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Policy forum: The drug scheduling debate

The view from Vienna

Ted Leggett

Research Officer, UNODC

Drug scheduling is the process of sorting controlled substances into categories, generally with the purpose of assigning higher levels of control over those drugs viewed as most hazardous. This implies a process of weighing the respective dangers and benefits of each drug, an undertaking of considerable complexity. As with many controversial topics, members of the public, and especially specialised academics may feel that their opinions are not given enough credit. This is particularly true for popular drugs with vocal supporters, such as cannabis.

There are as many mechanisms for evaluating drug harmfulness as there are agencies involved in the regulatory process. They all must confront certain core questions. One is the mechanism for arriving at a decision. **Who** gets to vote and how are decisions reached? Another is the criteria to be used in justifying decisions made. **How** is 'harmfulness' to be evaluated?

Many have argued that the process of drug scheduling could be improved, but exactly what this would look like remains controversial. The difficulties of scheduling drugs through scientific consensus were highlighted in a provocative article in *The Lancet*, entitled 'Psychoactive drugs of misuse: rationalising the irrational'.

The article argues that, in the United Kingdom,

'The current classification system has evolved in an unsystematic way from somewhat arbitrary foundations with seemingly little scientific basis' (Hall, 2007).

It suggests an alternative model, in which experts from a range of disciplines meet and

rank drugs based on a number of pre-selected criteria. The rankings are then averaged to produce a 'mean harm score', which the authors suggest should be associated with scheduling. The article then describes an attempt by the authors to implement that approach and the results it produced.

While such scientific input should undoubtedly be part of the scheduling process, and evaluations of the sort conducted by the authors should be encouraged, the devil is in the details. In the experiment, the key question of **who** was doing the evaluating is left vague, and the reasons behind refusals and dropouts are not well described. Not every expert rated every substance parameter, and the reasons for abstentions are unclear. Efforts were made to achieve a consensus, including a revision process in which outlier scores were challenged. The participants were also given review articles, including some by the authors of the research themselves. In the end, the study seems mainly to demonstrate the ability of the authors to guide a select group of authorities to a reasonably consistent position.

Despite a well thought out scheme of criteria, the question of **how** to evaluate harm also poses considerable difficulties. Many of these centre on the combination of two distinct types of assessment parameters, one dealing with harm to the individual and the other dealing with harm to society at large. Social harms are directly related to the availability of each substance. As the authors themselves note,

'direct comparison of the scores for tobacco and alcohol with those of other drugs is not possible since the fact that they are legal could affect their harms in various ways, especially through easier availability' (Hall, 2007).

However, this is precisely what they proceed to do, placing both sets of drugs on the same scale and even suggesting an appropriate scheduling for alcohol and tobacco. As a result, Associated Press coverage of this article proclaims, *'Booze and smokes more dangerous than some illegal drugs'*. While this is clearly not the intent of the article, it is a predictable misreading of the results.

Two-thirds of the assessment parameters are types of harm to individuals and one-third relate to social harm, an implicit weighting that is never justified, giving dangerous but rarely used drugs a higher overall harmfulness rating than commonly used ones. For example, ketamine, a drug used irregularly even among dedicated clubbers, is rated higher in overall harmfulness than cannabis, a drug used by nine per cent of the adult population of the United Kingdom every year, many on a daily basis. Whatever the value of this ranking to scheduling, the authors say they offer these rankings to provide guidance on relative risks so that resources can be more rationally distributed with regard to substance-specific interdiction, education, and treatment. Of course, it would make little sense to dedicate as many resources to ketamine as to cannabis, despite the fact that social harms were theoretically included in the overall harmfulness ranking.

Weighting among individual parameters is also troubling. For example, while the types of physical harm of the drug to individuals would seem to be covered by the two assessment parameters of 'acute harm' and 'chronic harm', a third harm parameter – the potential for intravenous injection – is included. This gives excessive weight to drugs that can be injected, without taking into consideration the prevalence of injection for that drug type. For example, cocaine is given the same injection harm rating as heroin (the highest possible rating), despite the fact that injection is more common among heroin users than cocaine users. If injection were removed from the physical harm assessment, cocaine would be deemed scarcely more harmful than alcohol. Even LSD gets a mild boost due to its alleged potential for injection, a practice that, if it occurs, is extremely rare.

It should also be noted that the results are specific to the United Kingdom, and cannot be generalised internationally. This is obvious for types of social harm, which are reflective of the extent of use – methylphenidate abuse would not figure in tallying the impact of drugs in most countries of the world. However, this social bias is also true of the harm to individuals caused by specific drugs. The low rate of physical harm attributed to solvent use, for example, can only be based on the way solvents are most commonly used in the UK, which is to say light recreational use. In developing countries, solvents are used by some groups, such as street children, on a continuous basis, and the impact on health is devastating. The fact that the author's ranking of drugs corresponds to that of studies conducted in other national contexts is offered in validation of the findings. Rather, it should draw suspicion, as it suggests that the study was less an independent inquiry into the specific types of harm experienced in the UK than a reflection of popular views on the relative harmfulness of these substances.

These concerns highlight the difficulties of objectively assessing the relative risks of drugs, particularly on an international basis. Specialists in many fields would like to see public policy decisions made by a referendum among experts, but the practicalities of this process are problematic. While there remains potential for developing this approach, and expert opinion will continue to be an important part of a complex evaluation, the question of who gets a say and how they should evaluate risk will remain at the core of the controversy.

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The ABC of UK drug classification – not fit for purpose

Steve Rolles

Information Officer; Transform

The debate over cannabis reclassification from B to C made the classification debate headline news, while last year's damning inquiry report by the Science and Technology Select Committee, combined with the 2007 *The Lancet* paper on drug harm rankings, have given the ABC system some long-overdue high-level scrutiny. However, the problem runs much deeper than whether certain drugs are misclassified.

The UK's ABC drug classification system has been in place since the Misuse of Drugs Act 1971, but its history can be traced back further to the 1961 UN drug convention to which the UK and over 160 other states are signatories. All EU member states (and most other signatories) classify drugs roughly according to the conventions, using the annexes from the 1961 convention and the 1971 UN convention (which list some 250 substances) as the guide, although there are some notable differences between states. These annexes prescribe the level of legal controls required by signatories for each category or 'schedule' of drug, nominally ranked according to harmfulness. The UK has therefore been locked into a prohibitionist legal system for more than 45 years, legally binding under international law (both EU and UN), that requires the criminalisation of production, supply and possession of non-medical use of some psychoactive drugs, the penalties for which are determined by a classification system also broadly established under international law.

Much of the 1961 convention was drafted in the 1940s, in an era when patterns of drug use and drug related harms were dramatically different to those we face today. At the time, the key concept of using a harm-based hierarchy of criminal penalties as the central plank for the wider aim of eliminating drug use was, while perhaps instinctively sensible, entirely without evidential foundation. The only major experiment with such a prohibition had been US alcohol prohibition in the 1920s, a benchmark for poorly thought out drug policy led by moral imperatives rather than evidence of effectiveness.

A historical perspective, therefore, suggests that it has been international and domestic

political forces, rather than rational analysis of available evidence, that has defined mainstream drug policy thinking and the classification system in the UK. Political discourse has been dominated by tough-talking rhetoric and drug war posturing, and it is in this context that the demonstrably unscientific, un-evidenced and ineffective system of drug classifications/punishments has evolved.

Why the classification system is fundamentally flawed

1. There is no evaluation or review of the classification system against meaningful indicators.

Before trying to establish if the classification system is effective we must ask what it is seeking to achieve. The Misuse of Drugs Act 1971 seeks to reduce the availability and misuse of prohibited drugs – its ultimate aim being a drug free society. The UK is a signatory to the 1998 UN General Assembly Special Session (UNGASS) resolution, with the motto: A DRUG FREE WORLD – WE CAN DO IT!

However, existing systems of policy evaluation and review are woefully inadequate, with neither drug availability nor levels of misuse (or health harms related to use) being measured in a meaningful or consistent way (Transform, 2007). The government simply has no way of establishing the impact of changes in the classification of individual drugs, or the effectiveness of the system as a whole.

2. The system is based on the un-evidenced assumption that criminal penalties are an effective deterrent and that stronger penalties are a stronger deterrent.

At the heart of the classification system, and indeed the entire prohibitionist paradigm within which it operates, is the assumption that criminal sanctions are an effective deterrent to use, specifically for the ABC classification system, that the heavier the sanctions the stronger the deterrence. However, there is zero published research

undertaken by the Home Office to establish any evidential base for this key assumption (Home Office, 2001). Crucially, there is also no evidence to show that key target groups understand or pay any attention to the classification system when making drug taking decisions.

The Science and Technology Select Committee challenged the government on this very specific point in conclusion 34 of their 2006 report *Drug Classification: Making a hash of it?*:

'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 in enforcing the penalties associated with the classification system, it is highly unsatisfactory that there is so little knowledge about the system's effectiveness.'

The government response is shockingly dismissive and inadequate:

'The Government fundamentally believes that illegality is an important factor when people are considering engaging in risk-taking behaviour...'

'It believes that the illegality of certain drugs, and by association their classification, will impact on drug use choices, by informing the decisions of dealers and users. Imposing penalties on the offence of possession is intended to deter use, particularly experimentation by young people.'

'...the Government accepts that there is an absence of conclusive evidence in relation to the deterrent effect of the existing classification structure...'

'...the Government will consider ways in which the evidence base in the context of the deterrent effect can be strengthened.'

The Select Committee very clearly points out, *'we have found no solid evidence to support the existence of a deterrent effect'*. The government produce nothing to challenge this beyond their 'belief' in the existence of such an effect, and yet they rejected the committee's conclusion outright regardless.

The scant independent research that has been done in this area suggests that the law and its enforcement are, at best, marginal factors in drug taking decisions – especially for the most excluded groups who are most

vulnerable to problematic use. The wider point here is that criminal law is intended to prevent crime, not 'send out' messages on public health. When this has been tried it has been spectacularly ineffective, as the unprecedented ballooning of drug use over the last 36 years demonstrates with some clarity. Moreover, it has been arguably counterproductive by fostering mistrust of police and public health messages among young people.

3. Alcohol and tobacco are not included in the classification system.

It is this omission that truly lays bare its fundamental lack of consistency, reasoning or evidence base. Any and all medical authorities will acknowledge that the greatest harm to public health from drugs stems from alcohol and tobacco use. Under any realistic assessment of toxicity, addictiveness and mortality rates, both drugs would certainly be criminalised and prohibited under the current system, as was notably acknowledged in the high profile *The Lancet* paper 'Development of a rational scale to assess the harm of drugs of potential misuse' (Nutt *et al*, 2007).

The reason they are absent from the classification system is that they are, for entirely political/historical reasons, absent from the international prohibitionist legal system. This distinction is arbitrary, perverse and illogical.

4. Drug harms are mediated by the nature of the user, the dose of drug consumed and the method of consumption – making a system based upon broad sweep single classifications for each drug is fundamentally unscientific and meaningless in most practical terms.

As an example, the classification system makes no distinction between coca leaf chewing and smoking crack; they are both cocaine (Class A). However, coca chewing is low dose and slow release and is not associated with significant health harms (and even some benefits) – whereas crack smoking is high dose and rapid release and consequently associated with high harm/risks. Similarly, some drugs are low risk if used occasionally, but become increasingly high risk with increasing intensity and regularity of use. The classification system makes no allowance for more responsible or

moderate use of any illegal drug, and completely ignores the possibility that some drug use may, on balance, be beneficial (pleasure, relaxation, pain relief etc).

5. Translating generalisations about harms/risks to an entire population into penalties for individuals is both unscientific and unjust.

Even if one accepts that consenting adult use of certain drugs should be a criminal act, it remains unethical and unscientific to base penalties for an entire using population – including the majority of non-problematic users – on the small proportion of drug users who experience difficulties or health problems. This is akin to punishing responsible drivers for the actions of reckless joy riders.

Discussion

To the objective observer the intellectual problems with the classification system are as obvious as its abject and ongoing failure on all meaningful indicators. The government's response to its critics, which now includes detailed and thoughtful work from the Police Foundation (2000), the Home Affairs Select Committee (2002), The Science and Technology Select Committee (2006), the RSA (2007), and even the ACMD (2006) and its technical advisers writing in the *The Lancet* (Nutt *et al*, 2007), has been nothing more than contemptuous and is entirely lacking in intellectual or empirical credibility. The Science and Technology Committee's conclusion that the system was 'not fit for purpose' was altogether too diplomatic.

There is certainly potential for ranking different drugs along the various vectors of drug harm that might usefully include toxicity, addictive potential, particular risks for specific populations (eg. sex, age group, mental health) safety critical activities (eg. driving) or behaviours (eg. injecting, poly-drug use, pregnancy). However, this sort of information does not lend itself to the broad generalisations of a simplistic ABC system, however well thought out the placing of individual drugs may be. People need honest and accurate information about drug risks so they can make informed decisions; the ABC system singularly fails to deliver.

More significantly, the debate over which drugs should be in which class is a distraction from the more profound problem that the ABC system exists primarily to determine a hierarchy of criminal penalties,

and there is no evidence whatsoever to demonstrate that this approach has either criminal justice or public health benefits. The government's refusal to honour the promise the Home Secretary (before last) made to the House of Commons in January 2006, to hold a review of the classification system is transparently a politically motivated one. Their 'belief' that the system is effective, when the opposite is demonstrably the case is simply not acceptable and should be a profound concern to everyone in policy making, law and the wider drugs field.

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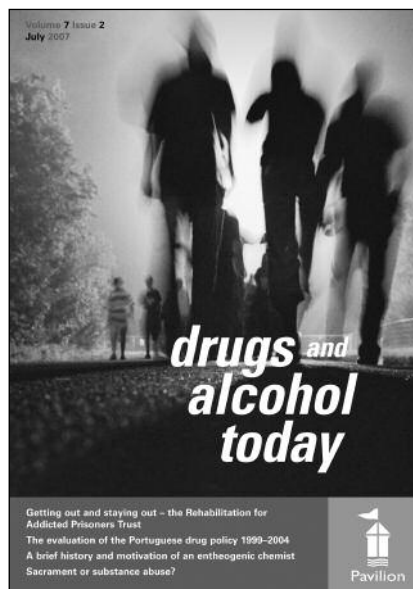
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