



House of Commons
Science and Technology
Committee

**Drug classification:
making a hash of it?**

Fifth Report of Session 2005–06

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Fifth Report of Session 2005–06

*Report, together with formal minutes, oral and
written evidence*

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The Science and Technology Committee

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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)	<ul style="list-style-type: none"> • Cocaine – 0.97 • Cannabis – 4.40 • amphetamine – 14.70 	<ul style="list-style-type: none"> • cocaine – 0.77 • cannabis – 11.40 • methamphetamine – 96.50 	<ul style="list-style-type: none"> • cocaine – 0.50 • cannabis – 6.90 • amphetamine – 8.00 	<ul style="list-style-type: none"> • 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 paragraphs 104–105.

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 reclassification, 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 reclassified 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.**

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 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)

Ecstasy 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 Adebawale	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

Professor Sir Michael Rawlins, Chairman of the Advisory Council, **Professor David Nutt**, Member of the Advisory Council and Chairman of the Technical Committee, Advisory Council on the Misuse of Drugs Ev 1

Wednesday 26 April 2006

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 Ev 18

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 Ev 28

Wednesday 14 June

Joan Ryan, Parliamentary Under-Secretary of State for nationality, citizenship and immigration, and **Mr Vernon Coaker**, Parliamentary Under-Secretary of State for policing, security and community safety Ev 35

Written evidence

1	Government	Ev 53
2	Parents Against Lethal Addictive Drugs (PALAD)	Ev 57
3	Transform Drug Policy Foundation	Ev 61
4	Rethink	Ev 66
5	Paul Flynn MP	Ev 75
6	Maranatha Community in association with the Council for Health and Wholeness	Ev 76
7	Multidisciplinary Association for Psychedelic Studies (MAPS)	Ev 82
8	Release	Ev 87
9	Drugscope	Ev 89
10	Advisory Council on the Misuse of Drugs (ACMD)	Ev 95, 103, 104, 110
11	Mary Brett, recently retired Biology teacher and UK representative on the board of Eurad (Europe Against Drugs)	Ev 103

Reports from the Science and Technology Committee

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