

An Inquiry into Scientific Advice,
Risk and Evidence:
how Government handles them

Submission

to the
House of Commons Select Committee
on Science and Technology

by
The Maranatha Community
in association with the
Council for Health and Wholeness

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House of Commons Select Committee on Science and Technology**

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I. Preface

THIS DOCUMENT

This document has been prepared in response to the call for evidence by the House of Commons Select Committee on Science and Technology on '*Scientific advice, risk and evidence: how government handles them.*'

This submission has been addressed to Mr Phil Willis, Chairman, Select Committee on Science and Technology. Email: scitechcom@parliament.uk; phone 020 7219 2793.

THE MARANATHA COMMUNITY

The Maranatha Community is a Christian movement with many thousands of members throughout the country active in all the main churches. Its membership includes a substantial number of people involved in the health and caring professions and in a wide range of voluntary work. Since its formation 25 years ago, it has been deeply involved in work amongst those with drug and alcohol problems, the elderly, the disabled and the disadvantaged. It has taken the initiative in a broad range of projects directly contributing to the health of the nation and it also has extensive international experience.

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The Maranatha Community Trust is a registered charity number 327627.
The Leader and co-founder of the Community is Mr. Dennis Wrigley.

THE COUNCIL FOR HEALTH AND WHOLENESS

The Council is a multi-disciplinary body embracing doctors drawn from a variety of specialist disciplines, nurses and various medical auxiliaries, counsellors, chaplains and others. It has close links with the healing ministry of the Christian church and is involved in a broad range of research projects.

The Council for Health and Wholeness is based in the offices of the Maranatha Community. Its medical co-ordinators are Dr. Hans-Christian Raabe & Dr. Linda Stalley.

2. Introduction

- 2.1 The Maranatha Community and the Council for Health and Wholeness welcome the inquiry by the House of Commons Select Committee on Science and Technology examining the way Government uses scientific evidence in formulating policies.
- 2.2 This submission focuses on **Case study 2 – the classification of illegal drugs**, especially the classification of cannabis under the Misuse of Drugs Act.
- 2.3 When the downgrading of cannabis from a Class B to a Class C drug was debated in both Houses of Parliament in October and November 2003, strong scientific evidence was available linking cannabis to serious mental illness including schizophrenia, psychosis and depression. This link between cannabis and serious mental illness has prompted the current Home Secretary, Charles Clarke, to review the classification of cannabis.
- 2.4 Timeline of events:
- October 2001 – The then Home Secretary, David Blunkett, announces that he intends to downgrade Cannabis from a Class B to a Class C drug, and asks the Advisory Council on the Misuse of Drugs (ACMD) to report to him.
 - March 2002 – The ACMD reports to the Home Secretary in their report, *The Classification of Cannabis under the Misuse of Drugs Act 1971*. This report recommends the downgrading of Cannabis from a Class B to Class C drug.
 - October 2003 – The House of Commons votes for a downgrading of cannabis from Class B to Class C to come into effect from January 2004.
 - November 2003 – The House of Lords votes for the downgrading of cannabis.
 - January 2004 – The downgrading of cannabis comes into effect.
 - March 2005 – The Home Secretary, Charles Clarke, writes to the ACMD, asking them to reconsider the classification of cannabis in view of evidence linking cannabis with mental illness.
 - January 2006 – Home Secretary Charles Clarke announces that cannabis should remain a Class C drug, however announces an educational program about its health effects and increased policing of cannabis offences.
- 2.5 In our submission we would like to present evidence that at the time both Houses of Parliament voted for the downgrading of cannabis, there was sufficient scientific evidence available to avoid making an unsound decision and having subsequently to consider a confusing u-turn on this issue.
- 2.6 The inquiry asks several questions about policy making. We would like to comment on several of these questions.

3. Sources and handling of advice

3.1 Under this heading, the inquiry asks the following questions:

- **Are existing advisory bodies being used in a satisfactory manner?**
- **Are Government departments establishing the right balance between maintaining an in-house scientific capability and accessing external advice?**

The first question is answered in paragraphs 3.1 to 3.22 below, and the second question answered in paragraphs 3.23 to 3.26.

3.2 In the case of drug policy, the main advisory body is the Advisory Council on the Misuse of Drugs (ACMD). An analysis of the composition of the ACMD when it initially reported on the classification of cannabis in early 2002 (*from Peter Franklin in 'Renewing One Nation', 2002.*) raises serious concerns about this body for the following reasons (however, we note that the composition of the ACMD has changed since their report on the classification of cannabis was issued in March 2002).

3.3 There were hardly any scientists and no recognised schizophrenia specialist on this body.

3.4 There was a significant imbalance in the membership. The majority of members were from groups and organisations that promote a 'liberal' drug policy or may even support legalisation of drugs. There were no representatives of groups or organisations that advocate a prevention-based drug policy.

3.5 The majority of ACMD members had a potential conflict of interest in that they were in receipt of government funding for the organisations they represented.

3.6 There were around 32 members of the ACMD according to the Home Office website (the different listings provided were inconsistent).

3.7 Four ACMD members were key figures in the Drugscope organisation, the foremost pro-liberalisation pressure group in Britain

- Roger Howard, chief executive of Drugscope.
- Sylvie Pierce, chair of the Drugscope board.
- Joy Barlow, until recently a member of the Drugscope board.
- Vivienne Evans, head of Drugscope's alcohol and drug education team.

3.8 Two ACMD members were on the steering committee of another pro-liberalisation pressure group, the UK Harm Reduction Alliance (UKHRA):

- Lorraine Hewitt.
- Kay Roberts.

3.9 Five ACMD members were patrons of the Methadone Alliance, which is linked to UKHRA, and not only wants drugs liberalised but made more easily available on the NHS:

- Joy Barlow (again).
- Martin Blakeborough.
- Lorraine Hewitt (again).
- Roy Robertson.
- John Strang.

3.10 Eight ACMD members were among the listed members of Action on Hepatitis C, another pro-liberalisation group allied to UKHRA and the Methadone Alliance:

- Joy Barlow (again).
- Martin Blakeborough (again).
- William Clee.
- Russell Hayton.
- Lorraine Hewitt (again) – founder of Action on Hepatitis C.
- Michael Narayn-Singh.
- Roy Robertson (again).
- Ian Sherwood.

3.11 Thus a total of thirteen members of the ACMD were **leading members of pro-liberalisation pressure groups**. Lorraine Hewitt and Joy Barlow are members of no less than three different pro-liberalisation pressure groups each.

3.12 All of these pressure groups are linked to numerous other pro-liberalisation pressure groups including Transform, the Drug Users Rights Forum and the International Harm Reduction Alliance – from which various former members of the ACMD have been drawn.

3.13 More than twenty of the ACMD members are members of the drugs policy establishment – involved in government funded research, treatment, education or campaigning.

3.14 Only seven members of the ACMD at most appear to have no financial interest in the direction of government drugs policy. Of these, only three or four are scientists.

3.15 The ACMD had no members from organisations that oppose the liberalisation of drugs, such as the National Drug Prevention Alliance or DARE (Drug Abuse Resistance Education).

3.16 There were **no recognised specialists on schizophrenia** such as Prof Robin Murray on the ACMD, nor any leading experts on brain function such as Prof Susan Greenfield, nor any of the foremost researchers on cannabis in the UK, such as Prof Heather Ashton.

3.17 **These facts are disturbing because the ACMD is presented as a neutral, objective and scientific advisory body.**

3.18 Not surprisingly, the ACMD recommended the downgrading of cannabis from a Class B to a Class C drug. Still, the report warned about the adverse health effects of cannabis that “*since cannabis use has only become commonplace in the past 30 years there may be worse news to come*”.

3.19 **The poor handling of scientific evidence by the ACMD as well as failure to consult with the relevant experts is shown in the following incident:** It is quite astonishing that the Chairman of the ACMD, Sir Michael Rawlins, claimed in a letter to *The Times* of 23 January 2004 that relevant evidence linking cannabis to schizophrenia published by Prof Robin Murray in November 2002 had been taken into account when the ACMD issued their report recommending the downgrading in March 2002. We quote from Prof Murray’s letter to *The Times*, 28 January 2004:

Sir, Sir Michael Rawlins (letter, January 23, 2004) reiterates the view of the Advisory Council on the Misuse of Drugs, which he chairs, that there is little evidence of a causal link between cannabis and schizophrenia. He claims that “Most of Professor Robin Murray’s research was known to the advisory council at the time that it was producing its cannabis report.” This is remarkable since the ACMD’s report was released in March 2002, but our first research on this topic was not published until eight months later, in the BMJ of November 23, 2002.

It was unfortunate that the ACMD did not include a recognised schizophrenia expert to alert it to the growing number of patients with cannabis-related psychosis. Nevertheless, the ACMD report could be defended in March 2002, since at that time there was only one report in the scientific literature suggesting that prolonged cannabis use increases the risk of later schizophrenia. However, subsequently five new studies have implicated heavy cannabis use as a contributory cause of psychosis.

Is it not time for the ACMD to examine the new evidence in detail and consult with the scientists who produced it?

Yours faithfully,

ROBIN M. MURRAY, (Professor of Psychiatry), Institute of Psychiatry, De Crespigny Park, SE5 8AF.

3.20 In addition, from our own correspondence with Sir Michael Rawlings, it is clear that the ACMD chose to disregard evidence-based warnings about the mental health risks associated with cannabis. On the 2nd April, 2004 we drew Sir Michael’s attention to evidence linking cannabis with mental illness and Professor Ghodse’s warning that “*It is quite worrying that we might end up in the next 10 or 20 years ... with our psychiatric hospitals filled with people who have problems with cannabis*”. Sir Michael’s reply of the 19th April, 2004 stated that the ACMD had “*concluded that there is little significant evidence of a causal link between cannabis use and the development of mental illness, particularly schizophrenia... I am of the view that any new evidence produced since the production of the ACMD’s cannabis report does not affect the overall weight of evidence on their conclusions about health risks.*”

3.21 As the make-up of the ACMD at the time of the report had no recognisable experts in the issues raised in the evidence, we conclude that **in this instance the Government’s use of the advisory panel was most unsatisfactory.**

3.22 The second question we answer in this section is: **Are Government departments establishing the right balance between maintaining an in-house scientific capability and accessing external advice?**

3.23 We were, and remain, seriously concerned that **the Home Office repeatedly refused to see eminent and leading scientists and others involved in research on cannabis, drugs and mental health in October 2003, prior to the debates in both Houses of Parliament.** A team of leading scientists and representatives of other organisations who would be affected by the proposed reclassification were keen to meet the Home Secretary in autumn 2003 prior to the planned downgrading. Our organisation was in frequent contact, both by phone and by fax to senior civil servants within the Home Office in order to facilitate such a meeting. All requests for this meeting were turned down by the Home Office. The group included:

- **Prof Robin M Murray**, Professor of Psychiatry, Institute of Psychiatry, London. Professor Murray has published a large amount of original research on the link between cannabis and mental health, including schizophrenia.
- **Prof John Henry**, Imperial College of Science, Technology and Medicine; Academic Department of Accident and Emergency Medicine, St Mary's Hospital, London. Professor Henry is an expert on the toxicology of illicit drugs.
- **Prof Heather Ashton**, School of Neurosciences, Division of Psychiatry, University of Newcastle. Professor Ashton was possibly the first UK researcher to examine the effects of cannabis on mental health.
- **Prof Colin Drummond**, Professor of Addiction Psychiatry, Department of Addictive Behaviour and Psychological Medicine, St George's Hospital Medical School, London.
- **Dr Clare Gerada**, Head of Substance Misuse Training, Royal College of General Practitioners, London. Apart from her official function, Dr Gerada has seen at first hand the effect of widespread cannabis use, especially among the young in Lambeth.
- **Mr Hamish Turner**, HM Coroner for the Torbay and South Devon District; Past President, Coroners' Society for England and Wales. As a coroner, he has first-hand experience of the effect of cannabis, especially on young people.
- **Jan Berry**, Chairman, Police Federation.

3.24 Despite the eminence of this group of scientists and others, and the appropriateness of their fields of expertise to the subject under inquiry, the Home Office refused to meet them.

3.25 Lord Alton of Liverpool expressed serious concerns about the refusal by the Home Office to meet these eminent and expert people in his contribution to the debate on the reclassification in the House of Lords. (*House of Lords Hansard; 12 November 2003: Columns 1496f*) The government minister, Baroness Scotland of Asthal, failed to comment on this issue during the debate.

4. Relationship between scientific advice and policy development

- 4.1 In this section the inquiry asks the following question:
- **What mechanisms are in place to ensure that policies are based on available evidence?**
- 4.2 We submit that, at the time both Houses of Parliament voted for the downgrading of cannabis proposed by the then Home Secretary, David Blunkett, sufficient scientific information was already available to question the recommendation to downgrade and at least delay this decision until further evidence was available. We particularly note that, if policy is supposed to be based on the precautionary principle, then a decision to downgrade should not have been taken.
- 4.3 **There is evidence going back many decades that cannabis is associated with mental illness including schizophrenia and psychosis.** For example, Dr Karel Gunning, a Dutch doctor working in Morocco in the 1950s, points out that a condition called ‘cannabinism’ was in evidence. This involved serious adverse mental health effects including ‘madness’ following the use of cannabis. (Dr Karel Gunning, personal communication, 2002). There have been many studies published that have pointed to a possible link between cannabis and psychosis, some of them published over 35 years ago. (*Talbot JA, Teague JW. Marijuana psychosis. Acute toxic psychosis associated with the use of Cannabis derivatives. JAMA. 1969; 210: 299-302.; Keup W. Psychotic symptoms due to cannabis abuse; a survey of newly admitted mental patients. Dis Nerv Syst. 1970; 31: 119-26; Bernhardson G, Gunne LM. Forty-six cases of psychosis in cannabis abusers. Int J Addict. 1972; 7: 9-16*). In a study published over 20 years ago of 1,325 young adults aged 24 to 25 years, adverse mental health effects of cannabis were described. (*Kandel DB. Marijuana users in young adulthood. Arch Gen Psychiatry. 1984; 41:200-9*)
- 4.4 **In November 2001, the Maranatha Community published a booklet ‘Cannabis – a warning’.** This document was sent to the Prime Minister, the Home Secretary, the Secretary of State for Health and other political and church leaders. In this document, evidence was presented regarding the adverse physical health effects of cannabis, including brain damage, heart and lung disease and the triggering of cancer. The document also warned about the adverse effects on mental health, including triggering schizophrenia and psychosis and the risk of addiction. (*The Maranatha Community: Cannabis – A warning. November 2001*)
- 4.5 **In November 2002, a major consultation examining the adverse health effects of cannabis was held in the House of Lords,** chaired by Lord David Alton. In this conference, Professors John Henry, Heather Ashton and Colin Drummond presented evidence regarding the adverse effects of cannabis on physical and mental health. The latest evidence including three studies published in the British Medical Journal linking cannabis to schizophrenia and other mental health problems was presented. In total, 14 experts from different backgrounds as well as former cannabis users and relatives of cannabis users presented evidence. The proceedings of this consultation were submitted to the Prime Ministers Office (*‘Cannabis – a cause for concern?’ – Consultation in the House of Lords, November 2002; available from the Maranatha Community*)

- 4.6 **The following is based on a presentation by Professor Robin Murray of the Institute of Psychiatry**, given in a consultation convened by the Maranatha Community in the **House of Commons on 21 October 2003**, ie, well before the House of Commons voted for the downgrading on 29 October 2003.
- 4.7 **Recent research into cannabis consumption and mental disorder shows that there is growing evidence that cannabis actually causes psychosis.** Patients with recent onset of psychosis are twice as likely to have used cannabis compared with a population without psychosis. While alcohol consumption and consumption of illicit drugs other than cannabis was roughly equal in both groups, cannabis was used by 39% of psychotic patients but only by 22% of non-psychotic controls. Psychotic patients are more likely to consume cannabis than the general population, but until recently the reasons for this have been unclear. Indeed, many psychiatrists continue to believe that their patients take the drug to counteract the negative symptoms (lack of interest in life, poor concentration, etc.) of the illness or the effects of medication. Furthermore, those psychotic patients who continue to use cannabis have a worse outcome than those who don't.
- 4.8 **Can cannabis consumption actually cause schizophrenia?** In 1987, a study of 50,000 conscripts into the Swedish Army revealed that those who admitted at age 18 to having taken cannabis on more than 50 occasions were six times more likely to develop schizophrenia in the following 15 years. (*Andreasson S, et al. Cannabis and schizophrenia. A longitudinal study of Swedish conscripts. Lancet. 1987 (8574): 1483-6.*) These findings have been largely ignored. However, in the last 18 months, a number of studies have confirmed that cannabis consumption acts to increase later risk of schizophrenia. A Dutch study of some 4,000 people in the general population showed that those taking large amounts of cannabis at the initial interview were almost seven times more likely to have psychotic symptoms three years later. Critics argued that the findings of the Swedish and Dutch studies could have been caused by those individuals who were already odd and destined to develop schizophrenia, rather than by the use of cannabis. Two further studies have, however, excluded this hypothesis. An expansion of the Swedish Army study demonstrated that the results held even when initial personality was taken into account. It has become clear that the risk of developing psychosis following cannabis use remains significant after controlling for factors such as disturbed behaviour, low IQ score, cigarette smoking, growing up in a city, and poor social integration. (*Zammit S, et al. Self reported cannabis use as a risk factor for schizophrenia in Swedish conscripts of 1969: historical cohort study. BMJ 2002; 325: 1199–2001.*) In a general population birth cohort study in Dunedin, New Zealand, it was found that those who used cannabis at age 15 were 4.5 times higher risk of developing psychosis by age 26. When the presence of psychotic-like ideas at the age of 11 was taken into account, the risk of schizophrenic symptoms at 26 was diminished, but was still important. (*Arseneault L, et al Cannabis use in adolescence and risk for adult psychosis: longitudinal prospective study. BMJ 2002; 325: 1212–3.*) Cannabis use in adolescence was a risk factor for experiencing symptoms of schizophrenia in adulthood, over and above psychotic symptoms prior to cannabis use. In addition, a strong developmental effect was found. Early cannabis use (by age 15) was a stronger risk factor for schizophreniform disorder than use by age 18. Furthermore, cannabis use by age 15 did not predict depressive outcomes at age 26 (indicating specificity of the outcome) and the use of other illicit drugs in adolescence

did not predict schizophrenia outcomes over and above the effect of cannabis use (indicating specificity of exposure).

- 4.9 **There is a dose response effect with higher doses of cannabis causing greater psychosis.** If cannabis is causally associated with psychosis, then we should expect to find a dose-response relationship in which a higher dose is associated with greater psychosis. Indeed, administration of Tetrahydrocannabinol (THC) can induce psychotic symptoms in controls and in schizophrenic patients, but more so in the latter: normal individuals experience a brief psychotic episode after intravenous application of THC, however individuals who have been psychotic suffer a greater increase in psychotic symptoms. Such a dose-response relationship was also observed in the above mentioned study among Swedish conscripts. Among the 50,000 Swedish 18-year-olds interviewed about their drug consumption when they were conscripted into the army, the relative risk of developing schizophrenia over the following 15 years was 2.4 for cannabis users compared to non-users at time of conscription. This rose to 6.0 for heavy users. Of course, it is possible to argue that the heavy users were already psychiatrically disturbed at age 18, and were taking cannabis as an attempt at self-medication. When this confounding factor was controlled for, the relative risk was roughly halved to 2.9, but remained significant. Furthermore, the Swedish findings have now been supported by four other prospective studies. Of course, only a small proportion of heavy cannabis users go on to develop schizophrenia. It seems heavy consumption over prolonged periods is necessary and psychosis develops particularly in those with some vulnerability.
- 4.10 **Why should cannabis be a contributing cause for schizophrenia?** Psychotic symptoms in conditions such as schizophrenia are mediated by dopamine, and recent evidence demonstrates that 9-THC increases the release of dopamine from the nucleus accumbens and the prefrontal cortex and raises the level of cerebral dopamine. Interestingly, it has recently been hypothesised that dopamine sensitisation plays a central role in explaining both the craving for cannabis and the positive symptoms (such as delusions, hallucinations, disorganised speech or behaviour) of schizophrenia.
- 4.11 A joint letter by Professor Heather Ashton, Dr Clare Gerada, Hamish Turner and Dr HC Raabe was published in the Independent on 23 January 2004, several days before Parliament voted for reclassification. In this letter it was stated:
- 4.12 **A person who uses cannabis by age 15 has more than a four-fold increased risk of developing schizophrenia symptoms** over the next 11 years compared with a person starting to use cannabis by age 18. **Eighteen-year-olds who have used cannabis 50 times have a nearly seven-fold increased risk of developing psychosis over the next 15 years.**
- 4.13 **Up to 80 per cent of new cases of psychosis currently seen in some psychiatric hospitals are triggered by cannabis abuse.** Psychiatric services, especially in London, are near crisis point due to cannabis-induced mental illness.
- 4.14 **Over the past three decades, a doubling of the prevalence of schizophrenia has been observed in London.** While it is too early to say whether this is due to the increase in cannabis abuse over the past decades, this possibility cannot be discounted on current evidence. (*Dr C Gerada, Director of drugs training programme, Royal*

College of General Practitioners, Professor H Ashton, Division of Psychiatry, University of Newcastle, H Turner, Immediate past President, Coroners Society of England and Wales, Dr HC Raabe, GP. Letter to the Editor, Independent, 23.01.2003)

4.15 We therefore submit that:

- **sufficient evidence existed at the time** to seriously question the downgrading of Cannabis,
- that **this evidence should have at least served to delay** any decision to reclassify, if policy is based on the precautionary principle, and
- that in this instance, **any mechanisms that does exist to ensure policy is based on evidence failed**, with grave consequences for the mental health of thousands of young people.

5. Treatment of risk

- 5.1 Under the third heading the inquiry asks the following question:
- **Is risk being analysed in a consistent and appropriate manner across Government?**
 - **Has the precautionary principle been adequately defined and is it being applied consistently and appropriately across Government?**
- 5.2 We are concerned that risk is not being analysed in a consistent and appropriate manner and that the precautionary principle has not been applied appropriately.
- 5.3 As mentioned in the previous section, there has been ample scientific evidence linking cannabis to many adverse health outcomes including psychosis for many years. Therefore the precautionary principle should be applied.
- 5.4 One definition of the precautionary principle in the field of environmental health has been defined in the Rio Declaration from June 1992:
- Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.** (*UN Environment Programme, The Rio Declaration, Principle 15; June 1992*)
- 5.5 The UK is a signatory to the Rio Declaration and therefore should adopt the precautionary principle into policy making. While this declaration refers to potential environmental damage due, for example, to man-made chemicals, this principle should apply to drug policy as well. At the time of making decisions and formulating policies, not all relevant scientific evidence may be available for a full risk assessment.
- 5.6 **From a public health point of view, therefore, a precautionary principle should be adopted regarding drug policy. In practice, this means that any drug is considered potentially unsafe. Drug policy should be based on this assumption.**

6. The system of classification of illicit drugs

- 6.1 We welcomed the announcement by the Home Secretary to review the classification system of drugs. In this inquiry, the Science and Technology Committee investigates the **classification of illicit drugs**. The British system is based on the Misuse of Drugs Act 1971, which classifies illicit drugs into three classifications, Class A, B and C. Whilst, strictly speaking, the remit of the Committee was not to examine the actual basis of the drugs classification system, we submit that after over 35 years this system needs to be replaced.
- 6.2 The classification system is based on a **comparative assessment of harmfulness**. For example to place cannabis in the same class as valium or temazepam, as happened after reclassification, involves essentially a value judgement that the two substances are broadly as dangerous as each other and less dangerous than substances from class B or A.
- 6.3 As one can see with the discussion about cannabis, there is an **endless debate on the classification** of certain illicit drugs, whether a certain drug such as cannabis (and many other drugs come to mind) should be classified in Class C, or B or even A.
- 6.4 Obviously, the classification of a drug is a complicated decision, as the total harm caused by a drug is not just limited to the purely medical adverse effects, but also includes the adverse effects on society, including crime and the cost to the criminal justice system. A drug with a moderate or perhaps even low medical risk may have enormously severe adverse societal effects, especially if it is taken widely. A drug with very high medical risk may have few adverse societal effects, especially if only taken very rarely. It is therefore not surprising that even experts will disagree on the appropriate classification of an illicit drug.
- 6.5 The **debate about reclassification in itself creates confusion**. Some members of the police had erroneously believed that cannabis had been legalised. The announcement of reclassification led almost 9 out of 10 primary school children to believe that cannabis was now legal and 8 out of ten pupils thought it was now safe. (*Life Education Centres, Children confused about cannabis; Press Release 05.09.2002*)
- 6.6 For these reasons, we submit that this **old classification system should be replaced** with a simpler regime similar to the Swedish approach.
- 6.7 In **Sweden, there is essentially only one class of illicit drugs**. The severity of a drug offence is determined by the amount of drug found on an individual. For example, possession of up to 50 gm of cannabis is considered to be a ‘minor’ offence; to have 2 kg of cannabis is a ‘major’ offence. A normal offence is the possession of between 51 gm and just under 2 kg of cannabis. For heroin, the respective figures are up to 0.39 gm ‘minor’, 0.4-25 gm ‘normal’ and more than 25 gm ‘major’. For amphetamines, up to 6 gm is considered ‘minor’, 6.1-250 gm ‘normal’ and more than 250 gm ‘major’. The sentencing is obviously more severe in the major categories compared to the normal and minor categories. Only in the minor category would a person escape a prison sentence. Essentially, it is assumed that every dose in excess of a single consumption

constitutes dealing. For this reason, this attracts a prison sentence. (*Tim Boekhout van Solinge. The Swedish Drug Control System. Cedro, Amsterdam, p.118ff*)

- 6.8 We need to point out that **Sweden has among the lowest rates in Europe for drug misuse** of the major drugs including cannabis, cocaine, amphetamines and ecstasy. (*Source: European Monitoring Centre for Drug European Monitoring Centre for Drugs and Drug Addiction, EMCDDA, various annual reports*)

7. Conclusions:

- 7.1 If the Government establishes an advisory body – such as the Advisory Council on the Misuse of Drugs – to guide decision-making on the classification of illicit drugs, then the Government has to make sure that at least two criteria are fulfilled. **Regarding the Advisory Council on the Misuse of Drugs and the reclassification of cannabis, neither of these criteria were met.**
- The membership of this body must be balanced in their views.
 - The membership of this body must have the relevant qualifications and experience to guide the Government in their decision-making.
- 7.2 **Scientific evidence was badly handled.** The ACMD chairman claimed to have incorporated research papers into the ACMD report that were actually published eight months after the release of this report.
- 7.3 It appears that **political considerations took precedence over scientific evidence** and over the precautionary principle. This is shown by the determination of the then Home Secretary, David Blunkett, to request an assessment of downgrading from the ACMD, and by the refusal of the Home Office to meet leading researchers on cannabis and mental health just before the vote was taken in Parliament.
- 7.4 We submit that the current classification system based on the Misuse of Drugs Act 1971 **needs to be replaced with a simpler and more effective system**, such as the Swedish model. Sweden has among the lowest rates of drug misuse among European countries.
- 7.5 We submit that it is futile to pursue discredited policies of so-called ‘harm-reduction’ and vital that the Government and the nation are totally committed to the ideal of a drug-free society.

20th January 2006