what the paperwork says. Let is look at the cannabis example, if I remember the figures correctly between the mid-80s and mid-90s cautioning became what happened with more than 50% of all cases. No change in the law occurred; it was how at a local level a change occurred. You ought to want to know and I ought to want to know whether that led to increased use? What did it lead to? There is not really any answer to that. Our interest needs to be in the law as it is applied, not some letter that is attached to it.

Q401 Mr Newmark: To what degree is the lack of both medical and social evidence in this area a limitation in determining the appropriate classification of drugs? In your experience how well does the Advisory Council cope with the challenge of making decisions on the basis of inconclusive evidence?

Professor Blakemore: I think I would challenge what you say about the availability of evidence on the medical effects of drugs. This is a rapidly moving, expanding field of knowledge. I am sure that John would say that because of funding this country is not in a position to make as big a contribution to that knowledge as we should. We know a great deal about how drugs act on the brain and how, in some cases they produce dependency or addiction, what their toxic impacts are and therefore what the medical implications are. There has, of course, also been a great deal of research on the social impact of drugs. I am no expert and I am not in a position to say whether that evidence is as full as the scientific and medical evidence. The problem is—and perhaps this is at the heart of your question—that evidence is never perfect; it is changing. That is the basis of science and the collection of data. For instance, five years ago I would have said that the evidence for a causative link between cannabis use and the precipitation of psychotic episodes was extremely low. I have changed my view; I think the evidence is overwhelmingly clear. The effects are small but definite.

Q402 Mr Newmark: That is because cannabis itself has changed and people are making it stronger.

Professor Blakemore: No, I do not think it is. We know the genetic basis of those effects now through work funded, I am glad to say, by the Medical Research Council at the Institute of Psychiatry, and we have a very good rational explanation for those effects. It is a very small effect but it exists. That, of course, gets to the heart of one of my concerns about the ABC system. Because it has these sharp boundaries between As and Bs and Cs it is quite difficult to move drugs around in the classification on the basis of new evidence; but science is constantly throwing up new evidence.

Professor Strang: I would agree with much of what Colin Blakemore is saying. We do have an increasingly good picture for understanding drug effects and drug problems in the sort of classic high tech science way. However I would actually like to draw your attention to the potential danger of that. As we have increasingly impressive scientific techniques, what we are likely to lose out on is low technology science that looks at things like the impact of whether at a low level of policing, a change to cautioning, leads to an increase or decrease. I think we crucially need to know that. But that type of proposed research would not have a snowball's chance in hell of getting funded as a project compared with someone imaging some particular bit of the brain that helps you understand how it works. Even though, in terms of answering the question that alters how you apply the law and how you run society, in my view it is much more valuable. Some mechanism for protecting lower technology policy type scientific studies is urgently required and the funding pressures on science means that there is likely to be even more of a contrast between the things that do get funded at the high technology end.

Q403 Mr Newmark: In order to improve the way we go about classifying we need more evidence; in order to get more evidence we need more money into doing the research. Is that what you are saying?

Professor Strang: I think so, but in terms of gathering more evidence you could go on in this field forever about getting a portfolio of information. But the special missing element in the existing research is an exquisite series of experiments of opportunity. You can easily list a dozen things where, if you knew that the changes you had made with temazepam capsules in the late 90s had led to less use and less harm because rescheduling or reformulation took place then you would be more confident about making a similar change with another drug. If you knew it had backfired on you and had gone the opposite direction, you would be pretty hesitant about going the same way again. You do not have that partly because a lot of your research machines are in-house government department research where

the vested interest is in making sure that the departmental decision or ministerial decision is propped up against criticism.

Q404 Chairman: Do you think, yes or no, that ACMD is in fact coping with this agenda? Is it the right organisation, the right body, the right set up to actually deliver what is being asked of it?
Professor Blakemore: In a single word, yes. It has the right range of expertise. It takes a lot of time and trouble in considering the evidence. If there is a deficiency in the system I would say it is in the mechanism for communicating.

Q405 Chairman: It does not commission any evidence. It does not do any research.
Professor Blakemore: It does not need to do research; research is available, published. It looks at the available literature. Perhaps it would be useful if it could feed better into policies and the setting of policy priorities and strategies. That might be a valuable role, but I think the principal deficiency is how that huge mass of knowledge in the Advisory Council is able to feed into policy. And that is a reflection I think on the Misuse of Drugs Act classification.
Mr Hayman: My answer is yes. I do not know whether members have had the opportunity to go along and sit in and witness what goes on in the ACMD. I have been participating in workshops, weekends away and also the full meetings. I challenge the notion that you have to have them commissioning any research because actually they are blessed with the experts in the room.
Chairman: I will leave it at that because we will be coming back to it.

Q406 Mr Newmark: Professor Blakemore, you have been making presentations on the concept of a scientifically based scale of harm for some years. When did you first draft the paper with David Nutt and others proposing this scale? My next question is, why has there been a delay in submitting it for publication?
Professor Blakemore: I did not draft the paper; David did; he is the first author and I think it must have been about 18 months ago.

Q407 Mr Newmark: I am curious as to why it has not been done. There are these scales that are out there to do with physical harm, dependence and social harms and in some ways it struck me that you are trying to make a science out of an art, particularly when it comes to social harms. I am curious as to why this analysis has not been published yet.
Professor Blakemore: It sometimes takes quite a time to get a scientific paper, particularly with four authors, into a form that everybody accepts is ready for publication. If I could explain the basis of the study, it did grow out of talks that I gave on the possibility of creating a sort of matrix in which numerical values could be given to assessments of harm in order to rank drugs, not just illegal drugs but also including the familiar, acceptable, legal drugs as a kind of calibrator for the scale as a whole. An 18 month delay in getting a paper ready finally ready for publication is not unusual, I am afraid, in science.

Q408 Mr Newmark: Are you in favour of using a scientifically based scale of harm to determine the legal status of drugs?
Mr Hayman: If I could see the detail of what that looked like I could give an opinion on it but I would be worried that we are just shifting from a classification process at the moment to a different style one which would still have the frailties that are currently in the present system.

Q409 Chairman: The concern is that on that scale of harm alcohol, ketamine, tobacco and solvents are all incredibly high up on the categories and yet none of them appear in any of the classifications at all. That is a concern we would have.
Professor Blakemore: I think the most striking conclusion from the study is that although it purports to do what the Misuse of Drugs Act says is the basis of its classification the result is not statistically correlated with the ABC classification at all. In the ranking of drugs according to nine categories of harm of the top eight most highly ranked drugs in terms of harm three were Class A drugs and two were legal (at the time legal—ketamine has just been classified as C). Of the bottom eight, in terms of harm, two were legal (khat and alkyl nitrites) and three were Class A drugs (LSD, ecstasy and 4-methylthioamphetamine).

Q410 Mr Newmark: I have to come to the conclusion then that part of the delay in coming out with this publication is that having come up with these parameters they are not quite fitting with your argument because of these other drugs that have been mis-categorised based on historical evidence of the way they have been categorised.
Professor Blakemore: I do not think that it is our argument. What it implies is that one of the ways of classifying drugs according to harm—the ABC system or ours—is wrong, or they are both wrong. They certainly do not agree with each other.

Q411 Margaret Moran: Professor Strang, I think the point you are making about the lower level research is very important. The fact that that research has not been done, is that a reflection on the effectiveness—or lack of effectiveness—of ACMD? Who should be commissioning that research?
Professor Strang: I think the lack of this type of research severely handicaps the ACMD and it severely handicaps government's process of making decisions. Personally I think it would be ill-conceived to expect ACMD to be the body that commissioned work of this sort ACMD needs that work to be done, but its membership is not the right kind of membership for trying to get good quality work done that feeds into it. I have had either the privilege or the curse in previous times of being on ACMD, and that type of research needs to be

done—but ACMD is the wrong type of body to conceive, consider or commission the specific research.

Q412 Margaret Moran: Who should be commissioning it if not ACMD? They are supposed to be the body who advises on it; surely they should be making the very point that you have been making.
Professor Strang: I think if you looked around the room at ACMD you would see very few people with a research pedigree. It would be an unfair request to ask ACMD members to adjudicate between a good proposal versus a poor proposal. I think they need that to be done just like Parliament needs it to be done, but then that is different from it being the commissioner of it. You would like to say that government departments with interest and responsibility in the area were the obvious people. However we must have serious doubts about that because I think they become pre-occupied with just blindly defending the decision that was made yesterday. What you want, what we need, is an investigation that has enough integrity and independence to be able to say that it was a well-intentioned decision but actually it has backfired and that is completely missing. I do not think the ACMD would achieve that; it would still have that heavy hand of the civil service on it.

Q413 Margaret Moran: What you are suggesting then is that ACMD is not sufficiently independent of the Home Office secretariat. Is that what you are telling us?
Professor Strang: I do not think that was what I was saying but I would have thought that probably is a correct observation.

Q414 Margaret Moran: What about the other members of the panel? Would you say that ACMD is not sufficiently independent of the Home Office?
Mr Hayman: I am not in a position to be able to comment on that; I just do not know.

Q415 Chairman: You are on it.
Mr Hayman: I might be on the ACMD but I do not have a clue what the secretariat of the Home Office does so therefore I am not in a position to be able to comment.

Q416 Margaret Moran: I am talking specifically about membership of the ACMD.
Mr Hayman: I am independent of the Home Office and I am on it.
Professor Strang: I was not referring to the members as individuals; I was referring to the body of this operation. I am sure the individuals have independence and integrity outside the process.

Q417 Margaret Moran: There is a suggestion that as currently constituted there is insufficient breadth of experience on ACMD. There is a suggestion that the breadth of expertise on ACMD is not sufficient to address the questions that it is being asked to deal with. Is that your view?
Professor Blakemore: It is a very big committee with a wide range of expertise. You are raising a very important issue about whether ACMD should be in a position to commission research. It is music to my ears that John would say that history shows that the best way of getting good research done is to do it independent of ministerial control. We know of examples in which research commissioned by a government department has produced the results that the department has wanted—there is an understandable tension. On the other hand if, in the research councils—which is where the independent research is done—there is no response to policy needs then there is a kind of disconnect between where the high-quality work is done and what government needs to know. It is joining up those two things which I think we need to think about carefully. We have a very good opportunity to do so in the medical field with the proposal that the funding of the Department of Health R&D and the Research Council funding of medical research might be conflated in some new way. This not only would increase the money for addiction research and other areas of research, but also perhaps give us a way to re-think the input of policy questions into independent research.
Professor Strang: It seems to me that you need to recognise the vulnerability of the field and where you look at countries that have deliberately pump primed the process (the US went from zero in the 1960s through to producing an amazing addictions research machine, so did Australia in the 1980s) you would have to protect the operation of that otherwise it just gets trampled underfoot with the bigger research players. That would be resisted because you would normally say: Throw it in the market place and the best researchers and topics will win. But with this one you would have to say: We have a special need to make sure that we support this. With the drug addiction research machine in the US we are talking of just over $1 billion per annum for NIDA (the National Institute on Drug Abuse), so where I say we are of a different order of magnitude, we are several orders of magnitude out and what we end up with in the UK is a Mickey Mouse operation compared with others.
Professor Blakemore: Could I say that I was glad you introduced me as being both from Oxford and being from the MRC. What I have said so far has been, as it were, as an independent academic but what I can talk about on behalf of the MRC are the figures for spend. In 2003 to 2004 we spent £2 million in total out of a £450 million budget on addiction research. The total budget of the three NIH institutes that work in this area is $2.9 billion so even if one takes a conservative estimate of how much of that is actually devoted to addiction research it comes out to about five hundred times higher than in the UK—in other words about a hundred times more per head of the population.

Q418 Chairman: If you take an issue like young people and drugs and the effect, for instance, that it has on young people's learning, I would have thought that the MRC or indeed something which

would be commissioned through the ACMD ought to be looking at that specific area rather than just saying "we think" and yet we do not. I am sure you would agree with that.
Professor Strang: The current position in which the MRC and any funding body operates is: Does that compete with some other high technology bid? It will not, and your choice is then to leave it in the market place and say that if it sinks we will have to do without it or to say that it has such importance to our societal process that we must protect it. There are special themes in all sorts of research initiatives and that would be a proper way of addressing it and that is currently absent.

Q419 Chairman: I just think perhaps that ACMD ought to have a budget or at least the power to be able to commission some of that research.
Professor Strang: They should certainly be able to identify areas where they felt handicapped by not having answers.

Q420 Chairman: Would you support that, Colin?
Professor Blakemore: Yes, and there are mechanisms for doing that. Calls for proposals highlighting areas of research of particular interest, or even specific calls for proposals with ring fenced funding, are both used by the research councils in areas of particular interest, whether policy interest or scientific interest.

Q421 Mr Newmark: How well do you think the ACMD handled the two requests from the home secretary to look into the classification of cannabis? To your knowledge did the Council have and make proper use of the right expertise in arriving at that decision?
Professor Strang: My understanding is that ACMD were asked to give a view on cannabis with a relatively short timescale in scientific terms. It is not an area that they had either chosen to or had paid specific attention to for something like twenty years. An initial opinion was given. Public opinion was shaped by that and policing action was shaped by that. Then some correction to that occurred. I am sorry to keep repeating myself, but what an exquisite experiment: you have a situation, you make those intriguing changes and then you even partially reverse it. I do not know—maybe you know—what impact that had on levels of use, levels of harm, levels of admission with related problems. How could you make the next decision without knowing the impact of the decisions you made recently had.

Q422 Mr Newmark: Do you think it is in the correct category now?
Professor Strang: I genuinely want to be helpful to the Committee but I am very much in what I call the Andy Hayman camp on this. Personally I do not think it is a hugely big issue. It obviously should be handled in different ways from other drugs like heroin, for example. In practice it is handled in a massively different way and it is the "in practice" which is far more interesting than what letter is attached to it.
Mr Hayman: I presume you are talking about the first process, not the one that has recently been completed when you are talking about classification. The interesting nuance we have following that process is that it has gone into category C but if you look at all the rest from the policing powers perspective all the other drugs in C do not have the power of arrest that was retained for cannabis. So it has retained its unique position there and operationally that does present a very difficult challenge for policing. It was an interesting development in the classification of cannabis.

Q423 Dr Iddon: Professor Blakemore, was the evidence about its causal or non-causal factor for mental illness available before all the media fuss arose after the re-classification?
Professor Blakemore: It was not really, no. I mean there was some epidemiological evidence which was not very secure and I think it is fair to say that has grown over time and there is now a broad consensus that there is a causal relationship, although I would qualify that again by saying that the effects are very small. I think the figure is an 8% increase in the probability of schizophrenia as a result of substantial exposure to cannabis. The evidence has grown from that point.

Q424 Dr Iddon: Of those people whose schizophrenia is triggered by cannabis do they eventually develop schizophrenia?
Professor Blakemore: Not always. Amongst identical twins if one twin is schizophrenic the other one has a 50% chance of developing schizophrenia. So it is not inevitable that if you have the genes which seem to be associated with schizophrenia you will always progress to develop the disease. It depends on life events and cannabis appears to be a particularly potent life event in tipping people into that, into a psychotic episode.
Professor Strang: There was a moderate body of evidence about a relationship with different types of mental illness and as Professor Blakemore is saying it is substantially stronger now than it was a few years ago, but we have known about cannabis induced psychosis since the 1840s so it is not that recent. What in a way has been disproportionate has been the sort of flip-flop nature of the public and the political view on it—that somehow it was completely safe or then completely harmful. I imagine all three of us would be trying to say that you have to find some understanding of it which is between those two extremes.

Q425 Mr Newmark: What input did ACPO give to the most recent review of cannabis classification and what were the key factors influencing your position? I am particularly interested in your answer in the context of lessons learned from the Lambeth pilot assimilated into your policy making process.
Mr Hayman: We are talking about the original process.

Q426 Mr Newmark: Yes.

Mr Hayman: I sat through every session with ACMD. It has to be said that the majority of the discussion was around the medical and scientific evidence that was available and I think that was highly appropriate. When it was appropriate for us to give input we did and that was around the impact on the community, discussions around crime and there were certainly discussions about drug driving. I think the work that was pioneered in Lambeth did not have a major feature in the considerations of ACMD because that was more about operational application on the street. What I think it did do was that it started to set a context from which maybe politically and maybe from the community that rose up in terms of a priority of consideration. We must not lose sight of course of the Foundation report which talked about the classification of cannabis and I think that was very influential. I think the two together set the context to politically consider it. In answer to your question as to whether it had much say in the consideration by ACMD it was minimal, if any.

Q427 Dr Iddon: Professor Nutt and Professor Rawlins told this Committee that they thought drugs were classified according to the harm to society and harm to the individual fifty fifty. Why then are psilocin and psilocybin in Class A? I have never known anybody use them; I have never seen them on sale; there is no public fuss about them so why are they in Class A?
Professor Blakemore: I think the short answer to that is because they were initially put in Class A and it is awfully difficult to get a drug out of one class into another, as we have seen with cannabis. This is one of the problems with the Act. When a new drug appears on the street and new concerns are raised about it the perfectly natural tendency is initially to classify it as being harmful and then to reassess and reconsider over time and have the opportunity to rethink how it should be classified. But with distinct categories of harm (as in the MDA system) it is difficult to move a drug from one category to another. The placing of the hallucinogens in category A was a reaction to the concerns about drugs which were newly available on the street in the 1960s and 1970s with not much scientific evidence about their actions and certainly their long term consequences. You are quite right, the situation now is that they are not widely used. The evidence of toxicity is very low. They are not addictive and I would rate them very low in their potential for harm.

Q428 Dr Iddon: So what you are saying to me is that in 2005 the Misuse of Drugs Act put magic mushrooms into the wrong classification because the only reason for putting them in Class A was they contained psilocin and psilocybin. Do you agree with me?
Professor Blakemore: I would say they are in a classification that if one could look at all the evidence for harm available now, including social harms, one would say it is wrong.

Q429 Dr Iddon: So the Government were not using evidence based science to put them in Class A.
Professor Blakemore: I am sure they were using the evidence that was available to them at the time. The question is whether that evidence was fully formulated and was quantitatively organised in a way that would inform the decision well.
Chairman: The ACMD are supposed to review these things.

Q430 Mr Devine: ACPO said it would support a decision to re-classify ecstasy as Class B as long ago as 2001. Why do you think this decision has not been taken?
Mr Hayman: I am trying to be really helpful on this but I do not know. I gave evidence to the Home Affairs Select Committee around that time and in fact the document that I alluded to earlier in answer to one of the earlier questions about the ACPO policy was in preparation for the appearance in front of the Home Affairs Select Committee. That is where it was positioned. Again, I do not know why that has not proceeded.

Q431 Mr Devine: Have you asked ACMD to re-consider this?
Mr Hayman: It is not a matter for us to ask that.

Q432 Mr Devine: Do you not take the views of your organisation to that body?
Mr Hayman: Our positioning of our view on ecstasy was in direct response to a question about it looking to advance it or lobby for that. We were asked that question and that is how we felt at the time. I would have to go back to the membership to see whether it is a valid view. My understanding was that as a professional body it was not really appropriate for us to be saying to ACMD what we should or should not be doing; it works in a slightly different way to that.

Q433 Mr Devine: Are you on there as an individual or are you on there from the police?
Mr Hayman: It is our body that is represented as a professional body. It just so happens I had the privilege to be asked when I became the chair of it to sit on it.[1]

Q434 Mr Devine: What about the others on the panel, do you accept the view of the ACMD chairman that the revaluation of the classification of ecstasy is not viable because of the lack of scientific evidence?
Professor Blakemore: If we had a flexible system of classification that would respond quickly to changing scientific evidence then there could always be the case for moving the classification of drugs. My own view—my personal view, not of the Medical

[1] *Note by the witness:* In fact, under Cabinet Office Guidelines, and public appointments rules, I was appointed to ACMD in a personal capacity, although clearly, as with all other ACMD members, my professional role, knowledge and experience will have played a key part in being selected for appointment. The Office of the Commissioner for Public Appointments approves the process.

Research Council—is that on the basis of present evidence ecstasy should not be a Class A drug. It is at the bottom of the scale of harm. There has been a great deal of scientific work on ecstasy in the last few years but it is still a confused field. I think John would agree that we do not have adequate evidence on the long term consequences; there is a particular concern there.

Q435 Chairman: Andy, in 2003 (this is the issue about whether cannabis is a gateway drug) you made a very interesting comment when you were chair of the ACPO Drugs Committee, that "The theory of 'gateway drugs', ie someone starts with cannabis and then migrates onto a more serious drug does not stand up". We commissioned a report from RAND who said exactly the same thing. In oral evidence to us this year the chairman of ACMD said, "We know that the early use of nicotine and alcohol is a much wider gateway to subsequent misuse of drugs than cannabis or anything like that". Do you stand by those comments? I wonder if the other two members of the panel would also stand by those comments.
Mr Hayman: Those comments were made on the basis of what I had read. I have no professional qualification at all to make that statement but I read it in the research and that was my interpretation having read that research. That is why I made that statement. If we had a cop making those kinds of statements that would be very safe.
Professor Strang: I am afraid my answer is that it all depends on what you mean by a "gateway drug". It is a correct observation that people who are using heroin went through gates on the way to where they are now. The crucial question is: if you had had the power to stop them going through that gate would it have altered their subsequent journey? It really does come back to experiments and opportunities that are thrown up. I presume going to primary school is a gateway to being a heroin addict but you are not implying there is a causal relationship between the one and the other and that is the bit that is missing from most of the debate. There will be individuals where you can see it in that individual's personal development, but that does not mean it is a generaliseable finding.
Professor Blakemore: I think one should ask what is likely to be the causal basis of a real gateway effect. I cannot think of a chemical or physiological basis. The obvious basis is supply. If you are buying your first drug from a person who then tries to persuade you to use a "better" one and a stronger one then there is a causal relationship which is determined by the supplier. The fact is that as I understand it cannabis supply is, to a large extent, rather different from the supply of harder drugs. There is numerical evidence though. One can look to Holland where the attitude to cannabis use is even more relaxed than it is in this country and where cannabis use amongst the population is a little less than it is in this country even though it is more easily available. Hard drug use is about one third of the rate in this country. So the availability and the legal acceptance of a soft drug is clearly in that case not automatically leading to a high rate of hard drug use.

Q436 Mr Newmark: So you are saying there is nothing physical, ie that taking something that has a chemical reaction on you physiologically does not cause a certain potential of people in the population then to want to crave something harder after having used that other drug.
Professor Blakemore: I am sure that John can answer that better than me but first of all I would say that cannabis is not classically an addictive drug; it can be very habit forming and produce dependencies but it does not trigger the same mechanisms of the requirement for further and higher doses that the opiates do. I do not know about cross-craving between drugs and whether there is a physiological basis for that.
Professor Strang: I think it is ever so important for you to get away from this notion (if you have it at all) that there is just a vulnerable percentage of the population who might develop problems and it is all right for everybody else. With alcohol and tobacco you can look at it exquisitely. With both price and availability and public acceptability the levels of use will go up and down over the decades and the amount of harm that society approves goes up and down and the amount of addiction or dependence out there in society goes up and down. You can measure it against price: roughly every 1% up you get $\frac{1}{2}$% down. You suddenly think that this is not a commodity where there are just some people with the equivalent of brittle bones; this is something distributed across the population. There will be vulnerable individuals who are more likely to come a cropper and that has to be laid on top of it, but that does not explain the problems of alcohol, tobacco or illicit drug use in society.

Q437 Mr Devine: Do you say there has been a lot of scientific evidence about re-classification of ecstasy? My understanding is that something like nearly 60% of young people going out at the weekend could be taking this going to clubs and pubs and what have you with apparently no ill effect. Is there a political reason why we are not re-classifying ecstasy?
Professor Blakemore: I think there is always a defensible political reason to be cautious about making any substance which might have dangerous effects more easily available. That is a natural conservatism and is entirely defensible. I do think the accruing evidence on ecstasy has increased confidence in one's judgment that this is not a very highly dangerous drug in the way that crack cocaine and heroin clearly are and yet it is in the same category as crack cocaine and heroin at the moment.
Chairman: Thank you very much indeed Colin Blakemore, John Strang and Andy Hayman. I am sorry the session has been rushed but, as always when you have an interesting subject, you want to go on and on and on.

Witnesses: **Mr Steve Rolles,** Information Officer, Transform Drug Policy Foundation, **Mr Martin Barnes,** Chief Executive, DrugScope and **Mrs Lesley King-Lewis,** Chief Executive, Action on Addiction gave evidence.

Q438 Chairman: My apologies for starting this session a little late, but I am sure you were fascinated by the comments of Panel One. Could I introduce Mr Steve Rolles, the Information Officer for Transform Drug Policy Foundation, Mr Martin Barnes, the Chief Executive of DrugScope and Mrs Lesley King-Lewis, the Chief Executive of Action on Addiction. You are all very, very welcome. Mr Rolles, because you are in the middle could we ask you to field questions wherever necessary. You have been chosen as the chairman of your panel by a unanimous decision of our Committee. The ACMD told us that the purpose of the ABC drug classification system was to "classify the harmfulness of drugs so that the penalties for possession and trafficking should be proportionate to the harmfulness of the particular substance". Do you think the classification is effective in achieving that objective?

Mr Rolles: I suppose that in the context of an ABC system up to a point. There has obviously been some discussion about anomalies of certain drugs and certain classifications and there will no doubt be more discussions on that. I do not think that anyone is disagreeing that there are anomalies within that system. I would say that the objections of the classification system are actually more than that in that it is at the very heart of the Misuse of Drugs Act and broader prohibition is paradigm, the aim of which is to reduce drug use and misuse, to reduce drug availability as a way of reducing drug use and misuse and more broadly to reduce harm related to drugs in society. I think if you look at the evidence of the last 45 years it has transparently not done any of those things. Drug use has gone up exponentially; drugs are more available than they have ever been and drug harms have increased correspondingly to an astonishing degree. On any criteria you choose with regards to misuse, availability and overall harm the classification system and the policy that it sits within have failed in quite spectacular fashion.

Mrs King-Lewis: I very much agree with Steve and I think we have missed that opportunity, in that we failed to measure any of the impacts which John Strang mentioned earlier. We have had so much opportunity to actually look at what is the impact that classification has had on society at large. Have we seen an increase in cannabis use? Have we seen a decrease? Have we seen more users within young people? What has been the actual effect and the impact? We have failed to measure all that so what we would really welcome is automatic review of outcome measures whenever there is a change of the classification or a change that has implemented policy. We have missed so much opportunity to gather that vital evidence.

Q439 Chairman: When you say "we" who do you mean?

Mrs King-Lewis: That is a very good question. We, as a research charity, are calling for government and ACMD and in respect of the previous argument I think a weakness there is that there is no-one who is proactively determining a research strategy for this country. There is no-one who is commissioning research and there is no money available. We really need an independent body to actually implement the research. I think there is a very good role for the ACMD to be more proactive identifying what the gaps are and then having the budget attached to it but getting it commissioned by an independent body. That is very important; it has to be independent.

Mr Barnes: I agree with Steve to some extent that if the goal is to reduce drug use or prevent drug use then clearly the lessons of the last thirty years show that we have not succeeded but I do not think you can put the blame just on the system of drug classification per se. We have the wider debate about the divide between legal and illegal drugs. You have covered alcohol and tobacco this morning in terms of the comparisons of harm, but within the context of setting a legal framework for illegal substances the drug classification system as it operates is far from perfect. However I think there is actually flexibility built into the system. The issue is perhaps why have we not seen since the Act was introduced sufficient change in the way certain drugs have been categorised. What are the triggers that should lead to those reviews and those changes? I think more importantly what are actually the barriers? We have covered a lot in previous inquiries in terms of anomalies where current drugs sit, the role of the ACMD but all of that operates within the political context, the way the media covers these issues and the fact that when we deal with the issue of drugs and drugs policy it is very difficult on almost any level to have an informed, objective, evidence based discussion. More often it is heat rather than light that it is generated and politicians are nervous about drugs policy; they are nervous about being seen to make changes and if we needed any evidence to confirm that just look at what happened with the cannabis re-classification. Historically it is a significant change but in terms of the system overall it is not that big, but that was not the way it was reacted to politically or in the media.

Q440 Dr Iddon: I would like to go into a bit more detail as to what each of you think the home secretary should be looking at. Could I put it to you that there are drugs available over the counter and there are drugs that are prescribed by doctors that are equally dangerous as some of the drugs that are already in the classification system? Have we not got it all wrong with this classification system and should we not start from a zero place and build up a new system?

Mr Barnes: I think the fact that the home secretary has announced a review is very welcome and we do not yet know the full detail as to how the consultation is going to happen, but obviously the wider, the more clean slate it starts the better. I think there is an opportunity there to address those issues

of over the counter medicines but also there substances that are not currently classified that can be bought on Camden High Street or on the Internet. People looking at the Internet in terms of those substances do not get terribly accurate information about the possible harms so there is a gap and a potential anomaly there as well that I think should be looked at, but it is an extremely complex subject and I do not think there is a simple answer.

Mr Rolles: I agree that we should start with a clean slate and I also welcome the fact that the home secretary has announced this inquiry and I also welcome the fact that this Committee is looking at this issue. It is very welcome to have the light of science pointed at this rather murky corner of policy making which seems to have been fairly unbothered by science historically. In terms of what they need to be looking at, I think we need to go beyond just determining and ranking the harm of drugs because that debate can go on forever. It is important up to a point but more important they need to look at the outcomes of this policy: is the policy effective at doing what it is supposed to do? If it is actually doing the opposite of what it is supposed to do if it is increasing harms and under the auspices of this policy use is increasing and availability is increasing, then you have to question the validity and utility of that policy more generally. What I would like to see is the entire scientific base of the policy itself examined. I would like to see some examinations of outcomes historically and consideration of possible alternatives to classifying drugs. We are talking about public health policy in terms of drug harms but significantly that is then transferred into criminal penalties. We have the classic category error here where you have a lot of excellent science in terms of determining harms of drugs which is then transferred into criminal justice penalties which have incredibly poor science in terms of determining the impact of the criminal justice penalties on outcomes from public health. There is great research at one end of the spectrum and a total absence of research and science at the other end. I think that is where we need to focus and hopefully the Committee and Home Office consultation will do that.

Mrs King-Lewis: I agree with Steve, we need to close that link between having the research there and very little output because it is based on those outcome measures which then inform policy. That is the area that is missing. I also agree with Steve to make it more of a public health agenda as well. It is very much focused on the criminal justice element but really looking from the start at what is the purpose of it? What are the objectives? What are we trying to reach? Certainly the public health agenda and advising the public as what the different harms of the drugs are it is very limiting just by classifying it A, B or C. We are not really giving the public much information. To my knowledge I do not think we have ever done any public survey. We do not even know if the public see that if a drug is in Class A is that more of a deterrent or is it actually an attraction? We cannot even answer those simply questions.

Q441 Dr Iddon: I asked the previous panel if there are any other countries that get it better than we do. I put it to you that the United Nations conventions are the limiting factors because they do not encourage countries to develop best practice.

Mr Barnes: I think it is true that the UN conventions are a limiting factor but there is flexibility within that. Look at the Netherlands, for example, which for certain drugs—by no means all—takes a more liberal approach to issues of possession. There are countries, for example, that have been piloting safe injecting rooms but there is a view that that is against the letter of the UN conventions, so the UN conventions are a potential stumbling block to very radical reform but I think the parameters within which domestic policy can operate are reasonably broad. I agree that we do need to look at the effectiveness of the way the current legal enforcement of drugs operates. Steve and his organisation come from the view point and are very clear on this that they want to see a system of legalisation. I do not think we are talking about science evidence base, that there is the evidence to say that legalisation is going to be the way to significantly reduce related harms. It is naïve to believe that if we had a system of legalisation it is going to take it out entirely of the harms of criminals. There was an interesting document published alongside the Budget this year looking at tobacco smuggling. If we did a word replacement and instead of "tobacco" put "cannabis" (assuming we have a situation where cannabis is legal) I suspect very similar problems of smuggling and criminal gang involvement would apply. Yes, we need to look at radical reform; the problem is that it is very difficult to have a debate about even cautious changes in drugs policy.

Chairman: I do not really want to go down that road so I am not going to invite you in on that. Our Committee is basically asking where is the scientific evidence to justify the current policy. That is what we are looking at.

Q442 Mr Newmark: Would you be in favour of using a scientifically based scale of harm to determine a legal status of drugs? Why or why not? In view of the fact that drugs policy is a politically sensitive area, what role should scientific evidence play in influencing decisions? I am asking the question in the context of David Nutt's analysis into which I think Lesley had some input. Steve?

Mr Rolles: I think in terms of a classification system as a public health tool then I think the simple ABC classification is almost completely useless; I do not think it is any use as a public health at all or it has very little, it is marginal. I think in terms of young people and the classification system I do not think it makes any difference really; it is must more based on their personal knowledge and information they get from their peers about risks and so on. I certainly do not think that young people are leafing through Hansard before they go out on a Saturday night. If anything they will ignore it completely. In terms of a criminal justice tool I think it is actively counter productive. I think criminalising drugs increases the

harm associated with those drugs. Not only does it create the secondary harms associated with illegal markets, it also increases the harms of the drugs themselves.

Q443 Mr Newmark: You are not answering my question. My question has to do with a scientific base scale of harm in determining drug policy.
Mr Rolles: The problem with the ABC system is that it hugely over-simplifies quite a complex series of drug using behaviours and the vectors of drug harm are far more complicated than just ABC. There is a series of determinates for any particular drug and any particular user.

Q444 Mr Newmark: You are moving to classification again; I am not talking about classification, I am looking at scientific evidence.
Mr Rolles: Obviously I believe that you should have scientific evidence for any policy. In terms of ABC I think that is a different area.

Q445 Mr Newmark: I am mainly focussing on scientifically based evidence in determining harm and having got that scientific evidence from a public platform then articulating that this is the science behind the decisions we are making as public policy makers.
Mr Rolles: I think I have answered that. It is great to have good science in terms of deciding what drugs are in which category, but there is no science for determining the fact that the classification system itself is effective in doing what it is supposed to do. I would just reiterate that point really.
Mrs King-Lewis: I think if we had the scientific evidence and used it appropriately we would not have the anomalies in the system today. It has already been mentioned about magic mushrooms being a Class A drug and the classification of other drugs. We have either ignored the evidence that exists or have not used it or other priorities have come into play.

Q446 Mr Newmark: How can government improve its approach in making policy decisions on drug classification where evidence is inconclusive?
Mrs King-Lewis: Identify the research gaps, fund it and get it funded by an independent body. The amount of money invested in this country is £3 million to £4 million. That is the average R&D budget for a small public company.

Q447 Mr Newmark: Which is Professor Strang's point.
Mrs King-Lewis: Absolutely.
Mr Rolles: I think we would all agree with that and with the previous panel that there is not enough research into drug policy issues and drug harm issues generally, but I think it is both of those. It is not just research into harms and addictive behaviours and so on, it is also research into outcomes specifically. Whilst we can identify holes in the research with regard to magic mushrooms or ecstasy or whatever, there are also huge holes in the research with regards to some of the things Andy Hayman was talking about such as the deterrent effect. The concept of the deterrent effect is central to the entire classification system and indeed the whole prohibition is paradigm specifically the idea of a hierarchy of deterrents associated with a hierarchy of penalties, but there is no research at all—not a single piece of research ever done by the Home Office that I am aware of—into the effectiveness of the classification system as a deterrent and the independent research that we do have—what little there is—suggests that at best it is a marginal impact on drug taking decisions. To me that is a striking gap in the knowledge that we have in terms of determining this policy.

Q448 Mr Newmark: Lesley, you have said you have reflected on what Professor Strang has also said, that there needs to be more funding, but how responsive do you feel government has been to your concerns? Have you had a chance to articulate those previously? What needs to be done is more funding, but should the primary responsibility for funding addiction research in your view lie with the Home Office, health or research councils?
Mrs King-Lewis: You have made a very interesting point; it is not just with drugs. There are different departments: alcohol is a department, sport and education; nicotine is a separate department; drugs. We almost need one body who has the accountability and responsibility for pooling research into all the different drugs, the legal and the illegal drugs. Obviously we are missing a trick there because there is no joined up thinking.

Q449 Mr Newmark: Do you think that as a result of that there would be more efficient use of limited resources, ie money, by pooling it together so there would not be competing groups effectively doing the same research?
Mrs King-Lewis: Exactly. There are cases where the Home Office has actually commissioned research which the Department of Health did not even know about and were commissioning a similar issue. There is a frustration there.

Q450 Chairman: What was the issue?
Mrs King-Lewis: I will have to get back to you on that. It is so frustrating when the little amount of money that has been allocated is then duplicated or, as has happened in the past when we have responded to a call, information can be sat on for a long time or never published.

Q451 Margaret Moran: We have heard the assertion that ACMD should be looking at the research gap. Leaving that aside what other weaknesses do you see that there are in ACMD? How could its effectiveness be improved?
Mrs King-Lewis: I have had personally very little dealing with it but from my objective point of view there seems to be very little transparency and it seems to be reactive and not proactive so I think the opportunity to be proactive would be great and would make a big difference.

Mr Rolles: I would agree with both those points. There is a lack of transparency although I did note that Professor Rawlins said that the minutes of meetings would be made available and hopefully we will get to see those at some point. Certainly the work that the ACMD actually produces is first class and no-one is questioning the good intentions of the ACMD. The problem is that the ACMD is set up within the framework of the Misuse of Drugs Act so it exists within a system that is signed up to the prohibitions paradigm and a criminal justice approach to managing drug problems in this country and as such it is very limited within that remit. It can question things within a criminal justice system but it cannot question using the criminal system per se as an effective tool in terms of dealing with drug problems even though there would appear to be a mountain of evidence to suggest that the criminal justice approach to managing drug use has not historically been effective given that the problem has got worse and worse over the last 45 years. I think the main problem is the political framework within which the ACMD operates, not the work that it actually does. The questions that they are asked they answer very well; it is the questions that they do not ask which is the problem.

Mr Barnes: As you probably know I am here as DrugScope Chief Executive but I am also a member of the ACMD which is possibly why I was not asked to comment on the previous question. I am concerned when I hear words like "lack of transparency" and "not reactive". The ACMD does do proactive work. To give you an example, it published a report three years ago on the issue of children living with parents who misuse drugs, a report called *Hidden Harm*. It took the Government two years to publish its response to that report; it took 18 months to two years for a fantastic piece of agenda setting work. On the issue of research one of its recommendations was that we need more research into the issue of the effects of drug use amongst parents of young people. The Government's response was that we have enough research on that issue. The ACMD's report on cannabis re-classification, the recent one, it did call for more on-going research into the effects of cannabis on mental health problems. As we have touched on, should it be the role of the ACMD to commission research? Perhaps it could be more assertive with government in terms of saying where the gaps are and what needs to happen, but given the ACMD's role that it is there to reach a judgment on the research, to gather it together, to look at its robustness, to reach a conclusion from that, there could be a tension between it being a commissioning body and also a body that then has to take that evidence into account and reach its judgments on the evidence it is looking at.

Q452 Mr Devine: How did you become a member of the ACMD and what do you see as your role?

Mr Barnes: I sit in a personal capacity but I would not have been appointed, I do not think, had I not been Chief Executive of DrugScope. As Chief Executive of DrugScope I hopefully bring to the Committee with all its range of expertise of its members particular knowledge or perspectives. Saying that, if I did not feel that the ACMD was a credible body, as Chief Executive of DrugScope I would not have applied to become a member.

Q453 Margaret Moran: We have heard evidence both in the previous session and in written evidence that the ACMD is supposed to be a scientific body therefore the question is why do you have campaigning organisations on there? What does that bring to it? Also there are significant gaps even in the science that should be on the ACMD. What would be your response to that?

Mr Barnes: Firstly I think if you are referring to DrugScope in particular we do campaign but we are not just a campaigning organisation. We have the largest library of drug information in the world; we do conduct research; we try to inform policy; we have a membership of around 900 organisations that represent the broad spectrum of people working in the drugs sector. So to have non-scientists if you like on there does bring value to the work of the ACMD. There are also people who work in treatment organisations and also people who work in education and they do bring that broad perspective to the issues. I think if the ACMD's role was simply to look at the narrow issue of the scientific and medical evidence as to what harms drugs do to individuals I think its role would be much clearer and easier, but its role is to look at the issue of a drug related harm in the wider context of wider harms, the harms that drugs can do not just to individuals but to their families, to the community, et cetera. That is what makes its role more challenging and, if you like, more complex where the research itself does not necessarily give you the answers—certainly not the easy answers—as to what the policy response to drug harm actually should be.

Q454 Mr Newmark: Lesley, you expressed concern following the decision to re-classify cannabis as Class C in 2002 that this could lead to an increase in the use by young people in particular. What conclusions do you think we can draw from the apparent decrease in the use that has actually occurred?

Mrs King-Lewis: I think it is very interesting but again we did not measure it. We missed a vital opportunity. The belief was that if we actually decreased it we expected usage—especially amongst young people—to increase. Actually what happened was that we saw a decrease. But that is all we know. What we do not really know is anything more than that so again we missed the opportunity to evaluate the effect of that change in policy.

Q455 Mr Newmark: There must be a reason behind your concern.

Mrs King-Lewis: Yes, because we had not expected the decrease. We expected that if we de-classified it the message being sent out to young people would be that it is okay, it is legal, we are no so concerned about the health messages, it is okay for you to use cannabis. We were concerned about the messages we

were sending out to young people and we were actually very surprised to see the overall trend—and the trend has been dropping for the last few years—continued to decrease but we do not know whether it is because of an existing trend, what other factors or because of the re-classification. We are still left in that same ignorant position so if we want to make another change on the cannabis policy we have not built a body of information to make an informed decision.

Mr Rolles: There is a lot of talk about sending out messages and the classification system being used to send out messages, but firstly there is no evidence to suggest it is effective at doing that at all which I think is something which needs to be borne in mind.

Q456 Mr Newmark: It goes back to your argument that in fact it should not really influence our thinking; classification is a red-herring.

Mr Rolles: There is a bigger point really. Why are we using the criminal justice system to send out public health messages at all? It is not the role of law and order to send out public health messages.

Q457 Mr Newmark: If something is illegal and is deemed illegal by Parliament there has to be a mechanism for enforcing the law and that is the whole point of deciding what is legal and what is illegal and therefore—going back to what Andy was talking about—you then have to have some form of classification to decide where should the resources be put in enforcing the law.

Mr Rolles: Transform's organisational position is that drugs should not be illegal and that making them illegal has actually increased the harm associated with those drugs. Just because something causes harm does not mean that you necessarily criminalise it. We do not criminalise pork scratchings or running with scissors. There are all sorts of things which are potentially risky but if you want to reduce harm associated with them you educate people and encourage them to make more responsible decisions; you do not criminalise them or put them in prison. That is not ethical and historically it has been completely ineffective. Drugs are a superb example of that. Drugs are quite anomalous in all of UK law and social policy where you use the criminal justice system to send out a public health message. We do not do that with tobacco or alcohol; we do not do that with glue sniffing or prescription drugs or dangerous sports or all sorts of potentially risky activities, but for certain drugs for reasons lost in the mists of time we have decided that we are going to send out a message using the criminal system which is quite bizarre.

Q458 Mr Newmark: To take a step back, prescription drugs have to be prescribed before you can take them.

Mr Barnes: Can I just comment on the cannabis issue and the continuing down trend? I think the home secretary in his interview with *The Times* before Christmas himself accepted that the Government could have handled the issue of re-classification at the time better. There was ample opportunity to have launched a comprehensive campaign, particularly for young people, to explain why the category was being changed. We are now getting a campaign sometime at the end of May and we look forward to seeing that. One of the consequences of re-classification with all the debate and controversy that it generated, is that I do not think we have ever had a more in-depth public debate about the known risks of cannabis. I can remember a couple of years ago hearing somebody on the radio who advocated legalising cannabis coming out with a statement that the worse that can happen if you use too much cannabis is that you fall asleep. That is patently nonsense.

Mr Rolles: I do not think Transform would agree with that.

Mr Barnes: I did not say it was you, did I? You are not the only pro-legalisation body. Let me make it clear, I have every respect for Transform and the work they do. I have no criticisms of that organisation so rest assured that I was not having a go. We do now have a more open debate which is difficult to have through the media admittedly. There might have been some initial confusion but research now shows that the vast majority of people do understand that the drug is illegal. I think the next challenge to get across is that they understand the potential harms that can go with its use. That is still the challenge.

Q459 Dr Iddon: Is there not still a big problem with the cannabis debate? People say today that the cannabis sold on the streets is stronger than it used to be. We are completely dishonest with young people. There are 23 varieties of the plant and what we are selling on the streets today is not the same plant extract that we were selling ten years ago on the street. We have skunk now which was not available some years ago. Is it not time we became honest with our young people and tried to explain what they are buying on the street?

Mr Rolles: That is absolutely right. What young people need is honest, accurate information at the place and time that it is needed. Going back to the point I made earlier, I do not think an ABC ranking system provides that kind of detail and nuance for what is a really quite complex set of variables in terms of determining drug related harms. It just does not do that. Class C drugs can be used in very risky ways; Class A drugs can be used in comparatively less risky ways. There are an immense number of determinates like the dose you take or the frequency of use or whether you are using certain drugs with other ones at the same time can amplify harms; your personal predispositions, whether you have pre-existing mental health problems or certain physiological conditions which would put you at risk. For all that complexity and all these different variables of harm, the ABC system does not provide any useful information at all.

Mrs King-Lewis: I agree; we need to be far more honest. I think there has always been a problem in this country and it is almost like we are reluctant to talk to our young people and give them the information. We almost seem to feel that we are

going to create a problem by acknowledging one exists and the information is not out there. They do not know the different types; they do not know what the levels are or who they are buying it from. We need to do a lot more work on educating. We need to do a lot more work on prevention as well. It is interesting because prevention does not come within the remit of the ACMD or the Drugs Misuse Act; it does not seem to fall anywhere but that is what we are particularly interested in, the prevention side: how do we talk to young people and, more importantly, how do we change their behaviour about drugs and alcohol? Information has to be a key factor in that.

Mr Barnes: Could I just reinforce the point that the system of drug classification within the context as we have it is one response to reducing drug related harm. I entirely agree that we also have to look much more at learning lessons and other areas of research around what works in terms of prevention. There is growing evidence that the link between socio-economic factors and drug use moving from casual into dependency, for example, and why are we not seeing tackling drugs as more of a key potential outcome of that as well? Education in schools. More investment around drug treatment. We have seen record amounts going in but there is clearly more to do in terms of improving the effectiveness of drug treatment. On the role of the ACMD it has looked at work around prevention. It published a report in 1998 that emphasised that if we are talking about genuine prevention we need to address the wider social factors, the upstream factors, and at the moment it is doing a very good piece of work I think in terms of looking at the effectiveness of policy responses in terms of young people's drug use. That work is on-going; they are meeting with officials at the moment to firm up the recommendations and I think it is due to be reported later this year.

Q460 Dr Iddon: The previous panel gave us the impression this morning that the ACMD were rushed into making a decision. You have just implied that more research is needed on cannabis so why did the ACMD make a recommendation to change the classification from B to C in view of what the previous panel and in view of what you have told us just now?

Mr Barnes: Firstly I was not on the ACMD, which recommended a change, the original recommendation was made and, as you know, it was not just the ACMD but in its recent report it did say, if I remember correctly, that there was a need for on-going and more research into the issue. It was asked by the home secretary to look again at cannabis re-classification and under the Act it had to do so. It spent two days considering the evidence. It was not rushed into a decision, it was at least a nine month process in terms of capturing the data, witnesses were called to give evidence on the first day of the inquiry as well. The report itself went through various stages. It went to the technical committee, it went back to the full ACMD. It was not a rushed process but in terms of reaching its conclusion to keep the classification at C but with a list of other recommendations as well, not least the need for a robust and comprehensive public education campaign, it could only base its decision on the evidence that we currently have.

Q461 Dr Iddon: Do we have it right now? Is cannabis in the right classification system?

Mr Rolles: The problems with the ACMD's deliberations were not that they did not look at all the evidence of the impact of cannabis on mental health and so on, but their decision in terms of recommendation for re-classification or not was based on an assumption that re-classification has some impact on levels of use and therefore mental health of cannabis users and there is absolutely no evidence at all to suggest it does so the whole exercise is just a big distraction. The whole thing is about the classification system and what impact that has on harms and because we do not measure it we have no idea so you can argue until you are blue in the face about which category it should be in. I have been trying to think of a metaphor for this and the best one I can come up with is that it is like arguing over what colour to paint a square wheel. Even if all the experts agree it should be blue it does not matter because that wheel does not turn. The classification system does not do what it is supposed to do, it does not reduce harm, it does not reduce misuse, it does not reduce mental health problems. In fact it seems to do the exact opposite so the whole thing is an exercise in distraction as we are concerned.

Q462 Dr Iddon: Have we not got it right based on the evidence available?

Mr Barnes: Yes, but let us keep it under review. I think coming back to the issue of research—and I was interested in Michael Rawlins' comments about ecstasy—firstly our knowledge base changes over time in terms of the harms or otherwise that the drugs themselves can do. Also the way that those harms interact with individuals and why society changes over time. Drugs do change in fashion and in use so research itself has to be an evolving on-going process. A word of caution is that we have to be careful that the research itself does not overly drive the public policy responses because a piece of research could reach what appears to be quite a firm, definite conclusion. If you respond too quickly to that and then find that a later piece of research contradicts or challenges—as so often happens, not just in the drugs field—that previous research, you are going to have a system of drugs bobbing in and out of classification. That would not be a better response I do not think.

Q463 Dr Iddon: I hope we are talking about peer review as well.

Mr Barnes: Yes.

Q464 Chairman: Lesley, yes or no?

Mrs King-Lewis: Only no in a few years time once we have evaluated the decision.

Q465 Mr Devine: Today the Scottish Police Federation are debating the legalisation of drugs and as politicians you can imagine our primary role

is to be re-elected. If we came out and said, "Legalise all drugs" we would be crucified by the media. I just wonder about media attention and how you think that that influences government decision making and how do we get what you want, a reasonable debate in the media and a discussion with young people about the real impact of drugs.

Mr Rolles: I think the problem really is that we have two generations of demonising drugs and demonising drug users and it is a highly politicised area. It is a very emotive issue and it is very difficult to step back from all that and just look at the evidence and rationally discuss the alternatives. I think as politicians it is behoven upon you to say, "Okay, this policy we have at the moment, all the outcomes are not what we would expect, they seem to be going the wrong way, are there other alternatives we can look at and consider in a rational and scientific way?" I think the key to that is to move away from its emotive war on drugs rhetoric or some of the polarised debate where you have the drug warriors on the one hand and the evangelical drug legalisers on the other hand and consider that actually there is a lot of common ground. We all want to reduce the harm drugs cause, let us look at the policy alternatives and see from the evidence which one is most likely to achieve the best outcomes. I think that by approaching it in a rational, non-confrontational way we can have a sensible debate and it does not necessarily mean that your election chances are going to be jeopardised.

Mr Barnes: My concern when we debate legislation is that there is a danger of focussing on that as the issue when actually there is a long way to go in the meantime in terms of incremental, radical and potentially controversial reform. It is at that stage itself that it is quite difficult to have an objective, informed debate. The recent front page article in *The Times* claimed "cocaine floods playgrounds" on the basis of an apparent report that showed an increase in cocaine use amongst seven to 15 year olds from one to 2%. That was the headline that parents on a Saturday morning would have seen when they opened their papers.[2] The issue of crystal meth, some of the ways that that has been reported—I know it is easy to criticise the media, we all so it—quite frankly has been irresponsible. I see in the ITV news van as the lead a story about Britain on the verge of a crystal meth explosion. The tea-time news explained that details about how to manufacture it are on the website and can be made with home made ingredients. Just coming back to the issue of the ACMD, when the recommendation was published by the home secretary, members of the ACMD were contacted by *The Daily Mail* to be asked, "Have you ever used drugs?" When we look at the issue of the transparency of the ACMD bear in mind that the people who sit on that committee have a very difficult role, have to tackle and make judgments on very difficult and potentially controversial decisions and I think to inform that role and to do it robustly there has to be some degree of protection in terms of those individuals fearing that they have the confidence to expose themselves in that way and take part in that process.

Mrs King-Lewis: We are keen to move the debate from a criminal justice angle to a public health, really informing the public, the young people in particular, of the different levels of drugs and the different and varying harms that they can do to themselves. We need a much more rational debate.

Q466 Dr Iddon: Bearing in mind that it appears that fresh magic mushrooms were put in Class A because psilocin and psilocybin were already there (which, of course, they contain) do you think we got it right in classifying fresh magic mushrooms as Class A drugs?

Mrs King-Lewis: No.

Mr Rolles: Absolutely not. There was a legal market there; that legal market did not seem to be causing a huge amount of problems before the 2005 Drugs Act but there were clearly issues in that the sale of these magic mushrooms was completely unregulated and unlicensed. What Transform was suggesting was that vendors were licensed and appropriate controls were put in in terms of age and information available at point of sale and various other appropriate restrictions. What did not happen in the Misuse of Drugs Act is that the regulatory impact assessment that was done on that particular clause within that particular Act should have, under regulatory impact assessment guidelines, considered in detail what the different options were and they did not consider in any detail the regulatory option, it was a throw away line in that regulatory impact assessment.

Q467 Chairman: Martin, yes or no?

Mr Barnes: I would say no.

Q468 Dr Iddon: Were the ACMD consulted about this?

Mr Barnes: I am not aware that the full council were asked to deliberate on this. I think because it was going through primary legislation and I think it was wrong for the home secretary to seek to enact it in primary legislation without properly consulting the ACMD and giving it time to deliberate on it. In terms of the classification the evidence has indicated that it is in the wrong classification, but I suspect that if the home secretary is presented with a fully considered report from the ACMD recommending change I think the answer would be no.

Q469 Dr Iddon: Is that going to happen?

Mr Barnes: I am not aware that the ACMD is planning to look at it; it certainly has not been asked by the home secretary to look at the classification of magic mushrooms.

Chairman: On that note could I thank you. I am sorry it has been a helter-skelter run through, but the bell is just about to go for the announcement of the session. Steve Rolles, Martin Barnes and Lesley King-Lewis thank you very, very much indeed for helping us today.

[2] *Note by the witness*: Although any increase is a concern, the actual increase was from 1.4 or 1.5% to 1.9%.

Wednesday 14 June 2006

Members present:

Mr Phil Willis, in the Chair

Adam Afriyie	Margaret Moran
Mr Robert Flello	Mr Brooks Newmark
Dr Evan Harris	Bob Spink
Dr Brian Iddon	Dr Desmond Turner

Witnesses: **Joan Ryan,** a Member of the House, Parliamentary Under-Secretary of State for nationality, citizenship and immigration, and **Mr Vernon Coaker,** a Member of the House, Parliamentary Under-Secretary of State for policing, security and community safety, gave evidence.

Q1142 Chairman: Good morning to our two ministers, Joan Ryan and Vernon Coaker. Welcome to this our final evidence session on two of our case studies on ID cards and the classification of illegal drugs. For your benefit and the benefit of visitors this morning, this is part of an overarching inquiry looking at how scientific evidence informs government policy, how it informs risk, and how Government takes advice from an evidence base and a scientific base. That is its purpose. Our job is not to decide whether ID cards are a good thing or a bad thing. It is very much a matter of looking at the science behind it, the evidence behind the Government's policy. We are, first, going to run through the issues on ID cards and then move on to drug classification. Several witnesses have said that they were unclear about the objectives of the ID card programme. Are you clear what they are? Would you give us a quick canter through that?
Joan Ryan: Yes, I think I am. I am happy to do that. The reason I am clearer than most is because I served on both the standing committees that took ID cards through the process in the Commons. I would outline four main reasons for ID cards. That is not to say there are not or will not be others as this develops but I think we have four key objectives. The first I would identify as being to enable people to have a secure means to establish and protect their identity. The second is to help to counter illegal immigration and work to strengthen our borders. The third is to counter the misuse of public services, to ensure that public services are used by those entitled to use them, and therefore also to improve efficiency and effectiveness in service delivery. I would identify the fourth as to counter organised crime and terrorism, to disrupt the activities of terrorists and organised criminals, and to make the UK the most difficult place in the world to use false identity.

Q1143 Chairman: Do you feel that from the beginning of this process the Government has been clear as to what its objectives are since David Blunkett announced them as the Secretary of State a good number of years ago now? Do you think there has been a clear timetable and are you working to that timetable? Are you conscious of a timetable?
Joan Ryan: I do think the Government has been clear right from the beginning and, as I say, I have had quite some involvement in that process from an early stage. I think we were very clear on the face of the Bill. We have been clear in the early discussions and consultations that took place. These four reasons have figured throughout. It is true that people have sometimes given them in a different order and perhaps with a different emphasis.

Q1144 Chairman: You are working to a timetable?
Joan Ryan: In terms of a timetable, we have what I would describe as a broad timetable with landmarks along it, rather than a detailed timetable. If we go back to David Blunkett in 2002, we can see the progression; we can see that a very big landmark was getting the legislation enacted. There was a delay there of a year. That is now part of the timetable. In the main, we are now at a stage where we are seeking to move to procurement and the procurement process itself will have a very big influence on determining the timetable from the point at which procurement happens.

Q1145 Chairman: As the Minister responsible, are you now clear in your mind that, from now until the time that we all have ID cards, not only is the timetable mapped out but there are no hurdles that are yet to be overcome and, if there are any, what are they? Is it all plain sailing?
Joan Ryan: On the timetable, we do not have a date at which I can say to you, "Here you are. On this date the scheme will be ready and we will start at that point rolling it out". I can tell you where we hope to be. However, as I have said, the procurement phase is crucial. We have landmarks in this timetable to work with our partners to deliver on our building blocks. The committee is probably aware of things like biometric passports, UK biometric visas and biometric residents' permits. Those kinds of developments and the feedback from them will help determine the timetable. The reason why the timetable is perhaps a bit looser than what might be called a very detailed timetable is because of that development and because we want to be very cautious on the basis of all the lessons we have learnt from good and bad projects.

Q1146 Chairman: You are giving the impression that there are no problems facing you at the moment, no scientific problems facing you at the moment, and all has been resolved.
Joan Ryan: I am not attempting to give that impression, Chairman. What I am saying is that the procurement phase is going to be absolutely crucial and trialling during that procurement phase in identifying for us where the issues are, if problems are going to have to be caught. It is because we are taking it in that incremental developmental way that we expect therefore to be able to deal with issues as they come up in that procurement.

Q1147 Chairman: Has procurement begun already?
Joan Ryan: No. We have done a preliminary information notice.

Q1148 Chairman: Has that thrown up any problems?
Joan Ryan: That has obviously alerted the market to the fact that we are seeking to go forward towards procurement. We have done some very detailed market soundings. What we have identified through this are risks rather than problems. De-risking is a very important part of the way we are going forward and of the incremental build with the building blocks I have mentioned and also the way in which we are hoping to structure procurement.

Q1149 Mr Flello: Do you think that perhaps some of the confusion and difficulty has arisen because actually as the whole idea around ID cards has evolved, more and more really good uses are being thought of for them, for example, in terms of employment? If somebody is coming to an employer and needs to prove their identity, ID cards would be a very good mechanism in that sense. Do you think that some of the confusion and difficulties have arisen simply because there are so many add-on benefits for an ID card?
Joan Ryan: I think that is exactly right. There are a number of other schemes in different countries around the world, all of which we are looking at and we are talking to the people involved. I know the committee has had some evidence on some of these issues and our conversations with people in terms of the US visit with the FBI; IDENT 1, the police fingerprinting scheme; and the Hong Kong scheme where they can use ID to counter on-line fraud. All of these developments continually bring forward, first, that this is a concept of its time now and, secondly, that there are growing advantages. Different bits of the advantages appeal to different people, and that is what they will emphasise. That is why it is important we have our four main objectives. As I said, that should not exclude developmental work on using the card in other ways as time moves on.

Q1150 Chairman: One of our concerns as a committee is about the principal objective. Let us say that there is an agreement and the Government is clear about its four major objectives. I understand that different things could be added on in the future, but at the moment take those four things. What we find difficult to understand is how it is possible to decide on a technology which will be most suitable when you do not really know what it is that you want the technology to do. You have some objectives. You are going out to procurement but you do not know what it is you are going to procure in order to achieve your objective. We find that difficult to understand, or I as a simple person do.
Joan Ryan: I am clear about that. Obviously I have had many meetings discussing these issues with my officials and those who advise me on scientific issues in recent weeks, and only in recent weeks as I am newly in post, as you will understand. That is a very crucial part of understanding how this is going to happen. I think the committee is right to ask the question because these are large expenditures and we have to get this right. My understanding is that the reason procurement will happen in the way it does is that we do have clear objectives and so we know what outcomes we want. The technology that will be developed through procurement will be driven by the outcomes we require. We are not going to the market to buy something off the shelf. We are not saying to the market, "The technology must look like, feel like and act like this". We are saying that the technology must be able to deliver these outcomes for us. We will test that through the trialling. The private sector suppliers are the experts in developing the technology. We want to use their expertise and continually stretch them throughout the procurement process, but always testing and ensuring that we meet our objectives; i.e. the outcomes we require in order to establish the identity card programme.

Q1151 Chairman: You are now totally in the hands of the market to deliver an unknown product on which you may or may not meet the specifications which have been laid down by the Department?
Joan Ryan: I do not accept that we are totally in the hands of the market. You will know that in the first instance when we go out to procurement, the first phase will be when the market will produce for us a pilot or prototype where they will bear the risk and they will compete with each other. We will then have trialling of that small-scale production as to how we will enrol people and how the technology will work. At the end of that phase, we will select either a consortium or a private sector provider.
Chairman: You are confident that that is going to work.

Q1152 Dr Iddon: While we have been taking evidence, industry has been quite critical of the Home Office. I will give you a quotation from Microsoft, who, after all, are one of the biggest firms, in the field. They said: "After all these consultations we still do not seem to have had an impact on the level of understanding about what makes for a good identity system". On the back of that quotation from Microsoft, I would ask: is industry going to be entirely clear in the procurement process about what you are asking them to deliver?

Joan Ryan: You will know that we have, as I said, had a comprehensive market sounding exercise, and we have worked closely with industry and technical bodies using the industry routes such as Intellect. We have also worked closely both with experts within the Home Office, through our Biometrics Experts Group, our Biometrics Advisory Group, across Government, through the Assurance Group and the Chief Scientific Officer and his panel. We have also looked very carefully at other schemes that are up and running. I cannot answer for any individual company's comment but I can say that we have worked closely with industry. We have taken a great deal of care to work closely with schemes that are already in operation. We are working with caution, I think it is true to say, to get these building blocks in place so that when we come to the procurement, we already have a large amount of evidence about the way in which biometrics are working. I think we are right to be cautious and to question. This is a big programme and a big expenditure. I am confident that the work we are doing with the market is in-depth work and that we will be able to move successfully through into procurement.

Q1153 Dr Iddon: It is not just Microsoft that are critical. Here is another criticism from another source. They say, and I quote, "You have people who are, frankly, scientists giving evidence to people who are, frankly, not". The implication there is that there are not enough scientists in the Home Office with which outside agencies and industry can engage at the same level and communicate properly.
Joan Ryan: Someone said to me on this position, "Don't you think it would be helpful if you were a scientist?" I said, "No, I do not. I think scientists are very helpful people and in fact I could say I am a scientist, a social scientist".

Q1154 Dr Iddon: I am not talking about you, Joan, but about the officers.
Joan Ryan: The point I was going to make is that I think we can demonstrate involvement at all levels of scientific and technological expertise both inside the Home Office and outside. It is also crucial that people who are not scientists are able to assess and understand this information and make a judgment about how confident we can feel in all the work that is being done. When we are running this out to the public, there is a huge issue of trust. We have a responsibility I believe, as Government and as Members of Parliament, to ensure that public trust and confidence in a project such as this is developed and maintained for all the right reasons. I think both scientists and non-scientists need to be able to understand it.

Q1155 Dr Iddon: What we are picking up, and it is not just in this inquiry but in other inquiries that this committee has undertaken, is that there used to be a scientific structure in the Home Office that seems to have been destroyed during the last couple of decades maybe and that the Home Office, when it comes to major procurement programmes like this, gets itself into difficulty because there is not enough technological understanding within the Home Office to be able to communicate with an industry that is going to deliver. Would you think that is a fair criticism or do you think the Home Office is well set with scientists and technologists able to handle this project?
Joan Ryan: I know that criticism has been made and there has been previous criticism of lack of a scientific culture in the Home Office. I also think that if we look towards the Home Office's Science and Innovation Strategy of 2005-06, which summarises the science in the Home Office and a series of reforms to invent science within the department, we can see that some of those concerns are perhaps not justified.

Q1156 Adam Afriyie: There are three main types of risk. We have a risk of time; it might take too long to deliver. We have a risk of money; it may cost too much to deliver. We have a risk of functionality; it may not deliver at all or it may not work. Which of those risks would you consider the easiest to mitigate—time, money or functionality—within each area?
Joan Ryan: All risks have to be mitigated. From what I have said previously to the Chairman about ultimately the issue of trust and confidence, the fact is that this is a large project involving large sums of money and all of those risks must be mitigated. If the honourable gentleman would like me to say a bit on each of those, I think we are working very hard to make sure that that de-risking does occur.

Q1157 Adam Afriyie: Perhaps you could say a few words on the type of risk in terms of time. You have a very tight time schedule here. I have 15 to 20 years' experience of IT projects. It seems almost inconceivable that you could trial new technology, develop it and have it deployed within the timescale set. Perhaps you could talk about how you are mitigating the risk of time so that all this does not take too long.
Joan Ryan: As I said, the timetable is not one that says to us, "Here is a ready-to-serve date. You must be rolling out ID cards at this point". We have aspirations built on some of the building blocks that we are putting in place, but the detail of the timetable will only become absolutely clear though procurement. That is as it should be because we would not be de-risking if we said to the committee, "We can absolutely guarantee to you that you will see the first ID card at such and such a date". If we did that, you would rightly say to me, "So are you going to learn no lessons through the procurement process? Are you going to learn no lessons through the trialling?" Obviously we have to work through the procurement process and the exact timetable will fall into place. I am sure we will have much more discussion about that as the process takes place.

Q1158 Bob Spink: Is the Minister now withdrawing the implementation timetable that had previously been announced for ID cards?

Joan Ryan: We do not have an implementation programme for me to withdraw, so I am not withdrawing anything. We do not have an implementation timetable.

Q1159 Chairman: We have been given evidence on that.
Joan Ryan: What we have been told is that there is a desire, and a strong desire, to see ID cards towards the end of 2008-09 being issued.

Q1160 Mr Newmark: Is that an aspiration or is that real timing?
Joan Ryan: That is a strong desire that we are working towards. As for the building blocks I have spoken about, I was watching ID cards being issued yesterday at Lunar House in Croydon. The ARC card for asylum seekers is, in effect, an ID card. You will know that from August every passport issued will be a biometric passport. All these building blocks are being put in place. We dealt with the secondary legislation on UK visas last week. By end 2007/early 2008, all UK visas will be biometric. That is a timetable and we are moving towards it, but that is not to say that I can give you a guarantee that the procurement process will have happened in a particular way.

Q1161 Chairman: To be fair, Joan, your predecessor did not give us a specific date either. We will not follow up on that. Risk is something on which we have not had a clear answer from you. Your predecessor appeared to be content to allow us to view the risk register. Why have you said no?
Joan Ryan: I hope I explained in my letter that there are potential confidentiality issues around parts of the risk register and obviously, at the point we go into procurement, this is crucial. Therefore, I took the decision that this could pose a difficulty.

Q1162 Chairman: What changed between your predecessor and you? Why am I not trusted to look at parts of the register?
Joan Ryan: Also, much of the register is outside the scope of this investigation. It is not a question of trust between myself and you, Chairman. I have said that I would be very happy, if you want to make a specific request, to do all that I can to meet that request and enable you to see those parts of the risk register within your specific request as it relates to the scope of this investigation and the work of the committee.

Q1163 Chairman: This inquiry is actually dealing with scientific evidence and risk. Particularly for those bits of the register that relate to science and technology underpinning the scheme, it would be very useful if in fact as a committee I can report back that we have actually seen the register and seen those elements of it and can say that that is happening.
Joan Ryan: I appreciate the point you are making and I would say that the offer I have made was very genuine. If you come back with specifics, then I will do all I can to accommodate that request. I understand that your desire is genuine and obviously the findings and the outcomes of the committee are helpful to us.

Q1164 Chairman: Of course they are and so I will be able to look at those elements of the register which refer specifically to the science and technology underpinning the scheme on a confidential basis?
Joan Ryan: I would ask the honourable gentleman, the Chairman, to respond to the offer made in my letter.

Q1165 Chairman: Why can you not just say yes?
Joan Ryan: I would like you to write to me with a specific request. It is important, with my responsibilities as an Under-Secretary of State, to consider carefully, particularly from a select committee, the requests that are made to me. I would like to give that consideration to your specific request. I can assure you that I will do that in good faith.

Q1166 Chairman: I find that very disappointing, if I might say so. One of the purposes of a select committee, particularly on an inquiry like this, is in fact to be able to have a trust between a minister and the committee. The idea that we cannot see and I cannot see elements of the register without going through a long process with you I think is disappointing, but there is no point in moving that on.
Joan Ryan: I am not saying you cannot, and I do hope that you will not be disappointed and that that trust will exist and does exist between us.

Q1167 Mr Newmark: Given that the Home Office has said that trials will provide vital new information, why is there at least a perception that this has been left so late? Is this not just increasing the risk of problems at a later stage?
Joan Ryan: That presupposes that no trialling has occurred, and I would not say that that was the case. First of all, there was some very important case work done early on in 2004 on the biometrics and technology options. There has been trialling since then. I would point to IDENT 1, which I think all are agreed has been a very successful procurement and build operation, and also obviously the IAFS immigration and asylum fingerprint system. The fact is that these are new, up and coming and existing programmes as IAFS is going to move into IAFS Plus to accommodate the UK visas and biometric resident's permit. They give us a huge amount of information and they are in effect trialling. However, that can only happen within the procurement phase because we want to trial what is being developed. We are able to do that in that first phase at the private sector's risk, which I think is a very good option for Government in procurement. Following that first phase, we will then, once we have our private sector partner and as the technology and the register are built, trial. For a system that will run for some 60 million entrants, we think somewhere around the first 2 million people

registered into it will in fact mean very large-scale trialling. That is another reason why we are taking it a step at a time.

Q1168 Mr Newmark: According to the evidence we received on 8 May, there is not going to be that sort of trialling of specific technical issues.
Joan Ryan: We have used evidence from the US National Institute of Science and Technology that does world class biometrics testing.

Q1169 Mr Newmark: Let us move on. One of my concerns is about what happens if the technology actually does not meet up with the expectations in these live enrolment trials. Just to give you an example, and I am sure you have heard this two or three times at least, in women in terms of iris recognition there are changes at various times of the month.
Joan Ryan: No, there are not. The retina might change but the iris does not. I think we have clarified that.
Chairman: We have sorted that out.

Q1170 Mr Newmark: That was one of the things they were not confident about when we went to the States.
Joan Ryan: Brian raised it with me in Home Office orals. I would understand any concern like that. I am very pleased it was raised with me.

Q1171 Mr Newmark: I will come back to a more generic statement. What happens if the technology does not meet expectations during live enrolment trials?
Joan Ryan: You can see from what I have been able to say when you read the answer about irises that we are alive to these issues and these risks, and we are alive to them because of the work that we are doing looking at the deployment of existing technology and working with using evidence from bodies like NIST. I think that is a very important part of our trialling. Clearly, as I have said, we would build on that.

Q1172 Mr Newmark: By definition, you would not be trialling if you had total confidence in the technology.
Joan Ryan: I think it is best and good practice to trial and we would be trialling. We are confident that we will achieve procurement to deliver a technology that will deliver the programme, but I think your committee would rightly ask me what I thought I was doing if I was not insisting that there was trialling through the process. If I did not do that, you might be worried.

Q1173 Mr Newmark: Adam has been in high tech for 15 years and I have been in business for 20 years. Things never run smoothly and that is why I am curious. Have you any contingency plans in case there are problems during procurement?
Joan Ryan: As we are not tied to this exact timetable, that of itself is a contingency because if there are issues, then there is time to resolve issues. That of itself is a contingency. I think the real contingency is the fact that we are building gradually and it is incremental. That is because of the lessons we have learnt. I would say something else, and perhaps it comes back to the three risks that Adam mentioned, and add a fourth. If we look at what happened perhaps with the passport service, which is now an excellent service and one of our great successes and deserves to receive an accolade for that, as you all know, it had a difficult period, shall we say. That was not to do with the technology; that was to do with people issues—staff, training and enrolment. That is the fourth risk I would identify and it is another area we will be doing a great deal of work on. We are doing some of that work now through trialling, i.e. rolling out the biometrics passport and seeking to go to authentication by interview because it is not just about biometrics, you understand, establishing identity and issuing a card; it is also about a biographical footprint. That work is already going on as well.

Q1174 Dr Harris: To what extent is the scheme governed by politically imposed deadlines? Are you alive to the fact that there is a tension between the need to deal with pesky Opposition politicians who say, "No, this will be delivered" and scientific advice saying, "Wait a minute. There needs to be scope for wriggle room if problems emerge"? How do you balance that?
Joan Ryan: I hope what I have already said about the timetable you will find reassuring. I do not feel I am running this according to some political deadline. We have the legislation. We are moving to procurement. We are seeking to deliver, but I am not pressured by any external deadline outside that programme.
Chairman: That is good to hear.

Q1175 Dr Harris: If scientific advice said that the planned timescale, even if it is informal, is not reasonable because of difficulties, then that would count a lot. Do you fear that there is a culture that says that because this has become so political, it has to be delivered and the scientists will just have to get on with it?
Joan Ryan: I would like to go back to an earlier answer when I said there is another issue and that is about our responsibility to the public and the issue of trust. I do not think anything can be more important than getting it right. That would be my answer. I hope we can do that in a timely fashion, meeting a reasonable timescale, but nothing is more important than getting it right. If scientific evidence comes forward that tells us there is an issue, it will depend on the evidence. We will have to have that evidence assessed. I have no doubt we will be discussing it here. It would depend on what the issue is. I cannot comment on a hypothetical problem. I am not anticipating something major that would completely delay or derail the programme. I would like to reassure the committee that nothing is more important than getting this right.

Q1176 Margaret Moran: We have been told by the Government that facial recognition will be effective in protection and prevention of fraud as a central plank of what we are talking about here. Yet, we have received evidence from Professor Angela Sasse to say that 90% of benefit fraud is committed by people who do not lie about their identity. What specific evidence do you have on the extent to which fraud is based on lies about identity? Could you also tell us how the ID card project will guard against this?
Joan Ryan: I think it is the case that the majority of benefit fraud is not perpetrated at present by people who are lying about their identity, as far as I am aware. Given your question, I will ensure that I look at specific evidence. That is my understanding. We would say that where there is a level of benefit fraud which relates to identity, then clearly it is important that that is tackled. Clearly, in that case identity cards will help. As I mentioned, there is the issuing system in the Hong Kong system. These technologies are developing. The way in which people access services and markets is changing. Much of it is internet-driven. We know that the ways in which people can commit fraud, in terms of use of identity and credit cards and all kinds of issues and stealing other people's identities, is on the increase. We know that these measures will help. I cannot put figures on that here and now for Margaret but I will of course look more carefully at that. I think what you say about benefit fraud is in fact correct.

Q1177 Margaret Moran: You referred to yourself earlier as a social scientist. We have heard from the Home Office that social science is being used to validate assumptions and that where that research rejects a current assumption, a change is made. Could you give us a specific example of where that has been the case, where social science has influenced a change of direction in a project?
Joan Ryan: I can say that we have undertaken nine separate pieces of social science research, and so we do think this is very important. One of the pieces of research is looking into people with special needs issues. We have undertaken 16 focus group discussions. Certainly, from all that we have learnt from that, it is not so much that we make an assumption and then change it; it is that we are learning from that kind of work and from the other social science I have mentioned done with the public. We are learning from them what the issues for them will be. I mentioned special needs in particular because you will know from the UK Passport Service that we have done trialling and we have found that elderly, people with various disabilities and some minority ethnic groups had more difficulty enrolling than others. That was not necessarily to do with technology.

Q1178 Chairman: Have you changed the system as a result of this?
Joan Ryan: It is informing the way in which we are enrolling people and the way in which we are enrolling them for a biometric passport. That will inform how we are going to enrol obviously for an ID card because a passport is the designated document. I am struggling to think of specific changes that we have made. We know that there are issues for people about how easy it is, given various disabilities, for them to deliver their fingerprints, whereas facial recognition is much easier.

Q1179 Chairman: Would it be possible for you to look at that and perhaps let us have in writing some ideas on the way you conduct the social science research and the way it has affected the programme is moved on?
Joan Ryan: I would be delighted to do that. As I say, there has been a lot of work done there. I would appreciate giving the committee more detail on that.

Q1180 Margaret Moran: The Gateway Review has been completed but that focuses on process. Could you tell us whether you are prepared to undertake a gateway review on the practical and technical feasibility of the project and make that available?
Joan Ryan: I would have to ask to write to the committee on that. I would need to understand the gateway review process and how it has been applied so far to this process and also to biometric residents' permits. I do not feel I can answer that at the moment.
Chairman: That will be acceptable.

Q1181 Dr Harris: You said you are not aware specifically and you will let us know of any specific changes that have been made following social science research. We are told in your evidence, and I quote, "the mechanism for incorporating the results of social science work into the programme is predominantly a robust change control process". Do you know what that means because I do not, I am afraid.
Joan Ryan: I think it means exactly what Margaret was saying. We undertake this research and from it we are able to acquire information about how best to do things like enrol people and deal with people's issues. One of the things we were interested in finding out from people was whether they felt that giving fingerprints meant that in some way that you are a criminal. There is a lot said about people's perceptions being that if you are asked to give your fingerprints, there is some notion of criminality and people would be very resistant to do this. We discovered through the research that that is not the case at all. People's attitude was pretty much: if you have nothing to hide, why would you be worried? We also discovered, through things like the biometrics road show, that people quite like testing out the technology and that, far from it being a barrier, the only times when it hit the barrier might be when there are physical reasons why it is difficult for people to use the technology. There are other issues as well, cultural issues. We have seen these through the roll-out of the passport as well and the new photograph in order to get the facial biometric; for instance, the wearing of head wear for certain groups is an important issue. Social science research has helped inform us about to how to deal with and approach those issues. It is not so much making a

complete change from one idea to another but it is informing us about how to approach and handle these issues.

Q1182 Dr Harris: Can I ask you about costs? To what extent would costs be a driver in choosing the technologies, or indeed the functionality? How do you balance costs?
Joan Ryan: I suppose we would want what is called best value in that the cheapest will not necessarily be our choice because it might not be able to deliver what we need to see delivered. Our business case has been seen by KPMG. It has been through the Office of Government Commerce gateway. It has had approval at many levels. We are confident that we have the funding and the costings, that they are robust, and we have built in contingency, optimism and bias. We feel we are going to be in a strong position in relation to cost and procurement, but clearly the priority is that we are confident we are (a) getting value for money but (b) that it will deliver.

Q1183 Dr Turner: Could either of you tell us something about the "joined-upness" of working between government departments on the ID scheme, both on the technology development and making sure that other departments can use it without any operational difficulties. Obviously the Department of Health is going to have an interest in this; DWP is going to have a considerable interest. What can you tell us about that aspect?
Joan Ryan: We have undertaken a great deal of work on what we call stakeholder engagement, which is what I think you are referring to in terms of the development of the identity card. We have also undertaken work with our delivery partners and then with other groups as well, such as industry groups and a technical group. Across government, the ID card programme managers are key stakeholders who may expect to realise benefits from the introduction of the scheme. We have account managers and they have been in place since 2004. They each have a key contact person at strategy board level. We draw in from that DWP, Department of Health, CRB, the police, and the Department for Communities and Local Government.

Q1184 Chairman: Are these contacts at ministerial level?
Joan Ryan: No, these are at civil servant level. Through that work, obviously we are attempting to get this cross-departmental recognition of benefits, the buy-in and working together. We also do that through working on our building blocks.

Q1185 Dr Turner: You will have taken steps to ensure that the technology is compatible across the whole piece?
Joan Ryan: Yes, it is absolutely crucial that interoperability exists. We have a number of ways in which that is being approached. We also ensure that with all other schemes we have the technical specification whereby everybody is going to be able to speak to each other.

Q1186 Dr Turner: One of our witnesses suggested that there has not always been the coherence that there might have been. Specifically they referred to the e-Borders programme where it is suggested that there has been a lack of sharing of evidence, a duplication of effort and a general overlap. There is a specific claim that there has been little coherence between the programmes, particularly in the early stages. What comment do you have to make on that?
Joan Ryan: In terms of interoperability, we have common technical standards as a start point. We have the e-Government Unit and the Government's Interoperability Framework. We work within that. Across departments, we have our stakeholder groups and our expert assurance groups to make sure that is all working together. You brought up the example of e-Borders. The e-Borders Programme has its own timetable. Although we would look to learn from particularly Project Iris for instance and issues around iris scanning, e-Borders and iris scanning do not actually have a card that relates to the database in that way. It is not perhaps as close a building block to the ID card scheme as some of the other building blocks I have mentioned. It would not be correct to say that there is no interaction between our e-Borders development team and the ID card scheme because there is and it is very important. I am not sure the relationship between what is being developed in both these things is as close as the relationship with UK Visas and biometric residents' permits.

Q1187 Bob Spink: Given the technological implementation uncertainties and the massive IT infrastructure requirement, procurement will, I guess from your answers, be a developmental process. Will it therefore be on a fixed-price basis, or are you returning to the old cost-plus contract basis for this procurement? Both of them have their problems.
Joan Ryan: I am loath to delve into talking about the cost issue at the point where we are about to go to procurement because I do not think that would be most sensible. At the point where we talk about that, we would want to discuss it.

Q1188 Bob Spink: I think that we as a committee and Parliament generally have a duty to hold the Government to account. If the Government is going to return to a cost-plus rather than a fixed-price contracting basis, then I think that is something of public concern.
Joan Ryan: We have given quite detailed information as far as we are able, without breaking commercial confidentiality or going outside the scope of the committee, on the business case. That is in the public domain. You will also know that we have undertaken every six months, subject to commercial confidentiality, to submit a report to the House of Commons, and that was agreed at the Lords' Amendment Stage.

Q1189 Chairman: It was and we are content with that. Joan, thank you very much indeed for answering all these questions. We will have further

questions later in the session. Can I briefly ask you this? Last week we had Paul Wiles in front of us, the department's Chief Scientific Adviser. We specifically asked him whether he had responsibility for ICT in the department and he said "no". Neither he nor in any evidence we have received from the Home Office have said who is responsible for ICT. Do you know who it is?
Joan Ryan: Could I ask to write to the committee on that point to confirm who I think it is?

Q1190 Chairman: That is interesting because it is actually Vincent Geake. What we would like to know is why in fact he has not been mentioned in any evidence at all and why you as the Minister did not know and neither did the Chief Scientific Adviser. Perhaps you would write to us on that issue because IT seems to be incredibly important to this project.
Joan Ryan: Obviously he is the Chief Information Officer. I was just a bit thrown when you said "technology". I do in fact know that that is his job. Also, he is newly appointed and so I was struggling to find his name, but I do in fact know it is him.

Q1191 Chairman: It was not a trick question but just that it is an important issue. Thank you very much indeed, Joan. We will return to you. We move on to Vernon Coaker and the issue of drug classification. Could I launch in straight away, Vernon, and say that the Chief Executive of the Medical Research Council described the current classification system, and I quote: "It is antiquated and reflects the prejudice and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical, consequences". Do you agree?
Mr Coaker: No, I do not agree with that.

Q1192 Chairman: Why not?
Mr Coaker: I think it is a fairly extreme view and I am sure it was meant to actually put a point of view. I think the classification system has generally served us well. There is a basis for the classification of the drugs. I think it is a system that is understandable to people and has credibility with the public.

Q1193 Chairman: You would defend it, as the Minister responsible?
Mr Coaker: I would defend it. That is not to say it is perfect.

Q1194 Adam Afriyie: Could I go back one step? What do you consider to be the aim of the UK drugs policy and the classification system in particular? Obviously we want to see drug use stopped. Is the policy to stop the users, is it to stop dealers, or is it to stop the suppliers? What is the aim of the policy of the classification system?
Mr Coaker: That is a very good question. It is not either/or. Sometimes, in these debates about drugs strategy, we get into an either/or situation. As an overall strategy, it is about tackling drugs, dealing with the street, trying to tackle that in terms of crime on the street and doing something about some of the problems that people see on their street. It is about getting more people into treatment, trying to do something about those people who are misusing drugs, and trying to support them. If you look at the numbers going into treatment, there is a record number of people going into treatment at the present time. It is about breaking that cycle. Alongside that, it is also about education and changing attitudes. I think the classification system helps in the sense that it identifies those drugs which are potentially harmful.

Q1195 Adam Afriyie: I am somewhat surprised that you argue that the classification system has been helpful when drug use has increased enormously since the introduction of the classification system. What does that say about the classification system when in other countries like Sweden drug use has virtually gone?
Mr Coaker: We have a situation where we have a drugs strategy that is tackling drug use out there; it is tackling the prevalence of drugs on the street and drug use. If we look at some of the statistics, in terms of the drugs strategy, we are seeing a degree of success with 16–24 year-olds. The 2004–05 British Crime Survey compared the present situation to 1998 and for 16–24 year-olds the proportion that reported that they had ever taken any drugs had fallen by 15%.

Q1196 Adam Afriyie: If we go back to when the classification system was first introduced, then I think the picture would be very different. It is easy to point at a graph, take a couple of dates and make a case. If you look at the overall picture since the introduction of the classification system, the evidence is completely the other way round, is it not?
Mr Coaker: If you go back to '71, we were in a different type of society. We are dealing with society and the community as it is now. I think in that sense we have a situation where there is an overarching drugs strategy, which is not just based on the classification system but on education; it is about changing attitudes and it is also about enforcement of the law. It goes back to what I said earlier. It is not one situation or the other; it is a package of measures trying to deal with the problem we have.

Q1197 Adam Afriyie: What precise or specific evidence is there that putting a drug in a higher class actually has a deterrent effect? From what I can see, sometimes it even seems to have the reverse effect.
Mr Coaker: I think that people out there—if we talk about the population in general, the public at large—if we have classified a drug as a Class A drug, realise that it is a serious drug; they realise that it is a drug that is harmful. It is a drug that has a particularly—

Q1198 Chairman: Where is the evidence? I am not doubting that you believe that, but where is the evidence to demonstrate your response to Adam's question?

Mr Coaker: The evidence is in the survey that we have taken recently where we have looked at drug use, and the statistics that I have just given out, where we have seen a reduction in the use of drugs.
Chairman: The point of Adam's question, if I get him right . . . . I am sorry, Adam, perhaps you should ask the question.

Q1199 Adam Afriyie: The point of the question is this. What specific evidence is there that when you move a drug to a higher class there is a deterrent effect on its use? Where is the evidence for that?
Mr Coaker: We take the advice of the ACMD; we take the advice of the police. The ACMD has scientific representatives on it. They are people who are professors of pharmacology, and so on. They advise us on that, and they advise us on the class of drug, where a drug should be classed, and we take evidence from them. Then that gives us the opportunity, as I say, to reflect on the impact that has on the public.

Q1200 Dr Harris: However, Professor David Nutt, who is the Chair of the ACMD Technical Committee, says, "I think the evidence base for classification producing a deterrent is not strong". So, on the basis of what you have just said, will you now take that away and change your answer? If you are referring to him, he disagrees with you by 180°.
Mr Coaker: Professor Nutt, as you know, is a member of the ACMD. We have a matrix which we use. That matrix is part of the way we determine which drug should be in which category. Of course, we always look at the evidence that people give us; we always look at the opinions that they give to us; but what we have there is Professor Nutt being part of the ACMD and we take his advice.

Q1201 Chairman: It is disturbing for the Committee—and this is about evidence and policy, Vernon, not about whether the Government's policy is right or wrong. What we are saying is this. Is there any occasion when the Home Office has commissioned research to show that when you put a drug into a higher classification it actually has a deterrent effect—or the opposite?
Mr Coaker: We have a scientific basis for determining harm. The ACMD refer to that when they classify drugs. When we come on to methylamphetamine, they risk-assessed that against the matrix, and that is when they have come forward with the proposals they have with respect to that drug.
Chairman: We will return to that specific drug.

Q1202 Adam Afriyie: I have just one last question around evidence and research. Have you commissioned any research to look at the classification of a drug and the level of crime associated with it? It does seem from studies in America and elsewhere in the world—I am not sure about the UK because I have not seen the research here—that if a drug is in a higher class, it therefore has a higher perceived street value; dealers get involved; there is a higher economic incentive for crime. Have you commissioned any research into that area?
Mr Coaker: The Department of Health carry out a lot of research and we work closely with them. They commission a lot of research into different aspects of drugs. I have here a number of reports, both by the Home Office and by the ACMD, which research into various aspects of drug and drug abuse.

Q1203 Adam Afriyie: Do they look at the class of a drug and the crime associated with that and the correlation between them?
Mr Coaker: There is an obvious example with respect to that recently. As Phil was saying, we will come back to the methylamphetamine. Cannabis is an example of a drug that they looked at and did some research into. Ketamine is another one that recently the Technical Committee looked at and, obviously, date rape. So there are a number of research projects which are going on at the present time, looking into various drugs—both recently and now.

Q1204 Chairman: Coming back to the ABC classification, in January the then Home Secretary announced that a consultation paper on the ABC classification system would be published within a few weeks. It has still not been published. Why?
Mr Coaker: I am sorry, could you repeat the question?

Q1205 Chairman: In January the then Home Secretary Charles Clarke announced that a consultation paper on the ABC classification system would be published within a few weeks. There was obviously a concern about it at that time. Why has it not happened?
Mr Coaker: Two things. First of all, the Home Secretary—in post for four weeks—has not yet taken a decision on how to proceed with the review of the classification system. With respect to the consultation document which is in draft form in the department, the view is that we will need to wait until such time as we decide how to proceed with respect to the review of the classification system and also, similarly, wait for the report of this Committee—which we want to take into account in determining the best way forward.

Q1206 Chairman: That is a very honest reply, if I may say so.
Mr Coaker: I am trying to be helpful.

Q1207 Chairman: Of course you are. Do you think, as the minister responsible now, the classification system should be directly related to the penalties for possession and trafficking? Do you think there should be that direct relationship between classification and penalties?
Mr Coaker: I think that the classification system is based on harm, and there is a relationship therefore between harm and the penalties that should be apportioned to them, according to that classification. Yes, I do. Class A drugs, for example,

are regarded as the most dangerous drugs and therefore in that sense the penalties associated with possession, supply, et cetera, correlate to that degree of harm.

Q1208 Chairman: So the greater the degree of harm of the drug should then attract the highest penalty?
Mr Coaker: That is a matter for the courts in the end, as to what they actually think; but certainly that is the way the legal system is based—on the potential harm.

Q1209 Chairman: Do you support that? Do you support that classification equals penalty?
Mr Coaker: Classification equals the degree of penalty which is available to the courts.
Bob Spink: Could I get clarification? Will methylamphetamine be reclassified as a Class A drug?
Chairman: You can answer that when we get on to that section.

Q1210 Mr Newmark: Is there a need for a more scientifically based scale of harm to be developed to facilitate education and debate, with an emphasis on a scientifically based scale of harm?
Mr Coaker: I referred earlier to the way the ACMD—which is the statutory body that we have to consult—have a harm index, which includes taking into account some of the scientific evidence that it gets. It also takes into account social harms, and so on. So there is a degree of assessment which is made, according to the matrix that they use.

Q1211 Mr Newmark: That is a form of matrix. I am talking specifically on the science of harm itself.
Mr Coaker: But they will receive reports; they will receive evidence; they will look at various things that are happening, and get people coming to them to talk to them. So scientists will come to them and talk to them about their scientific beliefs, their research. People will come to them with reports about what they think about particular things. The ACMD can take that into account when they are determining the way forward. The science plays an important part in the determination of the ACMD's conclusions.

Q1212 Mr Newmark: I am not sure if you have answered my question but, given that you put great stock in the ACMD, how do you respond to findings by experts, including the chairman of the ACMD Technical Committee, that tobacco and alcohol are more harmful than LSD and Ecstasy, both of which are classified as Class A drugs?
Mr Coaker: There is an important point to make about the ACMD. We put great store in what they say. We listen carefully to the comments that they make. However, it is not a cosy relationship; it is a challenging relationship. They will challenge us in a whole variety of areas. I think that is as it should be. It is an independent body. It is a body whose opinions we respect, and we try to work closely with them.

Q1213 Mr Newmark: Do you disagree then that tobacco and alcohol are not as harmful as those two particular drugs?
Mr Coaker: Alcohol and tobacco are legal drugs, and they operate within the framework of our society.

Q1214 Mr Newmark: But they are very harmful, are they not?
Mr Coaker: They are harmful in many respects, if abused—or alcohol, if abused. But they are socially acceptable drugs; they are drugs that most of us, particularly with respect to alcohol, will use sensibly. If we are looking at the real issues of society, alcohol and tobacco clearly are issues which, if abused—alcohol if abused, and smoking, as we know, is harmful—we are trying to combat, in terms of the abuse of alcohol and, in terms of smoking, trying to reduce that as well. However, they are legal drugs and we have to look at them within the context of the society in which we all live.

Q1215 Mr Newmark: How will that sort of thinking that is coming out of these experts influence future policy decisions on crime, with respect to drugs, crime and public health?
Mr Coaker: In terms of where we have particular representations made about drugs which are harmful, where they are talking to us about different things, then—as I was saying earlier in reply to Adam—that is the other aspect of drug policy, which has to be an enforcement policy. There has to be a policy which is out there, trying to tackle the supply and those people who deal in it on the streets. We have taken a number of measures in order to try to deal with that as well. For example, if you look at the recently established Serious and Organised Crime Agency, that has, as a very real focus and as one of its top priorities, the tackling of the supply of drugs.

Q1216 Mr Newmark: Why is it that in the UK spending on addiction research is so much lower per head than, for example, in the US? Is this a reflection of it being a lower priority over here versus over in the States?
Mr Coaker: We massively increased the spending on drugs, on trying to tackle the harm which drugs are causing in our communities. The drug treatment programmes, the establishment of the various projects that we have, have seen a massive increase in spending.

Q1217 Mr Newmark: And when it comes to addiction research?
Mr Coaker: With respect to addiction, there are priorities that people have. The health service and all the other bodies have seen big increases in spending. Do we want to see more spending on that sort of research? I think that is a legitimate question to ask and something we should look at.

Q1218 Mr Newmark: So would you like to see more money spent on it?
Mr Coaker: I think that it is something we should look at, yes.

Q1219 Mr Newmark: Do you feel that the lack of evidence in this area is actually an impediment to evidence-based policymaking itself?
Mr Coaker: You have taken evidence from the ACMD, but I think that they would say that their advice to us is evidence based. They take evidence from a variety of sources and, in taking that evidence, they make recommendations to us. I think they would say that the various reports that come to us, the various recommendations that they make, are based on evidence which they have taken and considered.

Q1220 Dr Harris: I do not think they do say that. Let us be very clear, because you have said three times now that you take advice from the ACMD; that the ACMD appear to take evidence; and that you are happy and they are happy that there is evidence. I quote Professor Nutt who chaired the ACMD Technical Committee, who argued to us that a more scientifically based scale of harm would be of value in the situation. He said, ". . . in education the message has to be evidence based. If it is not evidence based, the people you are talking to say it is rubbish". He co-authored a report that said that, with respect to the correlation between the class of a drug in the current ABC system and its harm score, calculated using their—I would say scientific—approach, was so low that it was "not statistically significant". So your main source of advice says that there is not enough evidence out there and the ABC classification in relation to harm has a non-statistically significant correlation. You should be furious about this: that your whole policy is based on an evidence vacuum.
Mr Coaker: We do not believe that it is based on an evidence vacuum. There is always a need to improve; there is always a need to look at the evidence that you take. However, as I say, the Nutt matrix forms part of the harm index matrix that the ACMD uses itself in order to determine the recommendations they make to us. They have a number of headings that they use. There are priorities within that. They score that according to the various priorities. There are nine priorities, I believe, and they score that. Then that determines the recommendations they make to us. So there is a matrix; there is a harm index which they use. That itself is influenced by Professor Nutt's criteria.

Q1221 Chairman: Why is he so critical, though?
Mr Coaker: That is something he has every right to say. We will always look at people who have criticisms to make; suggestions about improvements, and so on. The point I am making, however, is that the ACMD—which is a statutory consultee for the Government—does work according to a harm index which it uses to score drugs which it believes to be harmful. We will come back to a drug where it has actually used that in order to determine harm. It is fair comment and we will need to look at the comments Professor Nutt has made. That may be his individual view but, as I say, on the ACMD we have that harm index which is used by them.

Q1222 Dr Harris: Professor Nutt's quote that I gave was from a paper where he was calling for the scale to be a rational scale of harm. You say there is evidence. Are you aware that the amount we spend per head of population on addiction research is a hundredth what the Americans spend, and that the budget is somewhere between a hundredth and a thousandth? That is not a judgment call as to whether we are not spending enough versus other priorities. It is just 1% per head of the population of what the Americans spend.

Q1223 Mr Coaker: On . . .?

Q1224 Dr Harris: On research into addiction—which would include the evidence base around this. It is a real problem.
Mr Coaker: As I said to what Brooks was saying, the money that has been made available to drug treatment programmes and this whole area of work has increased significantly. There is always the question of where you spend that money. It may be addiction that should have more spent on it, alongside some of the other priorities that you have. So there is always a scale of priorities. One of the things we can do as a result of the report that the Committee will no doubt make about it is to have a look at that, to see whether it is appropriate for us to look at the amount of money that has been spent on it.

Q1225 Dr Harris: To what extent do headlines in the newspapers influence, as a politician, your policy in this area? Do you use the newspapers as a proxy for public opinion?
Mr Coaker: No, certainly not. We try very hard to have a drugs policy, which we drive according to what we think is in the best interests of the population and the best interests of the communities that we all represent. Going back to what I thought was Adam's very important point at the beginning, about what is the purpose of the drugs strategy that we have, as I say, it is about enforcement; it is about education; and it is about drug treatment. Obviously, within that there will be disagreements and debate about the best way of delivering all of those objectives. We are not driven by headlines; we are driven by what is best for the people that we seek to do our best for.

Q1226 Adam Afriyie: If there were a town, a city, or a country elsewhere—outside Britain, obviously—that had been almost totally successful in reducing the use of drugs and in getting rid of the harmful effects of acquisitive crime around drugs, would you be willing to look at that example, even if it meant that you had to re-look at the classification system?
Mr Coaker: I think that it would be very arrogant of anybody to say they would never look at what anybody else is doing, or try to learn. Indeed, part of what the Select Committee itself is about is to make recommendations to government about how to improve policy. Obviously, you have to look at that and consider it. Whether you then say, "This is applicable to our situation; this is applicable to our

communities; this is something that we will do", is a different matter; but certainly you should always look at what is going on, try to learn from other people, and see whether it is applicable.

Q1227 Chairman: Our concern, Vernon, is the way in which the Home Office goes about researching, getting proper evidence on which to make its policies. That is a genuine concern for us, which is why we are bringing this to you.
Mr Coaker: That is fine.

Q1228 Dr Harris: Do you think decisions on classification should—I think that you are saying this, whatever we think of the evidence base—be based on evidence of harm and therefore we classify on that basis, or should it be to send out signals to the public?
Mr Coaker: I think that what the classification does is categorise drugs according to harm. I also think that it does send out messages; it does send out signals to people, in a way which people understand. I think that most people, if you talk to them, would understand that Class A drugs are the most dangerous drugs. That is the advice we have received from ACMD, from the police, and so on. So I think that it is a balance of those things.

Q1229 Dr Harris: Andy Hayman, who chaired the ACPO Drugs Committee, told us in oral evidence, "I cannot envisage any user—a dependent user, that is—having any kind of thought as to whether it was a Class A, B or C drug they were consuming". I think the advice he would give, therefore, is that you cannot really send out messages to addicts with your classification system. I am saying that it has to be based on harm.
Mr Coaker: But is not part of any system with respect to drugs—as I think the Government would argue, and I would argue—not only trying to send messages out to people who misuse drugs but also about trying to send messages out to people out there in the community? So that when teachers are in schools, the parents are there, or the police are working, or whatever, there is a message there about which drugs are regarded by society as the most harmful. I would argue that it is about that as well.

Q1230 Dr Harris: If it is about that, then surely there should be evidence as to whether that is having any effect? Are you aware of any Home Office-commissioned evidence about the impact of the messages that you are trying to send out? Because if there is not any, then it is just rhetoric, is it not?
Mr Coaker: It is not just rhetoric, in terms of where we were before. The evidence base for us with respect to the last few years has been in the reduction of drug misuse. It has also been in the evidence that we receive from the ACMD, who advise us on these matters. We come back to this. If this is so unimportant in that sense—or not "unimportant"—if it is so unnecessary, why is it that people make such a big thing about the importance of reclassifying particular drugs? They do that because of the message that it sends out to people, and the belief they have that, by doing that, it sends an important message to people—which helps in controlling the prevalence of that drug.

Q1231 Margaret Moran: Coming on to the ACMD, we have had evidence from a variety of sources who raised concerns that this independent advisory committee is perhaps not functioning as well as it should. There was concern about the appropriateness of membership, about its expertise and transparency. Mary Brett, who is the UK representative on the board of Europe Against Drugs, asked the question, "Where are the biologists, the neurologists, toxicologists . . . ? . . . there is not a single member of an anti-drugs charity". In other words, in her words, "[the] committee lacks any sort of balance". Where is the independent evaluation of the quality of the ACMD's advice, given those levels of concerns? Would you support the introduction of a regular independent review?
Mr Coaker: As you know, the Home Secretary appoints the people to the ACMD. Looking at the list, I would say that there is a fair cross-section of people from across society. Does it always mean that every single section and part of society is actually represented? There is always a case for continuing to look at that; for continuing to make sure that the balance is there. We value very highly the advice we get from the ACMD. We believe that it is independent advice. We believe that it challenges us—which is very important. I think that we need to continue always to look at how we improve—

Q1232 Margaret Moran: I was asking specifically about independent evaluation by the Government of the quality of advice that is being offered, and regular reviews of the quality of that advice.
Mr Coaker: We always reflect on the advice that we get from the ACMD. Whether there is a case for us to reflect on how we might improve that, what more we might do, is comment we need to listen to and to think about. However, the advice comes in to us from there and we often take further advice on the advice we have received from the ACMD. We often consult with other bodies about it as well.

Q1233 Chairman: Who do you consult?
Mr Coaker: We may go out and we may say, "This is the advice". We talk to other ministers. We listen to what other people have to say. These things can often be a case for us listening to what others have to say about the information that we get.

Q1234 Chairman: With respect, other ministers will not give you the sort of evidence that Margaret is asking for, in terms of that independent review. Who else would do it?
Mr Coaker: An independent review? Obviously, as ministers, we often go out to consult with people about—

Q1235 Chairman: Like who?
Mr Coaker: Not formally, but we informally talk to charities or others about the sorts of policy directions that we have, and listen to what they have to say. For example, only last night drugs charities were in the Home Office, being asked about their views and opinions about the drug policy. So there is a whole variety of ways in which things feed into the decisions that are actually made. There was a formal event at the Home Office yesterday. Lots of drugs charities were there, lots of stakeholders there, talking about—

Q1236 Chairman: So it is a purely ad hoc process. That is what you are saying?
Mr Coaker: But there is a process.

Q1237 Margaret Moran: We talked about the balance of expertise of membership. I referred to that and so did you. The question then is who is appointing this independent panel. Do you not think that the chairman of the committee plays an overly influential role in appointing the panel? Surely the Chief Scientific Adviser should have some role or oversight in this?
Mr Coaker: The Home Secretary, in the end, is the person who determines the membership of the committee. Looking at the membership we have, I think that there is a fair reflection of the various sections of society across the board who are members of the committee.

Q1238 Chairman: But it is dependent on the chairman. That is the point that Margaret is making.
Mr Coaker: Dependent on the chairman to advise him as to who should be on that, but the Home Secretary in the end makes the final decision.

Q1239 Margaret Moran: Where is the Chief Scientific Adviser in all of this?
Mr Coaker: Again, who the Home Secretary consults, who the Home Secretary listens to—he will get the recommendations and he will take advice accordingly.

Q1240 Margaret Moran: So there is a formal role for the Chief Scientific Adviser?
Mr Coaker: As I say, the Home Secretary will get the suggested people who should be on the committee or who should be members of it, and he will make the final decision.

Q1241 Chairman: I would really like to know your views on this. The previous Home Secretary and the Chair of ACMD seemed to disagree about the role of ACMD in considering social harm. Charles Clarke said, " . . . clinical, medical harm is the advisory council's predominant consideration". That was backed up by Andy Hayman who said, "What is directing which classification a drug goes into is the scientific and medical harm". However, Sir Michael, who is the chairman, contradicted this by telling us that social harms were given "equal weight" in the committee's deliberations. What is your view?
Mr Coaker: The committee's deliberations on it include social harm, and I think that is an important consideration.

Q1242 Chairman: Sir Michael says, "given equal weight"; the previous Home Secretary said no to that and Andy Hayman said no to that. What is your view?
Mr Coaker: My view on it is that the committee have a number of things that they consider alongside social harm. They consider physical harm, withdrawal, pleasure, and so on. So they take a number of things into account as well as social harm. I think that the balance the ACMD currently has is right.

Q1243 Chairman: So you agree with Sir Michael rather than the previous Home Secretary?
Mr Coaker: No, I agree with what was being said before—the previous Home Secretary—that it is the balance, where you have physical harm, pleasure, withdrawal, as well as social harm.

Q1244 Chairman: No, the previous Home Secretary said, " . . . clinical, medical harm is the advisory council's predominant consideration". You agree with that, and not Sir Michael Rawlins, who says that the whole issue of social harm should in fact be given equal weight.
Mr Coaker: Social harm should be included in the research harm index which they do, which it currently is. So I agree with what Sir Michael is saying: that it is not only social harm; it is physical harm; it is pleasure; it is all of those sorts of things. That is the matrix that the ACMD currently use to help prioritise what their decisions are.

Q1245 Chairman: You agree with both of them, but they take contrary positions. That is not tenable.
Mr Coaker: No, what I am saying is that the research matrix, the harm index that the ACMD currently use, is a tested thing. Social harm is a part of that. It has a number of priorities within it, and social harm is one of those; but, alongside that, physical harm, pleasure and withdrawal also have to be used. So Sir Michael is right in pointing out that those are the things that they use to consider their decisions.

Q1246 Chairman: In terms of the role of the Association of Chief Police Officers, we were somewhat confused by the response we had from Andy Hayman about the role of ACPO on the committee. Do you feel that ACMD should consider evidence from the police in its deliberations, or is it for ministers to integrate that advice from police with advice from ACMD? We were concerned that he did not see it as his role to initiate anything on ACMD, even though he is representing all the police forces in the UK. What is your view?
Mr Coaker: My view on it is that Andy Hayman and indeed Howard Roberts, another senior police officer who is on the ACMD, play a very important role on the ACMD. I think the role that they bring to it is the knowledge they have of policing and law

enforcement in this particular area. It is that professional expertise which they are bringing to the committee, and that sits alongside all the other sorts of people you have on that. My own view is that, as well as reflecting the view of the police, they bring an independent voice to it, which is about law enforcement and the practical implications of the policies that the ACMD are considering.

Q1247 Chairman: Vernon, here is the rub. The police forces do collect evidence about the effects of drugs on the streets and how it interfaces with crime. They have that evidence. If we were going for evidence-based policy—and you have agreed that the ABC classification should in fact have a link between the degree of harm and punishment—surely the police, through their representatives, should be initiating advice to ACMD rather than just being there to comment on what is going through the committee?
Mr Coaker: ACPO will—

Q1248 Chairman: He said no. He specifically said no, that was not their role. He was there to deliberate rather than to initiate. I just want to know whether you think that he should be initiating rather than deliberating.
Mr Coaker: If he is in the committee, he will be informing the committee of his view based on his experience and the experiences of the police forces throughout the country. That is part of why he is there. He is there as a voice of police experience, if you like, as is Howard Roberts.

Q1249 Chairman: That is not the point I am making. The point I am making is that, if we are looking at evidence-based policy here, the police have a vast amount of evidence to bring to the committee. That does not appear to be happening. Do you think that it should?
Mr Coaker: You would expect and hope that the police are bringing that knowledge and experience of dealing with these issues to the committee. In my view, that would be why they are there: to bring that experience, knowledge and understanding to the committee—both with Andy Hayman and with Howard Roberts. Clearly ACPO sometimes, outside of that, will come to us about other matters and other issues.

Q1250 Dr Iddon: Could you confirm to us this morning that the Government is considering reducing the amount of all drugs, including cannabis, which individuals will be allowed to carry and bring them at risk of being charged, instead of with possession of the drug, with possession with intent to supply a drug? That brings a maximum sentence of 14 years in jail, of course.
Mr Coaker: As you will know, as a result of the Drugs Act, at the present time we are considering what the thresholds should be, in terms of coming to a conclusion as to what it should be for presumption of supply. No decisions have been made at the present time; but we are looking at that, yes.

Q1251 Dr Iddon: Will Parliament get a chance, either on the floor of the House or in delegated committee, to debate any changes, or can the Home Secretary do this without consultation?
Mr Coaker: No, it is affirmative resolution, so it will have to come before the House with respect to determining these thresholds.

Q1252 Dr Iddon: Will there be wide consultation with outside agencies before any decisions are made?
Mr Coaker: We have already consulted with different people. There was a consultation exercise which started in January and ran till March. Those consultations are currently being considered and, just recently, we have had the ACMD letter come back to us which has given us their view. We will take their view into account, and we will take into account the other consultations which took place in the three-month consultation period, before coming to a decision as to what we should do.

Q1253 Dr Iddon: We have changed the classification of cannabis from B to C; we are now considering changing it back again, from C to B. We are considering changing the amounts that people can carry, related to the charges that might be imposed upon them, and the previous Home Secretary agreed to look at the classification of drugs. Would it not be sensible if all this were done together, rather than in a piecemeal fashion?
Mr Coaker: We are trying to move forward with a coherent drugs strategy. No decision has been made as to how we move forward with respect to the review of the classification system. The Home Secretary has yet to make a decision on how we proceed with that. We are required by the Drugs Act to come to a decision about determining the thresholds at which we have to presume it is supply. There has been widespread consultation on that. With respect to cannabis, you will know that that was recently confirmed as a Class C drug—although, I emphasise, an illegal drug. Whatever system you have in place, there will always be issues which arise with respect to this. There will always be people who have opinions about what should happen—quite rightly, because it is a very important and serious matter—but there will be people who will argue and disagree about different aspects of it. We have a drugs strategy; we are moving forward on it, and we are taking decisions as and when appropriate.

Q1254 Dr Iddon: However, I think you would agree with me that the worst thing we can do is to confuse the public, and particularly the young people in the public.
Mr Coaker: With my background, I know how particularly important that is. I think it is very important for us to say from this Committee that, whatever the arguments there were about cannabis, it remains an illegal drug. That is the message we have been putting out from the Home Office. That is the message that I have continued to put out in the various road shows I have been to and will continue to go to; and that is the message that I will continue to push.

Q1255 Dr Iddon: What evidence do you or the Home Office have that led you to classify magic mushrooms as some of the most dangerous substances, aligned with cocaine and heroin? They are not addictive, of course.
Mr Coaker: The whole debate about magic mushrooms was really not with respect to classification; it was trying to clarify the law, and that is why it was changed in the Drugs Act. You know that psilocin, which is the active ingredient, is a Class A drug; but the problem with it was within fresh or natural mushrooms. We saw a huge increase in the number of people who were importing magic mushrooms into the country. There was a big increase in that. There was therefore a concern that there was a loophole in the law with respect to psilocin being got—for want of a better way of putting it—through this loophole. People were able to get psilocin through this loophole. We felt it important therefore, since psilocin is a Class A drug—and there was clearly a problem out there, there was a huge increase in the import of it—for us to take action. So we saw it as a clarification of the law rather than any classification change.

Q1256 Dr Iddon: We seem to have agreement between the Committee and yourself this morning that classification according to the ABC system is according to harm—50% harm to the individual, 50% harm to the society. That is what the ACMD have told us. If that is the case, psilocin and psilocybin are not sold in shops and are not available on the street. I have not met anybody in my capacity as chairman of the Misuse of Drugs Group who uses them. I do not know a single person who has been harmed by them. Why are psilocin and psilocybin therefore in Class A?
Mr Coaker: Because that is the advice: that they were powerful hallucinogenic drugs, and that is why they were categorised with respect to that.

Q1257 Chairman: But we are supposed to have an evidence-based policy. That is the point that Brian is making. There is no evidence at all to show that these have the degree of harm which should put them into Class A.
Mr Coaker: What we are saying is that, should they be used, they are harmful drugs. They are Class A on the basis of the harm that they would cause were they to be used. We saw huge increases in the numbers of magic mushrooms which were being imported—naturally grown mushrooms, which were outside of the law—which would suggest that, if they were being imported in increasing numbers, somebody out there was using them, because people would be bringing them in to—

Q1258 Chairman: There is absolutely no evidence about that.
Mr Coaker: The police were saying to us that clearly, if you have this increase in imported magic mushrooms, they are being imported for a purpose. The law with respect to psilocin is that it is a Class A drug. We were worried that this was a loophole and we have closed that loophole. On the basis of clarifying the law—as was made in one of the court judgments in 2004, somewhere in Gloucestershire I think it was, in Gloucester Crown Court—we were asked to do that, which is what we did.

Q1259 Dr Iddon: You have moved drugs up and down this classification. Bob is going to come to one that you have moved up. You have moved cannabis down. Why has nobody looked at psilocin and psilocybin in the classification, decided that they are not causing harm to society or individuals, and moved them down? In which case, magic mushrooms would not be in Class A with a maximum penalty of 14 years' jail.
Mr Coaker: The opportunity for drugs to be looked at will always be there, and that issue is there; but at the current time there are no plans to reclassify it. Those drugs are Class A drugs. No doubt people will have heard what you have had to say this morning and consider the evidence; but, as I say, that is where they are at the moment. There was a loophole in the law which we wanted to close.

Q1260 Dr Iddon: My final question is this. Can you cite another example of where the Home Office have moved a drug around in the classification system merely to clarify the law, instead of looking at the harm?
Mr Coaker: I may have to write to you on that one.

Q1261 Bob Spink: Minister, will methylamphetamine be reclassified as a Class A drug today?
Mr Coaker: The announcement that we are making from the Home Office today is that—subject to the proper procedures of the House, because obviously it has to go through the process—it is our intention to reclassify methylamphetamine from a B to an A.

Q1262 Bob Spink: I congratulate you on that. I think that early action on this drug—because it is not too prevalent in the UK yet—will protect individuals and society. It shows that the system is working in this case, and a certain sensitivity towards this very harmful and dangerous drug. So I thank you for that. I am delighted with it. The ACMD said last week that they had made this recommendation to you based on, for instance, evidence from the police forces that the police had found an increasing number of laboratories manufacturing that drug. Is that so?
Mr Coaker: Can I start by saying that I was at the debate a few weeks ago when the Honourable Member raised this whole issue—as a Whip at that time. I think it does show that Parliament listens. I would like to thank him for the comments that he made at the beginning. It just shows that sometimes these things can work. It is the case that, in the letter that we received from the ACMD—and this is one of the reasons why the ACMD changed its advice—they had become aware of a small number of illicit laboratories for synthesising this substance. It was a low number but, yes, that was one of the things.

Q1263 Bob Spink: That shows the police actually initiating action within the ACMD, which is contrary to the other evidence that we have received from the Association of Chief Police Officers. I just wanted to get that on record. The ACMD have previously given evidence to us that increasing the classification of the drug would increase its kudos and therefore increase its use. That is why they were not considering that at an earlier time. I accept totally that people change views as situations change, and you change your decisions—especially a marginal decision, as it clearly was. Do you accept that there is this tension and that increasing the classification of a drug might increase its kudos and use?
Mr Coaker: These are judgments, and very serious judgments, that are made. Bob himself thought that it was important that the drug was reclassified from B to A. Why was that? Because, listening to the points that he put, they are exactly the same as the points which the ACMD put. Although low use at the current time—and I think it is important to emphasise from this Committee that there is not an explosion of use at the present time, but there is low use—the potential for harm was there. That is why Bob, others, and the ACMD said that there was therefore a need to reclassify it to an A.

Q1264 Bob Spink: Why did the ACMD announce this last week, and why did they choose the *Guardian* to announce it to?
Mr Coaker: I cannot comment on how it got in the *Guardian*. I do not think that was chosen. We can speculate on why things happen. I will just leave that with the Honourable Member.

Q1265 Bob Spink: It appeared on the front page of the *Guardian*.
Mr Coaker: I know where it appeared. I am just saying that the route was not entirely clear to me.

Q1266 Bob Spink: Do you think it appropriate that the ACMD should have its deliberations often in secret, and its advice to ministers often in secret, but selectively to release certain decisions to instruments like the *Guardian*, which they selected very carefully?
Mr Coaker: We have a close relationship with the ACMD and that is based on trust. It is based on close co-operation. I have only been in the job, as you know, four or five weeks. I am trying to come to terms with that. I have every confidence in the ACMD, in the work that they do. How that appeared in the *Guardian*, I am not sure. I am not blaming anyone for it. All I am saying is that, at the end of the day, however it appeared, we are pleased to say that we accept the advice that the ACMD have given us.

Q1267 Bob Spink: Does the Government intend to ask the ACMD to look at the classification of Ecstasy?
Mr Coaker: We have no plans to do that, no, at the present time.

Q1268 Bob Spink: Have you considered the evidence surrounding the classification of Ecstasy and the arguments for looking at reclassification?
Mr Coaker: My understanding is that there was some research done ten years ago with respect to that, which showed that there were considerable harms out there. We also know that, if you turn it round, there is no research out there saying that it should be reclassified.
Bob Spink: That is a very good answer. I am sure that Leah Betts' parents will be delighted to hear it.

Q1269 Dr Harris: If you do not ask, you will never know. So if the Home Affairs Committee and the Runciman Report say there is a good case to move it from A to B, and if you are so confident that there is no research—and I have to say, given—
Mr Coaker: As far as I am aware.

Q1270 Dr Harris: . . . how much you know about the evidence base, or how much we all know about the evidence base as politicians, is questionable—what harm is there is asking the ACMD? Is this not just a case of "see no evil, hear no evil"? You do not want to ask something that you do not want to hear the answer to?
Mr Coaker: Not at all. We have no plans to reclassify Ecstasy. As Brian said, we regard it as a dangerous drug, and it is something we want to make clear to people that we see as potentially harmful. Because I thought that this may come up, I looked at some of the figures in terms of deaths where Ecstasy was actually mentioned on the death certificate. There were 48 in 2004; 33 in 2003; 55 in 2002, and so on.

Q1271 Dr Harris: Thousands in the case of heroin. Professor Blakemore said, " . . . on the basis of present evidence Ecstasy should not be a Class A drug. It is at the bottom of the scale of harm".
Mr Coaker: That is not the Government's view. The Government's view is that it is a harmful drug and we do not want to see it reclassified.

Q1272 Dr Harris: I know that you do not want to, but why do you not ask the ACMD to look at the evidence? They may reject the evidence.
Mr Coaker: The ACMD may come forward and look at that but at the current time, so far as I am aware, there are no plans for them to do so.

Q1273 Dr Turner: We can get off drugs now! I want to ask you both a much more general question. This Committee has in the past been critical of the Home Office for a lack of a scientific culture. That criticism has been mirrored by outside bodies. Do you think yourselves that the Home Office has sufficient expertise within it to be an intelligent customer for scientific and technological advice? If not, what are you doing to correct that?
Mr Coaker: Yes, there are a lot of committees and bodies now which have been set up: people responsible for considering the scientific evidence that comes in. On a general point, however, can I say this? The whole point and purpose of the Select

Committee system is to challenge the Government; it is to cause the Government to think. It has been a robust and interesting exchange of views that we have had here today. It would be arrogant for me, as a Home Office minister, to say that, whatever this Committee comes up with and makes as its recommendations, the Government would not need to go back and look to see whether it can learn from it. All I can say is that there are people responsible for evaluating the scientific evidence and research in the Home Office. Does that mean that we cannot learn from what the Committee may or may not say in its report? No, of course it does not. We will have to take that on board and listen to what is said—and we will do that.

Joan Ryan: Could I add to that? In the light of previous criticism, to be fair to the Home Office, we have to acknowledge the work that has been done to improve the level of scientific work, advice, expertise and experience within the Home Office. That is why I talked earlier about the Home Office science and innovation strategy. I particularly refer to the Science Research Group, which brought together several scientific units dealing with issues that cut across the Home Office and which were previously spread across Home Office departments. I think that this has significantly strengthened the science expertise availability and advice within the Home Office. I think that the use and extent of scientific expertise have grown substantially. From my own experience of the past four and half weeks, I can tell the Committee—as you know, I have responsibility for Forensic Science, for the DNA database, for licensing animal experiments, as well as all the identity scheme management issues and the science involved in all of those issues—I have never been exposed to so much science in my life, since I was about 15. I am very impressed with the clarity, the standard, the research, their ability to communicate all of that and their willingness to do so, and the amount of briefing that I receive. So from that point of view, yes, I think that they have made big efforts within the department and, personally, I am impressed with the scientific support that I am receiving in my role.

Q1274 Dr Turner: That is good to hear, though we are still in receipt of criticisms, and quite recent criticisms: notably, an academic who undertook research for the Home Office recently. To quote him, he said, "To participate in Home Office research is to endorse a biased agenda". Do you think that is fair?

Mr Coaker: No.

Q1275 Dr Turner: How do you protect research and evaluation from political pressures in the Home Office?

Joan Ryan: How do we . . . ?

Q1276 Dr Turner: Protect research and evaluation from political pressure? How do you stop evidence being selectively used to back whatever preconception you start with?

Joan Ryan: We do not just use science internally; we do commission research and development that underpins policy development. I think that there will always be individuals who have a variety of views, for a variety of reasons. Overall, looking at the expertise both inside the Home Office and the expertise they commission for the R&D from outside the Home Office, I think that there is a good balance there and a degree of independence that is reassuring. I think that the co-ordination with other government departments through the Chief Scientific Adviser's committee is also a very good example of pulling together science and research across departments and looking at this—not embedded within the department but in a cross-departmental way. So we have both: embedded science and cross-departmental science.

Q1277 Dr Turner: Do you agree that there is still a potential trap that, instead of doing what the Government professes to do, which is to make evidence-based policy, you can actually be doing evidence-informed policy, which is subtly different?

Mr Coaker: The evidence will come up. There is an attempt, and a very serious attempt, by the Home Office to give scientific evidence much more focus within the department. Various groups have been set up, as Joan has just been saying; various attempts to give a greater strategic direction to all of that. Part of that is to inform and advise us about the best way forward with respect to the policies that we pursue. Inevitably, people will make judgments about policy decisions. That is what we all do all of the time. However, what we want is frank and open information on which we base the decisions, and an informed scientific base, where appropriate, to the decisions that we make—and that is what we are trying to do.

Q1278 Dr Turner: How do you see the role of the departmental Chief Scientific Adviser? Has he made an impact on the department, and how do you interact with him?

Joan Ryan: Yes, I have now met with him on a number of occasions. I think that there is an impact there. He has a dual role: that of an adviser and a manager. He has a clear remit to ensure improvement in quality standards; better evaluation of policies; improvement in internal skills by increased training and professional development. For the Home Office, that means he has a lead role in taking forward those reforms and bringing together the statistics, social and physical sciences. An example of that might be the DNA use, for instance. He is increasing the range of social science work, which we think is important—for example, on issues like immigration—and increasing science work across the Home Office portfolio beyond policing. So we need continually to monitor that that is having an impact, but I think that, in his role and the lead he is taking, he is taking things forward. It is very much in line with some of the comments that you have been making this morning about your concerns and previous criticisms.

Q1279 Dr Turner: What do you see as the main benefit of having the Chief Scientific Adviser in the Home Office?
Mr Coaker: Again, I think it goes back to the point that you made before: that we are trying to make informed policy decisions. Inevitably there will be judgments about that.

Q1280 Dr Turner: But you said to inform, rather than evidence based.
Mr Coaker: Your decisions are informed by the evidence. The evidence is there. You need to be informed by the evidence. In the end, however, people make judgments. Sometimes the evidence conflicts, even from scientists. You get different scientists saying different things. Then what do you do? They are both saying that they have the right evidence. "I am a scientist. I have this evidence." Another scientist comes along with completely different evidence. In the end, there is a judgment that is made; but what you are trying to do is that your policy is informed by the evidence. That is the role of the Chief Scientific Adviser.

Q1281 Dr Harris: In an article in *Criminal Justice Matters*, Professor Tim Hope, who is Professor of Criminology at the University of Keele, said, " . . . it was with sadness and regret"—in dealing with the Home Office—"that I saw our work ill-used and our faith in government's use of evidence traduced". My question to you is this. Do you take allegations like that seriously, or do you think it is just not fair and can never happen? That was the impression I had from your answer to the earlier quote, "To participate in Home Office research is to endorse a biased agenda". Are you concerned about allegations like that, or is it just mischief-making in your view?
Mr Coaker: No. If people are making comments to you, you need to take those comments into account, even if you find them uncomfortable. You need to listen to what people have to say. The point I was making before was that sometimes you will get conflicting pieces of evidence, in that some people will put forward one thing and somebody else will make a completely different point. In the end, you have to make a judgment.

Q1282 Dr Harris: This is a different point. This is an allegation of misuse, a traducement, bad faith by the Home Office. It is a separate issue about whether the policy was right. My question is this. Are you sensitive to that?
Joan Ryan: There are a large number of people who say very complimentary things as well. So there is always a balance to be struck. It is true that different scientists take different views.

Q1283 Chairman: But you agree that they should be taken into account?
Mr Coaker: You do. They should always be looked at and taken into account. I am sorry if I gave the impression before that I did not, because I did not mean that—if I did give that impression.
Chairman: Vernon Coaker, Joan Ryan, thank you very much indeed. It has been a long session. We have enjoyed it enormously. It has been very valuable to us.

Written evidence

APPENDIX 1

Memorandum from the Government

1. The Classification of Illegal Drugs

Introduction

1.1 The Drug Strategy is a cross-government programme of policies and interventions designed to address the breadth of drug issues in the UK. There are four main elements of the strategy—young people, reducing supply, treatment and reducing drug-related crime. The Home Office leads on the delivery of the Strategy in collaboration with a number of other Government Departments, NGO's and a wide network of stakeholders.

1.2 The Updated Drug Strategy 2002 sets out a range of interventions that concentrate on the most dangerous drugs, the most damaged communities and individuals whose addiction and chaotic lifestyles are most harmful. It focuses on aims which complement action to restrict supply of illegal drugs with the action to diminish demand for drugs.

1.3 Illegal drugs are controlled substances defined by drugs legislation (primarily the Misuse of Drugs Act 1971); the Strategy does not cover alcohol misuse which is the responsibility of the Department of Health.

1.4 A key factor of the strategy is the classification of substances under the Misuse of Drugs Act 1971. With the focus of the strategy being Class A drugs, the legal position of a substance clearly directly relates to the harms it poses, and the level of enforcement activity that it attracts.

1.5 Advice on classification issues is primarily presented to the Government by the Advisory Council on the Misuse of Drugs (ACMD).

Legislation

1.6 The Misuse of Drugs Act 1971 (MDA) divides controlled drugs into three Classes; A, B and C. These Classes are linked to maximum penalties for related offences, in a descending order of severity, from A being the highest, to C, the lowest. The three-tier classification was designed to make it possible to control particular drugs according to their comparative harmfulness either to individuals or to society at large when they were misused.

	Class A	*Class B*	*Class C*
Examples	Cocaine, Crack, Ecstasy, Heroin, Magic Mushrooms	Amphetamines, Barbiturates, Methylamphetamine	Cannabis, Anabolic Steroids, Benzodiazepines, Buprenorphine, GHB, Ketamine

Penalties

1.7 The main offences under the 1971 Act are:- unlawful production and supply; and unlawful possession; and possession with intent to supply unlawfully.

1.8 The current maximum penalty for trafficking/supplying in Class A drugs is life imprisonment; and in Class B or C drugs is 14 years imprisonment. Possession of a Class A drug attracts a maximum penalty of seven years; for Class B a penalty of five years and for Class C, two years imprisonment.

1.9 Maximum penalties are not the standard or average penalty to which offenders are liable in all cases: rather they allow the courts discretion when dealing with individual cases. However, in the case of trafficking offences involving Class A drugs, there is, under the Crime Sentences Act 1997, a mandatory minimum sentence of seven years custody for the third such offence.

1.10 Section 7 of the MDA 1971 allows for regulations—currently the Misuse of Drugs Regulations 2001—to be made which authorise activities otherwise made illegal under the act. The Regulations identify those who may legitimately handle particular drugs, describe the circumstances in which drugs may be handled and control the purposes for which a particular drug may be applied. They also regulate where a drug may be produced or supplied.

The Advisory Council on the Misuse of Drugs (ACMD): Terms of Reference, Background and Membership

1.11 The Advisory Council on the Misuse of Drugs (ACMD) is a statutory and non-executive non-departmental public body, established by the Misuse of Drugs Act 1971.

1.12 Professor Sir Michael Rawlins is the Chair of the ACMD—he is a Professor of Clinical Pharmacology at the University of Newcastle and chair of the National Institute for Health and Clinical Excellence (NICE).

1.13 The terms of reference of the ACMD are provided for by Section 1 of the MDA 1971. In summary, the ACMD has a statutory duty to keep under review the situation in the United Kingdom with respect to the misuse of drugs and to advise Ministers of the measures which they consider should be taken to deal with social problems which arise from drug misuse. In addition, the ACMD has a duty to consider any matter relating to drug dependence or misuse that may be referred to them by Ministers. The Home Secretary is obliged by law to consult the ACMD before laying Orders or making regulations. This includes decisions relating to the classification of drugs. The full terms of reference as laid out in the Misuse of Drugs Act 1971 are attached in the Annex.

1.14 The scope of the statutory remit of the organisation is necessarily reflected in the wide range of its membership which includes police, judiciary, academics, GPs and other health care professionals, drug treatment service providers and the voluntary sector. Members of the ACMD, of whom there should be not less than 20, are appointed by the Secretary of State for a term of three years and in accordance with the guidance issued by the Office of the Commissioner for Public Appointments. Nominations come from a wide range of sources including relevant professional bodies, Public Appointments Unit of the Cabinet Office and self-nomination. Under the terms of the MDA 1971 the ACMD is required to include representatives of the practices of medicine, dentistry, veterinary medicine and pharmacy, the pharmaceutical industry, and chemistry (other than pharmaceutical chemistry); and members who have a wide and relevant experience of social problems connected with the misuse of drugs.

1.15 Membership currently stands at 38, including the Chair. The current term of office for members began on 1 January 2005. It will expire on 31 December 2007. All members are unpaid, although expenses are reimbursed.

1.16 The scope of the ACMD work runs across Government and officials from Department of Health, DfES and the devolved administrations are represented at Council meetings and those of the sub-committees. Representatives from other agencies are invited to meetings where appropriate. The position of these officials and representatives is that of "observer/adviser" rather than as a full member. Mainly they contribute by responding to questions of members or by asking questions for clarification of the discussion. They are there to support the ACMD in its functions.

The Advisory Council on the Misuse of Drugs (ACMD): Secretariat

1.17 The full Council currently meets routinely twice a year although it has powers to meet more frequently if required or requested. It has no staff or budget of its own, but administrative support and funding is provided by the Secretariat comprising of staff from the Drugs Legislation and Enforcement Unit (DLEU) of the Home Office's Drug Strategy Directorate. The team currently consists of four full time members of staff of various grades. The Secretariat forms the conduit between the ACMD and Ministers.

1.18 The functions of the Secretariat are important. Not only do they co-ordinate and arrange the day to day business of the ACMD, including organising meetings, dissemination of papers and development of work streams, but, as indicated above, they act as the key communication link between the Home Office and the ACMD.

1.19 This role manifests itself in a number of ways, from the purely administrative (eg arranging and co-ordinating schedules and timetables for work that are satisfactory to both organisations) to the more complex. ACMD work programmes, and its reports and recommendations to Government, are invariably supported by explanatory (and/or progress) notes from the Secretariat describing the nature, remit and background of the work being carried out by the Council. The Secretariat provides a direct link between the Government and the Council, and enables effective communications to take place.

Commissioning and Receipt of Scientific Advice from the ACMD

1.20 There are two key ways in which the ACMD's agenda is determined. Firstly, the ACMD is statutorily obliged to consider any relevant issue referred to them by the Government. This can relate specifically to the classification of a certain substance or substances, or to any other issue relating to drug misuse in the UK. Secondly, the ACMD is at liberty to set its own agenda (in addition to any tasks requested of it by Government) in response to the concerns or issues it is made aware of, either through the professional experience of its members or any other means.

1.21 When the Government requires advice on the classification of drugs from the ACMD, the usual process is for the work to be commissioned by way of a letter from the Home Secretary, the relevant Minister, or senior departmental official to Professor Sir Michael Rawlins, the chair of the ACMD, setting out what issues advice is required upon, and giving an idea as to the desired timescale for the work.

1.22 Through the secretariat, and in discussion with Ministers'/Senior Officials' private offices, timescales for the work are agreed, and the ACMD accept the commission, together with a target date for completion. This date is usually made public, either by way of routine correspondence or parliamentary questions, or during a debate in Parliament. This process ensures visibility and accountability, both to Parliament and the public, including on the setting of reasonable and realistic timescales.

1.23 On completion of their work, the ACMD will usually submit their advice on classification in the form of a report, with or without an executive summary (dependent upon its length and the complexity of the issues concerned), and with a covering, introductory letter from the Chair. Recommendations on classification issues are usually submitted directly to the Home Secretary, with Home Office and other Government Ministerial colleagues copied in where appropriate.

1.24 Other advice and recommendations from the ACMD on issues other than classification may be presented in the same way as outlined above, or simply by way of a letter from the Chair to the appropriate Minister, or from the Secretariat to Ministers and Senior Officials on behalf of ACMD.

Additional sources of evidence

1.25 It is important to remember that, although the key advice on classification of drugs comes from the ACMD, there are a number of other sources of information and advice which may come to Ministers. This may include other published research, consultations with key stakeholders, and the advice and experiences of practitioners within the drugs field upon whom the issue of classification has a direct impact (eg police enforcement colleagues and NGOs).

Government Consideration of Scientific Advice on the misuse of drugs

1.26 On receipt of a report from the ACMD regarding the classification of drugs the Home Secretary will usually require a period of time to consider the detail of the report and to analyse the Council's recommendations. In the majority of cases, and on the presumption that the period will not be too protracted, the ACMD will usually agree to defer the publication of their completed report and recommendations until the Government is ready to make its announcement on its chosen course of action (ie whether or not to accept the ACMD's recommendations, and any other actions Government sees fit). Their report can then be published on the same day as the Government announcement, making the recommendations and decisions public simultaneously.

1.27 Key stakeholders, and the ACMD would usually be informed of the decision shortly before an announcement is made, except where protocol requires that Parliament be told first. Work plans and implementation strategies for recommendations are developed and set in motion.

Criteria for consideration

1.28 ACMD advice usually takes a number of factors into account. These include: the physical harm to the individual of taking the drug on a single occasion and after prolonged use; the degree of pleasure; and the drug's potential for physical and psychological withdrawal; the effects on intoxication as well as harm to families and communities. The membership of the ACMD is sufficiently broad to ensure all of these issues are addressed in some detail in formulating advice for Government, but it is also able to take evidence from experts in the field.

Case Studies of Particular Interest to the Select Committee

1.29 It is our understanding the Select Committee has commissioned some independent research into drug classification to help focus their thinking on this matter, and that, at the request of the clerk, some specific reference in our written evidence to the case studies below, would be helpful:

Cocaine

1.30 The Government have not asked the ACMD to carry out any recent assessments into the classification of cocaine, nor has the Council presented any recommendations on this substance to the Government of its own volition.

Cannabis

1.31 The issue of cannabis classification has, without doubt, been the most high profile classification

debate in recent years. Following a referral by the then Home Secretary, David Blunkett, the ACMD recommended in 2002, following a detailed review of the scientific evidence, that cannabis should be reclassified from Class B to Class C. This was on the basis that, whilst cannabis could exacerbate existing mental health conditions, the harms it posed were not of the same order as those posed by other Class B drugs (for example: amphetamines).

1.32 The then Home Secretary accepted the recommendation, and in January 2004 Cannabis was reclassified as a Class C drug.

1.33 Following the reported emergence of new evidence strengthening the possibility of a causal link between cannabis use and onset of mental health problems, and the reported increase in incidence of high THC content "skunk" varieties of cannabis, the Home Secretary, Charles Clarke, asked the ACMD, in March 2005, to again provide advice on the issue of cannabis. He requested specific advice on the points mentioned above, but also requested an assessment of the classification issue. The process outlined in the section above was followed and the ACMD presented their comprehensive report and recommendations to the Home Secretary in December 2005. At the time of writing this submission (early January 2006) the Home Secretary was considering the detailed evidence presented to him in advance of announcing a decision.

Magic Mushrooms

1.34 The recent legislative change to the position of magic mushrooms came about as a result of a slightly different process to that outlined above. Case law had developed such that courts were of the opinion that unless the mushrooms were "prepared" (ie dried, prepared, packaged or cooked in anyway) that they were not, in fact controlled drugs. As a result, markets selling magic mushrooms were appearing across the country.

1.35 Magic Mushrooms are a powerful hallucinogen and can cause real harm, especially to vulnerable people and those with mental health problems. The substantial increase in the commercial sale of magic mushrooms in the UK raised concerns regarding public health.

1.36 Section 21 of the Drugs Act 2005, which came into force on the 18 July 2005, makes it an offence to import, export, produce, supply and possess with intent to supply magic mushrooms, whatever form they are in, whether prepared or fresh.

1.37 Because this was primarily a matter of legal clarification the Government was not obliged to seek scientific advice in the usual format from the ACMD. However, they did write to the ACMD, and ask for its views on their proposals before the Drugs Bill was introduced. The ACMD agreed that a clarification of the legal position was necessary.

Ecstasy and Amphetamines

1.38 In spring 2004, the Home Office asked the ACMD to consider Methylamphetamine, specifically whether its current classification as a class B drug was appropriate. The Technical committee of the ACMD established a Methylamphetamine working group which presented its preliminary findings to the ACMD's full meeting in November 2004. The committee advised that the current classification of methylamphetamine was appropriate, but was asked by the ACMD to consider issues relating to early warning systems and research further. It held further meetings and reported back to the ACMD. The ACMD presented their recommendations to the Home Secretary in November 2005. He accepted their recommendations in full, but given the nature of the drug, and the risk of the prevalence in the UK increasing, he asked the ACMD to keep a watching brief on the issue, and provide further advice in 12 months.

1.39 The Government have not asked the ACMD to carry out any recent assessments into the classification of either ecstasy or amphetamine (sulphate), nor has the Council presented any recommendations on these substances to the Government of its own volition.

January 2006

Annex

ADVISORY COUNCIL ON THE MISUSE OF DRUGS

Terms of Reference

"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:

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

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;

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;

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

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.

APPENDIX 2

Memorandum from Parents Against Lethal Addictive Drugs (PALAD)

Our Perspective

Parents Against Lethal Addictive Drugs is a voluntary organisation concerned with drug education who campaign for an integrated, evidence-based implementation of the Misuse of Drugs Act. We support the statutory requirement to teach all young people that alcohol and tobacco are harmful drugs, in accordance with the United Nations' definition of "drugs" and the scientific evidence. We agree with the Government's view that "drug laws must accurately reflect the relative harms of different drugs if they are to persuade young people in particular of the dangers of misusing drugs". We believe the Advisory Council on the Misuse of Drugs has a statutory duty to advise Government about the relative harmfulness of the intoxicant drugs alcohol and cannabis. We have spent two years attempting to find out how the Home Office and ACMD use scientific evidence in drugs policy making.

Summary

1. The Misuse of Drugs Act 1971 (MDA) drug classification was initially based upon UN drug Conventions. The intention was that the classification system would evolve with the scientific evidence base, with independent scientific advice provided by the Advisory Council on the Misuse of Drugs (ACMD). ACMD have a statutory duty to advise Government about harmful drug use "sufficient to constitute a social problem" and to provide Government with regulatory recommendations for "restricting the availability of such drugs". There is no indication that ACMD advice should exclude any harmful drugs on the basis of tradition or that their regulatory recommendations should be limited to prohibition.

2. The current classification is framed by two non-transparent assumptions that underlie UN drug Conventions:

   2.1 Drugs traditionally used in the west should be excluded irrespective of their harmfulness.

   2.2 Non-traditional drugs should be regulated with an extreme precautionary principle irrespective of their harmfulness.

3. Exclusion of traditional drugs:

   3.1 Contrary to Government claims, policy on harmful drug use is not based on scientific evidence. The Home Affairs Committee said harmful drug use "is a continuum perhaps artificially divided into legal and illegal activity". When the HAC Chairman asked the Home Office (HO) "Why are alcohol and tobacco not integrated into the drugs strategy?" the reply was that "any strategy has to take account of . . . societal attitude" and ". . . UN conventions"—non-scientific factors.

   3.2 ACMD's advice to Government does not include traditional drugs because their advice, intended to be independent, depends on Government policy, not just scientific evidence. When I asked why the ACMD do not provide advice on the harmful drugs alcohol and tobacco the ACMD Secretariat replied "Albeit independent, the ACMD as an advisory body has to be aware of the

Government's position, which has not given any intention to consider the control of alcohol, tobacco and caffeine". ACMD do not identify and refer to alcohol and tobacco as drugs, contrary to scientific evidence. This leads to inaccurate and misleading statements by ACMD. The Secretariat has declined to provide reasons for this.

4. Application of an extreme precautionary principle:

4.1 Government drugs policy is summarised by their statement "All controlled drugs are dangerous and no one should take them". Non-traditional drugs are identified with their maximum harmfulness instead of differentiating, for each drug, patterns of use that are (a) reasonable safe, (b) harmful to the consumer (a health issue) and (c) harmful to others (potentially a criminal issue), as occurs with the risk assessment of traditional drugs. No mention is made of a cautionary or precautionary principle but scientific evidence that use of a drug is not harmless is used to justify the prohibition of all use. In contrast the Government's response to this Committee's report The Scientific Advisory System said "Application of the precautionary principle does not usually mean imposing a ban. Its purpose is to ensure that where uncertainty exists, decisions err on the side of caution and so seek to avoid serious damage if things go wrong, yet meet criteria such as proportionality and cost-effectiveness".

4.2 ACMD's review of the classification of cannabis concluded that "the high use of cannabis is not associated with major health problems for the individual or society". This suggests harmful cannabis use is not "sufficient to constitute a social problem", the criteria required by the MDA. However the ACMD report continued "cannabis is not a harmless substance" and consequently recommended that cannabis remained prohibited, as a Class C drug, without assessing the option of licensed regulation. Harmless substances do not exist and to suggest the possibility is unscientific and misleading.

5. The ACMD Chairman's letter to The Times demonstrates how these two assumptions combine to frame the problem of harmful drug use unrealistically. He said "the classification system for drugs does not mean that any of these substances are harmless. If they were, they would not be included in the Misuse of Drugs Act". Such a view is not compatible with evidenced-based statements such as the World Health Organisation's that "More deaths are due to tobacco than to any other drug".

6. The classification system has not evolved with the evidence base, as intended by the MDA, because the ACMD's independent scientific advice depends on Government policy (3.2 above) while Government drugs policy depends on UN drug Conventions (3.1 above). The system is closed to scientific evidence—evidence that alcohol and tobacco are equally harmful drugs and that reasonably safe use of some non-traditional drugs is not only possible but widespread.

7. The Government uses scientific evidence selectively to:

— justify predetermined decisions or positions (compliance with UN drug Conventions);

— erroneously frame issues as predominantly scientific disguising moral or value judgements (traditional drugs used by the majority are good, non-traditional drugs are bad—independent of harmfulness); and

— delay making contentious or complex decisions (assessing drug risks and regulations equally).

8. ACMD provide little confidence that the MDA's classification is transparently evidence-based. The Chairman said in *The Guardian* "The basis on which any of the things were classified is obscure from reading the minutes". The ACMD annual report of 1999–2001 said "Subjects considered by Council: A review of the criteria used to consider whether a drug should be controlled under the Misuse of Drugs Act 1971 and the development of a new risk assessment protocol. This work is still in progress but should be completed in 2001–2002". This remains unpublished in 2006.

9. ACMD do not assess risks and evaluate regulatory options in accordance with Government guidance, as required by the Code of Practice for Scientific Advisory Committees. The HO does not follow Government guidance on the use of scientific advice, risk assessment and better regulation.

10. The current MDA classification of harmful drugs uses scientific evidence to justify discrimination between traditional drugs used by the majority and non-traditional drugs used by minorities. As a result the former have been under-regulated and the latter over-regulated. Other examples where the traditional majority discriminates against non-traditional minorities are sexism and racism.

Replying to the Committee's Specific Questions

11. *What impact are departmental Chief Scientific Advisers having on the policy making process?*

Professor Wiles, the HO CSA, has assured me that the Government does not interfere with the independence of the ACMD and that ACMD have freely decided not to advise them about traditional drugs. Concerning the lack of transparency surrounding the selective use of evidence (the omission of alcohol and tobacco from ACMD advice) he said "the ACMD is aware that the Government has no intention of controlling tobacco and alcohol under the Misuse of Drugs Act 1971. Alcohol and tobacco are so widely used in modern society that criminalisation of their supply and use is not considered appropriate".

He appears to assume that ACMD can only recommend prohibition, that prevalence of use is a factor in determining the regulatory option for harmful drugs and that a lack of transparency about these issues is of no concern.

12. *What is the role of the Government Chief Scientific Adviser in the policy making process and what impact has he made to date?*

Professor Sir David King replied to our concerns by firstly asking the HO CSA to address them. Consequently Professor King said "I note, of course, your concerns about transparency and the need to avoid the selective use of advice. I agree with you on these points. But in this case it is for the Committee itself to decide what to investigate, and to ensure it adheres to the Guidelines and Code". However the ACMD Chairman has not replied to our subsequent letter and the ACMD Secretariat has not replied to our last letter to them.

13. *Are existing advisory bodies being used in a satisfactory manner?*

No. ACMD is used for independent advice on risk assessment and evaluation of regulatory options. HO should evaluate that advice following the Guidelines on Scientific Analysis in Policy Making. However since both ACMD and HO assume that any evidence of risk justifies prohibition, they do not follow Government guidance on risk assessments (see 18 below) and the evaluation of regulatory options.

14. *Are Government departments establishing the right balance between maintaining an in-house scientific capability and accessing external advice?*

No. ACMD members do not appear to have expertise in risk or regulatory assessment. The full range of opinion is not reflected in ACMD advice and HO evaluation, though experts and the public hold entrenched polarised views in a sensitive cross-cutting policy area. Examples of external advice include:

- The Department of Health. Their report Dangerousness of Drugs [2001] includes the traditional drugs alcohol and tobacco, discusses methodological problems of obtaining, analysing and ranking evidence of drug risks and includes a wide range of methods of assessing evidence of risk, including the EU drug risk assessment guidelines of EMCDDA.
- The World Health Organisation advises on all drugs irrespective of tradition and legal status and provides scientific advice to UN drug agencies.
- Leading scientists. For example Colin Blakemore, Chief Executive of the Medical Research Council described the MDA's classification saying "It is antiquated and reflects the prejudice and misconceptions of an era in which drugs were placed in arbitrary categories with notable, often illogical, consequences. The continuous review of evidence, and the inclusion of legal drugs in the same review, will allow more sensible and rational classification" [A Scientifically Based Scale of Harm for all Social Drugs].
- Other stakeholders affected including consumers, suppliers and producers.

15. *What mechanisms are in place to ensure that policies are based on available evidence?*

None. The HO and ACMD appear unaccountable concerning their failure to follow Government guidelines.

16. *Are departments engaging effectively in horizon scanning activities and how are these influencing policy?*

No. There has been a continuous trend since the 1950s when the risks from drugs traditionally used in the west were under-estimated (they were not even viewed as drugs) while the risks from non-traditional drugs were exaggerated, with regulations proportionately biased. The change in the evidence base is exceptional: in 1955 the World Health Organisation's report Physical and Mental Effects of Cannabis stated "under the influence of cannabis, the danger of committing unpremeditated murder is very great; it can happen in cold blood, without any reason or motive, unexpectedly, without any preceding quarrel; often the murderer does not even know the victim, and simply kills for pleasure". Six years later the first UN drug Convention criminalised cannabis. In contrast WHO's 1995 cannabis report states "cannabis appears to play little role in injuries caused by violence, as does alcohol".

The trend is toward scientific evidence of actual risk steadily replacing perceived risk with social attitudes altering accordingly. Since 1971 public opinion in favour of drug policy reform ("legalisation") has increased at around 1% a year. Public opinion is now balanced roughly 50-50. Evidence that traditional drugs are harmful drugs has increased dramatically in the last decade. The long-term trend for traditional and non-traditional drugs is toward integration as the evidence base increases. This constitutes an inevitable risk to Government's currently dis-integrated alcohol, tobacco and "drugs" policy but also a significant opportunity. The UK could lead the world in integrating traditional and non-traditional drug misuse policy

based upon the Government's modernisation program. This could lead to significant improvements to substance misuse policy (drugs & food, see 17 below) and, more generally, to policy relating to altering the unconscious habitual unhealthy behaviour of the public.

17. *Is Government managing scientific advice on cross-departmental issues effectively?*

No. ACMD has stated that society's risk tolerance toward the legal drugs alcohol and tobacco influences attitudes to illegal drugs, especially for young people (Drugs & the Environment).

Alcohol is covered by the Department for Culture, Media and Sport and their advisory body, AERC; tobacco by DoH and their advisory body SCOTH; caffeine by FSA and their advisory body, COT; and "drugs" by HO and ACMD. DoH and DfES both identify and refer to alcohol and tobacco as drugs but HO and ACMD do not.

The failure to integrate traditional and non-traditional drugs policy has wider consequences. "Substance misuse" is a term currently incorrectly used to cover the harmful use of traditional and non-traditional drugs. The failure to correctly define "drug" and "substance" results in the failure to correctly identify harmful food consumption as being a form of "substance misuse". The harmful consumption of food and drugs is the largest public health problem and the major common risk is dependency. Dieters have the same relapse rate as recovering heroin addicts. Common risk and regulatory assessments are required to provide an integrated policy toward substance misuse.

18. *Is risk being analysed in a consistent and appropriate manner across Government?*

No. ACMD and HO do not follow Government guidance on risk assessment and management. They do not correctly frame the problem as "all harmful drug use" but instead frame it as "all use of only non-traditional drugs". Perceived benefits (eg relaxation, enjoyment, socialising) are taken to be risks of dependency, in contrast to alcohol policy. Risk impacts are listed but not their likelihood. Risk factors, such as frequency of use, route of administration and setting, are not sufficiently analysed. Voluntary risks, usually viewed as a health issue, are not distinguished from risks imposed on others, usually viewed as a criminal issue. Perceived risks, known to be strongly influenced by familiarity, are not identified and distinguished from evidence-based risk. Non-scientific factors (eg public opinion, economic factors such as competition and taxation, human rights and inequalities, international law) are not identified and distinguished from scientific factors. The ACMD's risk assessment is not consistent with that of any other harmful product, especially those voluntarily consumed. HO do not appear to carry out risk assessments to the public or to Government, relying solely on the ACMD's assessment of risk to the public.

19. *Has the precautionary principle been adequately defined and is it being applied consistently and appropriately across Government?*

No. See 4 above.

20. *How does the media treatment of risk issues impact on the Government approach?*

The risks of non-traditional drugs have been exaggerated and associated with intense negative value judgements in the past, initially by Government and international authorities, then by the media. Public opinion has been severely influenced. These three groups have formed a self-reinforcing system of biased risk perception fuelled by risk amplification and closed to evidence.

21. *Is there sufficient transparency in the process by which scientific advice is incorporated into policy development?*

No. There is no transparency concerning which types of scientific and non-scientific evidence have been considered relevant, how this has influenced policy-making and how conflicting rights and responsibilities of stakeholders have been balanced during policy making. ACMD do not publish minutes of their meetings, contrary to the Code of Practice. HO have not answered our concerns about the complete lack of evidence of risks to the public in the Regulatory Impact Assessment for the prohibition of magic mushrooms, though the RIA proposed criminalising one million people as Class A drug users.

22. *Is publicly-funded research informing policy development being published?*

No comment.

23. *Is scientific advice being communicated effectively to the public?*

No. There is inconsistent use of the word "drugs". The Government's drug education website, *Talk to Frank*, says "Drugs are illegal" and then "alcohol can play a major part in many people's social lives. That's why it's easy to forget that it's actually a very powerful drug".

24. *Are peer review and other quality assurance mechanisms working well?*

No. There appears to be little peer review or quality assurance.

25. *What steps are taken to re-evaluate the evidence base after the implementation of policy?*

None. Policy remains unchanged despite an improved evidence base, significant changes in public opinion and increasing non-compliance and enforcement costs.

When Home Office minister Bob Ainsworth was asked by the Home Affairs Committee "what evidence do the Government have to show that confiscation and the prosecution of drugs suppliers have made any difference to the amount of drugs use in this country?" he replied "As the law to date has been so relatively ineffective, I doubt whether it has made much difference at all".

26. *Our Conclusions*

To comply with Government guidelines, and perhaps their statutory duty under the MDA, ACMD should reframe their current advice to Government so it is consistent with the evidence that:

- Alcohol and tobacco are harmful drugs.
- Harmless drugs do not exist.
- Legal and illegal drugs are equally harmful according to scientific evidence.
- Different regulatory policies toward legal and illegal drugs are determined by non-scientific factors, not scientific evidence.
- Recreational drug consumption is widely accepted in society—90% of adults consume the stimulant and intoxicant drugs caffeine and alcohol.

January 2006

APPENDIX 3

Memorandum from Transform Drug Policy Foundation

Transform Drug Policy Foundation is campaigning policy think tank, and the UK's leading centre of expertise of drug policy and law reform. Transform is a registered charity (no 1088508) and company limited by guarantee (company no. 4882177).

Transform exists to minimise drug-related harm to individuals and communities by bringing about a just, humane and effective system to regulate and control drugs at national and international levels.

Transform's work includes:

- Carrying out research, policy analysis and innovative policy development.
- Challenging government to demonstrate rational, evidence based reasoning to support its policies and expenditure.
- Promoting alternative, evidence based policies to parliamentarians, government and government agencies.
- Advising non-governmental organisations whose work is affected by drugs in developing drug policies appropriate to their own mission and objectives.
- Providing an informed, rational and clear voice in the public and media debate on UK and international drug policy.

For more information please visit www.tdpf.org.uk or contact the Transform office on 0117 941 5810.

Transform provides policy responses to Government consultations on issues that have implications for drug policy and law. Transform also submits evidence to Select Committees, independent inquiries and other policy fora, and would welcome the opportunity to give oral evidence to the Science and Technology committee. Transform gave written and oral evidence to the Home Affairs Select Committee drugs inquiry in 2001.

For more information and discussion please see "*After the War on Drugs—Options for Control*", a major new report from Transform examining the key themes in the drug policy reform debate, detailing how legal regulation of drug markets will operate, and providing a roadmap and time line for reform. Transform can provide printed copies, or the report is available online at www.tdpf.org.uk.

Submission Summary

Transform Drug Policy Foundation argue that the drug classification system:

- is based upon the false assumptions underlying historical prohibition of specific drugs rather than evidence of the efficacy of the classification system at reducing drug harms;
- is not predicated on a framework that enables policy makers to make decisions about how to classify drugs—as no meaningful indicators exist to measure effectiveness;
- is neither strategically planned nor effectively reviewed and evaluated against meaningful indicators; and
- is compartmentalised and not subject to cross departmental review.

That government risk assessment regarding drugs is:

- inconsistent, frequently ignoring expert advice both internal and external; and
- driven by uninformed media coverage and non-scientific government disinformation based around the demonisation of illegal drugs rather than their inherent dangers.

That the Advisory Council's decision-making process is not transparent, is politically constrained, is ministerially determined, and has failed to advise on the most important policy issues.

That there is a distinct lack of publicly funded research in key policy areas because of the reticence of policy makers to expose policy failings.

That successive Governments have sought to hype the dangers of illicit drugs rather than communicate scientific advice effectively.

That the result of the above is a drug classification system that fails to deliver on its policy objectives and underpins a wider drug policy that increases drug harms rather than decreasing them.

Historical Background/Political Context to Drug Classification System

1. Any consideration of the UK drug classification system must consider the broader political context of UK and international drug policy thinking over the last century that has informed its development and implementation.

Drug Classification and the UN system

2. The UK drug classification system is an integral part of drug prohibition, a legal system established in international law under the UN drug conventions which criminalises and prescribes penalties for the production, supply and possession of certain drugs (excluding alcohol and tobacco) nominally according to perceived harms associated with use.

3. Some 250 substances are listed in the Schedules annexed to the United Nations *Single Convention on Narcotic Drugs* (1961), the *Convention on Psychotropic Substances* (1971) and the Convention against *Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988). As of 1 February 2003 179 states are parties to the Single Convention 1961 with 174 and 166 signatories respectively to the 1971 and 1988 Conventions is respectively. The UK is a signatory to all three conventions, and as all 15 countries of the EU have signed the three drugs conventions, these conventions have been incorporated into what is known as the EU's acquis or legal foundations. This means that all acceding countries also are obliged to sign them.[1]

4. According to the EU European Legal Database on Drugs; "The purpose of this listing is to control and limit the use of these drugs according to a classification of their therapeutic value, risk of abuse and health dangers, and to minimize the diversion of precursor chemicals to illegal drug manufacturers."[2] All EU member states classify drugs roughly according to the conventions, using the annexes from the 1961 convention[3] on narcotic drugs and the 1971 convention on psychotropic drugs[4] as the guide (although there are some notable differences between states). These annexes prescribe the level of legal controls required by signatories for each category of drug, with drugs categorised into one of four schedules according to harmfulness. The conventions, perversely, do not include the most harmful drugs in global public health terms; alcohol and tobacco.

[1] David Bewley-Taylor, (University of Wales), Cindy Fazey (University of Liverpool) "*The Mechanics and Dynamics of the UN System for International Drug Control*". (http://www.forward-thinking-on-drugs.org/review1-summary.html

[2] http://eldd.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5622&sLanguageISO=EN

[3] http://www.incb.org/pdf/e/list/yellow.pdf

[4] http://www.incb.org/pdf/e/list/green.pdf

5. The UK has therefore been locked into a prohibitionist system (for selected drugs), for more than 45 years, legally binding under international law (EU and UN), that requires the criminalisation of production, supply and possession of non-medical use of some psychoactive drugs, the penalties for which are determined by a classification system also broadly established under international law.[5] The UK classification system, based as it is upon international prohibition, also excludes alcohol and tobacco.

6. At the time of the drafting of the conventions, and indeed the UK's domestic policy response in the form of the 1971 Misuse of Drugs Act, the concept of using prohibition to eliminate drug use was entirely without evidential foundation. In reality the only major experiment with prohibition had been US alcohol prohibition, a benchmark for poorly thought out drug policy lead by moral imperatives rather than evidence of effectiveness. It should be noted that much of the 1961 convention was drafted in the 1940's in an era when patterns of drug use and drug related harm were entirely different to those we face today. However, the essential tenets of prohibition—using criminal law to enforce the moral view that all drug use is unacceptable—have remained unchanged since the Victorian temperance movement. Drug production and use have risen consistently since the Misuse of Drugs Act was commenced in 1971—the precise opposite of its policy objective.

Drug classification in the UK

7. Transform argue that it has been political forces, international and domestic, rather than rational analysis of evidence that has have defined drug policy thinking in the UK. Domestically drug policy is an intensely emotive and politicised issue, intimately intertwined with the populist/partisan law and order debates. Political discourse has been dominated by tough-talking drug war rhetoric, and it is in this context that the unscientific un-evidenced and ineffective system of drug classifications/punishments has evolved, supported by ineffective institutions and entrenched unscientific practices described below. (*This briefing will not go into detail about the numerous anomalies within the classification system—which will no doubt be highlighted by others.*)

Five Reasons why the Classification system is Fundamentally Flawed

1. *There is no evaluation or review of the classification system against meaningful indicators.*

8. Before trying to establish if the classification system is effective we must ask what it is seeking to achieve. The Misuse of Drugs Act seeks to reduce the availability and misuse of prohibited drugs—its ultimate aim being a drug free society. However there appear to be no effective systems of policy evaluation and review in place, or even a set of meaningful indicators by which the effectiveness of reaching these policy objectives can be assessed—for the classification or the policy as a whole. Neither drug availability nor levels of misuse (or health harms related to use) are measured in a meaningful or consistent way[6].

9. For example, in order for ACMD to make an informed decision about the recent reclassification of cannabis, they would need to know how changes in classification reduce or increase the mental health problems of users. The evidence for this did not, and does not exist. In his oral evidence to ACMD's recent cannabis review, Transform's director described the classification system as specious—prohibition and the classification system are both "deceptively attractive". They purport to do something for which neither have an evidence base: prohibition purports to eradicate and eliminate the problem in the first instance and, having failed, classification purports to accurately describe the harms associated with use and demarcate appropriate penalties to reduce those harms. Both are palpable nonsense. Ministers, quite simply, have no idea whether the classification system is working or not.

2. *The system is based on the un-evidenced assumption that criminal penalties are an effective deterrent and that stronger penalties are a stronger deterrent.*

10. At the heart of the classification system, and indeed the entire prohibitionist paradigm within which it operates, is the assumption that criminal sanctions are an effective deterrent to use, specifically that the heavier the sanctions the stronger the deterrence. However, Transform is aware of no piece of research ever undertaken by the Home Office to establish any evidential base, let alone prove this key assumption.[7] There is also no evidence to show that key target groups understand or pay any attention to the classification system or related announcements from the home secretary when making drug taking decisions. It can only be assumed that no research is commissioned on these key topics as it would expose policy failings.

[5] The ELDD notes that: "in some countries the law states that the sanction for possessing a controlled drug will depend on the type of drug in question, while in other countries the law foresees the same punishment for an activity, no matter which substance is involved." http://eldd.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=5622&sLanguageISO=EN

[6] Transform are happy to elaborate on this if requested, with an analysis of existing policy indicators.

[7] In response to a direct question on evidence of enforcement related deterrence from the Home Affairs Select Committee 2001 (see http://www.parliament.the-stationery-office.co.uk/pa/cm200102/cmselect/cmhaff/318/318m92.htm) the only research referenced by the Home Office was a single MORI poll commissioned by the Police Foundation in 1999. This same poll has been used by others to suggest the opposite—ie a weak deterrent effect.

11. The little independent research that has been done in this area suggests that the law and enforcement are, at best, marginal factors in drug taking decisions—especially for the most excluded groups; young people, those with mental health problems and those from socially deprived communities—who are most vulnerable to problematic use. Studies in Australia and the US have compared levels of cannabis use between different states with different enforcement regimes for cannabis offences (from harsh penalties to effective decriminalisation) and found no causal link between penalties and incidence of use.

12. Criminal law is supposed to prevent crime, not "send out" public health messages. When this has been tried it has been spectacularly ineffective, as the unprecedented ballooning of drug use over the last 35 years demonstrates. Moreover it has been actively counterproductive, making drugs more dangerous not less, whilst simultaneously fostering distrust of police and public health messages amongst young people. Since 1971 the use of all of the major illegal drugs of concern has increased dramatically, with the increase in the most risky class A drugs being the most dramatic. For example the current ballooning in the use of cocaine and crack cocaine, the rapid expansion of ecstasy use in the late 1980's early 1990's, and the 3,000% rise in heroin use since 1971.

3. *Alcohol and tobacco are not included in the classification system*

13. It is this omission from the classification system that, perhaps more than any other, truly lays bare its fundamental lack of consistency, reasoning or evidence base. Any and all medical authorities will acknowledge that by far the greatest harm to public health from drugs stems from alcohol and tobacco use. In the UK they are estimated to be responsible for 30,000 and 100,000 premature deaths each year respectively, more than 300 a day. This figure is approximately 40 times the total number of deaths from all illegal drugs combined, and even if relative numbers of users are taken into account, if classified under any realistic assessment of toxicity, addictiveness and mortality rates both drugs would certainly be criminalised and prohibited under the current system[8]. The reason they are absent from the classification system is that they are, for entirely political/ historical reasons, absent from the international prohibitionist legal system. This distinction is arbitrary, perverse and illogical.

> "Why not criminalise tobacco, place it within the Misuse of Drugs Act, put it into Class C and have two years for simple possession of this dangerous drug?. . . it is an awkward question in the debate that needs to be asked."
>
> *Griffiths Edwards (former chair of the ACMD) "Matters of Substance"*

14. It should also be noted that the special place of alcohol and tobacco in drug policy extends beyond the absurd exception from the UN and MDA classification system. Alcoholic beverages are the only food or beverage not required to list ingredients. Alcohol is also the only widely consumed dangerous drug not required to have standard pharmaceutical health warnings on the packaging. Tobacco products similarly are not required to list the many hundred of potentially harmful additives which can constitute up to 30% of their content. These policy anomalies further expose the bizarre a-scientific world in which UK and international drug policy is formulated.

4. *Drug harms are mediated by the nature of the user, the dose of drug consumed and the method of consumption—making a system based upon broad sweep single classifications for each drug fundamentally unscientific, and meaningless in most practical terms.*

15. *Nature of user:* some individuals will be susceptible to certain harmful effects of some drugs whilst others will not, the effects of cannabis on those with pre-existing mental health problems being a good example—there are many others.

16. *Dose of drug consumed:* As an example, the classification system makes no distinction between coca leaf chewing and smoking crack, because they are both cocaine use (class A). However coca chewing is low dose and slow release and is not associated with significant health harms (and even some benefits)—whereas crack smoking is high dose and rapid release and consequently associated with high harm/risk. Similarly some drugs are low risk if used occasionally but become increasingly high risk with increasing intensity and regularity of use. The classification system makes no allowance for responsible or moderate use of any illegal drug and completely ignores the possibility that some drug use may be beneficial (pleasure, relaxation, pain relief etc). Whilst society and policy makers (see Blair quote below) are entirely capable of making the distinction between responsible and irresponsible alcohol use (having a drink of wine with your evening meal compared to having a bottle of vodka with your breakfast) current legislation and most political discourse allows no such distinction.

> "Millions of us enjoy drinking alcohol with few, if any, ill effects. Indeed moderate drinking can bring some health benefits."

[8] It is smoked tobacco that is particularly harmful due to the effect of smoke, and its toxic constituents, on the lungs. Non smoked tobacco or other nicotine use (patches inhalers) are comparatively low risk. Cigarettes are designed to be smoked and therefore, unlike alcohol, always harmful when used as directed.

"Ultimately, however, it is vital that individuals can make informed and responsible decisions about their own levels of alcohol consumption. Everyone needs to be able to balance their right to enjoy a drink with the potential risks to their own—and others'—health and wellbeing."

Tony Blair (from the forword to the 2003 Alcohol Harm Reduction Strategy)

17. *Consumption methods:* most drugs can be eaten, smoked, snorted or injected (along with various other less common methods). Whilst the classification system increases penalties of some drugs if "prepared for injection", no differentiation is made between other consumption methods despite their being associated with significantly different levels of harm/risk.

5. *Translating generalisations about harms/risks to an entire population into penalties for individuals is both unscientific and unjust.*

18. Even if one accepts that consenting adult drug use is a criminal act (Transform does not) it remains unethical and unscientific to base penalties for an entire population—including the majority of non-problematic users—on the small proportion of drug users who experience difficulties or health problems.

Other Problems with the Classification System: Evidence and Policy Development

—The committee asks whether the existing advisory bodies are being used in a satisfactory manner:

19. The key advisory body regards drug classification is the Advisory Council on the Misuse of Drugs. This body is established under the 1971 misuse of drugs act to advise ministers within its remit in "preventing the misuse of such drugs or dealing with social problems connected with their misuse" and "restricting the availability of such drugs or supervising arrangements for their supply". Transform questions the utility of the ACMD and points out that the political backdrop of the Council's work mitigates against evidence based policy making and effective policy development in a number of key ways:

20. The ACMD is established and operates as part of the Misuse of Drugs Act 1971. As such it can make recommendations for minor tweaks to the policy of prohibition but cannot challenge its basic tenets. There is no history of the broader policy of prohibition being evaluated or reviewed (despite its obvious failings) or alternative policy options being considered.

21. ACMD members are appointed by a Government that is both legally locked into and publicly committed to the prohibitionist paradigm. As such the committee lacks independence—it operates within a highly restrictive political environment, one that stifles dissent and does not reflect the balance of opinion within the broader drugs field.

22. The ACMD lacks transparency—Its deliberations are not open to the public, are unpublished and are unavailable for independent comment or scrutiny.

23. The ACMD is essentially a reactive body—the Minister dictates its agenda and the scope and remit of its inquiries. It has limited capacity to proactively open up lines of inquiry and a limited or non-existent research budget.

24. Ministers also appear to misunderstand the role of the ACMD—the recent cannabis reclassification farrago provides an instructive example. Asked by a journalist recently what he intended to do about cannabis, the Prime Minister replied that he had referred it back to ACMD to find out whether its reclassification to Class C had sent the wrong message to young people. Drug policy experts had thought that ACMD had been asked to review new evidence of a link between cannabis and mental health problems, not whether it had caused a PR problem.

—The committee asks how media treatment of risk issues impact on the government approach

25. As noted in paragraph 7, drug policy has long been highly politicised, associated with populist law and order debates and dominated by emotive drug war rhetoric. The media have undoubtedly reinforced this, with shocking stories of drug related misfortune providing frequent and easy headlines for tabloid editors. Drugs have provided the fuel for classic "moral panics", such as the ecstasy panic in the late 80's, following a pattern established by the "reefer madness" scares from earlier in the last century. This coverage has been characterised by poor understanding of drug risks and with factual voids filled with exaggeration, anecdote and hysteria. Politicians have proved all too willing to jump on this bandwagon. They exploit misplaced popular fears to promote there own "tough on drugs and crime" credentials by demonising drug users and drugs, repeating popular myths, ignoring scientific evidence of actual dangers and calling for harsher penalties for drug offenders.

26. Ecstasy provides a useful example. There have been numerous calls for ecstasy to be reclassified to B from A. These have been based on clear evidence that, whilst toxic and not without risk, it is not an addictive drug and therefore should not be classified alongside heroin and cocaine in Class A. However, a series of high profile ecstasy related deaths that received saturation coverage in print and broadcast media (most notably Leah Betts) have clearly been instrumental in preventing Ministers from implementing the change.

—The committee asks if publicly funded research is being published

27. Whilst acknowledging that the Home Office undertakes and commissions much worthwhile and high quality published research in the drugs policy field Transform would also like to point out that a recent review of UK drug policy commissioned by the Prime Minister from the number 10 strategy unit was not published until a freedom of information request by Transform and others. Then it was only published in part, the remaining suppressed sections (that were highly critical of policy failings) only entering the public domain when they were leaked to *The Guardian* newspaper[9]. Transform notes that a page of information ranking drugs according to harm within this Number 10 report has glaring discrepancies from the rankings that underlie the classification system[10].

RECOMMENDATIONS

Transform Drug Policy Foundation recommends that the Science and Technology Select Committee:

Short term

28. Call for an overhaul of the drug classification system in line with expert evidence.

29. Call for ACMD deliberations to be fully transparent, and all reports to be made public.

30. Call for appropriate research to establish an evidence base for the classification system's effectiveness in reducing harm, including a set of meaningful indicators to be established against which such effectiveness can be measured.

Medium term

31. Call for a cross departmental review of the efficacy of the enforcement of prohibition and penalties as defined by the classification system.

32. Call for a quadripartite select committee to review UK drug policy more broadly including a more detailed consideration of alternative policy options including shifting the drug brief from the Home Office to the Department of Health, and the possibility of legally regulated and controlled production and supply of some or all currently illegal drugs.

January 2006

APPENDIX 4

Memorandum from Rethink

EXECUTIVE SUMMARY

Cannabis is the most widely used illegal drug in the UK. There is a now a substantial body of scientific research indicates a positive relationship between cannabis use in adolescence and the later onset of psychosis; other research establishes a positive relationship between cannabis use and relapse by people with psychotic illnesses; a small amount of research has now been undertaken on the relationship between cannabis use and wider mental health problems.

The UK Government has not contributed to the expansion of this evidence base, either through commissioning evidence or through funding applications submitted to it. It took a significant decision to reclassify cannabis to a class C drug in 2004, but did not use the subsequent information campaign to communicate the evidence. A project to provide information materials to people with mental illness was vastly under-funded and flawed. School drugs education has not covered this evidence either. The body charged with reviewing evidence by the Government, the Advisory Council on the Misuse of Drugs, was only asked to review this evidence following media pressure.

This poor record has been followed in January 2006 by a decision to keep cannabis at class C, invest further in health education and review evidence on the recommendation of ACMD and the majority of mental health and drug charities.

Rethink believes that the failures of Government policy to reflect the evidence base has been due to a number of factors, including the politicisation of the issue, the cross-cutting nature of the issue, a reliance on single experts in departments and professionals rather than people with mental illness and their carers to direct policy.

Hence, we make the following recommendations.

[9] http://www.tdpf.org.uk/Policy_General_Strategy_Unit_Drugs_Report.htm
[10] See p 35 of the No 10 Strategy Unit drugs report linked in footnote 9.

Recommendation 1:

Guidance to civil servants and Ministers stress the importance of considering and commissioning evidence on all aspects of cross-cutting issues.

Recommendation 2:

Guidance to civil servants should stress the importance of consulting a variety of resident experts and practicing professionals.

Recommendation 3:

A mechanism be created through which service users, carers and organisations representing these groups can inform Departmental decisions on research funding, commissioning and determining future priorities.

Recommendation 4:

Users of drug and mental health services, their carers and organisations representing these groups to be included in the make-up of committees such as ACMD.

Recommendation 5:

Guidance to civil servants to stress the need to consult service users and carers as well as professionals, at all stages of the policy-making process.

Recommendation 6:

A mechanism be created through which service users, carers and organisations representing these groups can inform Departmental decisions on research funding, commissioning and determining future priorities.

Recommendation 7:

The advice given by Government-appointed bodies such as ACMD and Government policy to be regularly evaluated by external organisations.

Introduction

Rethink is a national charity, with over 8,000 members comprising both people with severe mental illness and their carers. Rethink operates almost 400 services for people with severe mental illness across England and Northern Ireland.

Rethink has campaigned on the issue of cannabis for many years because our members have consistently identified it as a major issue and because of emerging scientific evidence linking cannabis and mental illness.

Cannabis is the most widely used illegal drug in the UK—rates of use among young people are said to be falling a small amount (Health and Social Care Information Centre, 2005), but are still the highest in Europe (European Monitoring Centre for Drugs and Drug Addiction, 2002).

A. What is the Evidence on Cannabis?

(1) *Cannabis use and the onset of psychosis*

(a) epidemiology

(i) association

A clear association between use of cannabis and psychosis has been established by several longitudinal population cohort studies. The US National Epidemiological Catchment Area Study examined 20,000 community and institutional residents in the early 1980s. Using this sample and matching cases and controls for social and demographic characteristics, Tien and Anthony (1990) reported that people who used cannabis on a daily basis were 2.4 times more likely to report psychotic experiences than non-daily cannabis users (after adjusting for alcohol use and psychiatric diagnoses). Similarly, the Australian National Survey of Mental Health and Well-being 1997 (Hall *et al*, 1998) found that those who met the *International Classification of Disease* (ICD)-10 criteria for cannabis dependence were nearly three times more likely to report that they had been diagnosed with schizophrenia than those without cannabis dependence disorder.

These studies do not, however indicate the direction of the association between cannabis and psychosis, suggesting two possible hypotheses:

1. "Temporal priority hypothesis"—Cannabis use precedes development of psychosis.
2. "Self-medication hypothesis"—Cannabis use is a consequence of psychosis with people using it to self-medicate their symptoms.

(ii) temporal priority

Other population studies provide evidence for cannabis use preceding the development of psychotic symptoms. The Swedish Conscript Cohort (Andréasson *et al*, 1987) followed up 50,087 Swedish conscripts and found evidence for a "dose-dependent" relationship between cannabis use at 18 years and diagnosis of schizophrenia 15 years later. Heavy users of cannabis, with no psychiatric diagnosis at conscription, were 2.3 times more likely to be diagnosed with schizophrenia later in life (after adjustment for confounding variables). The authors noted, however, that only 3% of heavy cannabis users went on to develop schizophrenia suggesting that it may only affect those who have some other pre-existing vulnerability to psychosis.

One of the limitations of this study is the large temporal gap between cannabis use at 18 years and onset of schizophrenia 15 years later, with no assessment of cannabis use or other drug use in the intervening period.

The sample was also followed up by Zammit *et al* (2002) across the period 1970 to 1996. They found that the risk of developing schizophrenia was increased (odds ratio = 1.9) in those who had ever reported cannabis use at baseline. A dose-dependent effect was again found, with those who had used cannabis more than 50 times prior to assessment having a further increased risk of developing schizophrenia (odds ratio = 6.7).

This study used a more complete psychiatric register and controlled better for confounding variables such as other drug use, known risk factors for schizophrenia, IQ and social integration, but still found a relationship between cannabis use and schizophrenia. The authors estimated that 13% of schizophrenia could be averted if all cannabis use were prevented.

The Netherlands Mental Health and Incidence Study (Van Os *et al*, 2002) examined the relationship between cannabis use and psychosis amongst the general population (n = 4,045) and subjects with self-reported symptoms of psychosis (n = 59). They found that users of cannabis at baseline were nearly three times more likely to show psychotic symptoms at follow-up three years later. This risk remained significant even after a variety of confounding factors were controlled for. They also found evidence for a "dose-dependent" relationship with the heaviest users showing the highest risk. The authors estimated the attributable risk of cannabis to psychosis to be 13%, similar to Zammit's earlier finding. The relationship between cannabis use and psychotic symptoms was found to be even stronger for people with more severe psychotic symptoms who required care. The attributable risk of cannabis to severe psychotic symptoms was estimated at 50%. This study is limited, however, by the short follow up period.

The Dunedin Multidisciplinary Health and Development Study examined a general population birth-cohort of 1,037 subjects born in Dunedin in 1972–73 with follow up at age 26. The key advantage of this study is that the authors collected data on self-reported psychotic symptoms at age of 11, before the onset of cannabis use. They found that individuals reporting cannabis use at ages 15 and 18 had higher rates of psychotic symptoms at age 26 when compared to non-users. This association remained significant after controlling for psychotic symptoms before the onset of cannabis use (Arseneault *et al*, 2002). A significant effect of age was also found, with cannabis use at 15 resulting in an increased likelihood of meeting diagnostic criteria for schizophreniform disorder at 26. Further, 10.3% of age 15 cannabis users were diagnosed with schizophreniform disorder at age 26 compared to 3% of controls. This suggests a strong developmental effect of early cannabis use.

In addition to establishing temporal priority, the Dunedin Study also found evidence for specificity of outcome, as cannabis use at age 15 did not predict depressive symptoms at age 26, and specificity of exposure, as the use of other illicit drugs did not predict schizophrenia outcomes over and above cannabis use. The authors concluded that "using cannabis in adolescence increases the likelihood of experiencing symptoms of schizophrenia in adulthood".

A significant effect of age was replicated in a recent study by Stefanis *et al* (2004), which examined 3,500 subjects who formed part of the Greek Birth Cohort Study. Participants were administered a postal questionnaire which examined drug use and psychotic symptoms at age 19. Cannabis life-time frequency use was associated positively with positive psychotic symptoms. This effect size was much larger for those who had started cannabis use earlier in adolescence (pre-15 years). This evidence is limited as it is cross-sectional only, although the significant effect of age suggests that cannabis use preceded the development of psychotic symptoms.

A second general population birth-cohort study, the Christchurch Health and Development Study, was conducted in New Zealand, which followed up 1,265 children at ages 18 and 21. As part of the study, data was collected on cannabis use and psychotic symptoms. They found that young people meeting DSM-IV criteria for cannabis dependence had elevated rates of psychotic symptoms at both age 18 (rate ratio = 3.7) and age 21 (rate ratio = 2.3) after adjusting for many variables, including self-reported psychotic symptoms, other drug use and other psychiatric disorders. The authors concluded that this showed that the development of cannabis dependence is associated with increased rates of psychotic symptoms.

More recently, Ferdinand *et al* (2005) conducted a longitudinal population based study with 2,076 young children and adolescents recruited in 1983 from the province of Zuid-Holland. Subjects were followed up in 1997, when they were between the ages of 18 and 30. They found that cannabis use was a risk factor for psychotic symptoms in initially psychosis-free individuals and that this risk was increased almost three-fold when compared to non-users. They also found some support for the self-medication hypothesis, with psychotic symptoms predicting future cannabis use. The hazard ratio for cannabis use preceding psychotic symptoms was higher than that for psychotic symptoms preceding cannabis use (2.81 versus 1.70).

Thus several studies have suggested clear temporal priority for cannabis use. We do recognise some problems with these studies, including heterogeneity of outcome across studies, the use of self-report measures and limited statistical power. However, conclusively demonstrating the causal role of cannabis in the development of psychosis is necessarily difficult, given the practical difficulties of using animal models and ethical impossibility of human controlled trials. Adjusting epidemiological data for confounding risk factors for psychosis also presents enormous statistical difficulties. Given these constraints, we find the evidence for a relationship between early cannabis use and later psychotic symptoms compelling.

We also believe that the level of evidence required should be set against the level of risk identified by these studies. The development of a psychotic disorder is a serious and significant experience in an individual's life. The studies presented above indicate that cannabis use significantly increases the risk of this outcome. It is in this context that we make our recommendations for policy. However, we would support further epidemiological research to confirm the results of these studies.

(iii) other findings

A variety of other epidemiological research weakens the self-medication hypothesis.

A follow-up study in 1989 of the Swedish Conscript Cohort (Andreasson *et al*, 1989) found that cannabis users who developed schizophrenia had better premorbid personalities, a more abrupt onset of the condition and more positive symptoms than non-cannabis users who had schizophrenia. Earlier research also suggested that cannabis users who develop schizophrenia have better premorbid adjustment as well as having fewer negative symptoms and better treatment outcomes (Allebeck, 1991). More recently, a study over five years of Issac (1995) found that among inpatients in South London, with the exception of patients with diabetes, cannabis users tended to have more severe psychotic symptoms on admission.

An innovative study (Verdoux, 2002) used self-reports of drug use and psychotic symptoms from 79 college students, taken at random times over seven days. A positive association was found between cannabis use and unusual perceptions and a negative association between cannabis use and hostility. There was no temporal relationship between reporting unusual experiences and cannabis use, as the self-medication hypothesis would predict.

A number of studies have found that people with schizophrenia give similar reasons to other substance users for their use of cannabis and other drugs, eg to relax or socialise, to feel good, relieve boredom or provide stimulation. (Dixon *et al*, 1990; Bergman *et al* 1985; Noordsky *et al*, 1991; Test *et al*, 1989).

Two reviews of the evidence concluded respectively that: "on the basis of the best evidence currently available, that cannabis use is likely to play a causal role with regard to schizophrenia" (Arsenault *et al*, 2004) and "cannabis is an independent risk factor both for psychosis and development of psychotic symptoms" (Semple *et al*, 2005).

(iv) outstanding issues

If cannabis were a risk factor for schizophrenia, one would expect that rates of schizophrenia would increase as cannabis use increases. In Britain, cannabis use amongst young people appears to have increased substantially over the past 30 years, from around 10% reporting lifetime use in 1969–70 to 50% reporting lifetime use in 2001.

Initial data on the incidence of schizophrenia suggests that it has not increased, but instead stabilised or slightly decreased over the relevant time period. However, there are a number of factors which may account for this data, in particular changes in service design and a narrowing of the diagnostic criteria for schizophrenia. Hence Kendell (1993) concluded that despite reports of a falling incidence for schizophrenia in the UK, it would be rash to conclude that rates of schizophrenia were falling (Kendell, 1993). In some specific geographical areas, it seems that the incidence of schizophrenia has increased significantly. Boydell (2003) concluded that the incidence of schizophrenia had doubled in thirty years in Camberwell, South East London (Boydell, 2003). This study included all psychiatric contracts, rather than just admissions, and thus minimised the effects of changes in service provision. It also identified all possible cases of psychosis in the first instance, to minimise the effect of diagnostic delay or administrative inaccuracy.

Given the difficulties in establishing changes in the incidence of schizophrenia, we do not believe that the current evidence on incidence refutes the significant amount of epidemiological evidence pointing to a relationship between both adolescent cannabis use and heavy cannabis use and later psychotic symptoms.

(b) Neuroscience

Neuroscientific research gives evidence of mechanism by which cannabis use may give rise to psychotic symptoms.

Two cannabinoid receptors have been identified: CB1 and CB2 (Institute of Medicine, 1999; Pertwee, 2002), though others may exist (Wiley and Martin, 2002). The CB1 receptor is responsible for the psychological effects of THC (Heustis *et al*, 2001), whereas the role of CB2 is less clear.

The CB1 receptor is most heavily concentrated in the mesolimbic and mesocortical pathways, both believed to be important for the development of schizophrenia (Ameri, 1999). Interaction between CB1 and dopamine D2 receptors has been documented in rats and monkeys (Meschler *et al*, 2001). Cannabis increases dopaminergic activity in the mesolimbic system (Ameri, 1999).

This research gives some biological plausibility to the temporal priority hypothesis discussed above.

(c) Conclusion

Epidemiological evidence, underpinned by neuroscientific research, suggests that there is a relationship between both adolescent cannabis use and heavy cannabis use and the onset of psychosis. However, many questions remain and require further study. We do not believe that the current evidence on incidence convincingly refutes the temporal priority hypothesis.

(2) *Other mental health problems*

Some epidemiological studies have also established an association between cannabis use and poor mental health more generally.

A cross-sectional study has found an association between cannabis use and low life-satisfaction, contact with mental health services and hospitalisation (Kandel, 1984). Fergusson, Horwood and Swain-Campbell (2002) found relationship between cannabis use and suicidal behaviour after adjusting for confounding variables, which was both dose-responsive and stronger the earlier the onset of cannabis use. Rey *et al* (2002) found that in a nationally representative sample of adolescent Australians, cannabis users were three times more likely than non-cannabis users to experience depression. Fergusson *et al* (1997) found evidence for a relationship between cannabis use and major depression among the Christchurch birth cohort, with heavy users (defined as having used 10+ times) twice as likely as non-heavy users (having used one to nine times) and three times more likely than non-users to meet criteria for mood disorders. The Zurich cohort study found that those meeting criteria for depression by age 30 were 2.3 times more likely than the general population to use cannabis regularly (Angst, 1996). Another study found that 68% of female cannabis users were depressed (Patton *et al*, 2002).

However, other studies have not found a relationship between adolescent and depression or found that it is insignificant after adjusting for confounding variables (Fergusson and Horwood, 1997; Brook, Cohen and Brook, 1998; McGee *et al*, 2000).

Some studies have also found evidence for a link between cannabis use and suicide among adolescents, which remains after adjusting for confounding variables (Borges *et al*, 2000; Beautrais *et al*, 1999, Andreasson and Allebeck, 1990). Other studies have found an association but not a relationship which remains after adjustment (Fergusson and Horwood, 1997; Patton *et al*, 1997).

In both these areas, there is a need for more research and better designed studies to clarify the relationship between cannabis use in adolescence and suicide and depression/affective disorders.

(3) *Relapse*

The negative effects of cannabis use on people with psychotic illness have been well-established, initially through case studies. In a retrospective study of people with schizophrenia, Negrete *et al* (1986) found higher rates of continuous hallucinations and delusions, and more hospitalisations amongst active users. Jablensky *et al* (1992) replicated these findings in a two-year follow up study of 1,202 patients with first-episode schizophrenia enrolled in 10 countries as part of a World Health Organisation (WHO) Collaborative Study. Linszen *et al* (1994) conducted the first large prospective cohort study, comparing 24 users with 69 non-users over a year with assessments of mental state on a monthly basis. Cannabis users experienced significantly more, and earlier, psychotic relapses or exacerbation of symptoms over the 12 month period and the effect was dose-responsive. Martinez-Arevalo *et al* (1994) followed up 62 young adults with schizophrenia over a one year period and found that cannabis use was the best predictor of relapse and hospitalisation during this time.

In a longer term prospective study, Caspari (1999) followed up 39 patients with schizophrenia over 68 months and found a significantly higher rate of rehospitalisation. Cannabis users also tended to have poorer psychosocial functioning than non-users and higher scores on the "thought disturbance" and "hostility" items of the Brief Psychiatric Rating Scale (BPRS), though the strength of these findings is weakened by the fact that only one assessment of mental state was made once at the end of the 68 months.

More recently, Issac *et al* (2005) studied 115 patients admitted to a psychiatric intensive care unit in South London, assessing mental state using the BPRS every two weeks during their admission period. People with a history of cannabis abuse were found to be younger on first admission and had more previous hospital admissions. Urinanalysis indicated that 25% of the sample used cannabis during admission, and those that did use during admission tended to spend longer in hospital.

There is clear evidence to support the hypothesis that the use of cannabis by patients with a diagnosis of schizophrenia does result in an exaceberation of psychotic symptoms. This mitigates against the self-medication hypothesis with patients using cannabis to alleviate their symptoms.

B. Use of this Evidence by Government

(a) Government policy on cannabis

In October 2001, the Home Secretary asked the Advisory Council no the Misuse of Drugs to review the classification of cannabis. In March 2002, the Advisory Council reported and concluded that:

> "no clear causal link has been demonstrated. The onset of schizophrenia often occurs in the late teens, when cannabis use is most common, so that an association is inevitable."

The report goes on to recommend that cannabis be reclassified from class B to C, on the basis that the harm associated with it was less than other class B drugs. It was subsequently reclassified in January 2004.

At the time this report was written, only the Andreasson (87) study had been made public, so there was not a large evidence base from which to make this judgement. However, by the time that cannabis was in actually reclassified to class C, in January 2003, a number of other studies had been published, including Zammit (02), Van Os (02), Arsenault (02). In the light of this, we find it surprising that a further review of the evidence was not ordered before the reclassification decision was implemented.

In January 2005, following an extensive media campaign by Rethink on the anniversary of reclassification, the Department of Health announced a review of epidemiological evidence on cannabis and the aetiology of mental illness. In March 2005, the Home Secretary asked ACMD to look again at evidence on cannabis and reconsider its classification.

In January 2006, ACMD's report was released, which recommended that cannabis remain a class C drug, that a sustained public education and information strategy about the hazards of cannabis be created, that services for individuals with cannabis problems be reviewed, measures to protect people with schizophrenia on in-patient wards be strengthened and a research programme on cannabis and mental health be instituted.

(b) Government's role in increasing the evidence base

The Government has singularly failed to commission looking at the impact of cannabis on mental health. No major study so far on this issue has hence originated from the UK. This seems a significant failure on the part of the Government, given that hints of an important impact on mental health date back to 1987, as noted above. ACMD in 2001 too failed to recommend more research on the issue, even though it noted that the debate on it was long-running.

Applications to the Department of Health for funding for studies on this question have also been consistently rejected, even though some were strong, in Rethink's view.

Government has also failed to commission studies looking at the impact of legal penalties or classification on the use of cannabis. There is very little knowledge globally on how the relative effectiveness of legal status, drugs education and information campaigns on reducing usage levels.

(c) Communication of evidence

(i) To the general public

To our knowledge, the British Government has never attempted to communicate the mental health risks of cannabis use to the wider public. Indeed, opportunities to do so have been missed.

For example, when cannabis was reclassified to Class C in the UK January 2004, the public health campaign that accompanied reclassification did not mention the possible mental health effects of cannabis, but instead concentrated solely on the physical health effects of use and its continued illegality.

This contrasts with the action of the French Government, which in 2005 invested €3.8 million in the communications side of its cannabis campaign. This is particularly noteworthy, given that the latest evidence suggests that France has a lower level of cannabis use among young people than the UK. In France,

35.7% of young adults report lifetime use (compared with 40.4% in the UK) and 4.9% of young adults report use in the last year (compared with 16.6% in the UK) (European Monitoring Centre for Drugs and Drug Addiction, 2002).

(ii) To school-age children

Opportunities within school drugs education have also been missed. Current DfES drugs guidance stresses the physical health effects of cannabis, the possibility of dependence and especially its illegality, but dismisses the evidence on mental health effects:

> ". . . there has been a lot of debate about whether the use of cannabis can lead to mental illness, especially schizophrenia. However, no clear causal link has been proven for the latter, although cannabis can worsen existing schizophrenia and other mental illnesses and lead to relapse in some people.
>
> *It is important for schools to reinforce to pupils the message that cannabis is harmful to health and is still an illegal drug, and that possession remains a criminal offence leading to a possible criminal conviction*" (DfES, 2004;25)(emphasis DfES)

Cannabis education in schools has also been conducted too late. Research suggests that one factor determining the success of drugs education is ensuring that it is delivered at a relevant time in young people's development (McBride, 2005) and the current statistics on cannabis use among young people in the Britain. The latest statistics reveal that 1% of 11 year olds, 2% of 12 year olds, 7% of 13 year olds, 17% of 14 year olds and 26% of 15 year olds had used cannabis in the last year (Health and Social Care Information Centre, 2005). This would suggest that any intervention in British schools should take place before the age of 14, possibly before the age of 13, with booster sessions following this, in order to maximize effectiveness.

Studies have also shown that school drugs education can delay the age of first use, can reduce the number of young people who go on to frequent or high use and reduce drugs-related harms (Maggs and Schulenberg, 1998; Dijkstra *et al*, 1999; McBride *et al*, 2004; DfES, 2004). Given that the major risks involved with cannabis are dependent on the age and quantity of use, drugs education in this area seems a particularly appropriate intervention.

Furthermore, there is evidence of an inverse relationship between recall of drugs cannabis education and cannabis use. Among Year 11 pupils, those who did not remember having lessons about drugs in the last year were more likely than those who did to have used cannabis in the last month (21% compared with 16%). This contrasts with the evidence on recall of tobacco and alcohol-related lessons, where recall was found to have no impact on rates of either tobacco or alcohol use (Health and Social Care Information Centre, 2005), suggesting that education in relation to cannabis may be even more effective in deterring use among young people than tobacco or alcohol education.

(iii) To people with mental illness

The 2001 ACMD report does note the potential risk of cannabis use to people with existing mental health problems. Its view on this was very clear:

> "Cannabis can unquestionably worsen schizophrenia (and other mental illnesses) and lead to relapse in some patients. Its use should therefore be particularly discouraged in all people with mental health problems."

Despite this, there was no attempt until 2004 to create information materials for people with mental illness about the risks of cannabis. Even this attempt was flawed, as only £230,000 was allocated to the project. With approximately 1% of the population currently experiencing psychotic symptoms, this equates to a spend of less than one pence per head of the population experiencing psychosis and in touch with mental health services.

As part of this project, research was commissioned from Cragg, Ross and Dawson (unpublished), to look at people's information needs and to make recommendations as to how the evidence on cannabis might be communicated. This researched highlighted an explanation used successfully by many psychiatrists in explaining the mental health risks of cannabis to their patients, especially those who were embedded in cannabis culture and hence could not believe that it was causing them harm when others seemed to be able to tolerate it well. The explanation used was that some people had a "cannabis allergy"—this was said to work very well as awareness of food allergies and intolerances was growing among the public. Despite this evidence from professionals of its usefulness, it was rejected by officials working on the materials after advice from the Department of Health. The grounds for rejecting it were that whilst people who had an allergy to a food experienced an adverse reaction to it very quickly, sometimes even instantaneously, those who experienced adverse mental health effects from cannabis often would not feel them until years later. Whilst there is some truth in this argument, there was no further work done to try and present this analogy in a way which would avoid this problem.

Once draft materials had been produced, further research was done with people with mental illness, their carers and professionals to test out the materials. The feedback gained from most groups was negative and hence it was decided to rework the materials. In this case, the decision was well grounded in evidence.

The project has now been put on hold, pending the advice of ACMD, despite the fact that the evidence on cannabis use by people with mental health problems was never in question.

As well as specific communications campaigns, there is an opportunity for Government to use existing health awareness programmes to communicate messages on cannabis. However, so far, such programmes (eg the Expert Patient Programme) do not, in our view, cover the issue of cannabis sufficiently, if at all.

C. Why has Evidence not been Reflected in Government Action?

(a) Politicised debate

Cannabis has been a politicised issue since the beginning of the twentieth century and "reefer madness". In this contested arena, it has been difficult for Departmental Advisors and experts of all kinds to look objectively at evidence. At a conference in September 2005 on cannabis, Griffith Edwards, the founder of the National Addiction Centre, pinpointed the two possible errors made in the cannabis policy arena: the positive error where too much credence is given to findings and the negative error, where findings are dismissed too easily. He concluded that 20 years ago, the positive error had been rife; now, it is the negative error that is rife. Hence the evidence has often not been looked at objectively. The ACMD report of 2005 is a notable exception to this trend.

(b) Role of the media

Because of the politicisation of this issue, there has been a high level of media interest. This has meant that the Government has sometimes been under pressure to make rapid decisions to respond to criticism in the media. Hence, the announcement of the Department of Health's review of evidence in January 2005. However, in the case of the decision to refer the issue to ACMD, this has led to well evidenced policy-making.

The media has, however, played an extremely important role in communicating evidence on cannabis and psychosis to the general public. Coverage of the issue has been significant and has made a valuable contribution to educating the public about this issue and in promoting discussion of it.

(c) Cross-over between departments

The issue of cannabis and mental illness does not fit easily into Governmental or Departmental structures, lying between the Home Office and the Department of Health and between public health, mental health, and substance misuse. Hence, monitoring research on this issue does not seem to have been part of the core function of any one team—officials seem to have "dipped into" the issue at certain points, because they were asked for advice, but not followed the succession of findings on the matter closely. This "dipping in and out" has allowed people to look at individual pieces of evidence within the context of their pre-conceived ideas on the issue, rather than questioning their view of cannabis.

Cannabis is part of both the law enforcement and health agendas. There has been no attempt to look at cannabis policy "in the round", to consider the interaction of public health education initiatives, information provision in mental health services, drug service provision and law enforcement. Officials and Ministers need to be encouraged to look at such cross-cutting issues in a more coherent and comprehensive manner.

Recommendation 1: Guidance to civil servants and Ministers stress the importance of considering and commissioning evidence on all aspects of cross-cutting issues.

(d) Reliance on a single experts in Government

Despite this, we have experience of officials relying on only one expert, often an internal expert, to provide advice on cannabis. Often, officials do not then challenge this advice—it is regarded as an "expert view" and is seen as absolute, though in fact it may be partial.

This seems to be particularly problematic if the "expert" in the Government department has a professional background linked to the issue—in this case, as a psychiatrist, mental health nurse or researcher. Often, people with a professional background are employed by Government departments and are seen as resident experts in that field by career civil servants, because of their experience "in the field". Whilst their advice can be valuable, it is too often seen by officials as absolute. Some of these experts are consulted on too wide a range of issues than they can reasonably be expected to have mastered, a far wider range than any official would be. The view of any one professional would be considered a useful, but partial view, if they were responding to a Government consultation—it does not seem right that a single official's view is prioritised purely because of their prior professional experience.

Furthermore, it is questionable how far the views of these experts reflect current professional practice—the longer they work in Government, the more removed are their experiences from current practice and experience. Given that cannabis use has increased significantly in the past two decades, professionals' experience in mental health facilities has changed also—experts who are out of touch with current professional practice are likely to be out of touch with these experiences.

Experts are also far more likely than practicing professionals to influence decisions on research funding and commissioning. Given that practicing professionals have more relevant experience, they should have a means in which to influence such decisions and recommend future priorities.

Recommendation 2: Guidance to civil servants should stress the importance of consulting a variety of resident experts and practicing professionals.
Recommendation 3: A mechanism be created through which service users, carers and organisations representing these groups can inform Departmental decisions on research funding, commissioning and determining future priorities

(e) Reliance on professionals, rather than service users

To our knowledge, there is no-one with personal experience of using drug or mental health services involved in making cannabis policy. This seems a significant omission especially in the make-up of ACMD. Including people with mental illness and/or substance use problems on such bodies could help ensure that they are more in touch with current issues for people and that views are grounded in experience, rather than preconceived ideas. Organisations which represent service users could also play an important role. A similar case could be made for carers playing a role on such bodies.

Service users also seem to be the last port of call for officials making cannabis policy—this was certainly our experience in the COI project to create information materials on cannabis. Given that these materials were destined for people with mental illness, it seemed foolish not to consult people with mental illness at an earlier stage about what kind of information they needed, as well as design and other issues. In the research on information needs, mentioned above, service users were not as well-represented as professionals.

There is currently no mechanism for service users, carers and organisations representing them to make suggestions and recommendations for future research funding.

Recommendation 4: Users of drug and mental health services, their carers and organisations representing these groups to be included in the make-up of committees such as ACMD.

Recommendation 5: Guidance to civil servants to stress the need to consult service users and carers as well as professionals, at all stages of the policy-making process.

Recommendation 6: A mechanism be created through which service users, carers and organisations representing these groups can inform Departmental decisions on research funding, commissioning and determining future priorities.

(f) Lack of evaluation

The policy making process on cannabis does not seem to be evaluated in a systematic or formal way. ACMD's advice, for example, has never been evaluated by an external body. We believe that these processes, like other Government processes, deserve to be reviewed by an external body.

Recommendation 7: The advice given by Government-appointed bodies such as ACMD and Government policy to be regularly evaluated by external organisations.

(g) Time lag

As noted above, there was a significant time lag between the review of ACMD in 2001 and the implementation of reclassification in 2003. In this period, a significant amount of new evidence emerged about cannabis and mental illness, but the cannabis decision was not revisited in the light of this. This did not happen despite the efforts of Rethink to bring the new evidence to the attention of Government. There needs to be a mechanism for reviewing evidence and updating recommendations between the point where policy recommendations are made and they are implemented. Once a major policy decision (such as that to re-classify) has been taken, further research relating to that decision should be systematically monitored and reported to Ministers responsible.

Recommendation 8: Major policy decisions to be accompanied by a commitment to monitor research developments until and following implementation.

January 2006

APPENDIX 5

Memorandum from Paul Flynn MP

Classification of Illegal Drugs

1. As a long-standing campaigner on issues relating to illegal drugs, I wish to make a short submission in contribution to this case study. I would also note my support for the submission made by Transform.

2. With very few exceptions, Government policy decisions on illegal drugs appear to be largely evidence free.

3. The Strategy Unit, based in No 10 Downing Street, produced a report in 2003 looking at policy to reduce the harm caused by illegal drugs. After much pressure and with the use of the Freedom of Information Act, the report was made public in 2005. The report reached conclusions which were surprising given the consensus about illegal drugs which tends to exist in Government against legalisation. A summary was provided by Transform (below) and concluded that current policies in the "war" on drugs had failed.

- Prohibition has failed to prevent or reduce the production of drugs.
- Prohibition has failed to prevent or reduce the trafficking/availability of drugs.
- Prohibition has failed to reduce levels of problematic drug use.
- Prohibition has inflated prices of heroin and cocaine, leading some dependent users to commit large volumes of acquisitive crime. Even if such supply interventions could further increase prices, this could increase harms, as dependent users commit more crime to support their habits.

(Strategy Unit Drugs Project TDPF Executive Summary, Phase 1 Report: "*Understanding the Issues*")

4. It is clear that, in spite of the powerful conclusions of this report, it has not been incorporated into Government policy.

Cannabis

5. The announcement by the Home Secretary to maintain the classification of cannabis as a Class C drug proves that the advice of the Advisory Council on the Misuse of Drugs has been considered and largely followed. In the same statement the plea for the prohibition of the drug Khat was rightly rejected. Ministers have not bowed to popular pressure in these instances.

Mushrooms

6. Prior to the General Election 2005, the Drugs Act classified magic mushrooms as a Class A drug. This is contrary to evidence that the Home Office itself presented as part of its argument supporting the change. In answer to a Parliamentary Question, I was given a list of the evidence used. None of these documents gave cause for concern.

7. The conclusions of the risk assessment by the Coordination Centre for the Assessment and Monitoring of new drugs (CAM) and the article by Hasler *et al* both suggest that public health factors are not a main determinant of policy. The CAM report states in its conclusion, "the use of paddos does not, on balance, present any risk to the health of the individual" and "the risk to public health is therefore judged to be low." The Hasler article concludes "our investigation provided no cause for concern that administration of PY to healthy subjects is hazardous with respect to somatic health."

8. The policy appears to have been driven by something other than evidence. Magic mushrooms present very little danger to public health (the ONS records one death from mushroom poisoning since 1993) and this policy ignores the fact that traders in mushrooms were very clear that they could advise customers about potential risks. The classification of one class of mushroom could create more harm by encouraging an unchecked trade more likely to involve those with malicious intent. Other more dangerous mushrooms, not covered by the current law, could be substituted for those that are prohibited.

January 2006

APPENDIX 6

Memorandum from the Maranatha Community in association with the Council for Health and Wholeness

1. Preface

This Document

This document has been prepared in response to the call for evidence by the House of Commons Select Committee on Science and Technology on "Scientific advice, risk and evidence: how government handles them."

This submission has been addressed to Mr Phil Willis, Chairman, Select Committee on Science and Technology. Email: scitechcom@parliament.uk; phone 020 7219 2793.

The Maranatha Community

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of people involved in the health and caring professions and in a wide range of voluntary work. Since its formation 25 years ago, it has been deeply involved in work amongst those with drug and alcohol problems, the elderly, the disabled and the disadvantaged. It has taken the initiative in a broad range of projects directly contributing to the health of the nation and it also has extensive international experience.

The Maranatha Community
UK Office, 102 Irlam Road, Flixton, Manchester M41 6JT Tel: 0161 748 4858 Fax: 0161 747 9192
Email: info-maranathacommunity.org.uk; www.maranathacommunity.org.uk
The Maranatha Community Trust is a registered charity number 327627.
The Leader and co-founder of the Community is Mr Dennis Wrigley.

The Council for Health and Wholeness

The Council is a multi-disciplinary body embracing doctors drawn from a variety of specialist disciplines, nurses and various medical auxiliaries, counsellors, chaplains and others. It has close links with the healing ministry of the Christian church and is involved in a broad range of research projects.

The Council for Health and Wholeness is based in the offices of the Maranatha Community. Its medical co-ordinators are Dr Hans-Christian Raabe and Dr Linda Stalley.

2. Introduction

2.1 The Maranatha Community and the Council for Health and Wholeness welcome the inquiry by the House of Commons Select Committee on Science and Technology examining the way Government uses scientific evidence in formulating policies.

2.2 This submission focuses on Case study 2—the classification of illegal drugs, especially the classification of cannabis under the Misuse of Drugs Act.

2.3 When the downgrading of cannabis from a Class B to a Class C drug was debated in both Houses of Parliament in October and November 2003, strong scientific evidence was available linking cannabis to serious mental illness including schizophrenia, psychosis and depression. This link between cannabis and serious mental illness has prompted the current Home Secretary, Charles Clarke, to review the classification of cannabis.

2.4 Timeline of events:

- October 2001—The then Home Secretary, David Blunkett, announces that he intends to downgrade Cannabis from a Class B to a Class C drug, and asks the Advisory Council on the Misuse of Drugs (ACMD) to report to him.
- March 2002—The ACMD reports to the Home Secretary in their report, *The Classification of Cannabis under the Misuse of Drugs Act 1971*. This report recommends the downgrading of Cannabis from a Class B to Class C drug.
- October 2003—The House of Commons votes for a downgrading of cannabis from Class B to Class C to come into effect from January 2004.
- November 2003—The House of Lords votes for the downgrading of cannabis.
- January 2004— The downgrading of cannabis comes into effect.
- March 2005—The Home Secretary, Charles Clarke, writes to the ACMD, asking them to reconsider the classification of cannabis in view of evidence linking cannabis with mental illness.

— January 2006—Home Secretary Charles Clarke announces that cannabis should remain a Class C drug, however announces an educational program about its health effects and increased policing of cannabis offences.

2.5 In our submission we would like to present evidence that at the time both Houses of Parliament voted for the downgrading of cannabis, there was sufficient scientific evidence available to avoid making an unsound decision and having subsequently to consider a confusing u-turn on this issue.

2.6 The inquiry asks several questions about policy making. We would like to comment on several of these questions.

3. Sources and Handling of Advice

3.1 Under this heading, the inquiry asks the following questions:

— *Are existing advisory bodies being used in a satisfactory manner?*

— *Are Government departments establishing the right balance between maintaining an in-house scientific capability and accessing external advice?*

The first question is answered in paragraphs 3.1 to 3.22 below, and the second question answered in paragraphs 3.23 to 3.26.

3.2 In the case of drug policy, the main advisory body is the Advisory Council on the Misuse of Drugs (ACMD). An analysis of the composition of the ACMD when it initially reported on the classification of cannabis in early 2002 (from Peter Franklin in "*Renewing One Nation*", 2002.) raises serious concerns about this body for the following reasons (however, we note that the composition of the ACMD has changed since their report on the classification of cannabis was issued in March 2002).

3.3 There were hardly any scientists and no recognised schizophrenia specialist on this body.

3.4 There was a significant imbalance in the membership. The majority of members were from groups and organisations that promote a "liberal" drug policy or may even support legalisation of drugs. There were no representatives of groups or organisations that advocate a prevention-based drug policy.

3.5 The majority of ACMD members had a potential conflict of interest in that they were in receipt of government funding for the organisations they represented.

3.6 There were around 32 members of the AC MID according to the Home Office web site (the different listings provided were inconsistent).

3.7 Four ACMD members were key figures in the Drugscope organisation, the foremost pro-liberalisation pressure group in Britain:

— Roger Howard, chief executive of Drugscope.

— Sylvie Pierce, chair of the Drugscope board.

— Joy Barlow, until recently a member of the Drugscope board.

— Vivienne Evans, head of Drugscope's alcohol and drug education team.

3.8 Two ACMD members were on the steering committee of another pro-liberalisation pressure group, the UK Harm Reduction Alliance (UKHRA):

— Lorraine Hewitt.

— Kay Roberts.

3.9 Five ACMD members were patrons of the Methadone Alliance, which is linked to UKHRA, and not only wants drugs liberalised but made more easily available on the NHS:

— Joy Barlow (again).

— Martin Blakeborough.

— Lorraine Hewitt (again).

— Roy Robertson.

— John Strang.

3.10 Eight ACMD members were among the listed members of Action on Hepatitis C, another pro-liberalisation group allied to UKHRA and the Methadone Alliance:

— Joy Barlow (again).

— Martin Blakeborough (again).

— William Clee.

— Russell Hayton.

— Lorraine Hewitt (again)—founder of Action on Hepatitis C.

— Michael Narayn-Singh.

— Roy Robertson (again).

— Ian Sherwood.

3.11 Thus a total of thirteen members of the ACMD were leading members of proliberalisation pressure groups. Lorraine Hewitt and Joy Barlow are members of no less than three different pro-liberalisation pressure groups each.

3.12 All of these pressure groups are linked to numerous other pro-liberalisation pressure groups including Transform, the Drug Users Rights Forum and the International Harm Reduction Alliance—from which various former members of the ACMD have been drawn.

3.13 More than 20 of the ACMD members are members of the drugs policy establishment—involved in government funded research, treatment, education or campaigning.

3.14 Only seven members of the ACMD at most appear to have no financial interest in the direction of government drugs policy. Of these, only three or four are scientists.

3.15 The ACMD had no members from organisations that oppose the liberalisation of drugs, such as the National Drug Prevention Alliance or DARE (Drug Abuse Resistance Education).

3.16 There were no recognised specialists on schizophrenia such as Prof Robin Murray on the ACMD, nor any leading experts on brain function such as Prof Susan Greenfield, nor any of the foremost researchers on cannabis in the UK, such as Prof Heather Ashton.

3.17 These facts are disturbing because the ACMD is presented as a neutral, objective and scientific advisory body.

3.18 Not surprisingly, the ACMD recommended the dowgrading of cannabis from a Class B to a Class C drug. Still, the report warned about the adverse health effects of cannabis that "since cannabis use has only become commonplace in the past 30 years there may be worse news to come".

3.19 The poor handling of scientific evidence by the ACMD as well as failure to consult with the relevant experts is shown in the following incident: It is quite astonishing that the Chairman of the ACMD, Sir Michael Rawlins, claimed in a letter to The Times of 23 January 2004 that relevant evidence linking cannabis to schizophrenia published by Prof Robin Murray in November 2002 had been taken into account when the ACMD issued their report recommending the downgrading in March 2002. We quote from Prof Murray's letter to *The Times,* 28 January 2004:

> *Sir, Sir Michael Rawlins (letter, January 23, 2004) reiterates the view of the Advisory Council on the Misuse of Drugs, which he chairs, that there is little evidence of a causal link between cannabis and schizophrenia. He claims that "Most of Professor Robin Murray's research was known to the advisory council at the time that it was producing its cannabis report." This is remarkable since the ACMD 's report was released in March 2002, but our first research on this topic was not published until eight months later, in the BMJ of November 23, 2002.*
>
> *It was unfortunate that the ACMD did not include a recognised schizophrenia expert to alert it to the growing number of patients with cannabis-related psychosis. Nevertheless, the ACMD report could be defended in March 2002, since at that time there was only one report in the scienflfic literature suggesting that prolonged cannabis use increases the risk of later schizophrenia. However, subsequently five new studies have implicated heavy cannabis use as a contributory cause ofpsychosis.*
>
> *Is it not time for the ACMD to examine the new evidence in detail and consult with the scientists who produced it?*
>
> *Yours faithfully,*
>
> *Robin M Murray (Professor of Psych iatry), Institute of Psychiatry, De Crespigny Park, SE5 8AF.*

3.20 In addition, from our own correspondence with Sir Michael Rawlings, it is clear that the ACMD chose to disregard evidence-based warnings about the mental health risks associated with cannabis. On the 2 April, 2004 we drew Sir Michael's attention to evidence linking cannabis with mental illness and Professor Ghodse's warning that "It is quite worrying that we might end up in the next 10 or 20 years . . . with our psychiatric hospitals filled with people who have problems with cannabis". Sir Michael's reply of the 19 April, 2004 stated that the ACMD had "concluded that there is little sign ificant evidence of a causal link between cannabis use and the development of mental illness, particularly schizophrenia . . I am of the view that any new evidence produced since the production of the ACMD's cannabis report does not affect the overall weight of evidence on their conclusions about health risks."

3.21 As the make-up of the ACMD at the time of the report had no recognisable experts in the issues raised in the evidence, we conclude that in this instance the Government's use of the advisory panel was most unsatisfactory.

3.22 The second question we answer in this section is: Are Government departments establishing the right balance between maintaining an in-house scientific capability and accessing external advice?

3.23 We were, and remain, seriously concerned that the Home Office repeatedly refused to see eminent and leading scientists and others involved in research on cannabis, drugs and mental health in October 2003, prior to the debates in both Houses of Parliament. A team of leading scientists and representatives of other organisations who would be affected by the proposed reclassification were keen to meet the Home Secretary

in autumn 2003 prior to the planned downgrading. Our organisation was in frequent contact, both by phone and by fax to senior civil servants within the Home Office in order to facilitate such a meeting. All requests for this meeting were turned down by the Home Office. The group included:

— *Prof Robin M Murray*, Professor of Psychiatry, Institute of Psychiatry, London. Professor Murray has published a large amount of original research on the link between cannabis and mental health, including schizophrenia.

— *Prof John Henry,* Imperial College of Science, Technology and Medicine; Academic Department of Accident and Emergency Medicine, St Mary's Hospital, London. Professor Henry is an expert on the toxicology of illicit drugs.

Prof Heather Ashton, School of Neurosciences, Division of Psychiatry, University of Newcastle. Professor Ashton was possibly the first UK researcher to examine the effects of cannabis on mental health.

— *Prof Cohn Drummond,* Professor of Addiction Psychiatry, Department of Addictive Behaviour and Psychological Medicine, St George's Hospital Medical School, London.

— *Dr Clare Gerada,* Head of Substance Misuse Training, Royal College of General Practitioners, London. Apart from her official function, Dr Gerada has seen at first hand the effect of widespread cannabis use, especially among the young in Lambeth.

— *Mr Hamish Turner*, HM Coroner for the Torbay and South Devon District; Past President, Coroners' Society for England and Wales. As a coroner, he has first-hand experience of the effect of cannabis, especially on young people.

— *Jan Berry*, Chairman, Police Federation.

3.24 Despite the eminence of this group of scientists and others, and the appropriateness of their fields of expertise to the subject under inquiry, the Home Office refused to meet them.

3.25 Lord Alton of Liverpool expressed serious concerns about the refusal by the Home Office to meet these eminent and expert people in his contribution to the debate on the reclassification in the House of Lords. *(House of Lords Hansard; 12 November 2003: Columns 1496)* The government minister, Baroness Scotland of Asthal, failed to comment on this issue during the debate.

4. Relationship Between Scientific Advice and Policy Development

4.1 In this section the inquiry asks the following question:

What mechanisms are in place to ensure that policies are based on available evidence?

4.2 We submit that, at the time both Houses of Parliament voted for the downgrading of cannabis proposed by the then Home Secretary, David Blunkett, sufficient scientific information was already available to question the recommendation to downgrade and at least delay this decision until further evidence was available. We particularly note that, if policy is supposed to be based on the precautionary principle, then a decision to downgrade should not have been taken.

4.3 There is evidence going back many decades that cannabis is associated with mental illness including schizophrenia and psychosis. For example, Dr Karel Gunning, a Dutch doctor working in Morocco in the 1950s, points out that a condition called "cannabinism" was in evidence. This involved serious adverse mental health effects including "madness" following the use of cannabis. (Dr Karel Gunning, personal communication, 2002). There have been many studies published that have pointed to a possible link between cannabis and psychosis, some of them published over 35 years ago. *(Talbott JA, Teague JW. Marihuana psychosis. Acute toxic psychosis associated with the use of Cannabis derivatives. JAMA. 1969; 210: 299–302.; Keup W Psychotic symptoms due to cannabis abuse; a survey of newly admitted mental patients. Dis Nerv Syst. 1970; 31: 119–26,' Bernhardson G, Gunne LM Forty-six cases of psychosis in cannabis abusers. Int JAddict. 1972, 7. 9–16)*. In a study published over 20 years ago of 1,325 young adults aged 24 to 25 years, adverse mental health effects of cannabis were described. *(Kandel DB. MarUuana users in young adulthood. Arch Gen Psychiati'y. 1984; 41:200–9)*

4.4 In November 2001, the Maranatha Community published a booklet "Cannabis—a warning". This document was sent to the Prime Minister, the Home Secretary, the Secretary of State for Health and other political and church leaders. In this document, evidence was presented regarding the adverse physical health effects of cannabis, including brain damage, heart and lung disease and the triggering of cancer. The document also warned about the adverse effects on mental health, including triggering schizophrenia and psychosis and the risk of addiction. (*The Maranatha Community.' Cannabis—A warning. November 2001*)

4.5 In November 2002, a major consultation examining the adverse health effects of cannabis was held in the House of Lords, chaired by Lord David Alton. In this conference, Professors John Henry, Heather Ashton and Cohn Drummond presented evidence regarding the adverse effects of cannabis on physical and mental health. The latest evidence including three studies published in the British Medical Journal linking cannabis to schizophrenia and other mental health problems was presented. In total, 14 experts from different backgrounds as well as former cannabis users and relatives of cannabis users presented evidence.

The proceedings of this consultation were submitted to the Prime Ministers Office ("*Cannabis—a cause for concern*?—Consultation in the House of Lords, November 2002," available from the Maranatha Community)

4.6 The following is based on a presentation by Professor Robin Murray of the Institute of Psychiatry, given in a consultation convened by the Maranatha Community in the House of Commons on 21 October 2003, ie, well before the House of Commons voted for the downgrading on 29 October 2003.

4.7 Recent research into cannabis consumption and mental disorder shows that there is growing evidence that cannabis actually causes psychosis. Patients with recent onset of psychosis are twice as likely to have used cannabis compared with a population without psychosis. While alcohol consumption and consumption of illicit drugs other than cannabis was roughly equal in both groups, cannabis was used by 39% of psychotic patients but only by 22% of non-psychotic controls. Psychotic patients are more likely to consume cannabis than the general population, but until recently the reasons for this have been unclear. Indeed, many psychiatrists continue to believe that their patients take the drug to counteract the negative symptoms (lack of interest in life, poor concentration, etc) of the illness or the effects of medication. Furthermore, those psychotic patients who continue to use cannabis have a worse outcome than those who don't.

4.8 Can cannabis consumption actually cause schizophrenia? In 1987, a study of 50,000 conscripts into the Swedish Army revealed that those who admitted at age 18 to having taken cannabis on more than 50 occasions were six times more likely to develop schizophrenia in the following 15 years. (*Andreasson 5, et al.* Cannabis and schizophrenia. A longitudinal study of Swedish conscripts. *Lancet*. 1987 (8574).' 1483–6.) These findings have been largely ignored. However, in the last 18 months, a number of studies have confirmed that cannabis consumption acts to increase later risk of schizophrenia. A Dutch study of some 4,000 people in the general population showed that those taking large amounts of cannabis at the initial interview were almost seven times more likely to have psychotic symptoms three years later. Critics argued that the findings of the Swedish and Dutch studies could have been caused by those individuals who were already odd and destined to develop schizophrenia, rather than by the use of cannabis. Two further studies have, however, excluded this hypothesis. An expansion of the Swedish Army study demonstrated that the results held even when initial personality was taken into account. It has become clear that the risk of developing psychosis following cannabis use remains significant after controlling for factors such as disturbed behaviour, low IQ score, cigarette smoking, growing up in a city, and poor social integration. (*Zammit 5, et al*. Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969. historical cohort study. *BMJ* 2002,— 325: 1199–2001.) In a general population birth cohort study in Dunedin, New Zealand, it was found that those who used cannabis at age 15 were 4.5 times higher risk of developing psychosis by age 26. When the presence of psychotic-like ideas at the age of 11 was taken into account, the risk of schizophrenic symptoms at 26 was diminished, but was still important. (*Arseneault L, et al Cannabis use in adolescence and risk for adult psychosis.' longitudinal prospective study. BMJ 2002; 325: 1212–3.*) Cannabis use in adolescence was a risk factor for experiencing symptoms of schizophrenia in adulthood, over and above psychotic symptoms prior to cannabis use, in addition, a strong developmental effect was found. Early cannabis use (by age 15) was a stronger risk factor for schizophreniform disorder than use by age 18. Furthermore, cannabis use by age 15 did not predict depressive outcomes at age 26 (indicating specificity of the outcome) and the use of other illicit drugs in adolescence did not predict schizophrenia outcomes over and above the effect of cannabis use (indicating specificity of exposure).

4.9 There is a dose response effect with higher doses of cannabis causing greater psychosis. If cannabis is causally associated with psychosis, then we should expect to find a dose-response relationship in which a higher dose is associated with greater psychosis. Indeed, administration of Tetrahydrocannabinol (THC) can induce psychotic symptoms in controls and in schizophrenic patients, but more so in the latter: normal individuals experience a brief psychotic episode after intravenous application of THC, however individuals who have been psychotic suffer a greater increase in psychotic symptoms. Such a dose-response relationship was also observed in the above mentioned study among Swedish conscripts. Among the 50,000 Swedish 18-year-olds interviewed about their drug consumption when they were conscripted into the army, the relative risk of developing schizophrenia over the following 15 years was 2.4 for cannabis users compared to non-users at time of conscription. This rose to 6.0 for heavy users. Of course, it is possible to argue that the heavy users were already psychiatrically disturbed at age 18, and were taking cannabis as an attempt at self-medication. When this confounding factor was controlled for, the relative risk was roughly halved to 2.9, but remained significant. Furthermore, the Swedish findings have now been supported by four other prospective studies. Of course, only a small proportion of heavy cannabis users go on to develop schizophrenia. It seems heavy consumption over prolonged periods is necessary and psychosis develops particularly in those with some vulnerability.

4.10 Why should cannabis be a contributing cause for schizophrenia? Psychotic symptoms in conditions such as schizophrenia are mediated by dopamine, and recent evidence demonstrates that 9-THC increases the release of dopamine from the nucleus accumbens and the prefrontal cortex and raises the level of cerebral dopamine. Interestingly, it has recently been hypothesised that dopamine sensitisation plays a central role in explaining both the craving for cannabis and the positive symptoms (such as delusions, hallucinations, disorganised speech or behaviour) of schizophrenia.

4.11 A joint letter by Professor Heather Ashton, Dr Clare Gerada, Hamish Turner and Dr HC Raabe was published in the Independent on 23 January 2004, several days before Parliament voted for reclassification. In this letter it was stated:

4.12 A person who uses cannabis by age 15 has more than a four-fold increased risk of developing schizophrenia symptoms over the next 11 years compared with a person starting to use cannabis by age 18. Eighteen-year-olds who have used cannabis 50 times have a nearly seven-fold increased risk of developing psychosis over the next 15 years.

4.13 Up to 80% of new cases of psychosis currently seen in some psychiatric hospitals are triggered by cannabis abuse. Psychiatric services, especially in London, are near crisis point due to cannabis-induced mental illness.

4.14 Over the past three decades, a doubling of the prevalence of schizophrenia has been observed in London. While it is too early to say whether this is due to the increase in cannabis abuse over the past decades, this possibility cannot be discounted on current evidence. (Dr C Gerada, Director of drugs training programme, Royal College of General Practitioners, Professor H Ashton, Division of Psychiatry, University of Newcastle, H Turner, Immediate past President, Coroners Society of England and Wales, Dr HC Raabe, GP. Letter to the Editor, *Independent*, 23.01.2003)

4.15 We therefore submit that:

- sufficient evidence existed at the time to seriously question the downgrading of Cannabis,
- that this evidence should have at least served to delay any decision to reclassify, if policy is based on the precautionary principle, and
- that in this instance, any mechanisms that does exist to ensure policy is based on evidence failed, with grave consequences for the mental health of thousands of young people.

5. Treatment of Risk

5.1 Under the third heading the inquiry asks the following question:

- *Is risk being analysed in a consistent and appropriate manner across Government?*
- *Has the precautionary principle been adequately defined and is it being applied consistently and appropriately across Government?*

5.2 We are concerned that risk is not being analysed in a consistent and appropriate manner and that the precautionary principle has not been applied appropriately.

5.3 As mentioned in the previous section, there has been ample scientific evidence linking cannabis to many adverse health outcomes including psychosis for many years. Therefore the precautionary principle should be applied.

5.4 One definition of the precautionary principle in the field of environmental health has been defined in the Rio Declaration from June 1992:

> Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation. (UN Environment Programme, The Rio Declaration, Principle 15 June 1992)—.

5.5 The UK is a signatory to the Rio Declaration and therefore should adopt the precautionary principle into policy making. While this declaration refers to potential environmental damage due, for example, to man-made chemicals, this principle should apply to drug policy as well. At the time of making decisions and formulating policies, not all relevant scientific evidence may be available for a full risk assessment.

5.6 From a public health point of view, therefore, a precautionary principle should be adopted regarding drug policy. In practice, this means that any drug is considered potentially unsafe. Drug policy should be based on this assumption.

6. The System of Classification of Illicit Drugs

6.1 We welcomed the announcement by the Home Secretary to review the classification system of drugs. In this inquiry, the Science and Technology Committee investigates the classification of illicit drugs. The British system is based on the Misuse of Drugs Act 1971, which classifies illicit drugs into three classifications, Class A, B and C. Whilst, strictly speaking, the remit of the Committee was not to examine the actual basis of the drugs classification system, we submit that after over 35 years this system needs to be replaced.

6.2 The classification system is based on a comparative assessment of harmfulness. For example to place cannabis in the same class as valium or temazepam, as happened after reclassification, involves essentially a value judgement that the two substances are broadly as dangerous as each other and less dangerous than substances from class B or A.

6.3 As one can see with the discussion about cannabis, there is an endless debate on the classification of certain illicit drugs, whether a certain drug such as cannabis (and many other drugs come to mind) should be classified in Class C, or B or even A.

6.4 Obviously, the classification of a drug is a complicated decision, as the total harm caused by a drug is not just limited to the purely medical adverse effects, but also includes the adverse effects on society, including crime and the cost to the criminal justice system. A drug with a moderate or perhaps even low medical risk may have enormously severe adverse societal effects, especially if it is taken widely. A drug with very high medical risk may have few adverse societal effects, especially if only taken very rarely. It is therefore not surprising that even experts will disagree on the appropriate classification of an illicit drug.

6.5 The debate about reclassification in itself creates confusion. Some members of the police had erroneously believed that cannabis had been legalised. The announcement of reclassification led almost nine out of 10 primary school children to believe that cannabis was now legal and eight out of 10 pupils thought it was now safe. (*Life Education Centres, Children confused about cannabis; Press Release 05.09.2002*)

6.6 For these reasons, we submit that this old classification system should be replaced with a simpler regime similar to the Swedish approach.

6.7 In Sweden, there is essentially only one class of illicit drugs. The severity of a drug offence is determined by the amount of drug found on an individual. For example, possession of up to 50 gm of cannabis is considered to be a "minor offence" to have 2 kg of cannabis is a "major" offence. A normal offence is the possession of between 51 gm and just under 2 kg of cannabis. For heroin, the respective figures are up to 0.39 gm "minor", 0.4-25 gm "normal" and more than 25 gm "major". For amphetamines, up to 6 gm is considered "minor", 6.1–250 gm "normal" and more than 250 gm "major". The sentencing is obviously more severe in the major categories compared to the normal and minor categories. Only in the minor category would a person escape a prison sentence. Essentially, it is assumed that every dose in excess of a single consumption constitutes dealing. For this reason, this attracts a prison sentence. (*Tim Boekhout van Solinge. The Swedish Drug Control System. Cedro, Amsterdam, p 18f*)

6.8 We need to point out that Sweden has among the lowest rates in Europe for drug misuse of the major drugs including cannabis, cocaine, amphetamines and ecstasy. (Source: European Monitoring Centre for Drug European Monitoring Centre for Drugs and Drug Addiction, EMCDDA, various annual reports).

7. Conclusion

7.1 If the Government establishes an advisory body—such as the Advisory Council on the Misuse of Drugs—to guide decision-making on the classification of illicit drugs, then the Government has to make sure that at least two criteria are fulfilled. Regarding the Advisory Council on the Misuse of Drugs and the reclassification of cannabis, neither of these criteria were met.

- The membership of this body must be balanced in their views.
- The membership of this body must have the relevant qualifications and experience to guide the Government in their decision-making.

7.2 Scientific evidence was badly handled. The ACMD chairman claimed to have incorporated research papers into the ACMD report that were actually published eight months after the release of this report.

7.3 It appears that political considerations took precedence over scientific evidence and over the precautionary principle. This is shown by the determination of the then Home Secretary, David Blunkett, to request an assessment of downgrading from the ACMD, and by the refusal of the Home Office to meet leading researchers on cannabis and mental health just before the vote was taken in Parliament.

7.4 We submit that the current classification system based on the Misuse of Drugs Act 1971 needs to be replaced with a simpler and more effective system, such as the Swedish model. Sweden has among the lowest rates of drug misuse among European countries.

7.5 We submit that it is futile to pursue discredited policies of so-called "harm-reduction" and vital that the Government and the nation are totally committed to the ideal of a drug-free society.

January 2006

APPENDIX 7

Memorandum from the Multidisciplinary Association for Psychedelic Studies (MAPS)

1. This submission comes from the Multidisciplinary Association for Psychedelic Studies (MAPS), a United States nonprofit organization whose mission is to develop Schedule I substances that may have medical or psychotherapeutic benefits into prescription medicines. This mission has made us familiar with the process in the United States for gathering scientific evidence relating to the classification of illegal drugs,

and the ways that this evidence is and is not incorporated into public policy decisions. We write to share our knowledge of this process and both its functional and nonfunctional elements, so that your committee might become aware of potential pitfalls that may also exist in England.

2. In the United States, the process for gaining the necessary permissions to conduct scientific research using currently prohibited substances is different for cannabis than for other Schedule I substances such as MDMA, LSD, or psilocybin. Despite broad interest among United States citizens and State governments, the process for conducting research into the medical uses of cannabis is seriously obstructed. This submission will first share information about the research requirements for substances other than cannabis, followed by a description of MAPS' experience with the politically hobbled process for getting cannabis approved as a prescription medicine.

3. MAPS has sponsored and assisted researchers in gaining approval to proceed with several studies involving MDMA (Ecstasy), and psilocybin. Currently, a study is underway in South Carolina investigating the use of MDMA to facilitate psychotherapy in patients with posttraumatic stress disorder (PTSD), with promising results. Similar MAPS-sponsored studies using MDMA-assisted psychotherapy to treat PTSD are fully-approved in Israel and under review in Switzerland. A study at Harvard Medical School testing MDMA to ease anxiety associated with advanced-stage cancer has received final approved from the DEA on 19 January 2006 and will begin soon. A completed pilot study at the University of Arizona-Tucson found positive benefits from the effects of psilocybin in reducing symptoms of obsessive-compulsive disorder (OCD).

4. The process for conducting studies with substances other than cannabis has mostly worked well, with some room for improvement. In order to proceed with research, the researcher must have the protocol approved by the Food and Drug Administration (FDA) and a non-governmental Institutional Review Board (IRB-also known as ethics committees), must obtain a Schedule I license from the Drug Enforcement Administration (DEA) and the appropriate State agency, and must obtain a legal source for the drugs to be studied. The FDA has for the last 16 years, as a matter of policy, reviewed psychedelic and medical marijuana protocols based on their scientific merit and not on political factors. Many IRBs also prioritize science. The DEA has by law a limited set of criteria that it can use to justify denying a Schedule I licence. This allows researchers to know in advance the likelihood of being able to obtain the license, encouraging the design of protocols involving Schedule I substances, and investment in research planning. One potential challenge is that while the FDA must review a research protocol within 30 days, the DEA has no time limit for responding to applications for a Schedule I licence. As will be apparent in our discussion of the process with cannabis research, this loophole potentially allows the DEA to obstruct research by indefinitely delaying responding to licence applications. To date, the DEA has taken substantially more than 30 days for the non-cannabis studies with which MAPS has been involved but in the end has approved the licenses, though sometimes only after inquiries from elected representatives. State agencies have issued Schedule I licences in a more timely manner. Most importantly, in terms of research materials, except for marijuana, there is a competitive market for the supply of all Schedule I substances, which are obtained from independent suppliers licensed by the DEA.

5. Unfortunately, the process for conducting medical cannabis research, despite its broad support by the public and the medical community, serves as an example for England of what not to do in designing the process of incorporating scientific knowledge into public policy decisions. Ideally, if the FDA determines that the use of the cannabis plant is safe and efficacious for some clinical indication, a physicians should be able to prescribe it in the form of an FDA-approved medicine that is standardized for purity and potency. For this outcome to be realized, a pharmaceutical company must first submit to FDA sufficient scientific data proving safety and efficacy in a specific patient population, with the data gathered in controlled clinical trials conducted with prior approval of the FDA and DEA.[11]

6. Despite persisting interest in the medical research community into the exploration of the medical uses of cannabis, no patients in the United States received cannabis in the context of an FDA-approved study during the 14-year period between 1984 and 1998, when Dr Donald Abrams at the University of California—San Francisco administered smoked cannabis to the first HIV+ subject in his groundbreaking study.[12] Dr Abrams struggled for five years to obtain permission to conduct a MAPS-sponsored study of marijuana in subjects with AIDS-wasting, three years of which was involved with a fruitless effort to obtain cannabis from the National Institute on Drug Abuse (NIDA) after his initial protocol had been approved by FDA.[13] Following and precipitated by California's 1996 passage of Proposition 215, which provided legal access to cannabis for patients whose physicians recommended it to them, the National Institute on Drug Abuse (NIDA) agreed to sponsor a redesigned version of Dr Abrams' study, contingent upon a new focus on safety in HIV+ subjects without AIDS wasting.

[11] See Food and Drug Administration, Guidance for Industry: Providing Clinical Evidence of Effectiveness for Human Drug and Biological Products (1998), available at http://www.fda.gov/cder/guidance/1397fnl.pdf

[12] Donald Abrams, Medical Cannabis:Tribulations and Trials. 30 *Journal of Psychoactive Drugs*, Apr–Jun 1998), at 163–69.

[13] Id.

Federal agencies have blocked the supply of cannabis for clinical research through unreasonable delay of applications.

7. The most serious barrier to medical marijuana research in the US has been DEA's and NIDA's obstruction of FDA-approved studies' ability to obtain a supply of cannabis for their research. MAPS' experience attempting to support medical cannabis research illustrates the importance of having adequate competition in the market for the research material, and also of divorcing the supply process from government agencies that have a conflict of interest that prevents objective research.

8. In the United States, NIDA has a monopoly on the supply of FDA-approved research-grade cannabis for use in human subjects.[14] Sponsors of research into the medical uses of cannabis cannot manufacture their own supplies but must instead petition to purchase federal supplies at cost from NIDA.[15] The NIDA monopoly has been an impediment to objective and accurate scientific research. NIDA's institutional mission is to sponsor research into the understanding and treatment of the harmful consequences of the use of illegal drugs and to conduct educational activities to reduce the demand for and use of these illegal drugs.[16] NIDA's mission makes it a singularly inappropriate agency to be responsible for expeditiously stewarding scientific research into potential beneficial medical uses of cannabis. Furthermore, as with many monopolies, the quality of its product is low,[17] and access is restricted.

9. Accordingly, members of the medical community have opposed NIDA's policies relating to the supply of cannabis for scientific research into its potential medical uses. In December 1997, the American Medical Association (AMA) House of Delegates urged the National Institutes of Health (NIH) to facilitate "well-designed clinical research into the medical utility of marijuana."[18] The Delegates stressed that "marijuana of various and consistent strengths and/or placebo" should be supplied by NIDA to clinical researchers who have received FDA approval, "regardless of whether or not the NIH is the primary source of grant support".[19] However, NIDA has resisted supplying research cannabis to MAPS' privately funded studies, which has limited research and hobbled the process by which cannabis could become available as a prescription medicine. This has not been the case in the United Kingdom, where GW Pharmaceuticals has been able to grow cannabis for extracts for use in clinical trials.

10. Cannabis research is further complicated by the fact that NIH's Department of Health and Human Services created guidelines and requirements that only apply to cannabis research, and that depart from the process for research using any other proposed medicine—not facilitating research as the AMA suggested, but doing just the opposite. HHS's guidelines require sponsors of privately funded and FDA-approved protocols who seek to purchase supplies from NIDA to submit their protocols for review and approval to the Public Health Service (PHS), an additional review process that exists exclusively for cannabis research.[20] HHS guidelines also specified a limited number of medical conditions for which cannabis should be tested, suggested that researchers conduct only "multi-patient" studies rather than the "single-patient" studies that FDA also considers scientifically valid, and discouraged researchers from conducting studies with the goal of getting natural cannabis approved as a prescription medicine. In addition, although FDA's statutory requirement is to approve a drug if it is proven safe and efficacious as compared to placebo (since some patients may respond best to a medicine that is not on average equal to or better than other medicines), HHS guidelines recommended that protocols be designed to prove cannabis equal or superior to existing medications.[21] None of these restrictions apply to research with any other substance, even those in Schedule I. Especially problematic, the HHS guidelines established no time limits within which HHS must evaluate protocols submitted to it for review, and the supposed peer-reviews are conducted entirely by government employees without any established appeal process.

[14] NIDA contracts with the University of Mississippi to grow cannabis for research purposes, under the direction of Professor Mahmoud ElSohly. The University of Mississippi facility holds the only licence issued by the DEA for the production of cannabis for human consumption.

[15] FDA has not permitted researchers to use seized cannabis for research purposes due to uncertain purity and the inability to conduct subsequent studies with a standardized and replicable product.

[16] See website of the National Institute on Drug Abuse, http://www.drugabuse.gov/about/AboutNIDA.html

[17] MAPS and California NORML conducted a scientific study of the potency of cannabis used by patients across the country. This potency was then compared to the average potency of the cannabis that NIDA provides to the seven remaining patients who are part of the Compassionate Investigational New Drug program. Patients preferred cannabis that was roughly three to four times more potent than what NIDA supplies. The primary advantage of more potent cannabis is that it enables patients to inhale less smoke and particulate matter per unit of therapeutic cannabinoids. Dale Gieringer, Ph.D. *Medical Cannabis Potency Testing Project*, 9 MAPS, Autumn 1999, available at http://www.maps.org/news-letters/v09n3/09320gie.html, at 20-22.

[18] Council on Scientific Affairs, AMA House of Delegates, Report 10—*Medical Marijuana, Recommendations* (1997).

[19] Id.

[20] The new HHS guidelines read, "After submission, the scientific merits of each protocol will be evaluated through a Public Health Service interdisciplinary process." Id.

[21] Id.

11. Almost immediately, HHS's policy had a chilling effect on medical cannabis research. In September 1999, Dr Ethan Russo received FDA approval for a protocol designed to examine the medical uses of cannabis in treatment-resistant migraine patients.[22] In February 2000, NIDA refused to supply Dr Russo with cannabis, based on criticisms of the protocol design by the PHS reviewers.[23] Since Dr Russo's protocol was approved by FDA and would have been privately funded, the decision by PHS and NIDA not to provide the cannabis at cost effectively halted the standard FDA drug development process.

Dr Lyle Craker's request for a licence to operate a cannabis production facility at UMass Amherst

12. To help remedy the supply problem, Prof Lyle Craker, the Director of the Medicinal Plant Program of the Department of Plant and Soil Sciences at the University of Massachusetts—Amherst, with sponsorship from MAPS, applied in June 2001 to DEA for a licence to establish a small medical cannabis production facility to supply high-quality research material to researchers with FDA and DEA-approved protocols.[24] Over four and a half years later, Prof Craker is in the midst of DEA Administrative Law Judge hearings and remains stuck in a bureaucratic morass.

13. A chronology of Prof Craker's application illustrates the inadequate and obstructed process for furthering medical cannabis research. In December 2001, Prof Craker was told by DEA that his application was lost. In February 2002, DEA refused to accept a photocopy of the application since it lacked an original signature, despite DEA having claimed to have lost the original document. On 6 June 2002, five Massachusetts Congressional Representatives sent a letter to DEA Administrator Asa Hutchinson expressing support for the licensing of a privately-funded cannabis production facility.[25] On 1 July 2002, Administrator Hutchinson replied to the Congressmen, stating DEA opposition to private production facilities based on supposed restrictions imposed by US international treaty obligations.[26] Later in July 2002, DEA returned the original application to Prof Craker, unprocessed, with no individual's name on the return address or cover note, and with a DEA date-stamp showing that it had, in fact, been received by DEA in June 2001. In August 2002, Prof Craker resubmitted his original application, along with an analysis of US international treaty obligations demonstrating that private production facilities were not prohibited.[27] On 16 December 2002, two DEA agents traveled to UMass Amherst to meet with Prof Craker and senior UMass Amherst officials. The DEA agents encouraged them to withdraw the application, which they declined to do.

14. On 4 March 2003, more than 20 months after his original application was filed, Prof Craker received his first written reply from DEA, indicating that he would need to submit "credible evidence" supporting his assertion that researchers were not adequately served by NIDA cannabis.[28] Prof Craker responded to this request on 2 June 2003. In October, 2003, DEA again heard from elected representatives in support of Prof Craker's application, when Massachusetts Senators Edward Kennedy and John Kerry sent a letter stating their opposition to the NIDA monopoly on research cannabis. The Senators noted that lack of adequate competition "jeopardizes important research into the therapeutic effects of marijuana for patients undergoing chemotherapy or suffering from AIDS, glaucoma, or other diseases."[29]

15. In addition to the delay tactics cited above, DEA has blatantly failed to follow the notice procedures and due process mandated by law regarding applications such as that submitted by Prof Craker. In July 2004, Prof Craker and MAPS sued DEA in the Court of Appeals for the District of Columbia for unreasonable delay in responding to Prof Craker's application. The DC Court of Appeals issued a decision in November 2004, ordering DEA to reply to the Court with its reasons for the delay.[30] Rather than reply to the court's order, DEA instead finally rejected Dr Craker's application,[31] which he is now challenging through the DEA Administrative Law Judge hearing process. The hearings began in August 2005[32] and the Administrative Law Judge should issue a recommendation around June 2006.

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[22] Letter from C McCormick, Director of FDA Division of Anesthetics, Critical Care and Addiction Drug Products, to Dr Ethan Russo (Sept 21, 1999). See also Ethan Russo, Cannabis for Migraine Treatment: The Once and Future Prescription?: An Historical and Scientific Review, 36 Pain, January 1998 at 3–8, available at http://www.druglibrary.org/crl/pain/Russo%2098%20Migraine_%20Pain.pdf

[23] Letter from Steven W Gust, PhD, Special Assistant to the Director of HHS, Public Health Service, to Dr Ethan Russo (1 February 2000),available at http://www.maps.org/mmj/russo1199/02010001.html

[24] Timelines and supporting documents available at www.maps.org/mmjfacility.html

[25] Letter from United States Congressmen Michael E Capriano, William D Delahunt, Barney Frank, James P McGovern, and John W Oliver to Asa Hutchinson, DEA Administrator (6 June 2002), available at http://www.maps.org/mmj/mmjfacility.html

[26] Letter from Asa Hutchinson, DEA Administrator, to Congressman Barney Frank (1 July 2002), available at http://www.maps.org/mmj/mmjfacility.html

[27] The legal analysis is available at http://www.maps.org/mmj/mmjfacility.html

[28] Id.

[29] Letter from Edward M Kennedy and John F Kerry, United States Senators for the State of Massachusetts, to Karen Tandy, Administrator, DEA (20 Oct 2003), available at http://www.maps.org/mmj/kkletter102003.html

[30] MAPS v United States, decision available at http://www.maps.org/sys/nq.pl?id=250&fmt=page

[31] Letter from Drug Enforcement Administration to Prof Lyle Craker (10 December 2004), available at http://www.maps.org/mmj/legal/dea121004-2.html

[32] In the Matter of Lyle E Craker, PhD, transcripts of hearings thus far available at http://www.maps.org/mmj/legal/craker-dea/index.html

Chemic Laboratories' request to obtain 10 grams of cannabis for a non-clinical study

16. The government also delayed and ultimately rejected the application of Chemic Laboratories, of Canton, Massachusetts ("Chemic") to obtain marijuana for a MAPS-sponsored study to evaluate the contents of the vapor stream from a cannabis vaporizer, that heats marijuana without burning it.[33] This study neither involves human subjects nor requires FDA approval, but would provide valuable knowledge about alternative cannabis delivery systems that might spare patients exposure to the potentially harmful elements of cannabis smoke.

17. On June 24, 2003, Chemic submitted separate but related applications to the US Department of Health and Human Services (HHS) and DEA seeking, respectively, approval of its research protocol so that Chemic could purchase 10 grams of cannabis from NIDA, and registration to import 10 grams of cannabis from the Dutch Office of Medical Cannabis ("DOMC"), part of the Dutch Ministry of Health. The DOMC operates in compliance with all international treaty obligations and is authorized to export cannabis to fully-licensed research projects. DOMC can supply cannabis of a quality that is unavailable from NIDA and that is required to complete the later phase of the vaporizer study. DEA verbally advised Chemic that it would not process the application until HHS determined the scientific merit of the vaporizer protocol. DEA also failed to publish a notice in the Federal Register, as is required by statute "upon the filing" of an import application.[34]

18. HHS failed to decide upon the scientific merit of the research protocol for over two years. HHS' first communication to Chemic with respect to its application came on October 10, 2003, more than three months after it was submitted, stating that there was insufficient information in the application to judge the merits of the protocol. Although the application had complied fully with HHS' announced procedures, Chemic submitted an expanded and revised protocol on January 29, 2004. In the months after this submission, Chemic made repeated attempts to ascertain the status of its application, which HHS officials refused to divulge. A communication from HHS indicated that the application was stalled awaiting the PHS review required only for cannabis research.[35]

19. On June 9, 2004, MAPS received a letter from NIDA that is perhaps the most telling evidence of the futility of pursuing medical cannabis research under the current regulatory system. In this letter, NIDA Director Dr. Nora Volkow explained that

> NIDA is just one of the participants on the HHS review panel . . . It is not NIDA's role to set policy in this area . . . Moreover, it is not NIDA's mission to study the medicinal uses of marijuana or to advocate for the establishment of facilities to support this research. Therefore, I am sorry but I do not believe that we can be of help to you in resolving these concerns."[36]

These statements highlight NIDA's conflict of interests, and the resulting chilling effect that the NIDA monopoly has on research that could demonstrate how medical cannabis can help sick patients.

20. On July 14, 2004, MAPS and Valerie Corral[37] filed a lawsuit in the Court of Appeals for the District of Columbia against both HHS and DEA, alleging unreasonable delay in processing these applications. Unfortunately, the Court ruled on November 22, 2004 that HHS' delay had not been so unreasonable as to justify mandamus and dismissed the lawsuit without prejudice,[38] HHS waited another nine months before rejecting Chemic's protocol and recommending that NIDA deny Chemic the 10 grams,[39] thus blocking this avenue of research. Chemic has appealed and addressed each of the HHS critiques, but five months later has heard nothing.

21. Fortunately, the lack of an independent source of cannabis for use in FDA-approved clinical trials is an aberration and not the norm for Schedule I drugs. However, this aberration is a formidable obstacle to pursuing medical marijuana research and creating a marijuana policy that is based on current science. In our opinion, the features of this policy that most obstruct research are twofold. First, the existence of a monopoly on research supply reduces product quality and access below the level at which good scientific research can flourish. Second, government agencies designed to control drug abuse have an institutional mission that will inherently bias them against investigations into the beneficial uses of Schedule I drugs. The

[33] MAPS and California NORML are sponsoring research into the use of vaporizer technology to heat the cannabis plant but not burn it. Preliminary evidence demonstrates that the vaporizer can release clinically significant amounts of cannabinoids without generating the compounds that come from combustion. This is part of an effort to develop non-smoking delivery systems for the cannabis plant.

[34] 21 CFR 1301.34(a).

[35] Email exchange between Dr Arthur J Lawrence, Rear Admiral, Assistant Surgeon General and NIDA Deputy Assistant Secretary for Health (Operations), and Willem Scholten, Head of the Dutch Office of Medicinal Cannabis (17 March 2004), available at http://www.maps.org/mmj/vaporizer.html

[36] Letter from Dr. Nora Volkow, Director of NIDA,to Rick Doblin, President of MAPS (9 June 2004), available at http://www.maps.org/mmj/mmjfacility.html

[37] Valerie Corral is a California-licensed medical cannabis patient and caregiver, and founder of the Wo/Men's Alliance for Medical Marijuana, with an office at 230 Swanton Road, Davenport, California.

[38] MAPS v United States, decision available at http://www.maps.org/sys/nq.pl?id=250&fmt=page

[39] Letter from Mr Joel Egbertson, HHS, to Dr Rick Doblin, President of MAPS (15 August 2005), available at http://www.maps.org/mmj/legal/chemic_dhhs_7.27.05/

DEA's and NIDA's recalcitrance against allowing even non-clinical trials that may forward the cause of prescription cannabis demonstrates the importance of leaving decisions effecting research in the hands of government agencies (such as the equivalent of our FDA) that will prioritize science over politics. We hope that in England your government designs a policy that facilitates research and supports informed policymaking.

January 2006

APPENDIX 8

Memorandum from Release

Release is the national centre of expertise on drugs and drugs law. Release seeks to meet the health, welfare and legal needs of drug users and those who live and work with them, through the provision of a range of services aimed at preventing or reducing the harm that drugs can cause. Release also acts as a source of independent expertise on a wide range of matters concerning drugs, the law and human rights.

The Science and Technology Committee has launched an inquiry which focuses upon the mechanisms in place for the use of scientific advice and how it impacts on policy making. This paper will comment on the use of scientific evidence in relation to the classfication of illegal drugs.

Background

The Advisory Council on the Misuse of Drugs ("ACMD") is the statutory body which advices the Government on issues relating to drug misuse. The ACMD derives its power from section 1 of the Misuse of Drugs Act 1971 ("MDA 1971"). The MDA 1971 states:

> "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 further duty is placed on the Advisory Council to consider any matter relating to drug dependence or the misuse of drugs which may be referred to it by any Government Minister (as defined in the Act).

Section 2(5) of the MDA 1971 places an obligation on Ministers to consult with the ACMD prior to laying a draft Order before Parliament or before making Regulations or changes to the Act.

The ACMD is made up of experts within the drugs field. There is a statutory requirement that the membership includes representatives from:

- the practice of medicine;
- the practice of dentistry;
- the practice of veterinary medicine;
- the practice of pharmacy;
- the pharmaceutical industry;
- chemistry other than pharmaceutical chemistry; and
- persons whom the Home Secretary considers to have wide and recent experience of social problems connected with the misuse of drugs.

The membership of the ACMD ensures that the advice given in relation to the classification of drugs encompasses a wide range of views.

It is in light of the ACMD's role that we consider the questions raised by the Committee in relation to relevant areas.

1. *Sources and handling of advice*

1.1 What impact are departmental Chief Scientific Advisers having on the policy making process?

It is clear that the ACMD plays an important role in the policy making process, especially in relation to the classification of drugs. The ACMD's recommendations in relation to the classification of Ketamine and GHB were adopted by the Government. Furthermore, the ACMD recently advised that cannabis should remain a Class C substance. We are pleased that the Government took their advice on this matter.

However, there are concerns that the Government is failing to consult the ACMD despite the obligations under the MDA 1971. Section 21 of the Drugs Act 2005 provided for the inclusion of fresh mushrooms containing psilocin in Part 1 of Schedule 2 of the MDA 1971. This meant that a previous uncontrolled product became a Class A drug. The Government failed to consult the ACMD on this matter. This undermines the potential impact of the advisory body.

1.2 What is the role of the Government Chief Scientific Adviser in the policy making process and what impact has he made to date?

It is the role of the ACMD to advise Ministers (Home Secretary, Education Secretary and Health Secretary) on current drug use and misuse. Specifically, the advice should relate to drugs which are considered "harmful" and as such to constitute a social problem.

The ACMD should also advise on measures which should be taken in relation to preventing misuse of drugs or dealing with the social problems connected to drug misuse. Section 1(2) of the MDA 1971 provides for particular circumstances where measures should be applied. In relation to classification of drugs the ACMD have a statutory duty to consider measures which would restrict the availability of drugs which they consider "harmful".

As previously stated, the ACMD has had some impact on the policy making process.

1.3 Are existing advisory bodies being used in a satisfactory manner?

The Government is obliged to consult the ACMD and in most cases the advice given by the ACMD is taken on board. However, we do not consider it satisfactory that it was not consulted in relation to the classification of fresh mushrooms containing psilocin (see above).

1.4 Are Government departments establishing the right balance between maintaining an in-house scientific capability and accessing external advice?

The ACMD has a number of committees and working groups which report directly to it. These committees and working groups can include members of the ACMD and experts who are co-opted in because of their knowledge in a specific area which will relate to the topic being researched.

In our opinion, it is right that there should be a reliance on external expert advice so that the ACMD is appropriately placed to advise the Government.

2. *Relationship between scientific advice and policy development*

2.1 What mechanisms are in place to ensure that policies are based on available evidence?

As stated, section 2(5) of the MDA 1971 places an obligation on Ministers to consult with the ACMD prior to laying a draft Order before Parliament or before making Regulations or changes to the MDA 1971.

However, there is no obligation for a Minister to act on the advice of the ACMD.

2.2 Are departments engaging effectively in horizon scanning activities and how are these influencing policy?

No comment.

2.3 Is Government managing scientific advice on cross-departmental issues effectively?

The ACMD is required to advise three departments within Government, namely the Home Office, Department for Education and Skills and the Department of Health.

We do not know how the information provided by the ACMD is managed by Government. However, in practice most ACMD reports are published and therefore available to the public as well as other Government departments.

What is not as clear is how far Government goes to ensure that there is a clear and cohesive response by departments to the scientific advice provided by the ACMD.

3. *Treatment of risk*

3.1 Is risk being analysed in a consistent and appropriate manner across Government?

No comment.

3.2 Has the precautionary principle been adequately defined and is it being applied consistently and appropriately across Government?

No comment.

3.3 How does the media treatment of risk issues impact on the Government approach?

It is clear that the media have an impact on Government policy with regard to the classification of drugs. Recent media comment on cannabis and methamphetamine has placed pressure on Government to react. However, in most circumstances the Government are appropriately referring such matters to the ACMD.

4. *Transparency, communication and public engagement*

4.1 Is there sufficient transparency in the process by which scientific advice is incorporated into policy development?

In most cases Government will make public responses to advice provided by the ACMD. There are concerns where policy is decided in the absence of scientific advice, for example, the classification of fresh mushrooms. In this case, there was no advice given by the ACMD. There was little transparency as to the reasoning behind this policy, which appeared to be devoid of an "evidence based" approach. This is an unacceptable situation.

4.2 Is publicly-funded research informing policy development being published?

The Research, Statistics, Development branch of the Home Office commissions and publishes research into issues surrounding drug misuse.

4.3 Is scientific advice being communicated effectively to the public?

It is clear that problems exist in relation to public understanding of scientific advice which pertains to drugs and their classification. Cannabis reclassification is a glaring example of where the Government has failed to effectively communicate the scientific advice relating to cannabis use and mental health. This, however, is also linked to the confusion within the scientific community itself.

5. *Evaluation and follow-up*

5.1 Are per review and other quality assurance mechanisms working well?

No comment.

5.2 What steps are taken to re-evaluate the evidence base after the implementation of policy?

As previously mentioned, the ACMD is required to keep up to date on issues relating to drug misuse. It is their involvement in the drug policy process which ensures that evidence is re evaluated.

Mechanisms should be put in place to allow Non-Governmental Organisations (NGOs) to request that the Home Secretary re-evaluate policy based on new evidence.

January 2006

APPENDIX 9

Memorandum from DrugScope

Introduction

DrugScope is an independent registered charity established in 2000 through the merger of the Institute for the Study of Drug Dependence (ISDD) formed in 1968 and the Standing Conference on Drug Abuse (SCODA) formed in 1971.

The primary mission of DrugScope is to inform the public debate on the misuse of drugs and we do that through:

— the provision of a public access database of over 100,000 documents on the misuse of drugs, one of the primary English-language collections in the world;

— publication of a wide range of materials both in print and through the website aimed at both the general public and professionals working in the field;

— the provision of a comprehensive information service available to anybody seeking drug information which is non-judgemental, current and based on the available evidence;

— consultation with our membership of around 1,000 individuals and agencies working in the drugs field and related areas; and

— regular contact with the media working both proactively and reactively to counterbalance much of the misinformation which surrounds this subject.

Remit of the Enquiry

The Select Committee is investigating the extent to which the classification of drugs under the Misuse of Drugs Act 1971 is evidence-based. It is particularly interested in the classification of cocaine, ecstasy, amphetamine, cannabis and hallucinogenic or "magic" mushrooms. As we understand it, the Committee is not making recommendations *per se* on the degree to which the current classification of all or any of these drugs is valid, However, should the outcome of the Enquiry indicate a lack of evidence for the positioning of certain drugs within the Misuse of Drugs Act, this should be addressed elsewhere. We note the recent announcement of the Home Secretary to conduct a review of the classification system.

Background

International Conventions

Globally, the primary response to the misuse of drugs is criminal sanction. Attempts by the international community to control the manufacture, import, export, supply and possession of certain drugs goes back to the early years of the last century—and represents one the earliest examples of groups of nations convening to discuss a social issue of common concern.

In 1961, various international treaties governing the control of "narcotics"[40] were consolidated in the Single Convention on Narcotic Drugs covering opiates, cocaine and cannabis.

This was followed in 1971 by the Convention on Psychotropic Substances which brought under control many of the non-plant based, synthetic drugs such as LSD, barbiturates and amphetamines. Some countries had already instigated controls on these drugs. For example unauthorised possession of amphetamine was already an offence in the UK in 1964, while LSD was controlled in both the USA and UK in 1966, as responses to concerns about non-medical use of these drugs by young people.

The main aim of these treaties was to control the supply of drugs, rather than their use. In other words, signatories to these treaties, were obliged to have in place laws against the possession of controlled drugs, but it was unclear whether this meant any possession including for personal use or simply possession as a preliminary to onward supply.

This ambiguity appeared to have been resolved in 1988 with the UN Convention Against the Illicit Traffic of Narcotic Drugs and Psychotropic Substances. This was primarily aimed not simply at curbing international trafficking, but also to restrict the supply of so-called precursor chemicals used to process and manufacture drugs and also to restrict the flow of drug trafficking proceeds through money-laundering. In addition, however Article 3.2 makes specific reference to an obligation on the part of signatories to have in place domestic laws against the possession of controlled drugs for personal consumption.

Even so, the Conventions allow considerable flexibility as to how the law might operate in practice, especially in regard to simple possession or possession for personal use[41]. This accounts for the fact that especially in Europe, Canada, Australia and parts of South America, the international consensus on drug control is nowhere near as solid as it used to be.

The Misuse of Drugs Act

Being signatories to the international conventions means that the UK is obliged to have in place laws which control the import, export, manufacture, supply and possession of proscribed drugs. The first Dangerous Drugs Act was passed in 1920. As the situation changed both nationally and internationally, there were subsequent new Acts, modifications and amendments until the late 1960s.

Our current drug laws are enshrined in the Misuse of Drugs Act 1971 [MDA]. The two innovations in this development of UK drugs law were:

[40] An American legal term to describe a range of drugs including not only the opiates [opium, morphine, heroin etc], but [incorrectly] also cocaine and cannabis. As the Americans were the prime movers in driving international legislation forward, it may be that the United Nations in turn adopted this terminology.

[41] Dorn, N ed *European drug laws: the room for manoeuvre*. The full report of a comparative legal study into national drug laws of France, Germany, Italy, Spain, the Netherlands and Sweden and their relation to three international drugs conventions. DrugScope, 2000.

1. To create a body of science and social science experts, the Advisory Council on the Misuse of Drugs [ACMD] to advice the government of the day. Either the ACMD or the Secretary of State at the Home Office can initiate research into the workings of the Act, but the Secretary of State cannot lay a draft order before Parliament without first consulting the ACMD. However, there is no legal obligation on the government to implement the advice given by the ACMD.
2. To group drugs into categories of "harm" ranging through A, B and C with differing penalties attached to each in descending order of severity. In drafting the legislation, it was clear that "harm" meant primarily physical and mental harms to the individual. However the ACMD was also charged to keep under review drugs which might be "otherwise harmful" and this can be more problematic, not least because there is no clear definition in the Act of what this actually means—although it is taken to mean "social harm", any collateral damage to the individuals and the community consequent on the use of the drug.[42]

The Current Evidence Base for the Classification of Drugs Under the Misuse of the Drugs Act

Some general points

1. As this is a brief submission, we can only make general observations about the validity of the evidence base rather than a detailed analysis.

2. While accepting the some problems caused by illegal drug use are actually a product of drug prohibition itself, neither DrugScope nor its members supports the blanket legalisation of drugs. We have seen no examples of an alternative control regime which would both substantially undermine the fortunes of international organised crime while safeguarding public health interests. Any moves towards a less rigorous control of drugs must be undertaken incrementally with a proper review process to monitor outcomes.

3. It is perfectly valid for the ACMD to conduct early warning assessments of drugs which might become problematic in the future and which should be kept under review, although any moves to control should be accompanied by a robust evidence base across physical, mental and social harms.

4. International obligations notwithstanding, there is no ready evidence that controlling a drug under the Misuse of Drugs Act actually deters use, especially where there is no data on prevalence before control. A case in point might be ketamine, controlled in January 2006 as a Class C drug, but with no prevalence data against which to track the impact of control. But even if we take a "common sense" view that controlling a drug will deter some potential users, there is no evidence to show that once a drug is controlled, the actual classification of the drug has an impact on prevalence of use. For example, the latest data on cannabis reveals a down turn in use among young people despite the decision to reclassify the drug from Class B to Class C.

5. The ACMD is charged with assessing the evidence base for the physical, mental and social harms attached to different drugs under consideration. Yet, the MDA does not define the meaning of the term "harm" [let alone the meaning of the term "drug"] and there is no standard assessment tool or set of criteria of harm against which to match the different drugs. However, the Independent Inquiry into the Misuse of Drugs Act chaired by Dame Ruth Runciman [hereafter Runciman Report] did suggest a set of criteria against which to make an objective assessment of relative harm as part of the decision-making process for classifying drugs. These are:

(i) addiction potential;
(ii) toxicity;
(iii) risk of overdose;
(iv) longer-term risk to life and health;
(v) potential for injecting;
(vi) association with crime;
(vii) association with problems for communities; and
(viii) public health costs.[43]

A similar typology was adopted by the National Addiction Centre [NAC], authors of a Department of Health report Dangerousness of Drugs (2001). The NAC considered factors associated with:

(i) acute adverse effects;
(ii) chronic adverse effects; and
(iii) a range of other facts which might mediate or moderate the dangers eg route of administration where for example, sniffing a drug is safer than injecting it.[44]

[42] The ACMD addressed the issue of definitions in the introduction to its 1979 report to the Home Secretary, the major recommendation of which was to reclassify cannabis to a Class C drug—advice which the government of the day rejected.
[43] Drugs and the law: report of the Independent Inquiry into the Misuse of Drugs Act 1971. Police Foundation, 2000. p 50.
[44] National Addiction Centre. Dangerousness of Drugs. Department of Health, 2001, p 13.

6. There has never been a thorough review of the Misuse of Drugs Act in terms of the current appropriateness of the drug classifications. As we outline below, doubt must be expressed about the evidence base for some of the current classifications. We also need more clarity on the different penalties that attach to the different classes. With the exception of simple possession, in the period 1973–85, there was in practice little difference in the penalties between Class A and B drugs. Changes in 1985 saw a much clearer division between the three classes in terms of penalties, a division which then disappeared when cannabis was reclassified from B to C in 2004. As part of the political horse-trading which allowed the passage of the reclassification, the penalties for supply of Class C drugs were increased as to make them indistinguishable from those in Class B[45]. However, if part of the purpose of the MDA is to educate the public as set out in the original legislation, then it is important that the drugs are appropriately categorised and penalised across the three classes.

Drugs of Particular Interest to the Committee

Cocaine

It is well-enshrined in international and in the domestic legislation of many countries that cocaine should be among those drugs most strictly controlled. There is a wealth of clinical evidence to indicate the physical and mental harms the drug can cause and the most general harms to society linked to crime. Cocaine is a Class A drug and DrugScope would not wish to call this into question.[46]

Nevertheless we would observe that, despite the body of evidence comprising individual studies worldwide [primarily from the United States], there has never been any international scientific evaluations of cocaine with one exception. In 1995, the World Health Organisation compiled such a study, but its publication was blocked by the United States. There were apparently two reasons for this:

1. The conclusion that the use of coca leaves by the indigenous populations of South America was not demonstrably harmful and might even confer some benefits.[47]
2. The conclusion that moderate and occasional use of cocaine powder [hydrochloride] was not especially harmful[48]. The contrasting levels of potential harm [by whatever index] between, coca leaf, cocaine powder and crack support the Dangerousness of Drugs contention that factors other than the chemistry of the drug itself mediate or modify harm—in this case, the formulation and the route of administration.

MDMA [Ecstasy]

This drug is part of the family of drugs which are commonly described as having effects which combine those of hallucinogenic and stimulant drugs. This is something of a catch-all because there are several drugs in this group, some of which are mild stimulants [like MDMA] while others are extremely powerful hallucinogens such as PMA.

MDMA is a Class A drug. It was added to the Act by a Modification Order in 1977. This was not because the drug was causing concerns in the UK. In fact the first article on what became known as Ecstasy did not appear in the media until 1985[49]. Nor does it appear that the ACMD were consulted on this. We have spoken to one member of the ACMD at the time and she has no recollection of a consultation process or report to the Home Secretary of the day. The reason MDMA was included seems to be that it is related to some drugs already controlled as Class A drugs. These are the tryptamines and the phenethlymines. There is some suggestion that there was evidence of the manufacture of the parent drug in this family 3,4-methylenedioxyamphetamine, during the UK investigation of 1975–77 known as Operation Julie which broke up what was then the largest LSD manufacturing operation in the world. This may have prompted a "pre-emptive strike" to control the drug in the UK.

The drug did not become popular in the UK until the late 1980s and the explosion of what became known as "rave culture". The drug has been consumed in the millions of doses and it would appear that the majority of consumers have come to no permanent harm nor can there be said to have been any collateral damage to society. In fact, anecdotally, at the early alcohol-free raves where ecstasy was being consumed instead, the public order problems for the police were greatly reduced in comparison to a typical weekend in a town centre at closing time.

[45] This is supposition based on informed guess-work. But while the ACMD social and clinical evidence is in the public domain, the evidence that might have been presented from the enforcement perspective is not.

[46] Although in our submission to the Home Affairs Select Committee into the government's drug policy [2002], we did take the view that those found in possession of small amounts of any drug should not be dragged through the criminal justice system.

[47] The cultivation and use of coca leaf is legal in Bolivia so long as the leaves are not additionally processed.

[48] The report seems to have leaked out into the public domain as it was summarised in the *British Medical Journal* 1 April 1995, but never formally published. In 1998, the USA also blocked the inclusion of a comparative study of the dangers of cannabis, alcohol and tobacco in the last WHO international review of cannabis—cf *Druglink*, March/April 1998, p 8. While politics may determine how the evidence base is used, these are far more invidious examples of how politics can intervene to compromise the evidence base itself.

[49] Nasmyth, P Ecstasy. *Face*: Oct, 66, 1985, p 88–92.

However, the drug carries risks: there have been around 200–250 ecstasy-related deaths since the first one was recorded in 1989 including the death of Leah Betts, arguably one of the most famous drug-related fatalities of modern times. Yet even with drug-related deaths, most of these were related to the circumstances of use rather than a toxic reaction to the drug itself. Of itself MDMA interferes with the body's temperature control mechanism, but the danger is greatly amplified if the person is in a hot sweaty environment and becomes dehydrated. The advice from drug agencies about how to deal with this probably helped save many lives. But the fatal adverse effects do seem to be idiosyncratic and no studies have convincingly demonstrated who might be especially vulnerable in this scenario. Concerns have also been raised about possible long-term psychological effects. But even though the drug has been prevalent in the UK for over 20 years now, there has been no reporting from general practitioners or the psychiatric services of any correlation between past ecstasy use and current levels of depression in those now in their early forties.

The Runciman Report concluded that ecstasy did not pose the same threat as other Class A drugs such as heroin or cocaine and should be regraded to Class B. This was rejected by the Home Secretary without reference to the ACMD.

Hallucinogenic or "magic" mushrooms

For many years, the classification of magic mushrooms as Class A drugs represented something of an anomaly in the Act. Under the Act, it was the psychoactive ingredient of the mushroom, psilocin, which was the controlled substance rather than the mushroom itself. This meant that so long as the person did nothing to the mushroom to extract the chemical, it was perfectly legal to pick and eat raw mushrooms. However, even to dry the mushroom or make it to a tea or other preparation could render the person liable to prosecution for possession of a Class A drug—although it is likely that very few cases would have appeared before the courts. The situation changed in recent years due to a growing interest in hallucinogenic drugs and altered states of consciousness consequent on the growth of rave culture. The main drug to satisfy this interest had traditionally been LSD. But manufacture and use of the drug had fallen dramatically through the 1990s and magic mushrooms represented a legal alternative. A commercial business grew up selling fresh magic mushrooms [largely imported] on the high street. The internet also played its part with individuals buying mushrooms and other so-called "legal highs" online.

In general the psilocin experience is akin to a milder LSD trip and as with all mood-altering drugs, it would unwise for those with mental health problems to use the drug. The other major danger is that the inexperienced might pick the wrong mushroom: some varieties of wild mushroom are highly toxic. But it does not appear from the evidence that the use of magic mushrooms has been a cause of significant harm among users on either count. Even so, a decision was taken to further control the drug, so that the mushroom itself became a Class A substance. This appears to have been done, not because the new situation was causing new health problems, but because of the high media profile given to what was seen as a commercial exploitation of a loophole in the law.

The control of mushrooms was brought in as part of the Drugs Act 2005 rather than through a Modification Order under the Misuse of Drugs Act. We are not aware that the ACMD was formally asked to consider the position of mushrooms and it may be that the provisions of the Act whereby the Home Secretary has to consult with the ACMD before presenting a Modification Order before Parliament was obviated by the use of different primary legislation.

If this set a precedent and the ACMD were not to be consulted on all such changes to the MDA in the future, then this would be a matter for concern.

Amphetamine

Amphetamine is a Class B drug. It was widely prescribed in the 1950s and 1960s as a slimming drug and as a stimulant for staying awake among long distance lorry drivers, students and so on. Use without a prescription was banned in the UK in 1964, but doctors continued to prescribe it primarily to women into the late 1960s and early 1970s. Voluntary restraint by GPs, the removal of amphetamines from the pharmaceutical market coupled with control saw use in the general population decline. However illegally manufactured amphetamine sulphate took the place of pharmaceuticals and that is the situation which prevails today.

Amphetamines are still prescribed in the treatment of narcolepsy and an amphetamine-like drug methylphenidate [Ritalin], a Class C drug, is controversially prescribed widely for a range of attention deficit disorders in children.

A unique aspect of Class B drugs is that if prepared for injection, they become Class A drugs. This applies to both amphetamines and barbiturates [formerly widely prescribed for sleep disorders] and seems to be the legacy of the injecting epidemics experienced with both drugs in the past. During the late 1960s, there was an outbreak of amphetamine injecting [as methedrine] among London drug users. The drug was being prescribed by doctors no longer able to prescribe heroin and cocaine to users in support of their habit through legislation passed in 1968. Ten years later, there was a very destructive outbreak of barbiturate

injecting among young drug users again in London. The idea of assessing the potential harm of a drug according to the dangers posed by the route of administration as one marker of harm rather than simply the effects of the drug is highlighted in both Runciman and the NAC report.

Concerns were raised recently as to the presence of methamphetamine on the UK drug scene in the form of "ice"—essentially a smokeable form of amphetamine [as crack is to cocaine] but much longer acting than amphetamine sulphate powder. At present, the drug can be found in pockets of the gay scene, but sensational media reporting suggested the UK was on the brink of a major drug epidemic. The ACMD commissioned a report in 2005 which concluded that while the situation should be kept under review, there should be no change to the MDA.

Cannabis

Probably more has been written about cannabis than any other drug used non-medically or recreationally. The evidence base is vast. It has been the subject of several national and international reviews going back to the Indian Hemp Commission report of the 19th century.[50] But despite all the controversy about the drug and the welter of published scientific information, the following simple distillation of the evidence base still holds true:

1. The majority of occasional users come to no obvious mental or physical harm.
2. The main physical risks are similar to those of smoking tobacco.
3. Those with mental health problems or who may be at risk of developing these should abstain.

The background as to how cannabis was controlled in the first place is too complex for this brief review. But sufficed to say that the clinical and social evidence for international control on a par with heroin and cocaine would not stand modern day scrutiny.

It may be that cannabis represents some kind of moral line in the sand when it comes to the behaviour of [mainly] young people that will or will not be tolerated. Cannabis lies at the junction between drugs which are clearly dangerous such as heroin and a drug like alcohol which can be just as medically and socially dangerous, but is tolerated for all kinds of socio-economic, political and historical reasons. There is no evidence for this view, except to quote from the French delegate to the 1973 session of UN Commission on Narcotic Drugs:

> "The question of the relative harmfulness of different variants of cannabis, of taking the drug in large or small doses etc, was doubtless of theoretical and clinical interest and WHO should certainly continue its investigations along these lines, but such investigations should not be allowed to influence international control measures in any way whatsoever"[51].

Conclusions

1. As signatories to international conventions, the UK is obliged to have in place laws to restrict a range of specified drugs.

2. However, the Misuse of Drugs Act is quite a flexible instrument and the UK is not obliged to either classify drugs or penalise their distribution within any rigid international framework.

3. This means that there is plenty of opportunity for an overall review of the whole classification of drugs in the light of current best evidence.

4. This is necessary because DrugScope would contend that the evidence-base for the current classification of drugs such as ecstasy and magic mushrooms is weak. There also needs to be more clarity over the penalty tariff between classes.

5. DrugScope feels that when dealing with such an emotional and highly-charged subject, it is most important that the government continues to make best possible use of the expert advice enshrined in the legislation.

January 2006

[50] DrugScope can provide a comprehensive list.

[51] Bruun, K *et al. The gentleman's club: international control of drugs and alcohol*. University of Chicago Press, 1975, p 202.

APPENDIX 10

Memorandum from the Advisory Council on the Misuse of Drugs (ACMD)

1. Introduction

1.1 The Advisory Council on the Misuse of Drugs (the Council) was established, as a non-departmental public body, by the Misuse of Drugs Act 1971 (the Act). Its current membership is shown in Annex A.

1.2 The Council's terms of reference are set out in the Act as follows:

"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 afffected by the misuse of such drugs to obain proper advice, and for securing the provision of proper facilities and services for the treatment, rehabilitation and aftercare 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."

1.3 A further duty is placed on the Council in the Act to consider any matter relating to drug dependence, or the misuse of drugs, which may be referred to it by anyone of the Secretaries of State (as defined in the Act). The Home Secretary is, moreover, obliged to consult the Advisory Council before making any amendment to the Regulations to the Misuse of Drugs Act 1971.

1.4 The Council ordinarily meets, in full session, twice each year but it has powers to meet more frequently if necessary. Much of the detailed work of the Council is carried out by its Technical Committee and its Prevention Working Group. *Ad hoc* working groups, with limited life-spans, are also established from time to time to undertake detailed examinations of specific issues. Over the past 18 months, for example, the Council has had a specific working party to examine the implications of the reports of the Shipman Inquiry. The committees and working groups report to the Council since that is the body responsible for formally advising the Home Secretary.

2. The Work of the Council

2.1 The Council fulfills its responsibilities in various ways:

2.1.1 The Council advises on whether substances should be controlled under the Act and, if so, into which Class and Schedule they should most appropriately be placed. The initial scrutiny of the available evidence is normally undertaken by the Technical Committee. The Technical Committee's membership is drawn from Council as well as others—co-opted members—with particular expertise. The Technical Committee's members are appointed by the Council, and the Committee reports to Council. Membership of the Technical Committee is shown at Annex B.

2.1.2 The Council advises on arrangements for the safe custody, prescribing and disposal of medicinal substances controlled under the Act.

2.1.3 The Council reviews arrangements for reducing the harmful effects of controlled drugs amongst those who continue to use them; and advises on appropriate harm reduction measures.

2.1.4 The Council undertakes major reviews, through its Prevention Working Group, of problem areas relating to substance misuse. While much of this work relates to harm reduction (secondary and tertiary prevention), it also encompasses primary prevention. Its latest Inquiry report was Hidden Harm: Responding to the needs of children of problem drug users.

2.1.5 The Council published its Reports, in previous years exclusively in hard copy and more recently, on its webpages at www.drugs.gov.uk Since 1977, the Council has published 27 reports.

3. Classification and Scheduling of Substances under the Act

3.1 Substances controlled under the Act are placed, on the basis of their harmfulness to individuals and society, into one of three classes:

Class A (most harmful) includes cocaine, diamorphine (Heroin), 3,4-methylenedioxymethamphetamine (Ecstasy) and lysergic acid diethylamide (LSD).

Class B (an intermediate category) includes amphetamines, barbiturates and codeine.

Class C (less harmful) includes cannabis, benzodiazepines, anabolic steroids and gamma-hydroxy butyrate.

3.2 This system of classification of drugs, under the Act, is related to determining the penalties for their possession and supply. The current maximum penalties are as follows:

Class A drugs: For possession—seven years imprisonment and/or a fine; for supply—life imprisonment and/or fine.

Class B drugs: For possession—five years imprisonment and/or a fine; for supply—14 years imprisonment and/or fine.

Class C drugs: For possession—two years imprisonment and/or a fine; for supply—14 years imprisonment and/or fine.

3.3 The Misuse of Drugs Regulations 2001 (Statutory Instrument 2001/3998) defines the categories of people authorised to supply and possess drugs controlled under the Act. In these Regulations, drugs are categorised under five schedules:

Schedule 1 includes substances such as lysergic acid diethylamide and cannabis that are not available for medical purposes. Possession and supply are prohibited without specific Home Office approval.

Schedule 2 includes prescription drugs such as morphine and diamorphine that, because of their harmfulness, are subject to special requirements relating to their safe custody, prescription, and the need to maintain registers relating to their acquisition and use.

Schedule 3 includes barbiturates and are subject to special prescription, though not safe custody, requirements.

Schedule 4 includes benzodiazepines and are subject to neither special prescribing arrangements, nor to safe custody requirements.

Schedule 5 includes preparations that, because of their low strength, are exempt from most of the controlled drug requirements.

4. The Council's General Approach to the Control, Classification and Scheduling of Drugs

4.1 The Council and its Technical Committee consider evidence, from a variety of sources, about substances that are—or might potentially be—controlled under the Act. Sources of intelligence include information from:

- formal surveys undertaken for, or on behalf of, Government including the British Crime Survey, the Forensic Science Service statistics, general population surveys, school surveys as well as international/European surveys such as European School Survey Project on Alcohol and other drugs (ESPAD);
- the law enforcement agencies;
- voluntary sector organisations with concerns and responsibilities, for those who misuse drugs;
- professional bodies;
- published and unpublished scientific literature; and
- submissions from special interest groups and the general public.

4.2 Substances considered by the Council and its Technical Committee over the past three years include:

- amineptine;
- benzodiazepines (as a class);
- buprenorphine;
- cannabis;
- gamma-hydroxybutyrate;
- gamma-butyrolactone;
- ketamine;
- khat;
- magic mushrooms;
- methylamphetamine;

— methylphenidate; and
— midazolam.

4.3 When considering whether a substance should be brought under the scope of the Act (ie be designated as a controlled drug) the Council's advice is based on three domains of harmfulness:

— Physical and mental health;
— Dependence-producing potential; and
— Societal.

4.3.1 Consideration of the harmfulness of a substance to physical and mental health covers three areas. The acute harmfulness of a substance refers to its propensity to produce harm during the hours (or sometimes days) after administration. Examples include respiratory arrest after excessive doses of barbiturates, or acute psychosis with amphetamine. Chronic harms are those which persist after short-term exposure or which develop as a consequence of repeated use. Cannabis-induced relapse, in individuals with schizophrenia, is an example of the former; whilst the carcinogenic effect of anabolic steroids is a feature of the latter. Substances that are given by intravenous injection pose special hazards because of needle-sharing by consumers. This is particularly the case for the transmisssion of blood borne infections (such human immunodeficiency virus and hepatitis C virus).

4.3.2 Drug dependence is a complex phenomenon whose nature differs from substance to substance. It is related to the duration and amount used, as well as to characteristics of the user. It is also related to the pleasure that use of the substance gives. Dependence is generally associated with an increasing reliance on the drug, with psychological craving when consumption is reduced or stopped, and sometimes (though not invariably) with the development of physical withdrawal symptoms.

4.3.3 Social harms include the potential damage to others when individuals are under the influence of the substance; other adverse consequences such as acquisitive crime to finance continued access to the substance. Costs falling on the National Health Service, to treat the consequences of the physical and psychological harms (including dependence), are also considered.

4.4 Much of the evidence about a substance's physical and psychological harmfulness can be found in the relevant chemical, pharmacological, clinical and epidemiological literature. In assessing harmfulness the Council generally undertakes, or commissions, a review of the published and (wherever possible) unpublished literature. Valuable information can also be obtained from information about seizures made by law enforcement officers.

4.4.1 The pharmacological, clinical and epidemiological literature is of particular value in assessing the physical harmfulness of a substance.

4.4.2 Reliable evidence about the dependence-producing potential of a substance can sometimes be obtained from these same sources; but there can be serious omissions. The prevalence of dependency on individual controlled substances in the UK, for example, has been notoriously difficult to establish.

4.4.3 Evidence about social harms is often the weakest data-set because of the inherent problems in gathering relevant information. In particular, evidence about the quality and potency of material used by consumers, their pattern of consumption, and the social consequences of their use, are all too often absent. In some instances the Council has commissioned primary research into areas of particular significance. In other cases the Council has had to relay on anecdotal evidence provided by individual Council members or others with expertise in the particular field. The Council does, however, gain invaluable information form studies carried out by organisations such as the British Crime Survey, the Forensic Science Service, and the National Criminal Intelligence Service.

4.5 As with other national advisory bodies, the Council ultimately has to make informed judgements based on the available evidence and the collective experience and expertise of its members.

4.6 The Council's advice to ministers is conveyed as either:

— a formal report with a covering letter from the chairman;
— a letter from the chairman; or
— a submission to ministers, from the Council's secretary.

In some instances, the Council's chairman may request a meeting with ministers, or ministers may request a meeting with the chairman, to discuss the Council's advice. During the tenure of office of the current chairman of the Council (ie since 1998), no request for a meeting with ministers has been declined.

4.7 On occasions, meetings are also held between the Chairman and the Director of the Home Office Drugs Strategy.

5. Specific Substances

5.1 We understand that the Committee seeks information about the Council's consideration of cocaine, cannabis, magic mushrooms and amphetamines. As indicated in paragraph 4.2, the Council has not discussed cocaine but has advised on the other three substances.

Cannabis

5.2 Cannabis produces its effects on the brain through interactions between most active psychoactive ingredient, Δ^9-tetrahydrocannabinol (THC), and specific proteins on the surface of cells known as cannabinoid receptors. Other psychoactive components in cannabis preparations, especially cannabidiol, interact with other receptors in the brain.

5.3 Cannabis products were categorised as class B substances in 1971 (apart from cannabis oil, which was classified in Class A). Athough reviewed periodically, between 1971 and 2002, no change in legal status was made.

5.4 The Council was asked to advise on the appropriate classification of cannabis, in October 2001, by the then Home Secretary (Rt Hon David Blunkett MP). The Council presented its report—The classification of cannabis under the Misuse of Drugs Act 1971—(available at www.drugs.gov.uk/drugs-laws/acmd), in March 2002, and advised that all cannabis products should be reclassified as class C. The necessary legislative changes came into force in January 2004.

5.5 The current Home Secretary asked the Council, in March 2005, to review the classification of cannabis in the light of recent evidence about its possible adverse effects on mental health. He also asked the Council to advise on the extent to which the potency of cannabis products, as used by consumers, had increased over the past few years. The chronology of the development of the Council's consideration of this issue is in Annex C; and the Council's final report—Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971— which was sent to the Home Secretary in December 2005, can be found at www.drugs.gov.uk/drugs-laws/acmd

5.6 The Home Secretary announced his decision to accept the Council's recommendations, in full, on 19 January 2006. The Council's report was published on the same day.

Amphetamines

5.7 Amphetamine and its derivatives are known, pharmacologically as the phenylethylamines. The phenylethylamines include:

— amphetamine;
— methylamphetamine (metamphetamine);
— methylphenidate;
— phentermine; and
— fenfluramine.

5.7.1 The substituted amphetamines include:

— methylenedioxyamphetamine (MDA); and
— 3,4-methylenedioxymethamphetamine (MDMA, Ecstasy).

5.8 Whilst the phenylethylamines have common pharmacological properties, there also are differences in both their qualitative and quantitative effects. These may be due to (apparently) small changes in their chemical structure or their chemical form (eg as base or salt). The phenylethylamines also exist as optical isomers which, despite their chemical similarities, differ in their pharmacological actions and potencies.

5.9 Amphetamines and subsituted amphetamines are controlled under Misuse of Drugs Act 1971. Amphetamine and methylamphetamine are class B substances. The substituted amphetamines (MDA and MDMA) are class A substances.

5.10 Following a visit to the US, in late 2003, the Permanent Secretary for Crime, Policing, Counter-Terrorism and Delivery at the Home Offfice asked the Council to undertake a detailed assessment of the harms posed by methylamphetamine; and to recommend measures that might need to be taken to prevent its misuse in the UK. Although there was at that time little evidence of such misuse in Britain, the Permanent Secretary was concerned that the widespread problems associated with its misuse in the US might spread to the UK.

5.11 The details of the preparation of the Council's report on methylamphetamine are described in Annex D; and the report itself can be found at www.drugs.gov.uk/drugs-laws/acmd

Magic mushrooms

5.12 Magic mushrooms contain, as naturally-occuring substances, psilocin and psilocybin. These compounds, like lysergic acid diethylamide, have hallucinogenic properties and are particularly harmful to those with mental illnesses.

5.13 Under the Act products containing psilocin or an ester of psilocin are controlled as class A substances. However, the wording of the legislation (as well as its legal interpretaion in the Courts) suggested that magic mushrooms were only controlled (under the provisions of the Act if supplied in the form of a product. This included those that had been dried, or treated, prior to sale but excluded magic mushrooms sold as "fresh".

5.14 In March 2004 the Technical Committee heard that, over recent years, there had been a substantial increase in the number of retail outlets selling "fresh" magic mushrooms. In fact HM Customs and Excise estimated the importation of 8,000–16,000 kgs during 2004.

5.15 In December 2004, the ACMD received a letter from the Home Office notifying them of the Government's intention to initiate a change in the law that would clarify the legal position regarding magic mushrooms. The letter sought feedback from the ACMD, which was generally supportive and the Council agreed that clarification of the law would be helpful.

5.16 The Government introduced this change in law by way of the Drugs Act 2005. Associated regulations were required to exclude some individuals from the offences under the Misuse of Drugs Act 1971. In May 2005 the Council endorsed a draft Regulation that would provide these exemptions in the law. The Council's opinion was communicated to officials in the Home Office, in a letter from the chairman, in June 2005. The Regulation came into force in July 2005.

January 2006

Annex A

MEMBERSHIP OF THE ADVISORY COUNCIL ON THE MISUSE OF DRUGS AS AT JANUARY 2006

Professor Sir Michael Rawlins (chairman)
Chairman, National Institute of Health and Clinical Excellence and Professor of Clinical Pharmacology, University of Newcastle upon Tyne.

Dr Dima Abdulrahim.
Research Briefings Manager
National Treatment Agency

Lord Victor Adebowale
Chief Executive, Turning Point.

Mr Martin Barnes
Chief Executive, DrugScope.

Dr Margaret Birtwistle
Specialist General Practitioner, Senior Tutor—Education and Training Unit, St George's Hospital and Forensic Medical Examiner.

Reverend Martin Blakeborough
Director, Kaleidoscope Drugs Project, Kingston upon Thames.

Dr Cecilia Bottomley
Specialist Registrar in Obstetrics and Gynaecology, London.

Ms Carmel Clancy
Principal Lecturer in 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
Public Health Policy Support Officer, Government Office for Yorkshire and Humberside.

Mr Robert Eschle JP
Local Councillor and Magistrate, Kent.

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 Advisor, Durham County Council Education Department.

Mr Paul Hayes
Chief Executive, National Treatment Agency.

Mr Andrew Hayman
Assistant Commissioner of the Metropolitan Police, and Chair of the Association of Chief Police Officers Drugs Committee.

Mr Russell Hayton
Clinical Nurse Specialist and Clinical and Services Governance Manager, Plymouth Drug and Alcohol Action Team.

Ms Caroline Healy JP
Director, ChildLine and Magistrate, London.

Dr Matthew Hickman
Deputy Director, Centre for Research on Drugs and Health Behaviour, Senior Lecturer in Public Health, Bristol University.

Mr Alan Hunter
Director, Law Regulatory & Intellectual Property and Secretary to the Association of British Pharmaceutical Industry.

Professor Leslie Iversen FRS
Professor of Pharmacology, Oxford University.

His Honour Judge Thomas Joseph
Resident Judge, Croydon Crown Court.

Professor Michael Lewis
Professor of Oral Medicine, Cardiff University.

Dr John Marsden
Research Psychologist, Institute of Psychiatry, London.

Mr Peter Martin
Former Chief Executive, Addaction.

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, Bristol University.

Dr Richard Pates
Consultant Clinical Psychologist and Clinical Director, Community Addiction Unit, Cardiff.

Mr Trevor Pearce
Acting Director General, National Crime Squad.

Mr Howard Roberts
Deputy Chief Constable, Nottinghamshire Police.

Mrs Kay Roberts
Pharmacist, Glasgow

Dr Mary Rowlands
Consultant Psychiatrist in Substance Misuse, Exeter.

Dr Polly Taylor
Veterinary Surgeon, Cambridgeshire.

Ms Monique Tomlinson
Freelance Consultant in Substance Misuse, London.

Mr Arthur Wing
Assistant Chief Officer, Sussex Probation Area.

Annex B

MEMBERSHIP OF THE COUNCIL'S TECHNICAL COMMITTEE AS AT JANUARY 2006

Professor David Nutt FMedSci (Chairman)
ACMD member

Mr Martin Barnes
ACMD Member

Professor Geoff Phillips
Advisor to the Home Office

Dr Clare Gerada
ACMD Member

Dr Noel Gill
Public Health Laboratory Service

Professor CR Ganellin FRS
ACMD Member

Alan Hunter
ACMD Member

Dr S L H Thomas
Reader in Clinical Pharmacology, University of Newcastle upon Tyne
National Poisons Information Service (Newcastle Regional Drugs and Therapeutics Centre)
Dr Les King
Advisor to the Home Office
Former Head of Drugs Intelligence Unit (Forensic Science Service)

Kay Roberts
ACMD member

Dr Polly Taylor
ACMD member

Dr Dima Abdulrahim
ACMD member

Dr Margaret Birtwistle
ACMD member

Robert Eschle
ACMD member

Dr Tom Gilhooly
General Practitioner

Professor Leslie Iversen FRS
ACMD member

Matthew Hickman
ACMD member

Baroness Ilora Finlay
Professor of Palliative Medicine, Cardiff

Annex C

CHRONOLOGY OF EVENTS LEADING TO THE ACMD's 2005 REPORT ON CANNABIS:

"FURTHER CONSIDERATION OF THE CLASSIFICATION OF CANNABIS UNDER THE MISUSE OF DRUGS ACT 1971"

(1) Following the publication of the Council's 2002 report on cannabis the issue remained a standing item on the agendas of both the Council and its Technical Committee.

(2) At its meeting in October 2004 the Technical Committee invited Dr Stanley Zammit—who had undertaken further analysis of the Swedish conscripts of 1969 historical cohort study—to attend and to provide an overview of the relationship between cannabis use and psychotic illness.

(3) In March 2005, the Home Secretary wrote to the chairman of the Council, seeking advice on recent evidence (published since its 2002 report) about the effects of cannabis on mental health. He also asked the Council for advice on the alleged increase in potency of cannabis products currently available.

(4) At its meeting in May 2005, the Council agreed to a process by which it would review the available evidence and appointed a Steering Group (comprising the chairman of the Council, the chairman of the Technical Committee, Professor Leslie Iversen, Mrs Kay Roberts, Dr Matthew Hickman, Dr John Macleod and Dr Leslie King) to undertake the detailed planning on its behalf.

(5) The Steering Group, through the secretariat, commissioned the preparation of additional information:

- Forensic Science Service: *An Update on Cannabis Potency*;
- Dr Matthew Hickman: *Cannabis and schizophrenia: model projections and impact of the rise in cannabis on historical and future trends in schizophrenia (England and Wales)*;
- Home Office: *FRANK statistics*;

— National Poisons Information Service: *Enquiries relating to suspected cannabis toxicity;*

— British Crime Survey: *(Then) unpublished data on cannabis use (2004–05).*

(6) With the assistance of the Council's secretariat, the Steering Group also undertook the identification and retrieval of the relevant published literature on the effects of cannabis on mental health, and the potency of THC in cannabis products.

(7) The Steering Group invited the submission of evidence from interested parties. These included specific requests to individuals in the UK, and overseas, who were known to have expertise in the area; as well as arrangements to consider unsolicited submissions (including those made directly to the Home Secretary) from both special interest groups and the general public.

(8) The Steering Group invited, on behalf of the Council, selected outside experts and representatives of voluntary organisations to present their data or views at a special meeting of the Council convened on 23 September 2005. Those invited to give oral evidence are identified in the Council's final report (at Annex 3 of that report).

(9) The Steering Group also asked five additional experts (in psychiatry, epiemiology and statistics) to attend the special meeting of the Council and to act as additional scientific advisors. These individuals are identified in Annex 2 of the Council's report.

(10) All relevant written material submitted to the Council, including submissions and letters from the special interest groups and general public, was included in a 500+ page pack of papers and sent to Council members, and to the five expert advisors, well in advance of the special Council meeting in September 2005.

(11) The day after the special open meeting of the Council, a closed session was held to consider the evdience and draw provisional conclusions. Those attending this session were limited to the Council members, the five additional expert advisors, a limited number of relevant officials and the secretariat.

(12) The Steering Group took responsibility for drawing up the draft report which was considered by the Technical Committee, and the full Couincil, at their meetings on 3 and 24 November (respectively). The final report was sent to the Home Secretary in December with a covering letter from the Council's chairman.

Annex D

CHRONOLOGY OF EVENTS LEADING TO THE ACMD 2005 REPORT ON METHYLAMPHETAMINE

(1) Following the receipt of the Permanent Secretary's request the Technical Committee undertook a preliminary examination of the global misuse of methylamphetamine at its meeting on 11 March 2004. This was informed by a presentation from Dr John Marsden and Dr Mike Farrell (Institute of Psychiatry, London). The Committee recommended to Council that, despite the lack of evidence of widespread misuse in the UK, a detailed assessment should be undertaken.

(2) At its meeting on 1 April 2004, the presentation by Drs Marsden and Farrell was repeated to the full Council who decided to establish a Working Group, under the immmediate jurisdiction of the Technical Committee, to investgate the matter further and to draft a report for Council.

(3) The Working Group met on three occasions between April and September 2004. The evidence base constructed by the Working Group was as follows:

— a review of the relevant scientific literature;

— additional (unpublished) reports provided by:

  — National Criminal Intelligence Service: *Misuse of Pharmaceutical Products in the Illicit production of Methylamphetamine;*

  — Forensic Science Service: *Chemistry, Seizure Statistics < Analysis, Synthetic Routes and History of Illicit Manufacture in the UK and USA.*

— oral evidence from:

  — Professor Charles Marsden: *Pharmacology of methylamphetamine;*

  — Dr Val Curran: *Literature Review of Methylamphetamine;*

  — Mr Ronald Geer: *Experience of Methylamphetamine Misuse in the US;*

  — Professor Robin Murray: *Drug induced psychoses;*

  — Dr Judy Miles: *Treament Issues.*

(4) The Working Group's draft report was considered by the Technical Committee in October 2004, and by the Council, in November 2004. At the request of the Council the Working Group was asked to undertake additional work. The Working Group met on one further occasion and its final report was considered by Council in April 2005. After amendments, the report was sent to the Home Secretary who accepted the Council's advice in full.

APPENDIX 11

Memorandum from Mary Brett, recently retired Biology teacher and UK representative on the board of Eurad (Europe Against Drugs)

In my opinion the Government does usually receive sound advice from scientists but it is sometimes the composition of the investigating committee that is at fault. This is certainly the case with the ACMD. I attach my analysis of this body. The main points being that not one single expert on cannabis, psychosis or schizophrenia was a member. Surely they should be the first people to be recruited when the main concern was about mental illness. And no single member of an avowed anti-drugs organisation was present. From my list you will see that there was a preponderance of representation of the more liberal views. I wrote and sent a paper to this committee linking cannabis and psychosis/schizophrenia citing evidence going back to the 70s, I attach it. [Not published]

I also gave oral and written evidence to the HASC on Cannabis. This time the committee took evidence from very few scientists or anti-drugs campaigners. The main bulk of evidence was given by those of a more liberal outlook, eg Drugscope, the Charity that advises this government. There was even evidence from a libertarian group with something like 18 members.

February 2006

APPENDIX 12

Supplementary memorandum from the Advisory Council on the Misuse of Drugs (ACMD)

ASSESSMENT OF HARMFULNESS

1. The Council's advice on whether a substance should be brought under the scope of the Act (ie "controlled"), and into which class it should be placed, is based on three domains of harmfulness. These are similar to those used by the Police Foundations Independent Inquiry into the Misuse of Drugs Act.

2. These domains comprise:
   - harms to individuals' physical and mental health;
   - dependence-producing potential; and
   - societal harms.

3. Harmfulness to physical and mental health encompasses:
   - acute (ie immediate or short-term) toxicity including the consequences of overdose;
   - chronic (ie long-term) toxicity particularly after repeated use; and
   - parenteral use.

3.1 The impact of a substance on physiological functions, such as the control of respiration or blood pressure, are major determinants of the acute toxicity of a substance.

3.2 Chronic toxicity generally relates to the adverse effects of a substance following repeated exposure. Adverse effects can, in some instances, occur at long intervals of time after exposure.

3.3 Parenteral use poses two problems. First, routes leading to very rapid absorption (especially intravenous and inhalational administration) can have serious, and sometimes lethal, consequences. Examples include respiratory arrest following the administration of diamorphine and acute psychotic reactions to inhaled methylamphetamine hydrochloride. Second, the injection of substances carries the potential to transmit blood-borne infections such as human immunodeficiency and hepatitic viruses.

4. The likelihood of dependence and addiction relates to:
   - the intensity of the pleasure derived from use of a substance;
   - the nature and intensity of psycholgical withdrawal symptoms; and
   - the nature and intensity of physical withdrawal symptoms.

4.1 The pleasure that is derived from the misuse of a substance has two components. The initial effect, of rapid onset, is often called "the rush". The euphoria that follows, and which can extend over several hours, is known as "the high". The intensity of "the rush" is, in part, related to the rate of entry of the substance into the circulation and is particularly associated with the intravenous or inhaled routes of administration (see paragraph 3.3 above).

4.2 Psychological dependence describes a regular user's craving for a particular substance if denied access. It may, or may not, be associated physical dependence.

4.3 Physical dependence describes non-psychological symptoms and signs that may occur in regular users denied access to a substance. Examples include tremors, sweating, insomnia and increased heart rate.

5. The societal harmfulness is assessed from:

— the consequences to the individual, and to others, of acute intoxication;

— the risks of causing other social harm; and

— the costs to the healthcare system arising from the need of individuals, and others, to seek help.

5.1 Substance misuse may lead to inappropriate behaviour by intoxicated individuals. This includes harms resulting from an inability to concentrate (eg driving) as well as outbusts of aggression. Drugs have also been used to coerce others to engage in sexual activity ("date rape").

5.2 Substance misuse may have detrimental effects on families including the neglect of children. Substance misuse also leads to acquisitive crime.

5.3 Substance misuse also has significant impact on the National Health Service as a consequence of the services that have to be provided for dug users themselves, or those they injure.

6. These three domains of harmfulness provide a framework by which the Council can evaluated the risks associated with particular substances. Professor David Nutt and his colleagues have developed an assessment matrix which includes all nine parameters of risk (Table 1).

Table 1

RISK ASSESSMENT MATRIX

Category	*Parameter*
Physical harm	Acute Chronic Parenteral
Dependence	Intensity of pleasure Psychological dependence Physical dependence
Social harms	Intoxication Other social harms Healthcare costs

6.1 Using this matrix, and assigning a score to each parameter (0 = no risk; 1 = some risk; 2 = moderate risk; 3 = extreme risk), Professor Nutt and his colleagues have developed an overall harm rating. They have not, as yet, attempted to weight individual parameters.

February 2006

APPENDIX 13

Supplementary evidence from the Advisory Council on the Misuse of Drugs (ACMD)

1. *Sir Michael said in oral evidence: "I think it is fair to say that I did have a discussion with [the Home Secretary] and I said that if he felt that he wished to re-examine the classification system the Council would welcome it" [Q120].*

— *Has the Council itself or one of its committees or working groups ever discussed the case for reviewing the classification system?*

— *Has the ACMD provided advice to the Home Secretary on previous occasions suggesting that the classification system be reviewed?*

(a) The Council has never formally discussed the case for reviewing the classification system. However, at its special two day meeting on 23 and 24 September 2005 to consider the classification of cannabis, there was a brief discussion on the classification system at the end. There was general consensus amongst Council members that there was scope for a review, but we did not have the opportunity to consider this more fully before the Home Secretary announced, in January, his intention to review the system. However, as we stated in our evidence, we welcome the announcement.

(b) No.

2. *Sir Michael stated in oral evidence: "there is some lack of flexibility and that is one of the reasons why we welcome the Home Secretary's decision to review the classification system" [Q123]. What are the other reasons behind the ACMD's support for a review of the classification system?*

The misuse of drugs poses serious problems for both public health and public order. The classification system is only one component of a broader attempt to reduce the availability of, and demand for, controlled substances.

The Misuse of Drugs Act places obligations on government and the criminal justice system that addresses, primarily, issues related to public order. The classification and schedules, established by the Act, provide measures in respect of the supply side but does little to curb the demand for controlled drugs. The maximum penalties for possession (ie five years imprisonment for class B drugs, and two years for class C drugs) are rarely enforced; and to do so would place intolerable burdens on society and the criminal justice system.

The Council has, under my chairmanship, never undertaken a detailed consideration of alternative approaches to the classification of drugs. I do not consider that the Council possesses the necessary expertise to provide advice on this issue; and I am conscious of the comments of Lord Phillips (in the BSE Inquiry) about the importance of government advisory bodies avoiding offering advice about matters that are beyond their competence.

The current arrangements, however, were established over 35 years ago and at a time when the misuse of dugs was substantially less than it is now. In my personal view, the current classification scheme provides too simplistic an approach to assessing the components of "harmfulness". Substances currently categorised as Class C substances include, for example, benzodiazepines, anabolic steroids and cannabis. The main hazards of benzodiazepines are related to their dependency-producing potential; those of anabolic steroids are due to their long-term effects on the physical health (including cancer) of users; and those of cannabis are due to their effects on the mental health of vulnerable consumers (including children, adolescents and those with mental illness). Whether it is sensible, now, to aggregate all these facets of harmfulness within a single entity is, to my mind, questionable.

3. *Sir Michael noted that "early use [. . .] of nicotine and alcohol is a much wider gateway to subsequent misuse of drugs than cannabis or anything like that" [Q128]. What is the evidence for this?*

This statement accurately reflects the statements (paragraph 4.6) in the Council's 2002 report *Classification of Cannabis under the Misuse of Drugs Act 1971*. The relevant pages (9 and 10) are appended to this letter.

4. *Please provide an estimate of the proportion of the AMCD's work which is (a) proactive, ie initiated by the ACMD and (b) undertaken in response to requests from Government [Q133]. Please also indicate how frequently advice is provided to Government on an informal basis (as opposed to reports that become publicly available).*

(a) The key part of the ACMD's agenda that is initiated by the council itself is the work of its Prevention Working Group. This group undertakes, over a two to three year period, inquiries in areas which the Council believe are important in understanding, and preventing, drug misuse; or in reducing the harms caused by drug misuse. "*Hidden Harm*", the Prevention Working Group's most recent inquiry, was published in 2003. It considered the impact of parental drug misuse on the lives and life chances of their children. The current Inquiry examines the pathways into hazardous substance misuse by young people.

The workloads of the various different sub-committees of the Council change over time, but I would estimate that approximately 40% of the Council's work is initiated by the Council themselves.

(b) The remainder of the work (approximately 60%) involves consideration of classification of substances, or detailed consideration of other legislative provisions initiated by ministers.

Advice on the classification of drugs is normally in the form of a report published on the Council's website.

5. *Professor Nutt said: "we have evaluated across the whole range almost every drug in the Act in a systematic way, given the current level of evidence, so we have set up a system where we can be proactive in terms of individual drugs and also we have reviewed the relative harms and risks of all the drugs" [Q134]. Please provide this information and a copy of the draft paper for the Lancet referred to in Q180.*

A copy of the draft paper is attached (not published).

6. *Sir Michael said that ACMD working groups "interact with experts in the field, seeking their written evidence, seeking oral evidence from them and seeking their views on the systematic review and whether we have left anything out" [Q136]. Does the role of these external experts include formal peer review of the Council's draft reports?*

External experts are invited to examine the systematic reviews underpinning the advice of the Technical Committee and the Council, as well as providing additional evidence. They are not asked to "peer review" the Council's final reports. These reports are, ultimately, those of the Council itself and it is the Council's membership that, in effect, undertakes responsibility for "peer review".

7. *Sir Michael stated that the ACMD has relations with the Department of Health and the Department for Education and Skills [Q137]. Please provide recent examples illustrating how the ACMD has worked with these Departments.*

Officials from the Department of Health routinely attend, and contribute to, both meetings of Council as well as meetings of its working groups. Over the past 18 months there have been numerous intense interactions with the Department of Health in relation to the findings of the Shipman Inquiry. Indeed, the Department of Health was represented on the Council's Shipman Inquiry Working Group. There have also been extensive interactions with Department of Health officials in respect of the proposed extension of the prescribing of controlled drugs to other healthcare professionals (including nurses). This included a meeting between a subgroup of the Council and members of the Medicine's Commission. I also briefed the Secretary of State for Health about the Council's recent advice on the classification of cannabis.

Interactions with the Department for Education and Skills have been particularly in relation to the work of the Prevention Working Group's report *Hidden Harm*. After publication of this report, the Council established a group to monitor the implementation of its recommendations. This resulted in extensive, and productive, interactions with the DfES.

8. *With regard to the membership of the ACMD, Sir Michael undertook to provide:*
   - *details of attendance of Council members at ACMD meetings [Q160];*
   - *the proportion of Council members who are scientists [Q169]; and*
   - *the overlap in membership between the Council's consideration of cannabis on 2002 and 2005 [Q218].*

(a) Attendance at recent twice-yearly Council meeting are shown below:
   - 24 November 2005—34 of 38 members present.
   - 19 May 2005—31 of 36 members present.
   - 4 November 2004—22 of 35 members present.
   - 1 April 2004—24 of 35 members present.

Attendance at our sub-committees reflects the level of commitment, both from our full ACMD members, and from co-opted members. In addition, at both Council and sub-committee meetings, we have strong attendance from relevant invited officials.

(b) Current membership of the ACMD is shown below:

Professor Sir Michael Rawlins	Professor of Clinical Pharmacology, University of Newcastle upon Tyne.
Dr Dima Abdulrahim	Briefings Manager, National Treatment Agency.
Lord Victor Adebowale	Chief Executive, Turning Point.
Mr Martin Barnes	Chief Executive, Drugscope.
Dr Margaret Birtwistle	Specialist General Practitioner, Senior Tutor—Education and Training Unit, St. George's Hospital and Forensic Medical Examiner.
Reverend Martin Blakebrough	Director, Kaleidoscope Drugs Project, Kingston upon Thames.
Dr Cecilia Bottomley	Specialist Registrar in Obstetrics and Gynaecology.
Ms Carmel Clancy	Principal Lecturer (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, CNWL Mental Health Trust.
Ms Dianne Draper	Public Health Policy Support Officer, Leeds.
Mr Robert Eschle	School Teacher and Magistrate.
Ms Vivienne Evans	Chief Executive, ADFAM.
Professor C Robin Ganellin FRS	Emeritus Professor of Medicinal Chemistry.
Dr Clare Gerada	General Practitioner, London; Primary Care lead for Drug Misuse.
Mr Patrick Hargreaves	Adviser (Drugs and Alcohol), Durham County Council Education Department.
Mr Paul Hayes	Chief Executive, National Treatment Agency.
Mr Andrew Hayman	Assistant Commissioner, Metropolitan Police, Chair of the Association of Chief Police Officers Drugs Committee.
Mr Russell Hayton	Clinical Nurse Specialist and Clinical and Services Governance Manager, Plymouth Drug and Alcohol Action Team.
Ms Caroline Healy	Director of Childline.
Dr Matthew Hickman	Deputy Director, Centre for Research on Drugs and Health Behaviour, Senior Lecturer in Public Health.
Mr Alan Hunter	Director—Law Regulatory and Intellectual Property and Secretary to the Association of British Pharmaceutical Industry.

Professor Leslie Iversen FRS	Professor of Pharmacology, University of Oxford.
His Honour Judge Thomas Joseph	Resident Judge, Croydon Crown Court.
Professor Michael Lewis	Professor of Oral Medicine, Cardiff University.
Dr John Marsden	Research Psychologist, Institute of Psychiatry.
Mr Peter Martin	Former Chief Executive, Addaction.
Mrs Samantha Mortimer	Head of PSHE and Citizenship, St Paul's Catholic High School, Manchester.
Professor David Nutt	Director of Psychopharmacology Unit, University of Bristol.
Dr Richard Pates	Consultant Clinical Psychologist and Clinical Director Community Addiction Unit, Cardiff.
Mr Trevor Pearce	Acting Director General, National Crime Squad.
DCC Howard Roberts	Deputy Chief Constable, Nottinghamshire Police.
Mrs Kay Roberts	Pharmacist, Glasgow.
Dr Mary Rowlands	Consultant Psychiatrist in Substance Misuse, Exeter.
Dr Polly Taylor	Veterinary Surgeon.
Ms Monique Tomlinson	Freelance Consultant in Drug Misuse.
Mr Arthur Wing	Assistant Chief Officer, Sussex Probation Area.

Of the 38 members of the Council, 17 have professional expertise in a scientific subject. In addition, a number of the co-opted members on the sub-committees are also scientists.

(c) Members of the ACMD involved in the 2006 cannabis report, and who were also members at the time of the publication of the 2002 cannabis report, are:

- Professor Sir Michael Rawlins;
- Mr Martin Blakeborough;
- Ms Vivenne Evans;
- Mr Russell Hayton;
- Mr Alan Hunter;
- Professor David Nutt;
- Mrs Kay Roberts;
- Dr Roy Robertson; and
- Dr Laurence Gruer.

Drs Robertson and Gruer have now retired from the ACMD having completed the maximum term (ten years) allowed under guidance from the Office of the Commissioner for Public Appointments.

9. *What criteria are used to ensure that the Council maintains an appropriate balance of expertise in its membership and to determine the overall number of members? Who has ultimate responsibility for this and what role does the Chairman of the Council play in the selection and appointment of members?*

The chairman and members of the Council are formally appointed by the Home Secretary in compliance with the guidance issued by the Office of the Commissioner for Public Appointments. The Misuse of Drugs Act requires the Council to include individuals with specific expertise in:

- the practise of medicine;
- the practise of dentistry;
- the practise of veterinary medicine;
- the practise of pharmacy;
- the pharmaceutical industry; and
- chemistry other than pharmaceutical chemistry.

Beyond this, membership of the Council is made up of individuals with relevant and recent expertise in the range of subjects that are necessary for the Council to provide appropriate advice. Successive Home Secretaries have permitted me, as chairman, to identify those areas in which I consider the Council needs expertise. I have therefore sought to ensure that the Council includes individuals with expertise and experience of:

- Pharmacology (especially neuropharmacology);
- Pharmacy;
- Psychiatry, psychology and psychiatric nursing;
- Epidemiology and public health;
- Primary care;
- Criminal justice (including the judiciary, the magistracy and senior police and probation officers);
- Social policy;

— Social work;
— Treatment;
— NGOs working with substance misusers and their families; and
— Education (including primary and secondary).

Appointments are made following public advertisement both in the national media, and on the Cabinet Office public appointments website. After shortlisting the applications there is then an interview of potential candidates. The shortlisting and interviews are chaired by the chairman of the ACMD but also include participation from a representative from the sponsoring department (Home Office) and an independent assessor approved by the Public Appointments Commissioner.

On the basis of the shortlisting and the interviews, recommendations for appointment to the Council are forwarded to the Home Secretary. The Home Secretary has never rejected any of the appointments recommended by the appointments panel.

10. *Sir Michael said: "I would hope that the 90,000 people you represent would understand, if they had the opportunity to sit there and listen, the reasons why we come to the conclusions that we do"" [Q164]. Has the ACMD ever held open meetings at which decisions were made regarding recommendations?*

No. Nevertheless, this is an issue about which I have some considerable interest and I would be willing to provide the Committee, in a personal capacity, with a separate note on this issue.

There is, however, a particular problem for ACMD because it is sometimes provided with police or enforcement agency intelligence which cannot be disclosed to the public (at the present time). Although it might appear to be possible to exclude the public from those agenda items that include sensitive material of this nature, members might wish to raise such matters during the discussion of other agenda items. Failure to do so could place the Council at a serious disadvantage and impair the quality of its advice.

11. *Sir Michael also said that anybody who asked for minutes of ACMD meetings would "get a version of it" but that "there is sometimes material in the minutes that we would need to remove because they are based on intelligence that would not be appropriate in the public domain" [Q165].*

— *What kind of information does the latter statement refer to (please give examples)? To illustrate the point, please also provide examples of a typical set of full unpublished minutes and the version that would be released to members of the public requesting a copy.*
— *How many times have amended versions of the minutes been provided, upon request, to members of the public in the last 12 months?*

(a) The ACMD, as a public body, is subject to the requirements of the Freedom of Information Act 2000. As required by the Act, the ACMD has produced and published its publication scheme (available at www.drugs.gov.uk) stating what information from the Council will be routinely made available and what information will be available on request.

Any request for information under the Freedom of Information Act will be responded to in full compliance with the Act. In other words, the ACMD will release all information requested unless it is subject to one of the exemptions under the Act that preclude it from being released, subject to a public interest test.

Exemptions which might apply to the work of the ACMD might include section 22 (Information intended for future publication), section 35 (formulation of Government Policy) or section 41 (Information provided in confidence).

It is important to note, that exemptions applied to an information request to the ACMD may not last forever. There will, for example, be information that we do not release at the time requested, because it is subject to one of the exemptions, but which, at a later date we would be able to release, because the reason for the exemption would have passed.

I am unable to provide you with an example, as requested, because of the point made above. What would be released would be dependent on when the request was made. For example, minutes of meetings where we discuss the recommendations we intend to make to the Home Secretary, on the classification of certain substances, would be withheld from release until our advice to the Home Secretary had been submitted and the report containing our recommendations had been published. This information could be withheld under either Section 22 or 35 of the FOI Act. However, once a report has been published, sensitivity about releasing the minutes would be reduced.

12. *Professor Nutt referred to a letter that he had written to Professor Colin Blakemore about Home Office representation on the MRC [Q172]. Please provide a copy of this letter and any response received.*

Professor Nutt checked the details of the letter to which he referred, and in fact it was a letter to Professor Sir George Radda (Professor Blakemore's predecessor as chief executive of the Medical Research Council). It is attached.

13. *Sir Michael commented on the difficulty of capturing "the values of a community and a society" [Q187]. To what extent does the ACMD consider it to be within its remit to do this and how does it go about it?*

Unlike many (most) government scientific advisory bodies, the Council's membership is drawn from a very wide circle and represents a cross-section of views and experiences. Capturing "the values of a community and a society" is not easy. For the Council, data from surveys and focus groups would not provide the necessary insights: the issues are too complicated to be garnered without devoting considerable time to explaining the issues and allowing participants to deliberate. The National Institute for Health and Clinical Excellence (NICE) has established a "Citizens Council" to fill this role for the Institute's advisory bodies. Although successful in the context of NICE, I am not certain as to the extent it is yet transferable to other types of organisations. Nor am I certain as to whether it would add value to the range of expertise that forms the Council's membership.

14. *Professor Nutt said: "we are not as sophisticated with cocaine in terms of the law as we are with amphetamines" [Q236]. What discussions has the ACMD had regarding the fact that no distinction is made between cocaine used for snorting and coca leaves used for chewing?*

This apparent anomaly in the Act has been noted by the Technical Committee but we have little experience of, or knowledge of research into, the effects of chewing coca leaves in this country. The current Act would make such research difficult but if were data to be published that showed significantly less harm from the leaves, than from prepared cocaine, we would be pleased to review the classification of the leaves.

15. *Professor Nutt stated that the reason the ACMD decided not to recommend moving methylamphetamine to Class A was "mostly because there could be a perverse effect. If people saw methylamphetamine as a more dangerous drug, a more Class A amphetamine, we might well have begun to see importation" [Q237].*

- *What evidence was this assessment based on and how does it relate to the criteria in the risk assessment matrix?*
- *Are there other examples where the ACMD has examined the evidence base for the relationship between the classification of a drug and the message 'sent out' to potential users? If so, please provide details.*

The Council's methylamphetamine report describes the paradox that, although this drug is present in significant amounts in the Netherlands, there is little importation into the UK. Making methylamphetamine a class A drug might give a message that it was of greater "recreational value" than amphetamine and hence encourage importation. In addition the forensic problems of correctly distinguishing methamphetamine from amphetamine in seizures are not trivial. Taken together it seemed to us that the best approach was to continue with the *status quo* but be prepared to act swiftly if importation and/or use were observed to increase.

The issue of "glamorising" or drawing attention to drugs is always one we consider carefully in discussions re classification. In the ketamine review we debated this issue in detail, having similar concerns as with methylamphetamine, but recommended classification to C nevertheless. We will be monitoring the effect that this change in legal status will have on use. Similarly, with gamma-hydroxy butyrate we thought classification at level C was warranted.

The question of differential classification of drugs of similar chemical and pharmacological actions is one that always causes tensions that are difficult to resolve definitively.

16. *Sir Michael agreed to submit information on the topics on which the ACMD has either commissioned research or has requested it be commissioned [Q243–4].*

The ACMD generally commissions research either to underpin its assessment of particular substances, or to assist its Prevention Working Group Inquiries. Both the most recent Inquiry, and the current Inquiry, *Pathways into Hazardous Substance Misuse by Young People* have commissioned research to contribute to the work of the Inquiry. These commissions have usually taken the form of systematic reviews, or assessments, of existing data. Commissioned primary research has been mainly been in support of the Prevention Working Group Inquiries.

The ACMD has also made recommendations for further research in many of its recent reports including those on cannabis, khat and methylamphetamine. These recommendations usually relate to areas where the ACMD have found the evidence to be inadequate and where further research would inform the Council's future deliberations.

17. *Professor Nutt and Sir Michael indicated that the ACMD has worked with the Department of Health and Home Office in order to commission research [Q249]. Please provide details of instances where this has happened.*

The ACMD works closely with the research managers in the Home Office and the Department of Health in a number of different ways. For example, recommendations made in ACMD reports about further research might be health focused. In this instance the ACMD would engage with Department of Health Officials during the report-writing process to explore the proposed recommendation.

There are no specific examples of cases where the ACMD has jointly commissioned research with either department.

18. *Professor Nutt said that the ACMD identifies external sources of scientific expertise on the basis of publications [Q245]. What other criteria are used to decide which organisations or individuals the ACMD will seek written or oral evidence from or will co-opt onto working groups and committees?*

Expertise is sought usually on the basis of published work but this can be in the form of articles other than scientific papers. We also approach institutions with proven expertise in addiction such as University groups and others [eg International Society for Harm Reduction]

Finally there is one other matter about which, when giving evidence, I promised to provide additional information. The mechanism of the toxicity of Ecstasy paragraph 51 of the RAND report is described thus:

> *The ecstasy deaths are mainly due to dehydration because the drug causes blood vessels to constrict to maintain blood pressure so the individual stops losing heat their body temperature rises and body systems fail one by one. Ecstasy also causes the kidneys to stop processing water correctly, so drinking too much water can swell the brain and also cause death.*

This is not entirely accurate. Reports of severe or fatal adverse reactions to ecstasy mainly describe two distinct patterns of toxicity. In one form, patients develop severe hyperthermia which is probably due to a direct effect of the compound on the temperature regulating centre in the anterior hypothalamus and which results in multi-organ failure (the so-called "heat-shock syndrome"). In the other form, patients develop hyponatraemia, probably as a result of the effect of the compound on the release of anti-diuretic by the pituitary gland, leading to cerebral oedema. The hyperthermic reaction appears to be associated with excessive physical activity, a high ambient temperature, and inadequate fluid replacement. The hyponatraemic reaction has been described in association with excessive intake of water during physical activity. The concurrent use of other substances, including alcohol, may have a potentiating effect.

April 2006

APPENDIX 14

Supplementary memoranda from the Advisory Council on the Misuse of Drugs (ACMD)

A RATIONAL SCALE FOR ASSESSING THE RISKS OF DRUGS OF POTENTIAL MISUSE

Introduction

Drug misuse is one of the major social, legal and public health challenges in the modern world. In the UK, the total burden of drug misuse, in terms of health, social and crime-related costs, has recently been estimated to be somewhere between £10 billion and £16 billion per year (Ref 1).

The main current approaches to drug misuse are interdiction of supply (via policing and customs control), education and treatments. All three demand clarity in terms of the relative risks and harms that drugs engender. At present, attitudes to policing and the punishments for possession and supply of drugs are scaled according to their classification under the Misuse of Drugs Act (MDAct), while education and health care provision are nominally tailored to the known actions and harms of specific drugs.

In the current MDAct, the three Classes—A, B or C— are intended to reflect the dangers of the drug, Class A being the most harmful and C the least. The classification of a drug determines several factors, in particular the legal penalties for importation, supply and possession, as well as the degree of police effort targeted at limiting its use. As well as being given a Class, all drugs are also placed in one of five Schedules depending on whether they have clinical utility and, if so, their safe-keeping and prescribing requirements. Drugs with no present clinical use are in Schedule 1 (eg MDMA, LSD), the most abusable clinically useful drugs (eg diamorphine [heroin], morphine) are in Schedule 2 and the less risky drugs are in lower Schedules. The current classification system has evolved in an unsystematic way from somewhat arbitrary foundations with seemingly little scientific basis. In this paper we suggest a new system for evaluating the risks of individual drugs that is based as far as possible on facts and scientific knowledge. We suggest it could form the basis of a new classification system for the MDAct. It provides a rational means to rank the relative threat from any new street drug, as well as to respond to evolving evidence about the potential harm of current drugs.

Beginning from first principles, we suggest that there are three main factors that together determine the harm associated with any drug of potential abuse. These are:

- The physical harm to the individual user caused by the drug;
- The tendency of the drug to induce dependence;
- The impact of drug use on families, communities and society.

The MDAct classification refers only to drugs that are currently illegal in the UK. The system we propose is intended to be of more general value. We intend this to be flexible and of broad utility. It is applicable to different cultures and traditions, and to changing social attitudes. It applies to all drugs, legal or illegal, when used for other than medicinal purposes.

Categories of Harm

Physical harm

Assessing the propensity of a drug to cause physical harm, ie damage to organs, involves a systematic consideration of the safety margin of the drug in terms of its acute toxicity, as well as its likelihood to produce health problems in the long term. The impact of a drug on physiological functions, such as respiration and the heart, are major determinants of physical harm. The route of administration is relevant to the assessment of harm. Drugs such as heroin, especially taken intravenously, carry a high risk of causing sudden death from respiratory depression, and they therefore score highly on acute harm. Tobacco and alcohol have a high propensity to cause illness and death on chronic administration. Recently published evidence shows that long-term cigarette smoking reduces life expectancy, on average, by 10 years (Ref 2). Tobacco and alcohol together account for about 90% of all drug-related deaths in the UK.

The Medicines and Healthcare Regulatory Authority [MHRA], through the Committee on the Safety of Medicines (CSM), has well-established methods of assessing the safety of medicinal drugs that can be used as the basis of this aspect of risk appraisal. Indeed a number of drugs of abuse have licensed indications in medicine and will therefore have had such appraisals, albeit, in most cases, determined many years ago. Three separate aspects of physical harm can be identified:

- Acute—meaning the immediate effects, eg respiratory depression with opiates, acute cardiac crises with cocaine, and fatal poisonings;
- Chronic—referring to the health consequences of repeated use, eg psychosis with stimulants, possible lung disease with cannabis;
- The specific aspect of intravenous (iv) use.

The route of administration is relevant not only to acute toxicity but also to "secondary" harms. For instance, administration of drugs by the iv route can lead to the spread of blood-borne viruses such as hepatitis and HIV, which have huge health implications for the individual and society. The potential for iv use is currently taken into account in the MDAct classification and was treated as a separate parameter in our exercise.

Dependence

This dimension of harm involves interdependent elements—the pleasurable effects the drug produces and its propensity to produce dependent behaviour. Highly pleasurable drugs such as opiates and cocaine are frequently abused and the "street value" of drugs is generally determined by their pleasurable potential. Drug-induced pleasure has two components—the initial, rapid effect (colloquially known as the "rush") and the euphoria that follows this, often extending over several hours (the "high"). The faster the drug enters the brain the stronger the "rush", which is why there is a drive to formulate drugs in ways that allow them to be injected intravenously or smoked: in both cases, effects on the brain can occur within 30 sec. Heroin, crack cocaine, tobacco (nicotine) and cannabis (tetrahydrocannabinol) are all taken by one or other of these rapid routes. Absorption through the nasal mucosa, as with powdered cocaine, is also surprisingly rapid. Taking the same drugs by mouth, so that they are only slowly absorbed into the body, generally has a less powerful pleasurable effect, although it can be longer-lasting.

An essential feature of drugs of abuse is that they encourage repeated use. This tendency is driven by a variety of factors and mechanisms. The special nature of drug experiences certainly plays a part. Indeed, in the case of hallucinogens (LSD, mescaline, etc) it might be the only factor that drives regular use, and such drugs are usually rather infrequently used. At the other extreme are drugs such as crack cocaine and nicotine, which, for most users, induce powerful dependence. Physical dependence or addiction involves increasing tolerance (progressively higher doses being needed for the same effect), intense craving, and withdrawal reactions, such as tremors, diarrhoea, sweating and sleeplessness, when drug use is stopped. These indicate that adaptive changes occur as a result of drug use. Addictive drugs are repeatedly used, partly because of the power of the craving and partly to avoid withdrawal.

"Psychological" dependence is also characterised by repeated use of a drug but without tolerance and without physical symptoms directly related to drug withdrawal. Some drugs, such as cannabis, can lead to habitual use that seems to rest only on craving without obvious physical withdrawal symptoms. But some other drugs, such as the benzodiazepines, can induce psychological dependence without tolerance, in which physical withdrawal symptoms occur through fear of stopping. This form of dependence is less well studied and understood than addiction but is a robust phenomenon, in the sense that withdrawal symptoms can be induced simply by persuading a drug user that the drug dose is being progressively reduced while it is, in fact, being maintained constant (Ref 3).

The features of drugs that lead to dependence and withdrawal reactions have been reasonably well characterised and include:

- The drug half life (those that are cleared rapidly from the body tend to provoke more extreme reactions).
- The pharmacodynamic efficacy of the drug (more efficacy = more dependence).

— The degree of tolerance that develops on repeated use (more tolerance = more dependence and withdrawal).

For many drugs there is a good correlation between the phenomena seen in humans and those observed in studies on animals. Also, drugs that share molecular specificity (having similar tendencies to bind with or interact with the same target molecules in the brain) tend to have similar pharmacological effects. Hence, some sensible predictions can be made about new compounds before they are used by humans.

Social harms

Drugs harm society in a number of ways. The main ones are through the various effects of intoxication, through damaging family and social life, and through the costs to the healthcare, social care and policing systems. Drugs that lead to intense intoxication are associated with huge costs in terms of accidental damage to the user, to others and to property. Alcohol intoxication, for instance, often leads to violent behaviour and is a frequent cause of car and other accidents. Many drugs cause major damage to the family, either because of the impact of intoxication or because they distort the motivations of users, taking them away from their families and into drug-related activities including crime.

Societal damage also occurs through the immense healthcare costs of some drugs. Tobacco is estimated to cause up to 40% of all hospital illness and 60% of drug-related fatalities. Alcohol is involved in over half of all A&E visits and orthopaedic admissions (REF 4). Intravenous drug delivery brings particular problems in terms of blood-borne virus infections, especially HIV and hepatitis, leading to the infection of sexual partners as well as needle-sharers.

Assessment of Harm

Table 1 shows the assessment matrix that we designed, which includes all nine parameters of risk, created by dividing each of the three major categories of harm into three sub-groups described above.

Table 1

ASSESSMENT PARAMETERS

Category of harm	*Parameter*	
Physical Harm	1	Acute
	2	Chronic
	3	IV harm
Dependence	4	Intensity of pleasure
	5	Psychological dependence
	6	Physical dependence
Social Harms	7	Intoxication
	8	Other social harms
	9	Healthcare costs

Participants were asked to score each substance for each of these nine parameters, using a four-point scale, with 0 being no risk, 1 some, 2 moderate and 3 extreme risk. For some analyses [eg Table 3], the scores for the three parameters for each category were averaged to give a mean score for that category. An overall harm rating was obtained by taking the mean of all nine scores.

The scoring procedure was piloted by members of the panel of the Independent Inquiry into the MDAct (the Runciman Committee 2000; Ref 5). Once refined through this piloting, an assessment form based on Table 1, with additional guidance notes, was used. Two independent groups of experts were asked to perform the ratings. The first was the national group of consultant psychiatrists who were on the Royal College of Psychiatrists' register as specialists in addiction. Replies were received and analysed from 29 of the 77 registered doctors canvassed on 14 compounds (those listed in legend to fig 2). Tobacco (cigarettes) and alcohol were also included because their extensive use has provided reliable data on their risks and harms: hence, they provide familiar benchmarks against which the absolute harms of other drugs can be judged.

Following this assessment a second group was convened that also assessed these 14 substances and for completeness an additional six abused compounds (khat, 4MTA, GHB, ketamine, methylphenidate, alky nitrites (Table 2)). This group was made up of individuals with a wide range of expertise in addiction—ranging from the forensic science service through to general practitioners and epidemiologists and included law enforcement officers. Scoring was done independently and individual scores were then presented to the whole group for a "Delphic" type discussion. Individuals were allowed to revise their score on any of the parameters in the light of this discussion, after which a final mean score was calculated. The number of members taking part in the scoring varied from eight to 16 over the course of several meetings.

Table 2

THE 20 SUBSTANCES ASSESSED SHOWING THEIR CURRENT STATUS UNDER THE MDACT AND THE MISUSE OF DRUGS REGULATIONS

Substance	*Class in Act*	*Schedule in Regulations*	*Comments*
Ecstasy	A	1	Essentially MDMA
4-MTA	A	1	4-methythioamphetamine
LSD	A	1	Lysergide
Cocaine	A	2	includes crack cocaine
Heroin	A	2	Crude diamorphine
Street Methadone	A	2	
Amphetamine	B	2	
Methylphenidate	B	2	eg "Ritalin"
Barbiturates	B	most in 3	
Buprenorphine	C	3	Pending move to Class B
Benzodiazepines	C	most in 4(1)	
GHB	C	4(1)	4-hydroxybutyric acid
Anabolic Steroids	C	4(2)	
Cannabis	C	1	
Alcohol	–	–	Not controlled
Alkyl Nitrites	–	–	Not controlled
Ketamine	–	–	Not controlled, but moving to class C in 2006
Khat	–	–	Not controlled
Solvents	–	–	Not controlled
Tobacco	–	–	Not controlled

Results and Discussion

Use of this risk assessment system proved straightforward and practicable. The overall mean scores by the independent group averaged across all scorers, are plotted in rank order for all 20 substances in Figure 1. The classification of each substance under the MDAct is also shown by the shading of the bars of the histogram. Although the two substances with the highest harm ratings (heroin and cocaine) are Class A drugs, overall there is a surprisingly poor correlation between MDAct Class and harm score. Of both the 8 highest and the 8 lowest substances in the ranking of harm, three are Class A and two are unclassified. Alcohol, ketamine, tobacco and solvents (all unclassified) were ranked as more harmful than LSD, ecstasy and its variant 4-MTA (all Class A). Indeed, the correlation between MDAct classification and harm rating was not statistically significant (Kendall's rank-correlation = -0.18; 2P = 0.25. Spearman's rank-correlation = -0.26; 2P = 0.26). Interestingly, of the unclassified drugs, alcohol and ketamine were rated particularly high, and the Advisory Council on the Misuse of Drugs has recently recommended that ketamine should be added to the MDAct (as Class C) [Ref 5A] .

Figure 2 compares the overall mean scores (averaged across all nine parameters) for the psychiatrists with those of the independent group for the 14 substances that were ranked by both groups (see legend to Fig.2). The average scores for the two groups were remarkably well correlated ($r = 0.892$; $t = 6.8$; $P < 0.001$) which suggests the scores and process have validity.

Figure 1

The mean scores for 20 substances (all parameters; independent experts)

The respective classification, where appropriate, under the Misuse of Drugs Act is shown above each bar. Class A drugs are indicated by black bars, B by dark grey, and C by light grey. Unclassified substances are shown as unfilled bars.

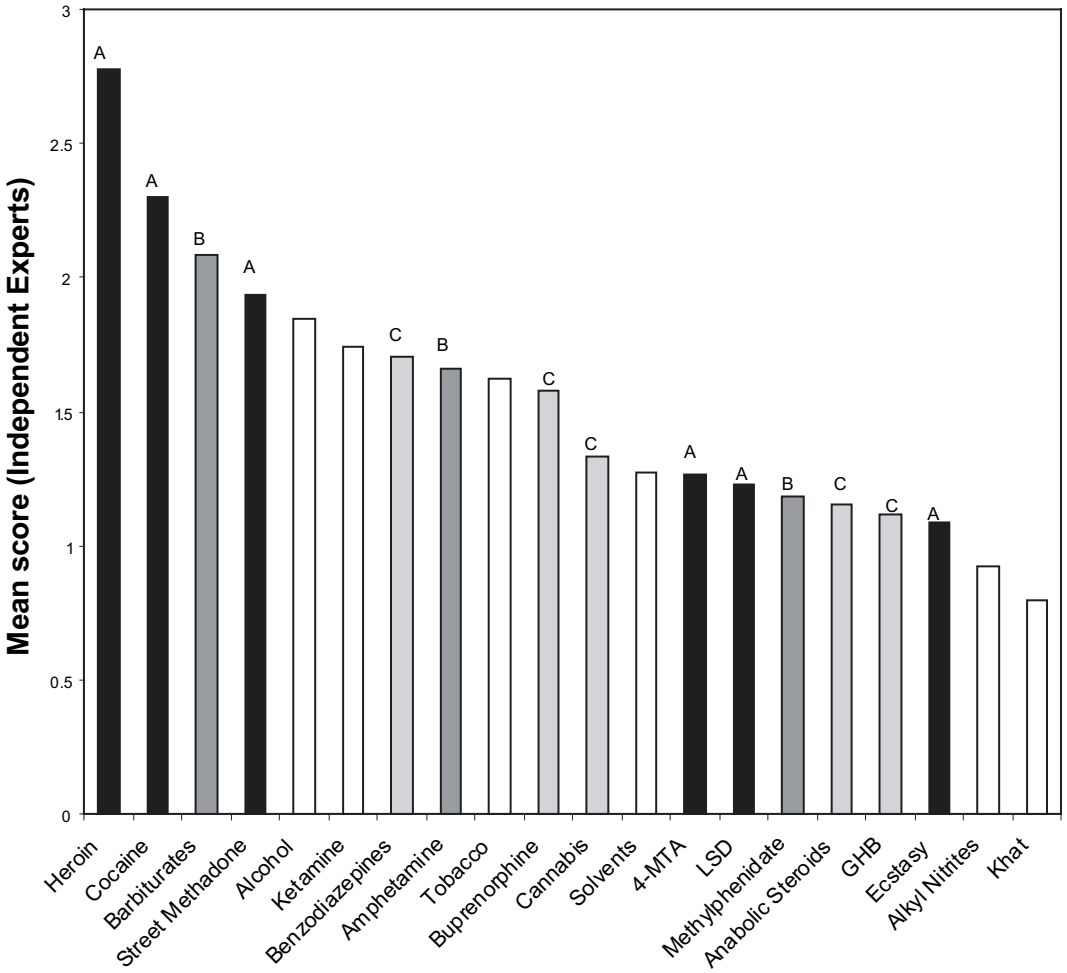


Table 3 lists the independent group results for each of the three sub-categories of harm. The scores in each category were averaged across all scorers and the substances are listed in rank order of harm, based on their overall score. Many of the drugs were consistent in their ranking across the three categories. Heroin, cocaine, barbiturates and street methadone were in the top five places for all categories of harm, whereas khat, alkyl nitrites and ecstasy were in the bottom five places for all. On the other hand, some drugs differed considerably in their harm rating across the three categories. For instance, cannabis was ranked low for physical harm but somewhat higher for dependence and harm to family and community. Anabolic steroids were ranked high for physical harm but low for dependence. Tobacco was high for dependence but distinctly lower for social harms (because it scored low on intoxication) and physical harm (since the ratings for acute harm and potential for iv use were low). There was also good agreement between the independent group and the psychiatrists in their scores for the individual categories of harm.

Table 3

THE MEAN INDEPENDENT GROUP SCORES IN EACH OF THE THREE CATEGORIES OF HARM, FOR 20 SUBSTANCES, RANKED BY THEIR OVERALL SCORE, AS SHOWN IN FIGURE 1

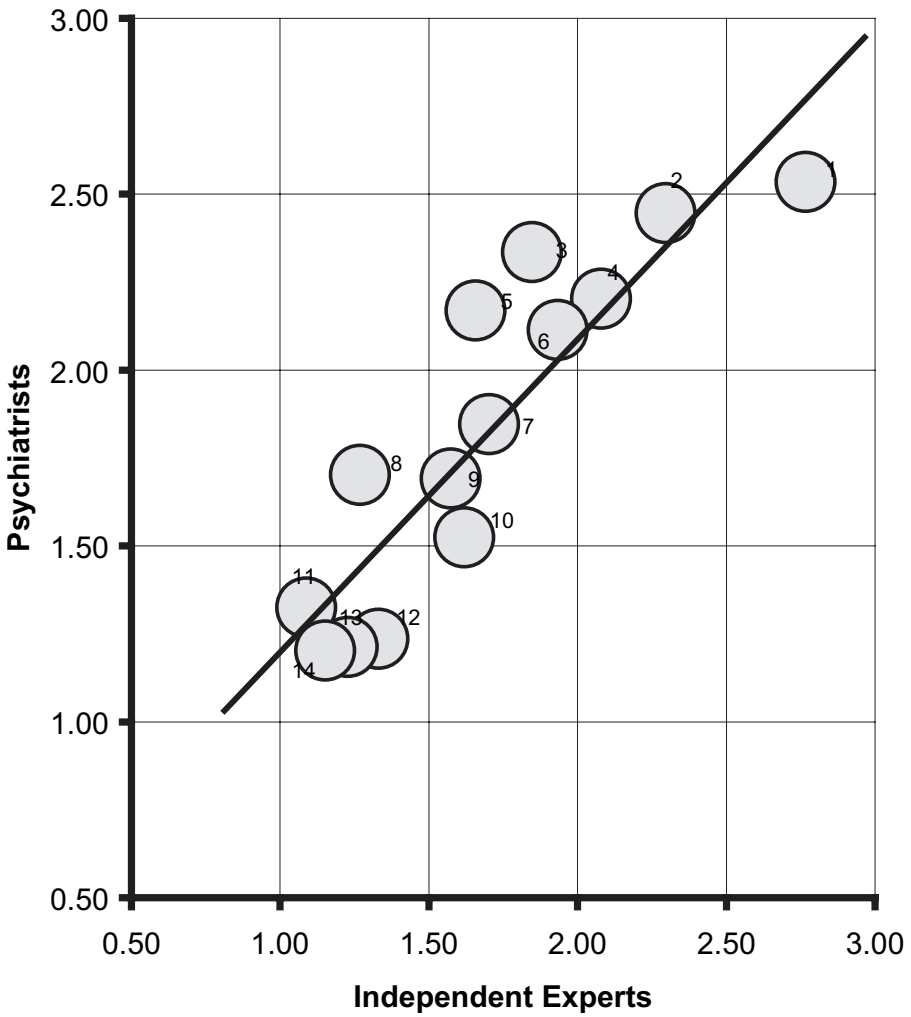
Substance	*Group 1 Physical harm*	*Group 2 Dependence*	*Group 3 Social harms*
Heroin	2.78	3.00	2.54
Cocaine	2.33	2.39	2.17
Barbiturates	2.23	2.01	2.00
Street Methadone	1.86	2.08	1.87
Alcohol	1.40	1.93	2.21
Ketamine	2.00	1.54	1.69
Benzodiazepines	1.63	1.83	1.65
Amphetamine	1.81	1.67	1.50
Tobacco	1.24	2.21	1.42

Buprenorphine	1.60	1.64	1.49
Cannabis	0.99	1.51	1.50
Solvents	1.28	1.01	1.52
4-MTA	1.44	1.30	1.06
LSD	1.13	1.23	1.32
Methylphenidate	1.32	1.25	0.97
Anabolic Steroids	1.45	0.88	1.13
GHB	0.86	1.19	1.30
Ecstasy	1.05	1.13	1.09
Alkyl Nitrites	0.93	0.87	0.97
Khat	0.50	1.04	0.85

Drugs that can be administered by the iv route were ranked relatively high, and this was not caused solely by exceptionally high scores for parameter three (propensity for iv use) and nine (healthcare costs). Even if the scores for these two parameters were excluded from the analysis, the high ranking for such drugs persisted. In other words, drugs that can be administered intravenously were also judged to be substantially harmful in many other respects.

Figure 2

Correlation between mean scores from the independent experts and from the psychiatrists. one = heroin; two = cocaine; three = alcohol; four = barbiturates; five = amphetamine; six = methadone; seven = benzodiazepines; eight = solvents; nine = buprenorphine; 10 = tobacco; 11 = ecstasy; 12 = cannabis; 13 = LSD; 14 = steroids. The correlation coefficient is r = 0.892 ($P < 0.001$). The straight line shows the least squares fit.



The results of this study do not provide justification for the sharp A/B/C divisions of the MDAct classification. Distinct categorisation is, of course, convenient for setting the priorities for policing, education and social support, as well as for determining sentencing for possession or dealing. But, first, the

rank ordering of drugs in the MDAct classification is not confirmed by the more complete assessment of harm described here. Second, sharp divisions in any ranking system are essentially arbitrary unless there are obvious discontinuities in the set of scores. There is only a hint of a discontinuity in the spectrum of harm in Figure 1 is the small step in the very middle of the distribution, between buprenorphine and cannabis. Interestingly, alcohol and tobacco both appear in the top 10, higher-harm group. There is a rapidly accelerating harm value for drugs higher than alcohol. So, one possible interpretation of our findings is that drugs more dangerous than alcohol might be Class A, cannabis and those below might be Class C, and drugs in between might be B. In that case, it is salutary to see that alcohol and tobacco—the most widely used unclassified substances—would have harm ratings comparable to Class B illegal drugs.

The participants in this study were asked to assess the harm of drugs in the form that they are normally used. In a few cases, it was clear that the harms caused by a particular drug could not be completely isolated from interfering factors associated with the particular style of use. For example, cannabis is commonly smoked mixed with tobacco, which might have elevated its scores for physical harm, dependence, etc. There is a further level of uncertainty resulting from polydrug use, particularly in the so-called recreational group of drugs including GHB, ketamine, ecstasy and alcohol, where adverse effects may be attributed mainly to one of the components of common mixtures. Crack cocaine is generally considered to be more dangerous than powdered cocaine, but here they were considered together. Similarly the scores for the benzodiazepines might have been biased in the direction of the most abused drugs, especially temazepam. Individual scoring of particular benzodiazepines and of other drugs that can be used in different forms might be more appropriate.

With such relatively small numbers of independent scores, we did not think that it was legitimate to estimates correlations between the nine parameters. It is quite likely that there is some redundancy: that is to say, they might not represent nine independent measures of risk. Similarly, the principal components of the parameters were not extracted, partly because it was felt that there were insufficient data and partly because it might not be appropriate to reduce the number of parameters to a core group, at least until further assessment panels have independently validated the entire system.

Our analysis gave equal weight to each parameter of harm: individual scores have simply been averaged. Such a procedure would not give a valid indication of harm for a drug that has extreme acute toxicity, such as the "designer" drug contaminant MPTP, a single dose of which damages the *substantia nigra* of the *basal ganglia* and induces an extreme form of Parkinson's disease. Indeed, this simple form of the system of scoring might not deal adequately with any substance that is extremely harmful in only one respect. Take tobacco, for instance. Smoking tobacco beyond the age of 30 reduces life expectancy by an average of up to 10 years (A1) (Ref 2). It is the commonest cause of drug-related deaths, and it is a huge burden on the Health Service. But its short-term consequences and social effects are modest. Of course, the weighting of individual parameters could easily be changed, to emphasize one aspect of risk or another, depending on the importance attached to each. And other procedural mechanisms could be introduced to take account of extremely high values for single parameters of harm.

Despite these qualifications, we were impressed by the consistency of the scores between different groups of scorers and the correlation between scores across the categories of harm, for most drugs. Our findings raise questions about the validity of the current MDAct classification, despite the fact that this is nominally based on an assessment of risk to users and society. This is especially true in relation to psychedelic type drugs. They also emphasise that the exclusion of alcohol and tobacco from the MDAct is, from a scientific perspective, arbitrary. The fact that these two legal and widely used drugs lie in the upper half of the ranking of harm is surely important information to be taken into account in public debate on the impact of illegal drug use.

We believe that a system of classification like ours, based on the scoring of harms by experts, on the basis of scientific evidence, has much to commend it. It is rigorous, and involves a formal, quantitative evaluation of several aspects of harm. And it can easily be reapplied, as knowledge advances. We note that a numerical system has also been described by MacDonald *et al*. (Ref 6) for assessing the overall harm of drug use: an approach that is complementary to the scheme described here.

Conclusions

The approach to harm estimation that we propose provides a comprehensive and transparent process for the evaluation of the danger of drugs. It could be developed to aid in decision-making by regulatory bodies such as the UK's Advisory Council on the Misuse of Drugs and the European Medicines Evaluation Agency. Moreover, our findings reveal no clear distinction between socially accepted and illicit substances. We note that other organisations [eg the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (REF 7) and the CAM committee of the Dutch government [REF 8] are currently exploring other risk assessment systems, some of which are also numerically based. Such approaches might help society to engage in a more rational debate about the relative risks and harms of drugs, by basing discussion on a formal assessment of harm rather than on prejudice and assumptions.

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