Submission of evidence by DrugScope to the Commons Science and Technology Select Committee

DrugScope

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The evidence base for the classification of illegal drugs

Introduction

DrugScope is an independent registered charity established in 2000 through the merger of the Institute for the Study of Drug Dependence (ISDD) formed in 1968 and the Standing Conference on Drug Abuse (SCODA) formed in 1971.

The primary mission of DrugScope is to inform the public debate on the misuse of drugs and we do that through:

- the provision of a public access database of over 100,000 documents on the misuse of drugs, one of the primary English-language collections in the world;
- publication of a wide range of materials both in print and through the website aimed at both the general public and professionals working in the field;
- the provision of a comprehensive information service available to anybody seeking drug information which is non-judgemental, current and based on the available evidence;
- consultation with our membership of around 1000 individuals and agencies working in the drugs field and related areas
- regular contact with the media working both proactively and reactively to counterbalance much of the misinformation which surrounds this subject.

Remit of the Enquiry

The Select Committee is investigating the extent to which the classification of drugs under the Misuse of Drugs Act 1971 is evidence-based. It is particularly interested in the classification of cocaine, ecstasy, amphetamine, cannabis and hallucinogenic or 'magic' mushrooms. As we understand it, the Committee is not making recommendations *per se* on the degree to which the current classification of all or any of these drugs is valid, However, should the outcome of the Enquiry indicate a lack of evidence for the positioning of certain drugs within the Misuse of Drugs Act, this should be addressed elsewhere. We note the recent announcement of the Home Secretary to conduct a review of the classification system

Background

International Conventions

Globally, the primary response to the misuse of drugs is criminal sanction. Attempts by the international community to control the manufacture, import, export, supply and possession of certain drugs goes back to the early years of the last century – and represents one the earliest examples of groups of nations convening to discuss a social issue of common concern.

In 1961, various international treaties governing the control of 'narcotics'[i] were consolidated in the Single Convention on Narcotic Drugs covering opiates, cocaine and cannabis.

This was followed in 1971 by the Convention on Psychotropic Substances which brought under control many of the non-plant based, synthetic drugs such as LSD, barbiturates and amphetamines. Some countries had already instigated controls on these drugs. For example unauthorised possession of amphetamine was already an offence in the UK in 1964, while LSD was controlled in both the USA and UK in 1966, as responses to concerns about non-medical use of these drugs by young people.

The main aim of these treaties was to control the *supply* of drugs, rather than their use. In other words, signatories to these treaties, were obliged to have in place laws against the *possession* of controlled drugs, but it was unclear whether this meant any possession including for personal use or simply possession as a preliminary to onward supply.

This ambiguity appeared to have been resolved in 1988 with the UN Convention Against the Illicit Traffic of Narcotic Drugs and Psychotropic Substances. This was primarily aimed not simply at curbing international trafficking, but also to restrict the supply of so-called precursor chemicals used to process and manufacture drugs and also to restrict the flow of drug trafficking proceeds through money-laundering. In addition, however Article 3.2 makes specific reference to an obligation on the part of signatories to have in place domestic laws against the possession of controlled drugs for personal consumption.

Even so, the Conventions allow considerable flexibility as to how the law might operate in practice, especially in regard to simple possession or possession for personal use[ii]. This accounts for the fact that especially in Europe, Canada, Australia and parts of South America, the international consensus on drug control is nowhere near as solid as it used to be.

The Misuse of Drugs Act

Being signatories to the international conventions means that the UK is obliged to have in place laws which control the import, export, manufacture, supply and possession of proscribed drugs. The first Dangerous Drugs Act was passed in 1920.

As the situation changed both nationally and internationally, there were subsequent new Acts, modifications and amendments until the late 1960s.

Our current drug laws are enshrined in the Misuse of Drugs Act 1971 [MDA]. The two innovations in this development of UK drugs law were:

1. To create a body of science and social science experts, the Advisory Council on the Misuse of Drugs [ACMD] to advice the government of the day. Either the ACMD or the Secretary of State at the Home Office can initiate research into the workings of the Act, but the Secretary of State cannot lay a draft order before Parliament without first consulting the ACMD. However, there is no legal obligation on the government to implement the advice given by the ACMD.
2. To group drugs into categories of 'harm' ranging through A, B and C with differing penalties attached to each in descending order of severity. In drafting the legislation, it was clear that 'harm' meant primarily physical and mental harms to the individual. However the ACMD was also charged to keep under review drugs which might be 'otherwise harmful' and this can be more problematic, not least because there is no clear definition in the Act of what this actually means – although it is taken to mean 'social harm', any collateral damage to the individuals and the community consequent on the use of the drug.[iii]

The current evidence base for the classification of drugs under the Misuse of the Drugs Act

Some general points

1. As this is a brief submission, we can only make general observations about the validity of the evidence base rather than a detailed analysis.
2. While accepting the some problems caused by illegal drug use are actually a product of drug prohibition itself, neither DrugScope nor its members supports the blanket legalisation of drugs. We have seen no examples of an alternative control regime which would both substantially undermine the fortunes of international organised crime while safeguarding public health interests. Any moves towards a less rigorous control of drugs must be undertaken incrementally with a proper review process to monitor outcomes.
3. It is perfectly valid for the ACMD to conduct early warning assessments of drugs which might become problematic in the future and which should be kept under review, although any moves to control should be accompanied by a robust evidence base across physical, mental and social harms.
4. International obligations notwithstanding, there is no ready evidence that controlling a drug under the Misuse of Drugs Act actually deters use, especially where there is no data on prevalence before control. A case in point might be ketamine, controlled in January 2006 as a Class C drug, but with no prevalence data against which to track the impact of control. But even if we take a 'common sense' view that controlling a drug will deter some potential users, there is no evidence to show that once a drug is controlled, the actual classification of the drug has an impact on prevalence of use. For example,

the latest data on cannabis reveals a down turn in use among young people despite the decision to reclassify the drug from Class B to Class C.

5. The ACMD is charged with assessing the evidence base for the physical, mental and social harms attached to different drugs under consideration. Yet, the MDA does not define the meaning of the 'term' harm [let alone the meaning of the term 'drug'] and there is no standard assessment tool or set of criteria of harm against which to match the different drugs. However, the Independent Inquiry into the Misuse of Drugs Act chaired by Dame Ruth Runciman [hereafter Runciman Report] did suggest a set of criteria against which to make an objective assessment of relative harm as part of the decision-making process for classifying drugs. These are:

    i. addiction potential
    ii. toxicity
    iii. risk of overdose
    iv. longer-term risk to life and health
    v. potential for injecting
    vi. association with crime
    vii. association with problems for communities
    viii. public health costs[iv]

A similar typology was adopted by the National Addiction Centre [NAC], authors of a Department of Health report *Dangerousness of Drugs* (2001). The NAC considered factors associated with:

i. acute adverse effects
ii. chronic adverse effects
iii. a range of other facts which might mediate or moderate the dangers eg route of administration where for example, sniffing a drug is safer than injecting it.[v]

6. There has never been a thorough review of the Misuse of Drugs Act in terms of the current appropriateness of the drug classifications. As we outline below, doubt must be expressed about the evidence base for some of the current classifications. We also need more clarity on the different penalties that attach to the different classes. With the exception of simple possession, in the period 1973-85, there was in practice little difference in the penalties between Class A and B drugs. Changes in 1985 saw a much clearer division between the three classes in terms of penalties, a division which then disappeared when cannabis was reclassified from B to C in 2004. As part of the political horse-trading which allowed the passage of the reclassification, the penalties for supply of Class C drugs were increased as to make them indistinguishable from those in Class B[vi]. However, if part of the purpose of the MDA is to educate the public as set out in the original legislation, then it is important that the drugs are appropriately categorised and penalised across the three classes.

Drugs of particular interest to the Committee

Cocaine

It is well-enshrined in international and in the domestic legislation of many countries that cocaine should be among those drugs most strictly controlled. There is a wealth of clinical evidence to indicate the physical and mental harms the drug can cause and the most general harms to society linked to crime. Cocaine is a Class A drug and DrugScope would not wish to call this into question.[vii]

Nevertheless we would observe that, despite the body of evidence comprising individual studies worldwide [primarily from the United States], there has never been any international scientific evaluations of cocaine with one exception. In 1995, the World Health Organisation compiled such a study, but its publication was blocked by the United States. There were apparently two reasons for this:

1. The conclusion that the use of coca leaves by the indigenous populations of South America was not demonstrably harmful and might even confer some benefits;[viii]
2. The conclusion that moderate and occasional use of cocaine powder [hydrochloride] was not especially harmful[ix]. The contrasting levels of potential harm [by whatever index] between, coca leaf, cocaine powder and crack support the *Dangerousness of Drugs* contention that factors other than the chemistry of the drug itself mediate or modify harm – in this case, the formulation and the route of administration.

MDMA [Ecstasy]

This drug is part of the family of drugs which are commonly described as having effects which combine those of hallucinogenic and stimulant drugs. This is something of a catch-all because there are several drugs in this group, some of which are mild stimulants [like MDMA] while others are extremely powerful hallucinogens such as PMA.

MDMA is a Class A drug. It was added to the Act by a Modification Order in 1977. This was not because the drug was causing concerns in the UK. In fact the first article on what became known as Ecstasy did not appear in the media until 1985[x]. Nor does it appear that the ACMD were consulted on this. We have spoken to one member of the ACMD at the time and she has no recollection of a consultation process or report to the Home Secretary of the day. The reason MDMA was included seems to be that it is related to some drugs already controlled as Class A drugs. These are the tryptamines and the phenethlymines. There is some suggestion that there was evidence of the manufacture of the parent drug in this family 3,4-methylenedioxyamphetamine, during the UK investigation of 1975-77 known as Operation Julie which broke up what was then the largest LSD manufacturing operation in the world. This may have prompted a ‘pre-emptive strike’ to control the drug in the UK.

The drug did not become popular in the UK until the late 1980s and the explosion of what became known as ‘rave culture’. The drug has been consumed in the millions of doses and it would appear that the majority of consumers have come to no permanent harm nor can there be said to have been any collateral damage to society. In fact,

anecdotally, at the early alcohol-free raves where ecstasy was being consumed instead, the public order problems for the police were greatly reduced in comparison to a typical weekend in a town centre at closing time.

However, the drug carries risks: there have been around 200-250 ecstasy-related deaths since the first one was recorded in 1989 including the death of Leah Betts, arguably one of the most famous drug-related fatalities of modern times. Yet even with drug-related deaths, most of these were related to the circumstances of use rather than a toxic reaction to the drug itself. Of itself MDMA interferes with the body's temperature control mechanism, but the danger is greatly amplified if the person is in a hot sweaty environment and becomes dehydrated. The advice from drug agencies about how to deal with this probably helped save many lives. But the fatal adverse effects do seem to be idiosyncratic and no studies have convincingly demonstrated who might be especially vulnerable in this scenario. Concerns have also been raised about possible long-term psychological effects. But even though the drug has been prevalent in the UK for over twenty years now, there has been no reporting from general practitioners or the psychiatric services of any correlation between past ecstasy use and current levels of depression in those now in their early forties.

The Runciman Report concluded that ecstasy did not pose the same threat as other Class A drugs such as heroin or cocaine and should be regraded to Class B. This was rejected by the Home Secretary without reference to the ACMD.

Hallucinogenic or 'magic' mushrooms

For many years, the classification of magic mushrooms as Class A drugs represented something of an anomaly in the Act. Under the Act, it was the psychoactive ingredient of the mushroom, psilocin, which was the controlled substance rather than the mushroom itself. This meant that so long as the person did nothing to the mushroom to extract the chemical, it was perfectly legal to pick and eat raw mushrooms. However, even to dry the mushroom or make it to a tea or other preparation could render the person liable to prosecution for possession of a Class A drug – although it is likely that very few cases would have appeared before the courts. The situation changed in recent years due to a growing interest in hallucinogenic drugs and altered states of consciousness consequent on the growth of rave culture. The main drug to satisfy this interest had traditionally been LSD. But manufacture and use of the drug had fallen dramatically through the 1990s and magic mushrooms represented a legal alternative. A commercial business grew up selling fresh magic mushrooms [largely imported] on the high street. The internet also played its part with individuals buying mushrooms and other so-called 'legal highs' online.

In general the psilocin experience is akin to a milder LSD trip and as with all mood-altering drugs, it would unwise for those with mental health problems to use the drug. The other major danger is that the inexperienced might pick the wrong mushroom: some varieties of wild mushroom are highly toxic. But it does not appear from the evidence that the use of magic mushrooms has been a cause of significant harm among users on either count. Even so, a decision was taken to further control the drug, so that the mushroom itself became a Class A substance. This appears to have been done, not because the new situation was causing new health problems, but because of

the high media profile given to what was seen as a commercial exploitation of a loophole in the law.

The control of mushrooms was brought in as part of the Drugs Act 2005 rather than through a Modification Order under the Misuse of Drugs Act. We are not aware that the ACMD was formally asked to consider the position of mushrooms and it may be that the provisions of the Act whereby the Home Secretary has to consult with the ACMD before presenting a Modification Order before Parliament was obviated by the use of different primary legislation.

If this set a precedent and the ACMD were not to be consulted on all such changes to the MDA in the future, then this would be a matter for concern.

Amphetamine

Amphetamine is a Class B drug. It was widely prescribed in the 1950s and 1960s as a slimming drug and as a stimulant for staying awake among long distance lorry drivers, students and so on. Use without a prescription was banned in the UK in 1964, but doctors continued to prescribe it primarily to women into the late 1960s and early 1970s. Voluntary restraint by GPs, the removal of amphetamines from the pharmaceutical market coupled with control saw use in the general population decline. However illegally manufactured amphetamine sulphate took the place of pharmaceuticals and that is the situation which prevails today.

Amphetamines are still prescribed in the treatment of narcolepsy and an amphetamine-like drug methylphenidate [Ritalin], a Class C drug, is controversially prescribed widely for a range of attention deficit disorders in children.

A unique aspect of Class B drugs is that if prepared for injection, they become Class A drugs. This applies to both amphetamines and barbiturates [formerly widely prescribed for sleep disorders] and seems to be the legacy of the injecting epidemics experienced with both drugs in the past. During the late 1960s, there was an outbreak of amphetamine injecting [as methedrine] among London drug users. The drug was being prescribed by doctors no longer able to prescribe heroin and cocaine to users in support of their habit through legislation passed in 1968. Ten years later, there was a very destructive outbreak of barbiturate injecting among young drugs users again in London. The idea of assessing the potential harm of a drug according to the dangers posed by the route of administration as one marker of harm rather than simply the effects of the drug is highlighted in both Runciman and the NAC report.

Concerns were raised recently as to the presence of methamphetamine on the UK drug scene in the form of 'ice' – essentially a smokeable form of amphetamine [as crack is to cocaine] but much longer acting than amphetamine sulphate powder. At present, the drug can be found in pockets of the gay scene, but sensational media reporting suggested the UK was on the brink of a major drug epidemic. The ACMD commissioned a report in 2005 which concluded that while the situation should be kept under review, there should be no change to the MDA.

Cannabis

Probably more has been written about cannabis than any other drug used non-medically or recreationally. The evidence base is vast. It has been the subject of several national and international reviews going back to the Indian Hemp Commission report of the 19th century.[xi] But despite all the controversy about the drug and the welter of published scientific information, the following simple distillation of the evidence base still holds true:

1. The majority of occasional users come to no obvious mental or physical harm
2. The main physical risks are similar to those of smoking tobacco
3. Those with mental health problems or who may be at risk of developing these should abstain

The background as to how cannabis was controlled in the first place is too complex for this brief review. But sufficed to say that the clinical and social evidence for international control on a par with heroin and cocaine would not stand modern day scrutiny.

It may be that cannabis represents some kind of moral line in the sand when it comes to the behaviour of [mainly] young people that will or will not be tolerated. Cannabis lies at the junction between drugs which are clearly dangerous such as heroin and a drug like alcohol which can be just as medically and socially dangerous, but is tolerated for all kinds of socio-economic, political and historical reasons. There is no evidence for this view, except to quote from the French delegate to the 1973 session of UN Commission on Narcotic Drugs;

“ The question of the relative harmfulness of different variants of cannabis, of taking the drug in large or small doses etc, was doubtless of theoretical and clinical interest and WHO should certainly continue its investigations along these lines, *but such investigations should not be allowed to influence international control measures in any way whatsoever’*[xii] [emphasis added].

Conclusions

1. As signatories to international conventions, the UK is obliged to have in place laws to restrict a range of specified drugs
2. However, the Misuse of Drugs Act is quite a flexible instrument and the UK is not obliged to either classify drugs or penalise their distribution within any rigid international framework.
3. This means that there is plenty of opportunity for an overall review of the whole classification of drugs in the light of current best evidence.
4. This is necessary because DrugScope would contend that the evidence-base for the current classification of drugs such as ecstasy and magic mushrooms is weak. There also needs to be more clarity over the penalty tariff between classes.
5. DrugScope feels that when dealing with such an emotional and highly-charged subject, it is most important that the government continues to make best possible use of the expert advice enshrined in the legislation.

[i] An American legal term to describe a range of drugs including not only the opiates [opium, morphine, heroin etc], but [incorrectly] also cocaine and cannabis. As the Americans were the prime movers in driving international legislation forward, it may be that the United Nations in turn adopted this terminology.

[ii] Dorn, N. ed. European drug laws: the room for manoeuvre. The full report of a comparative legal study into national drug laws of France, Germany, Italy, Spain, the Netherlands and Sweden and their relation to three international drugs conventions. DrugScope, 2000.

[iii] The ACMD addressed the issue of definitions in the introduction to its 1979 report to the Home Secretary, the major recommendation of which was to reclassify cannabis to a Class C drug – advice which the government of the day rejected.

[iv] Drugs and the law: report of the Independent Inquiry into the Misuse of Drugs Act 1971. Police Foundation, 2000. p.50

[v] National Addiction Centre. Dangerousness of Drugs. Department of Health, 2001, p13.

[vi] This is supposition based on informed guess-work. But while the ACMD social and clinical evidence is in the public domain, the evidence that might have been presented from the enforcement perspective is not.

[vii] Although in our submission to the Home Affairs Select Committee into the government's drug policy [2002], we did take the view that those found in possession of small amounts of any drug should not be dragged through the criminal justice system.

[viii] The cultivation and use of coca leaf is legal in Bolivia so long as the leaves are not additionally processed.

[ix] The report seems to have leaked out into the public domain as it was summarised in the *British Medical Journal* 1st April 1995, but never formally published. In 1998, the USA also blocked the inclusion of a comparative study of the dangers of cannabis, alcohol and tobacco in the last WHO international review of cannabis – cf *Druglink*, March/April 1998, p.8. While politics may determine how the evidence base is used, these are far more invidious examples of how politics can intervene to compromise the evidence base itself.

[x] Nasmyth, P. Ecstasy. Face: Oct., 66, 1985, p.88-92.
[xi] DrugScope can provide a comprehensive list
[xii] Bruun, K et al. The gentleman's club: international control of drugs and alcohol. University of Chicago Press, 1975, p.202.