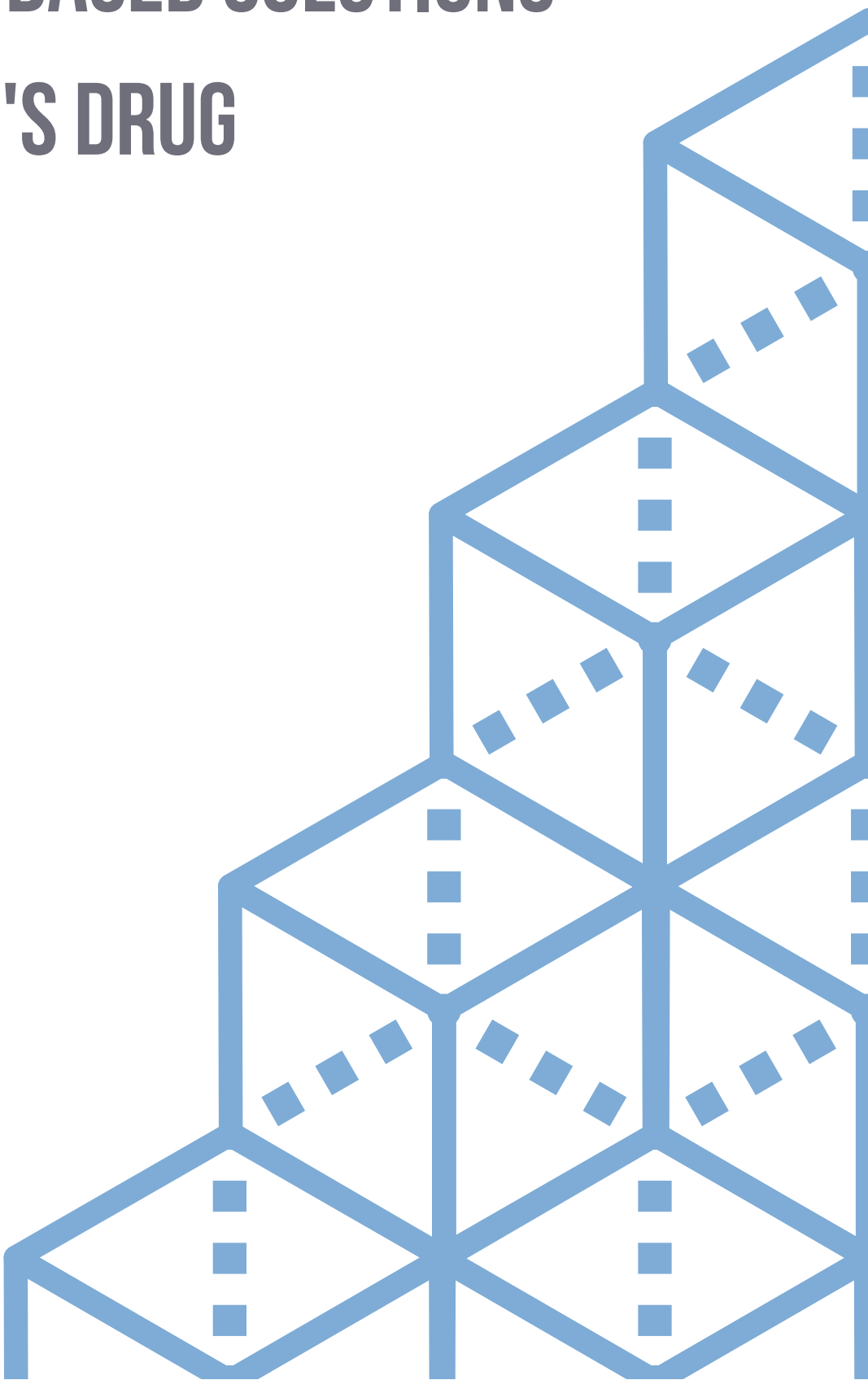
centre for evidence based drug policy

EMPOWERING THE ACMD:

EVIDENCE BASED SOLUTIONS TO THE UK'S DRUG PROBLEM



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PUBLIC RELEASE
SEPTEMBER 2023

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FOREWORD

I joined the ACMD in 1994 as a co-opted member representing the Forensic Science Service. I was struck by the considerable authority of the ACMD and the respect shown to it by both politicians and the scientific community. The then Home Secretary (Michael Howard, MP) came to at least one of the ACMD meetings. I don't recall that happening again under later Home Secretaries. Although the Home Office made requests for advice, it was clear that the ACMD had considerable freedom to determine its own agenda. In short, it was an independent body. My first activity in 1994 was to assist in the drafting of legislation to control anabolic steroids under the Misuse of Drugs Act, 1971. I was told that this had long been suggested by the Home Office, but the ACMD had, for some years, decided not to act as it saw such control as unnecessary.

I later became a full member of the ACMD in the position then known as the 'Statutory Chemist'. I resigned following the dismissal of the Chairman, Professor David Nutt in 2009. In the weeks after, six other members also left. That affair reflected how the ACMD had changed since those early days with the work plan now more often determined by the Home Office. I witnessed the gradual emasculation of the ACMD as an independent body. Thus, the ACMD was not involved in the 1999-2000 Independent Enquiry into the Misuse of Drugs Act nor the framing of the Drugs Act, 2005. The Home Office initially objected to publication of the 'Scale of Drug Harm' – a project on which the ACMD and its working groups had spent much time in the years 2000 – 2003.

Despite the 'ACMD – Home Office Working Protocol', the desired outcome of classification advice was regularly and publicly anticipated. The ACMD has yet to publish a second report into 'barriers to research with controlled drugs'. Part of the reason was that the original call for evidence was, according to the Home Office, "self-commissioned": a phrase that tells us much about a lack of autonomy. It even seems at times that the ACMD has been treated as if it were part of the Civil Service.

I therefore welcome this report by the Centre for Evidence Based Drug Policy. The loss of independence damages the environment in which unbiased scientific advice can be generated and provided. If advice is regularly ignored and the ACMD becomes a rubber stamp for Government policy then a short-term gain for political expediency may be won at the cost of long-term damage to the wider society .

Leslie A King, PhD. Former member of ACMD (1994 – 2009)

EXECUTIVE SUMMARY

The Advisory Council on the Misuse of Drugs (ACMD) is a statutorily mandated body responsible for reviewing the landscape of substance abuse in the UK, offering evidence-based policy recommendations to government ministers, and fulfilling additional roles that warrant immediate attention. However, concerns have been mounting about the ACMD's eroding authority and independence, which, in turn, compromise the empirical foundations of the UK's drug policy. Alarmingly, the council operates on a budget that is a mere fraction—0.0001%—of the national expenditure on drug related issues. Adequate funding for the ACMD is crucial not only for shaping effective policies but also for maintaining the UK's reputation as a frontrunner in the fields of drug policy and biosciences.

The relationship between the ACMD and the government, notably the Home Office, has been fraught with issues of political expediency, neglect and controversy. This has had far-reaching repercussions across various sectors, including the economy, public health, and bioscience innovation. Whether the council's advice pertains to drug classification, evidence-based approaches to addiction treatment and overdose prevention, or scientific research agendas, its recommendations have often been sidelined or outright dismissed. Such actions have not only led to significant financial burdens but have also had the tragic consequence of lost lives.

To gauge the internal sentiment, a survey among past and current members of the ACMD revealed palpable frustrations over the scarcity of resources and the government's inconsistent application of their expert advice. Among the suggestions that emerged were the need for enhanced financial support, greater integration of the council's recommendations into legislative processes, and stronger mechanisms for accountability in the case of ignored advice. This feedback underscores the urgent need for reform, lest the ACMD’s invaluable work continue to be marginalized, undermining the UK's credibility and efficacy in tackling the complex challenges of drug misuse. An in-depth review of the ACMD's recommendations further revealed that the government has repeatedly breached the established working protocols with the Council.

In light of these findings and recommendations, it is imperative to empower the ACMD as a cornerstone of evidence-based drug policy in the UK. The ACMD must be given the resources, autonomy, and institutional respect required to fulfill its mission effectively. This includes not just increased funding, but also structural reforms to ensure that its recommendations are woven seamlessly into policy decisions insulated from political maneuvering and public opinion pressures. With the council's expert advice being consistently sidelined, the UK risks not only financial loss and compromised public health but also jeopardizes its position as a leader in biosciences and drug policy reform. Empowering the ACMD will strengthen the UK's approach to complex drug-related challenges, enhance its reputation for evidence-based policy, and ultimately contribute to the well-being of its citizens.

RECOMMENDATIONS

Drug Classification System

- Reform and Validate: Ensure the system focuses solely on scientifically validated representation of harm.
- Systematic Validation: Engage the ACMD in thorough review and alignment of current classifications.
- Regular Review: Implement periodic reviews to keep the system updated with ongoing research.

ACMD Proceedings

- Enhanced Transparency: Regularly post ACMD meeting minutes and all reports online.

ACMD Funding

- Increase Funding: Increase budget allocation for research, staffing, and studies.
- Remunerate Members: Fairly compensate ACMD members for their contributions.
- Transparency and Accountability: Establish clear guidelines for fund utilization.

Reviews and Accountability

- Regular Reviews: Conduct independent evaluations of ACMD's operations at least every 5 years.
- Accountability for Implemented Recommendations: Transparently track progress and outcomes.
- Accountability for Rejected Recommendations: Require detailed explanations and ongoing monitoring for any rejected ACMD recommendations.

Council Composition

- Enhance Political Expertise: Integrate members with legislative and political experience.
- Formal Oversight Body: Establish a body for ongoing oversight and implementation follow-up.

Appointment Authority

- Transition of Sponsorship: Move ACMD oversight to the Department of Health and Social Care (DHSC).
- Inclusion of Multiple Ministries: Involve multiple departments in ACMD member selection.
- Democratisation of Chair Selection: Include outgoing Chair and Council members in selecting a new Chair.

International Collaboration

- Memorandum of Agreement: Establish formal ties with the EMCDDA (or the newly formed EU Drugs Agency) for research and data sharing.

Research Support

- Dedicated Research Budget: Allocate a budget for ACMD's independent research.
- Dedicated Research Team: Create a team to assist in research and data collection.

Structural Reforms

- Operational Independence: Consider reforming the ACMD similar to the Bank of England's Monetary Policy Committee.
- Executive Authority: Explore the possibility of transforming the ACMD into an Executive NDPB to ensure evidence-based implementation of policies.

By implementing these recommendations, the UK can progress towards a more scientifically grounded, transparent, and accountable drug policy framework.

1. INTRODUCTION TO THE ADVISORY COUNCIL ON THE MISUSE OF DRUGS (ACMD)

History and Background

The 1971 Misuse of Drugs Act, which statutorily established the ACMD, was enacted to consolidate policies regarding drug use in the UK (Appendix B). This legislation built upon earlier laws such as the Pharmacy Act of 1868 and the Dangerous Drugs Act of 1920, which prohibited the possession of opiates and cocaine and introduced the medical prescription of these drugs 1,2. The Departmental Committee on Morphine and Heroin Addiction subsequently clarified the Dangerous Drugs Act in the Rolleston Report of 1926, resulting in the establishment of the "British System" whereby drug addiction was recognised as a medical illness and could be treated by physicians. Doctors were authorised to prescribe opioids to patients with withdrawal symptoms '*which cannot be satisfactorily treated under the ordinary condition of private practice;*' or to patients who '*while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quantity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn*' 3. However, this health-oriented approach to drug addiction and abuse was short-lived, and in 1967, the Dangerous Drugs Act was revised to require doctors to apply for Home Office licences in order to prescribe certain drugs 4 and the British System gradually faded.

Drug use, and in particular cannabis, continued to be associated with the "counterculture" of the late 60s and after several highly publicised efforts to reform cannabis legislation by popular figures at the time the government decided to convene another committee which argued cannabis should be made distinct in law from other illegal drugs. The recommendations made by Baroness Wootton were largely ignored and a Bill which represented a "single comprehensive measure" to control drugs was introduced to Parliament, approved in May 1971, and given royal assent the same month. Thus, the 1971 Misuse of Drugs Act (MDA) was born out of a governmental effort to suppress a counterculture and a "permissive society" with little understanding of the complexities of drug policy even by the limited standards of the era. This move was also influenced by pressure from international allies, especially following the UN Single Convention on Narcotic Drugs in 1961, pushing the UK to strengthen its drug laws. 5

The MDA has since been described as doing '*less good and more harm*' *than any other law in the statute book* 6 and '*one of the worst pieces of social legislation passed by the British Parliament in its lifetime*' 7. While the premise of the MDA that choking off the supply of henceforth illegal drugs and criminalising users would lead to a decrease in illegal drug use proved to be a failure, one of the more sensible and pragmatic stipulations succeeded. The MDA's first section established the Advisory Council on the Misuse of Drugs (ACMD), a committee of experts on various aspects of drug use and

treatment, commissioned to provide guidance to the government on issues of drug policy 8.

Remit of the ACMD

The ACMD is an advisory non-departmental public body sponsored by the Home Office and created as part of the Misuse of Drugs Act 1971 (Section 1, paragraph 1). Their remit is to keep under review drug policy in the United Kingdom with respect to drugs which are being, or appear to them likely to be misused, or having harmful effects sufficient to constitute a social problem. The Council provides independent expert advice to any one or more of the Ministers on measures which in the opinion of the Council ought to be taken to prevent the misuse of such drugs or address social problems connected with their misuse. The Council's advice may involve measures for restricting the availability of such drugs, supervising the arrangements for their supply, enabling persons affected by their misuse to obtain proper advice, securing the provision of proper facilities and services for the treatment, rehabilitation, and after-care of such persons, promoting cooperation between various professional and community services dealing with social problems connected with the misuse of drugs, educating the public about the dangers of misusing drugs, and promoting research into any matter which is of relevance for the purpose of preventing the misuse or social problem associated with the use of drugs 8. The ACMD also considers matters relating to drug dependence or misuse referred to them by Ministers and advises them accordingly. In practice this aspect of their remit occupies the majority of the ACMD's resources.

From the legislation it is clear that the ACMD, as the UK's panel of experts on issues relating to drug misuse, was intended to take a proactive role in the design of drug policy. In recent years it has mainly fulfilled a reactive role, responding to the requests of Ministers (primarily from the Home Office), and does not appear to have the capacity or budget to act as a proactive body. In the last 10 years, the proportion of self commissioned work produced by the ACMD has been steadily declining (Figure 1). This represents a worrying trend as the independent Council composed of leading experts, is intended to conduct thorough research in order to provide a measured and appropriate response to the threat posed by drugs in the UK. They provide Ministers with expert advice, a service the writers of the MDA 1971 clearly believed was fundamental to the design of drug laws in the UK.

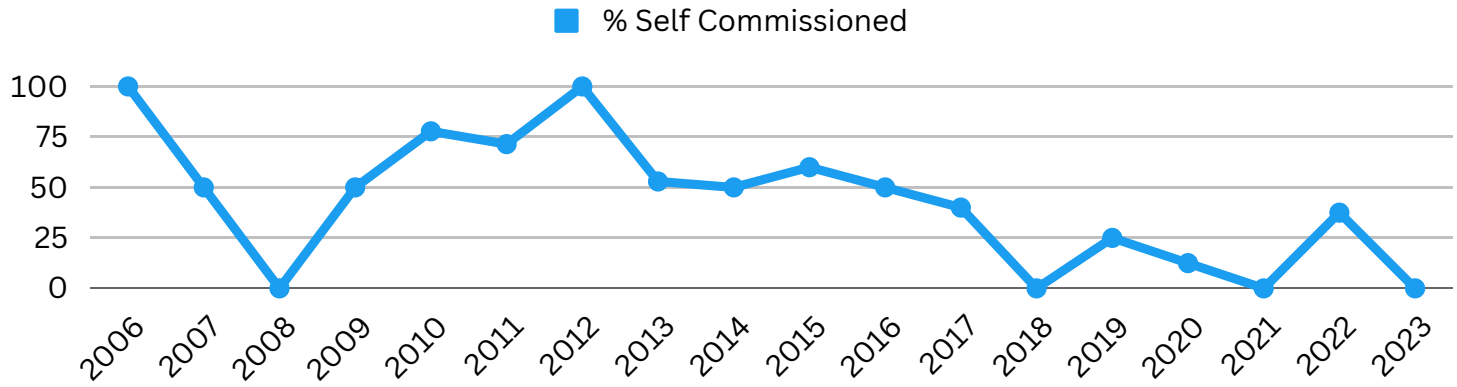


Figure 1. The proportion of self commissioned reports published by the ACMD has been decreasing in the last 10 years. Reports were retrieved from the government's website 10. The downward trend underscores potential challenges in the council's capacity to independently evaluate and respond to emerging drug-related issues.

While the Council's recommendations are not binding, they should carry significant weight in the shaping of the country's drug policy and Ministers are required to "give appropriate consideration to the ACMD's advice" before issuing a response to its recommendations [9].

The Role of the ACMD in Drug Classification

The ACMD is also responsible for providing advice on the classification of drugs, a system which also originated in the 1971 Act. The Class of a drug, which ranges from A-C (A being the strictest class), determines the level of criminal penalties for their possession/supply and is intended to ensure that the penalties for possession and trafficking are proportionate to the harmfulness of the particular substance. In many cases however, the classification system does not accurately reflect the relative harm of drugs [11]. Contrary to the ACMD's advice, the classification system is often used by the government to "send messages" to the public, rather than being enacted as an effective scale of relative harms of drugs caused to a person and society [11]. It should be noted however that there appears to be no evidence of a deterrent effect upon use when drugs are placed in higher classes as has been stated in several government publications and oral evidence submitted by a chairman of the ACMD, the chair of the Association of Chief Police Officers (ACPO) Drugs Committee, third sector investigations, a report by the Academy of Medical Sciences, the Runciman Report and a standing Home Secretary [11–17]. In 2000-2003 efforts were undertaken by the ACMD to establish a scientific measure of the relative harms of drugs, a draft which was included in evidence submitted to the Science and Technology Committee's report [11]. However, past members of the ACMD have alleged that the publication of this method was prohibited by the government, and it was never implemented. A landmark publication was subsequently conducted by an ex-chairman of the ACMD and has been published [18]. This work has been highly cited in the literature, and reproduced internationally [19–21]. Importantly, the scientifically determined relative harms of many substances fail to align with their place in the Classification system.

It is of note that the Class of a drug and its Schedule are legally distinct designations. The 2001 Misuse of Drugs Regulations outline the guidelines for the legality of possessing, distributing, producing, exporting, and importing controlled substances for medicinal purposes. The allowable actions vary based on the specific schedule assigned to each controlled substance. There are a total of five schedules. Schedule 1 covers drugs with little to no medical benefits and is subject to the most stringent control measures. In contrast, Schedule 5 includes drugs with medicinal value that can be easily obtained as over-the-counter medications.

Class	Drug	Penalties for possession	Penalties for supply
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)	Up to 7 years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (for example mephedrone, methoxetamine)	Up to 5 years in prison, an unlimited fine or both	Up to 14 years in prison, an unlimited fine or both
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat	Up to 2 years in prison, an unlimited fine or both (except anabolic steroids - it's not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both
Temporary class drugs	Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), methylnaphthidate (HDMP-28), isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethylnaphthidate, propylphenidate) and their simple derivatives	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

Table 1: Classification System Established by the Misuse of Drugs Act 1971. This table outlines the three distinct classes (A, B, and C) under which controlled substances are categorised, based on their perceived harmfulness. Each class is associated with specific penalties for offences such as possession, production, or trafficking. The categorization aids in defining the legal framework and enforcement policies related to psychoactive substances. The government can ban new drugs for 1 year under a 'temporary banning order' while they decide how the drugs should be classified.

Recommendation 1: Reform and Validate the Drug Classification System

Commit to Accurate Representation: Ensure that the Classification system functions solely as an indicator of the relative harms of drugs. The system should not be used to "send messages" to the public but must focus on a scientifically validated representation of harm.

Systematic Validation of Classifications: Engage the ACMD in a thorough review of all current classifications and schedulings, aligning them with scientifically determined relative harms and medical utility. The review must be conducted objectively and transparently, free from political interference using reproducible and scientifically validated measures.

Regular Review and Alignment: Implement a periodic review process, supervised by the ACMD, to ensure that both classification and scheduling according to the Misuse of Drugs Act and Misuse of Drugs Regulations accurately reflect ongoing research and understanding of substance-related harms.

By embracing these measures, the UK can cultivate a Classification system that is consistent, scientifically grounded, and reflective of the actual harms posed by different substances. This alignment would promote a more rational and effective approach to drug regulation, penalties, and societal understanding.

Organisation of the ACMD

The ACMD has been prescribed a momentous task, one which requires a wide range of expertise and considerations. It is therefore fitting that the ACMD is populated by experts from a variety of professions including addiction psychiatry, criminology, pharmacology, forensic science, health economics, and clinical pharmacology. There are also public health officials and physicians on the Council. Members of the ACMD are unremunerated and appointed by the Home Secretary usually for a term length of three years, extendable for two further three-year terms in accordance with the guidance issued by the Commissioner for Public Appointments 22-23. When considering certain issues the ACMD also frequently co-opts experts outside of the Council to provide specialist knowledge where it may be lacking.

Chair of the ACMD

The Chair of the ACMD is responsible for providing effective leadership to the Council. They are responsible for setting the strategic direction of the ACMD, ensuring the operation and output of the Council, and conducting appraisals. The Chair also ensures that every member of the ACMD is heard and that no view is overlooked or ignored. They ensure that the ACMD meets at appropriate intervals, explores any significant diversity of opinion, and operates under a presumption of openness. Additionally, the Chair represents the ACMD to the public and media, reports the ACMD's advice to the

government, and ensures the Council acts in accordance with the ACMD Code of Practice 24. Dr Owen Bowden Jones was reappointed for a third three-year term as chair of the ACMD ending December 31st 2025. He is currently a Consultant in Addiction Psychiatry and an Honorary Professor at Imperial College's Division of Brain Science 25.

Members of the ACMD

Members of the ACMD are experts in the field of drugs and drug-related issues. Their role is to provide independent advice to the UK government. They are appointed as individuals and have a duty to act in the public interest, not as representatives of any particular profession or interest group 24, and are expected to contribute to at least one of the working groups. As of August 2023, there were 24 members on the advisory Council 22. The current members of the ACMD, as listed in Appendix C, consist of nine individuals working in academia (e.g. professors in criminology, social research and substance use, pharmacology, health economics, forensic science, and clinical pharmacy practice), 11 healthcare professionals (specialised in fields such as psychiatry, pharmacy, clinical pharmacology, emergency medicine), one member from law enforcement and intelligence services, and three individuals working in areas related to drug and public health policy 22.

ACMD Committees and Working Groups

The working groups of the ACMD are formed to explore specific issues and provide advice to the Council. Each working group should be chaired by a member of the ACMD and has a mix of members and external experts. The role of the working groups include providing advice on the scope and methodology of evidence gathering, analysing data, identifying key issues and trends, and developing recommendations. The working groups may also engage with stakeholders to ensure that a broad range of perspectives is considered in their advice. The recommendations and reports produced by the working groups are submitted to the Council for approval before being sent to the government as advice.

While working groups are composed of a smaller number of members, are created to examine a particular topic in detail and are disbanded once their task is complete, a committee is a more formal structure within the ACMD that has a specific remit and meets regularly. Committees may have a more permanent role and ongoing responsibilities, such as overseeing the implementation of ACMD recommendations or providing ongoing advice on a particular topic. Committees are typically chaired by a member of the ACMD and may have members from outside of the Council, such as experts in a particular field or representatives from relevant organizations 22.

There are 4 standing committees on the ACMD:

- **The recovery committee** is designed to support the ACMD's recommendation to the government on how to best prevent drug and alcohol misuse and its associated harms, and how to best support people to recover from drug and alcohol dependence.

- **The technical committee** whose main purpose is to provide technical advice on the classification and scheduling of substances under the MDA 1971 and its regulation.

- **The novel psychoactive substance committee** which was implemented to monitor the prevalence and harms of novel psychoactive substances and provide advice to the government on them.

- **The prevention committee** serves to establish a dynamic collaboration with the Joint Combating Drugs Unit (JCDU) and various government departments. Working as a platform for policy deliberations, the committee offers expert recommendations supported by research to enhance the evidence on drug use and harm prevention. Its main objective is to encourage agile interactions and evidence-driven decision-making for proposed initiatives and suggestions.

What is the JCDU?

The Joint Combating Drugs Unit (JCDU) is a recently established government entity in the UK, designed to comprehensively address the problem of drug misuse. Comprising various governmental departments including Health and Social Care, Home Office, Education, Justice, Work and Pensions, and Housing and Local Government, it aims to provide a unified and collaborative approach to drug-related challenges. The JCDU's multifaceted role extends beyond mere treatment to include wider support measures such as employment and housing assistance to facilitate recovery. Created in alignment with recommendations from Dame Carol Black's Independent Review of Drugs, it emphasizes significant investment in drug treatment and recovery systems, coupled with a commitment to robust enforcement measures.

There are 8 working groups on the ACMD covering a range of issues around drug abuse:

- Cannabis-based products for medicinal use (CBPMs)
- Image and Performance Enhancing Drugs
- Monitoring of emerging Novel Psychoactive Substances (NPS)
- Barriers to Research
- Scheduling Standard Operating Procedures (SOP)
- Young people and substance misuse treatment
- Naloxone implementation
- Chemsex

Secretariat of the ACMD

The ACMD Secretariat provides administrative support to the ACMD and assists the Chair in ensuring that the Council operates effectively. The Secretariat is made up of staff from the Home Office and is responsible for coordinating the work of the ACMD and its subgroups, including arranging meetings, providing administrative support, managing finances and resources, and ensuring that the Council's advice is communicated effectively to the government and other stakeholders. The Secretariat also assists the Chair in ensuring that the Council's work is conducted in accordance with the ACMD Code of Practice and relevant legal requirements 24. Crucially, the Secretariat is the main point of contact between the Home Office and the ACMD and is responsible for making the ACMD aware of any information which has been withheld from it on the grounds of the Code of Practice on Access to Government Information, the Freedom of Information Act, or for information outside the influence of the Government. The Secretariat acts in theory as an impartial reporter, respecting the independence of the Council. The Secretariat is also responsible for bringing any emerging issues of concern to the attention of the Council 24. However, as a representative of the Home Office, this task may be confounded by political motivations, or be subject to influence by media reporting. Finally, the Secretariat is responsible for the documentation of the Council's proceedings 24. The ACMD's minutes have not been posted since 2015 22 .

Recommendation 2: Increased Transparency in the ACMD Proceedings

In light of the fact that the ACMD's minutes have not been posted since 2015, it is imperative to enhance transparency regarding the council's workings and decision-making processes. To address this issue, the following recommendation is proposed:

Enhancing Transparency: The Advisory Council on the Misuse of Drugs (ACMD) and the Home Office should commit to regularly posting meeting minutes online. This commitment will foster greater transparency and public trust, allowing stakeholders and the general public to have insight into the council's deliberations, recommendations, and the rationale behind their decisions. Ensuring consistent and timely access to this information would not only align with principles of openness and accountability but also contribute to a more informed public discourse on drug policy in the UK.

Funding of the ACMD

All funds for the ACMD are provided by the Home Office for the expenses incurred by members such as facilities for meetings and the expenses of the members associated with their roles. Importantly, members of the ACMD are not remunerated for their work and contribute to the Council and their working group/committees on a completely voluntary basis 26. According to a triennial review of the Home Office's Non-Departmental Public Bodies (NDPB), most of the expenditure for the ACMD is spent on the cost of IT (because the body operates digitally), and no areas where savings could be accrued were identified 27.

In the latest annual report published by the ACMD covering the period of 2017-2019, the expenditure of the ACMD ranged from £26,264.00 to £46,067.34 per financial year 26. For comparison, the cost of enforcing drug laws in England alone is an astounding £1.4 billion each year 28. This includes £688 million spent on drug-related police enforcement costs, as well as an additional £733 million spent across the criminal justice system (including courts, prisons, and probation) 28. The "direct cost" associated with the current approach to drugs in the UK was estimated by Dame Carol Black's Part One review at £9 billion per year. This is more than the budget for the Ministry of Justice over the same period 29. Overall, the cost of addiction and drug misuse is a staggering £19 billion a year 30,31. Therefore the budget of the government's Council of experts providing evidence for the design of drug policy for the year 2017/18 represented one 735,468th of the overall cost of illegal drugs to the UK (approx. 0.0001%) 26.

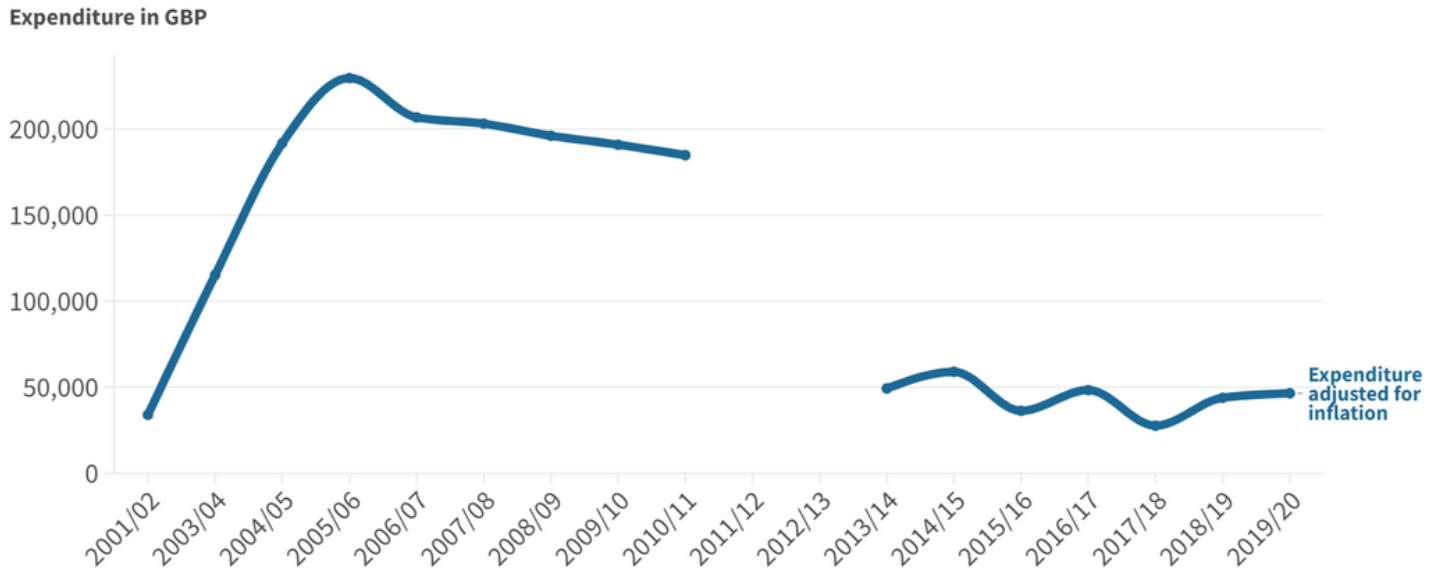


Figure 2. Funding for the ACMD has significantly dropped in the past 20 years. In 2019/20 (the latest available figure) funding from the ACMD dropped to only 24.22% of what it was in 2003/04. Data for the years 2010/11 and 2011/12 were not available (no annual reports published). All figures were adjusted for inflation to their value in 2020 according to the rates determined by the Bank of England.

While it remains unclear how the ACMD obtains funds from the Home Office, and whether there are any imposed limits (either explicit or implied) to how much the Council may spend it is clear that they are underfunded. Given the range of responsibilities of the ACMD (e.g. advising ministers, promoting research, educating the public, promoting cooperation between professional and community bodies involved in the treatment of drug addiction) the current expenditure does not allow adequate fulfilment of the Council's objectives. For example, the triennial review of the ACMD, published in 2017 noted that no annual reports had been published since 2010/11 due to a lack of resources 27. Furthermore, serving as the evidence basis for the government's decision about drug policy, a particularly costly policy area 32, the adequate funding of the Council is a necessary expense which would undoubtedly lead to significant savings nationally, should the Council's advice be incorporated into policy. The ACMD's funding has been discussed on a number of occasions in Parliament 33. MPs have raised concerns about the impact of funding cuts on the ACMD's ability to carry out its work, however the government did not commit to increasing funding for the ACMD when directly asked to 34.

As was observed in the government's own report published in 2010, the ACMD represents excellent value for money 23. At the time the annual cost of the ACMD was around £150,000 per fiscal year. Since then there has been a significant drop in funding for the Advisory Council to £44,620 per year as reported in the ACMD annual report for 2013, dropping as low as £26,264 in 2017 26. It is noteworthy that this decrease in funding occurred after the dismissal of the ACMD's chair, David Nutt, following a public statement wherein he expressed evidence-based views on the relative safety of Class A drugs 18,35, in particular MDMA (which is currently being investigated as a promising treatment for PTSD in Phase 3 trials abroad, and given breakthrough status by the Federal Drugs Administration) 36. Following the dismissal of Dr. Nutt, seven other experts also resigned in protest 37. One could surmise that the reduction in funding for the ACMD was a backlash from the Home Office, aimed at keeping the Council in check and preventing it from carrying out its full remit such as commissioning research or proactively suggesting policy changes to the government. This is especially concerning as the ACMD has a history of presenting what appears to be interpreted as inconvenient truths to the government and advocating for an evidence-based and health-centred approach to drug policy. While these have been proven to be cost-effective and beneficial to public health in pilot programs in the UK and abroad, they often go against the Home Office's prohibitionist rhetoric.

Recommendation 3: Adequate Funding and Remuneration for the ACMD

The analysis of the ACMD's budget, responsibilities, and current limitations illustrates a pressing need for appropriate funding and support. The following recommendations are proposed:

1 - **Increase Funding:** The Home Office should significantly increase the funding allocated to the ACMD. Adequate funding will enable the council to hire additional staff, conduct essential research, commission relevant studies, and fully fulfill their wide-ranging remit. This investment in the ACMD should be seen as a vital aspect of evidence-based and health-centered drug policy design and implementation, which has been proven to be cost-effective and beneficial to public health.

2 - **Remunerate Members:** Considering the important role that the ACMD members play, they should be fairly remunerated for their contributions. Providing compensation will allow members to commit more time and resources to the council, enhancing their ability to make proactive and informed recommendations.

3 - **Transparency and Accountability:** To ensure that the funding is used effectively, there should be clear and transparent guidelines regarding how the ACMD obtains and utilizes funds from the Home Office. Regular reviews and audits should be conducted to prevent undue influence or limitations imposed by the Home Office.

4 - **Align Funding with National Savings:** It should be recognised that a properly funded ACMD, operating with evidence-based principles, could lead to significant national savings in the overall cost of addiction and drug misuse. The investment in the ACMD should be seen in this broader economic and societal context.

By implementing these recommendations, the UK can ensure that the ACMD is empowered to act as a robust and independent advisory body, capable of shaping a drug policy that is grounded in scientific evidence, public health best practices, and fiscal responsibility.

Accountability of the ACMD

As a non-departmental public body the ACMD is not directly accountable to Parliament, however, the Ministers of its sponsoring department the Home Office, who ultimately make decisions about drug policy are. Furthermore, according to guidance provided by the Cabinet Office, Ministers of the sponsoring department are also to be held accountable for the actions of the non-departmental bodies, thereby making Home Office Ministers and the Home Secretary directly responsible for the proper proceeding of the Council 38. However, when asked in WPQs about the affairs relating to the Council, Ministers deny responsibility 39. This arrangement limits the extent to which the ACMD can be directly held accountable. However, as a public body, the ACMD is required to abide by its official code of practice 24, which was developed by the Government Office for Science Code of Practice on Scientific Advisory Committees 40.

Under this code of practice, the ACMD is accountable for its activities and advice and must comply with the Code of Practice on the discharge of public authorities' functions under the Freedom of Information Act. The Council is also expected to operate with a presumption of openness, comply with legislation pertaining to freedom of information and environmental information, and publish basic details about its functioning and work on the Home Office website. Furthermore, the ACMD is subject to the Code of Practice for Scientific Advisory Committees, which incorporates the Seven (Nolan) Principles of Public Life. Both codes of practice set out expectations concerning accountability and transparency 9.

While the ACMD is not held responsible for its decision by any legal means, several inquiries have been made into the ACMD. The first was the fifth report from the House of Commons Science and Technology Committee “Drug classification: making a hash of it?” (2006). In addition to finding that the classification system was unscientific, failed to reflect the harm of drugs, and had no deterrent effect on their consumption, the committee noted several shortcomings in the functioning of the ACMD. Recommendations included the need for improved transparency with regard to the Council’s proceedings, decision-making process, and communication with Ministers. In addition, the report found a pressing need for the Home Office to establish independent oversight of the ACMD, as well as a recurring independent review of the ACMD at least every 5 years 11. The ACMD welcomed this recommendation 41 and it was also accepted in principle by the government 42. Since then only 2 reviews of the Council have taken place.

Recommendation 4: Regular and Independent Reviews of the ACMD

To foster continuous transparency, effectiveness, and accountability within the ACMD, it is recommended that regular reviews of the ACMD be conducted at least every 5 years. These reviews should be carried out by an independent body, assessing the council's operations, decision-making process, communication with Ministers, and overall functioning. The findings and recommendations should be publicly available and actively implemented to address identified shortcomings or areas for improvement. A clear accountability structure must be established, and details of the review process, schedules, findings, and changes should be consistently published on official channels. By adhering to this recommendation, the UK can ensure that the ACMD remains an effective and accountable public body in its proceeding with the Home Office, aligned with its objectives and the broader principles of public life.

A second review of the ACMD was conducted by Sir David Omand in 2010 in order to evaluate the effectiveness and value for money of the ACMD 23. It concluded that despite limited resources, the ACMD has been effective in fulfilling its remit of providing advice on the harms of drugs and represents an excellent value for money. Furthermore, the report underscores the necessity of the advisory body of experts given the complexity of drug policy and the necessity of the Home Office to conduct a review of the ACMDs resource needs to fulfil at a minimum level its statutory duties (no evidence of this review being conducted was found). However, the report delineated several problems with the ACMD which still hold true today, such as the lack of speed with which the government responds to the reports of the ACMD and the lack of implementation of advice, even if it is explicitly accepted by the Home Office. This led to a feeling within the ACMD that advice was provided to the Home Office without a clear mechanism for tracking the follow-up of a recommendation being taken forward.

Finally, of particular relevance to the present political climate is the concern raised that there may be a shift towards more political influence on drug policy, especially if the ACMD loses its role as the primary provider of wider advice. The recent controversies covered in the following sections highlight this sensitive issue. The government's response to the Science and Technology Committee 2006 Report was also noted as a potential threat to the utility of the ACMD as a scientific and expert advisory committee in an increasingly political arena 23.

A third review of the ACMD was conducted in 2017 as part of a Triennial review of Home Office Science NDPB 27. Through a call for evidence and an investigation, this report concluded that the ACMD performs a technical function which cannot be properly provided by an internal government body, and which requires political impartiality as the area of drug policy is deeply controversial and should remain independent from government. Work by the Conservative Drug Policy Reform Group (CDRPG) showed that 70% of members of parliament feel it is difficult to have an objective debate about drug policy underlines the need for independence 43. When asked whether the ACMD should remain independent of the government 94.12% of respondents strongly agreed, and 79.41% strongly agreed that it needs to act independently to establish facts 27.

Furthermore, while several other third-sector organisations which provide similar services as the ACMD were identified, no evidence was found that they could provide the same advice to the government as the ACMD 27. It should be noted that at the time of the review, there was a significant lack of accountability within the ACMD. While advice and correspondence were being published on the government's website, no annual report had taken place since 2010/11, owing to a lack of resources in the secretariat 27. At the time of writing (August 2023) no meeting minutes have been published since 2015 22.

The ACMD is intended to be an independent body and is an essential instrument in the implementation of evidence-based drug policy, but in recent years it has become increasingly evident that its sponsoring department the Home Office exercises unreasonable oversight and undue influence over its operations and often fails to implement its key recommendations. The purpose of this report is to highlight the issues surrounding the ACMD and make policy recommendations to empower the ACMD to be a more effective tool for informing drug policy and education.

Recommendation 5: Accountability for Implementing ACMD Recommendations

To ensure that the advice and recommendations of the ACMD are not only heard but acted upon, it is recommended that a clear mechanism be instituted to hold the Home Office accountable for implementing agreed-upon recommendations. This mechanism should include transparent processes, timelines, and regular updates, allowing both the ACMD and the public to track the progress and outcomes of implemented recommendations. Such an approach will reinforce trust, enhance collaboration between the ACMD and the Home Office, and foster a more responsive and evidence-based approach to drug policy in the UK.

Recommendation 6: Accountability for Rejected ACMD Recommendations

When the Home Office chooses to reject a recommendation made by the ACMD, it is vital that this decision is not made lightly or without transparent justification. Therefore, it is recommended that the Home Office be held explicitly accountable for the outcomes of decisions to reject ACMD recommendations. This accountability should include a detailed explanation of the reasons for rejection, the expected approach, and ongoing monitoring and reporting on the effects of the decision. By ensuring that such rejections are carefully considered, justified, and tracked, the UK can foster greater transparency, accountability, and integrity in its approach to drug policy, and uphold the importance of evidence-based decision-making.

2. CHALLENGES WITH THE ACMD

A series of controversies have plagued the ACMD, most of which are no fault of their own. Senior scientists hired for their world-leading expertise on drug policy issues were sacked or resigned for politically motivated reasons when they spelt out “inconvenient truths” to the government 35. Even when research is commissioned from the ACMD by the government, key recommendations are often ignored, resulting in an unacceptable and demoralising waste of researchers’ time. Certain reports are simply not answered, like the ACMD’s report on CBD, which dates back to December 2021, despite the Home Office’s own working protocol stating that a response should be published within 3 months of receipt 9. Ironically, where it feels it must keep the ACMD “in check”, the Home Office has exerted undue influence upon the ACMD’s hiring process, leading to the resignation of senior scientists 44,45 and the suppression of key reports 46.

The Government Consistently Ignores the ACMD, with severe consequences

MDMA

Disregarding the recommendations of the ACMD has had important consequences for the health and economy of the UK. One example of this is the classification and scheduling of the stimulant MDMA. The ACMD was reportedly not consulted when MDMA was classified in 1977 11. In 2006 the House of Commons Science and Technology Committee urged the ACMD to conduct a review of its Class A status, which was subsequently self-commissioned and published in 2008 47. In its review, the ACMD advised the government to reclassify MDMA from Class A to Class B and to keep under review its status as a Schedule 1 drug under the Misuse of Drugs Regulation 2001 to ensure research could be conducted 47. This decision would have maintained the drug's illegality while bringing its classification more in line with its potential harms, as well as facilitating important research into its properties as a novel treatment for mental health conditions 47. However, several key recommendations in the report were rejected for apparently political reasons, with unintended consequences.

The recommendation to keep MDMA’s schedule under review, which would have facilitated research, was rejected. This disregard for the ACMD's advice has hampered important research on MDMA's potential as a treatment for PTSD. In the United States, Canada and several European countries MDMA is now being researched as an adjunct to psychotherapy for PTSD. By extinguishing the fear response for a period of time 48 it becomes possible for those suffering to remember and work through traumatic experiences, sometimes feeling safety or love for the very first time 49. A recent Phase 3 double-blind randomised placebo-controlled trial achieved significant results - after 3 sessions of MDMA-assisted therapy 2/3 of participants no longer met the requirements of a PTSD diagnosis 50.

The application of MDMA in the treatment of PTSD could generate net healthcare

savings of $132.9 million over 30 years for every 1000 patients, accruing 4856 quality-adjusted years of life and averting 61.4 premature deaths of loyal servicemen and women, victims of sexual abuse, and accident victims 51. The current prevalence of PTSD is approximately 4% in the UK 52, with this number expected to rise in the coming years due to COVID-19 53. MDMA-assisted therapy is estimated to break even on cost at 3.8 years, making it a cost-effective solution for treating PTSD 51. Unfortunately, the Home Office's stance on MDMA has prevented it from benefiting from these opportunities, putting our most loyal citizens at risk of a life of severe mental illness without effective treatment options available.

Going against scientifically validated evidence and undermining the point of the classification system, the government chose to reject ACMD recommendations in order to signal to party-goers that MDMA is a serious drug, a wholly unfounded claim both in terms of the danger it represents 18 and the deterrent effects of such actions 11, and a tactic for which the Misuse of Drugs Act Classification scheme was not intended 11,14.

Furthermore, in its 2008 report the ACMD made multiple recommendations involving the dissemination of increased harm reduction information in order to protect the public. The tragic and widely publicised death of Leah Betts in 1995 had been the direct result of her attempts to avoid harm by a 'dangerous drug'. She was not killed by MDMA but by a substance she had understood to be at worst innocuous and at best protective - water. She died after drinking 7 litres of water in a 90-minute period following the ingestion of a single pill while celebrating her 18th birthday at home with friends 54. She had consumed an excessive amount of water in an attempt to protect herself from the perceived dangers of the drug. In the absence of clear information, her anxiety distorted and exaggerated the good harm reduction advice that to prevent dehydration and overheating while dancing stimulated by MDMA at crowded raves one should regularly take breaks to sip water. Had the information she had received been more clear the risk she took in consuming a relatively safe albeit unregulated and possibly adulterated drug would have been reduced, with possible life-saving consequences. In light of the evidence the risks of MDMA use appear to be associated with a lack of education and regulation; irregular dosages, the circumstances of use and possible adulteration, as opposed to physiological toxicity. Indeed while MDMA is used by 15 times more of the population than heroin 55 (also Class A) it is associated with 94.5% fewer deaths 56.

Opioids, needle exchanges and naloxone

The UK is currently facing an unprecedented drug-related death epidemic, deemed by experts to be a public health crisis 57. Dame Carol Black's seminal review found that 86% of the cost of drug misuse is attributable to illicit opioid and crack cocaine use 58. Despite numerous warnings from the ACMD over the years the government has failed to heed its advice and the opioid crisis has continued to mount. Today, facing an opioid supply increasingly made up of synthetic opioids like fentanyl and nitazenes 59,60, and an ever-increasing death count, the government's lack of implementation of the ACMDs advice is leading to severe consequences. Now more than ever, it is time for the government to listen to the Council on this critical issue and implement evidence-based, and life-saving, drug policies.

How the UK ended up with the highest rates of overdose deaths in Europe is a complex story, however, it is clear that the government often failed to listen to the ACMD on critical recommendations which may have changed the outcome. Since 2009 the ACMD has written to the government 10 times on issues relating to opioids, overdoses, drug injection and blood-borne viruses. Of these, 7 reports were self-commissioned, a significant stance for the ACMD whose average output is only 37% self-commissioned 10. One such report, published in 2016 made specific recommendations on reducing the opioid-related deaths in the UK 61. One of the most significant recommendations in this report was to maintain investments in high-quality opioid agonist treatments of optimal dosage and duration 61. However, funding for drug treatment fell by 14% overall between 2014 and 2017 (with some Local Authorities cutting their budget up to 40%) 31. Furthermore, as pointed out by Dame Carol Black, the lack of ring fenced funding for public health services in 2021 may have further aggravated the problem 31. While there was no figure found on spending for opioid agonist treatment, some experts claim it has been decreasing since 2010 62, despite its high efficacy when delivered appropriately 63. Concomitantly, opioid-related deaths related to increased by 11.14% in that period 56.

Following the publication of Dame Carol's Black Review, the government committed to increased spending on drug treatment and recovery 30,64 and significant advances have been made 65. However following several years of cuts 66, the system needs to be rebuilt which is causing delays in the implementation of treatment initiatives 65.

Additionally, in an effort to address the escalating number of drug-related deaths in the UK, the ACMD conducted an in-depth analysis of harm reduction strategies, culminating in a recommendation for the introduction of Drug Consumption Rooms (DCRs) 67. These facilities would be medically supervised, providing a safer environment for consumption and immediate access to medical care if necessary. The ACMD's proposal highlighted the success of DCRs in other countries, showcasing their efficacy in reducing fatalities and minimising health risks associated with drug misuse. However, despite the compelling evidence, the recommendation was met with resistance from the UK government. In 2018, the Home Secretary at the time rejected the proposal, citing legal and ethical concerns 68. By then an HIV outbreak among people who inject drugs in Glasgow had been registered 69. This decision underscores the tension between evidence-based policy recommendations and political considerations in the realm of drug legislation in the UK, and the resistance the ACMD is met with when suggesting evidence-based and progressive harm reduction methods. The Home Office's response ignited outrage among several academics specialising in drug policy, including one prominent figure who expressed her dismay at the decision. She was subsequently blocked from joining the council, ostensibly due to her social media activity commenting on this issue and other controversial but unrelated government policies, such as those concerning the Windrush scandal and Brexit 70. As noted in an op-ed by this academic, "*Independent expert advice – even if that expert disagrees with government policy – is fundamental to the development of evidence-based policy*."

On the other hand, when the ACMD made recommendations to increase the availability of naloxone and remove barriers to its access, the government changed legislation

allowing drug treatment services to provide the normally prescription only naloxone to patients, family members, and friends in order to save their life in an emergency. This change in legislation has proven essential to curbing drug-related deaths in the UK. The initial report on naloxone was followed up by a self-commissioned review of the status of the naloxone availability in the UK and made specific recommendations to improve it 71. The report concludes that naloxone is an important initiative to sustain in order to reduce the harms caused by drugs and "*more work is needed to widen the access to, and increase the uptake of, naloxone in multiple initiatives, spanning across the UK*" 71. The government has still not formally responded to the ACMD's second naloxone report more than one year later, however efforts have been made through project ADDER to increase the distribution of naloxone.

CBD Regulation in the UK

Cannabidiol (CBD) has propelled itself in recent years to the forefront of the health and supplements market, in addition to its clinical uses such as in the treatment of chronic pain 72, PTSD related symptoms such as nightmares 73, cancer related symptoms such as anxiety, nausea or vomiting 74, and seizure disorders 75. The value of the commercial UK CBD market was estimated at £690 million in 2021, increasing more than a third from 2019 76, thereby representing a significant economic opportunity with the UK being the world's second largest consumer of CBD after the US 76, and this despite an unclear regulatory framework within which the industry operates. Indeed, the lack of a legal regulatory pathway for licensed cannabinoid production in the UK has allowed foreign companies to exploit this gap, with the result that nearly all the economic benefits of the UK's CBD surge are going to foreign companies 76. Currently stores on every British high street sell CBD oils, drinks, food supplements, cosmetics and vape liquids. In 2019, the Food Standards Agency (FSA) introduced the 'Novel Foods' authorisation process for ingestible CBD products, creating a legal route for sales 77. Yet, this approach didn't address the issue of cultivating CBD domestically, limiting British hemp farmers' involvement. While CBD regulations are expected to tighten, inconsistencies remain in its governance for consumers, pets, cosmetics, and vape products.

The ACMD was tasked in January 2021 with providing guidance to the government regarding the creation of a lawful structure for CBD products intended for consumers. Specifically, the government sought out advice on appropriate levels of THC in CBD products. A working group dedicated to this was formed, and in December 2021, the ACMD responded with a comprehensive report. Among its recommendations, the ACMD called for the limitation of THC and other controlled phytocannabinoids to a maximum of 50 micrograms per consumption unit, defined as the typical quantity of CBD product consumed at one time. This would necessitate amendments to the Misuse of Drugs Act by the Home Office. Additionally, the ACMD emphasised the importance of standardising testing methods and protocols due to the potential for significant testing discrepancies when dealing with minute quantities. It's noteworthy that the ACMD acknowledged the unsuitability of a uniform limit for all products, recognising that the mode of delivery (such as absorption through the skin in cosmetics or oral consumption in pill or oil form) significantly influences controlled cannabinoid absorption. The report also highlights that plant-derived consumer CBD products would generally lack sufficient controlled

phytocannabinoids or their precursor acids to induce noticeable psychoactive effects unless deliberately added (i.e., spiked). To prevent the possibility of spiking, the ACMD recommended setting limits for all controlled phytocannabinoids in consumer CBD products 78.

While the cultivation, manufacture, and sale of consumer CBD products is a complex issue requiring the collaboration of several governmental departments, the report specifically tasks the Home Office with three out of the four recommendations 78. Indeed while certain issues such as labelling of products and quality control are regulated by the FSA or the Department for Business, Energy and Industrial Strategy, the Home Office is responsible for legislation regarding controlled substances such as Δ9-THC or its precursor Δ9-THCA. Almost 3 years following the publication of this report, the government has still not responded to the ACMD's recommendations, leaving one of the UK's most important emerging markets in limbo. In multiple WPQs, the government has acknowledged the lack of response 79. The lack of legal framework has created significant uncertainty in the UK market for CBD and limited investments in this burgeoning field 76. Despite an absence of institutional support, the UK maintains an influential role in the research and consumption of CBD and other cannabinoids 76, a position which would only be strengthened by a proper regulatory framework.

Cannabis Regulation in the UK

The ACMD has played a key role in the development of cannabis legislation in the UK. The Council has provided independent advice to the government on the risks and benefits of cannabis. Regrettably, however, its recommendations have not had a significant impact on the law, which appears rather to have been steered by other, potentially political considerations.

The appropriate classification of cannabis has been a subject of contention since the introduction of the Misuse of Drug Act where it was placed in Class B alongside Amphetamine and Codeine (both of which have significant addictive potential and demonstrable harms to society) despite explicit recommendations in the Wootton report (1969) that it be treated separately from other drugs (perhaps with a similar apparent exemption as is granted to alcohol and tobacco). In 1979 the ACMD recommended that cannabis be placed in Class C based on its limited harms to health and society and to save police resources, advice which was not heeded 11. This view was echoed by the Runciman report in 2000 which found that its harms to society and health were not commensurate with its Class B status 12. This view was once more expressed by the ACMD following a ministerial commission in 2001 by the Home Secretary to review the classification of cannabis 81. This report and another by the Home Affairs Committee led to the reclassification of cannabis as Class C in 2004 (announced in 2002) 42.

Only one year later, the ACMD was again commissioned to revisit the classification of cannabis by the new Home Secretary, engendered by anecdotal reports of more frequent use of higher potency cannabis. The House of Commons Science and Technology Committee found that this review was likely brought about by increased

media pressure on the issue 11. The Council's second report made several recommendations, none of which involved reclassification, and concluded that while cannabis consumption may represent a significant risk factor in the development of schizophrenia it is neither necessary nor sufficient to cause mental health issues, and dispelled the notion that the potency of cannabis had increased 82. These recommendations were accepted in full by the government, which also acknowledged that reclassification had not led to an increase in use 17. On this occasion, the government listened to the ACMD and it paid off. During this time illicit cannabis consumption decreased 83 and significant policing efforts were saved. Research from King's College estimated that in the first year of reclassification, more than 3.5 million pounds or 69,327 officer hours were saved 84.

Despite this, the ACMD was once more commissioned in 2007 to review the classification of cannabis. For the third time the ACMD recommended that cannabis should remain as a Class C drug, and noted the decrease in use, minimal health consequences, and stable concentrations of THC over time 83. Despite this cannabis was reclassified to Class B. The Home Secretary cited "*considerations of public perception*" as the primary reason for her decision despite warnings from the ACMD that the reclassification was "*neither warranted, nor will it achieve its desired effect*" 85.

In an apparent dismissal of the evidence, the current Home Secretary Suella Braverman has hinted at the reclassification of cannabis to Class A 86. Citing the need to deter the use of cannabis (a tactic which has repeatedly been proven to be ineffective) and the potential for cannabis to act as a gateway drug (which has been dispelled by numerous reports and studies 11,87). Indeed, the view that cannabis is a gateway drug is a misleading perspective. While the ACMD's 2002 report states that cannabis use may be associated with other Class A drug use, reliably demonstrating the gateway theory is "*very difficult due to the many confounding factors that might also act as gateways*" 88. While it is true that early exposure to cannabinoids has been shown in preclinical studies to reduce dopamine system reactivity later in life and induces cross-sensitisation 89,90 the majority of cannabis users do not go on to abuse other Class A substances 91. Additionally, cross-sensitisation and altered dopaminergic responses to drugs of abuse are not unique to cannabis and also occur with nicotine 92 and alcohol 93. It is therefore difficult to disentangle which drug is considered to be the "gateway" drug. Arguments could easily be made for nicotine and/or alcohol being the "true gateway" drug. Finally, the notion of a "gateway" drug in itself is misleading as it fails to account for the social and economic factors which fundamentally influence patterns of drug misuse and its associated consequences 94,95.

The narrative of cannabis classification in the UK unfolds as a cautionary tale, one wherein a government, apprehensive about public perception, consistently disregarded the counsel of its panel of experts and specialised committees, resulting in detrimental outcomes for its citizens. Enormous financial resources, possibly reaching billions, were squandered on futile law enforcement endeavours. Moreover, this misclassification perpetuated the growth of substantial criminal enterprises that continue to inflict considerable harm upon society. Despite experts affirming cannabis as a comparatively safe substance, free from societal repercussions, the UK lags behind more than a decade

after its reclassification, persistently clinging to outdated notions.

Psilocybin and Magic Mushrooms

While emerging evidence shows that psilocybin is physiologically safe and has potential in the treatment of depression 96–100, anxiety 101–103, and addiction 104–106 it remains unnecessarily difficult for research 107,108 and impossible for patients to access, without justification beyond historic precedent. Psilocybin and its psychoactive metabolite psilocin were placed in Class A of the Misuse of Drugs Act 1971 despite an absence of evidence of harm associated with these compounds. Michael Rawlins, a celebrated British pharmacologist and chair of the ACMD (1998-2008) said "*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*" 11.

Psilocybin is consistently found to be one of the safest controlled drugs, is physiologically non-toxic, does not form dependence, and risks are further mitigated within supportive psychotherapeutic environments 109. Contrary to popular fears around these drugs, a review of the 20 years of psychedelic therapy research in the UK prior to 1971 found that out of 4000 patients, totalling 50,000 doses, there were only two completed suicides and thirty-seven patients with a prolonged negative reaction (>0.1%) 110. Even publications such as the RAND report and the government's own harm reduction website ("Talk to Frank") continue to suggest the social and personal harms of psilocybin containing mushrooms are nonexistent. The Talk to Frank website clearly states that the biggest danger when it comes to psilocybin is accidentally eating a different kind of mushroom that doesn't contain it 111.

Since psilocybin was first controlled there has been no review of the evidence of the harms nor clinical utility of psilocybin commissioned by the Home Office, as confirmed by WPQs 112,113. A clarification of the law in Section 21 of the Drugs Act 2005 was made, formally banning the import, export, production, supply and possession of magic mushrooms in any form, legislation which filled a loophole wherein fresh magic mushrooms were not considered a controlled drug. The House of Commons Science and Technology Committee's report on the topic criticised this arguing that the move contravened the spirit of the Misuse of Drugs Act 1971, and had ostensibly been done in such a way as to avoid giving the ACMD a chance to consider the evidence and make recommendations based on evidence 11. Nor has a formal review of the evidence been self-commissioned by the ACMD 113, surely owing to a lack of resources and interest in having the government once more ignore its advice.

Meanwhile, Psychiatrists in Australia, Canada and some US states are already able to use their expertise and discretion to prescribe psilocybin to patients who may benefit ahead of market authorisation 114,115. In 2018 the United States' FDA already granted psilocybin breakthrough therapy status for depression fast tracking it through the process to medical access, and some states including Oregon and Colorado have legalised access to professionally guided psilocybin sessions for adults over the age of 21 116,117. In January 2002 Canada psychiatrists became able to prescribe psilocybin to patients for end of life distress related to terminal cancer diagnoses and post traumatic illness through their

Special Access Program ahead of market authorisation - patients have already begun to receive prescribed access. In February 2023 the Australian TGA rescheduled psilocybin and MDMA 114 allowing licensed psychiatrists to prescribe them for the treatment of depression and PTSD from July 2023.

In the UK psilocybin's Schedule 1 status under the Misuse of Drugs Regulations 2001 blocks the ability of psychiatrists to use their discretion and expertise to decide whether to prescribe it to patients who may benefit, as well as increasing the cost, duration and stigma associated with research into Schedule 1 substances. The requirements on researchers to hold multiple costly Home Office licences seriously hinders neuroscientific and clinical research 118. While research into Schedule 1 drugs is possible, only a tiny fraction of the possible research actually takes place, almost all of which is conducted by large pharmaceutical companies trying to bring drugs to market. This red tape not only artificially discourages competition as only very big companies can afford to conduct the research, it also means that as the research is unnecessarily more expensive, it will be the taxpayer who ultimately picks up the bill through higher drug prices for the NHS 107. The difficulties researching Schedule 1 drugs has also led to eminent researchers leaving the UK to continue their careers in more conducive and less burdensome regulatory climates abroad.

The self commissioned work streams of the ACMD for 2020, published in December 2019, included the creation of a working group to establish scheduling decisions making including Standard Operating Procedures (SOP) for their scheduling recommendations under the MDR 2001 with the goal of establishing "a systematic process for ensuring consistency", itself published in May 2021.

The Home Office has a history of unnecessarily maintaining a climate of inertia in relation to rescheduling Schedule 1 substances beyond psilocybin. In July 2017 Amber Rudd, then Home Secretary, commissioned a review of the barriers to research caused by drugs designated as Schedule 1 under the MDR 2001. In December 2017 the ACMD submitted their short and long term recommendations, but it took over a year, until January 2019, for the so-called 'short-term' recommendations to be acted upon, whereas the long term recommendations were rejected entirely as unfeasible leaving the barriers unaddressed 5 years after the work being initially commissioned.

In February 2020, the ACMD put out a call for evidence regarding barriers to legitimate research with controlled drugs, specific to synthetic cannabinoid receptor agonists (SCRA). The report Considerations of barriers to research Part 1: Synthetic cannabinoid receptor agonists (SCRA) was published on 30th July 2021. The ACMD are currently undertaking this 'Part 2' of their report, after it having first been commissioned in March 2021, and again in December 2022, and for a third time in June 2023. As of August 2023, no publication date for 'Part 2' has yet been announced. The ACMD's report will produce recommendations intended to mitigate barriers to research, which may or may not be accepted, but will not review the evidence for psilocybin's Schedule 1 status, leaving a 50 year injustice unaddressed, patients without access and the UK falling behind other jurisdictions.

The situation surrounding the classification of psilocybin in the UK is deeply entrenched in historical and political precedents rather than scientific evidence. While psilocybin has been shown to be safe, non-addictive, and effective in treating mental health issues, it remains unjustifiably restricted for both research and medical application. The government's decision to maintain psilocybin under Class A of the Misuse of Drugs Act in 1971 appears to have been arbitrary at best and political at worst, and done without the consideration of the ACMD. This move has resulted in stigmatising the drug, making it difficult for scientists to conduct necessary research and for patients to access potential treatments. It is disheartening that the government failed to consult the ACMD even when countries like Australia, Canada, and parts of the U.S. have already recognised the medicinal potential of psilocybin. This situation reflects a broader pattern where the Home Office consistently delays or ignores the ACMD's advice on rescheduling Schedule 1 substances. Such reluctance to address these issues not only obstructs scientific progress but also denies patients potential treatments. It is an indictment of a system that chooses bureaucracy over evidence and the wellbeing of its citizens. As other nations move forward, the UK remains ensnared in outdated regulations, to the detriment of its research community and the patients they aim to serve.

Novel Psychoactive Substances (NPS) and the Psychoactive Substance Act 2016

The Psychoactive Substance Act 2016 represents perhaps the most significant piece of UK drugs legislation since the enactment of the Misuse of Drugs Act in 1971. Despite this, the statutorily appointed ACMD was not appropriately consulted in its design, and its recommendations and reservations were largely dismissed. In a letter to the Home Secretary in 2015 the Chair of the ACMD raised concerns about the bill. For example, the Chair noted that the Psychoactive Substance Act would bring about the closure of many 'headshops' specialised in the sale of so-called 'legal highs', inconsistencies in the supply of NPS causing increased harms, a shift to the black market, and limit on research into these substances 119. It has been argued by experts in the field that the closure of headshops led to a lack of education in the public on novel psychoactive substances and the unregulated escalation of these substances from relatively 'mild effects' to increasingly stronger molecules, endangering the public who proceeded to unknowingly consume the substances without proper harm reduction information and ultimately fuelling the rapid rise in drug consumption observed following the writing into law of the Psychoactive Substance Act 2016 7. Furthermore, the prohibition on research significantly hindered the advancement in understanding the health consequences of consuming these substances.

As warned by the Chair of the ACMD at the time, the Psychoactive Substance Act produced numerous negative consequences for the health of the UK public. Notable is the introduction of dangerous synthetic cannabinoid receptor agonists into the existing supply of illegal cannabis in the country, causing unsuspecting users to consume a far more dangerous drug than the relatively harmless cannabis 120. In addition, the Act led to an increase in the number of drug dealers, more aggressive marketing and supply tactics, and more variability in the content and potency of illegal cannabinoid receptor agonists 120. The consequence of this is the increased demand on an already strained NHS, high levels of synthetic cannabinoid receptor agonist use in already vulnerable

populations, and a corresponding increase in the demand on emergency services 120. In addition, while NPS purchased legally provided a relatively pure and inexpensive source of psychoactive substances for consumers, the purity and price of traditional street drugs such as MDMA and cocaine decreased, leading to a decrease in their use. Nonetheless drug related deaths associated with NPS were far exceeded by deaths associated with MDMA and cocaine, even during prime periods of NPS use, suggesting that NPS provided a safer alternative than "traditional" street drugs.

Similarly the NPS 4-methylmethcathinone (mephedrone) emerged as a cheap and accessible stimulant, rapidly gaining popularity in the UK. While mephedrone was a drug of choice from 2008 to 2011 121, drug related deaths from stimulants overall halved and prevalence of stimulant use by 16-59 year olds remained stable 56. However, since the generic ban on cathinones was introduced, stimulant related deaths have increased five-fold, mainly driven by cocaine 56. While the ACMD recommended a generic control of synthetic cathinones, the council also significantly emphasised the need for education of the public on the topic 122, a recommendation which was accepted in the Explanatory Memorandum to the The Misuse of Drugs Act 1971 but does not appear to have been fulfilled 123,124. Furthermore the recommendation was criticised as being rushed, unduly influenced by the Home Office, and supported by weak evidence, ultimately being described by former Home Secretary Alan Johnson as "*a collapse in integrity of scientific advice in the UK*" in a leading scientific publication 125. Notable as well, is that the generic ban of cathinones exempted bupropion, an antidepressant and anti-smoking drug. The generic nature of the ban led to a stunt in the development of variants of potentially more efficacious derivatives of this medication, due to the cost of complying with regulations associated with handling Schedule 1 substances 126.

With regards to the overarching bans imposed by the Psychoactive Substance Act the ACMD presented the government with an opportunity to safeguard public health it was unaware of; by controlling the supply of NPS and introducing regulations and limits around their sale, the use of NPSs may have remained controlled and relatively unharmful. The ACMD warned the government clearly, stating that "*that the Bill, as drafted, may not achieve its aims and may produce serious unintended consequences*" 127. However warnings were ignored, leading to an increase in drug-related deaths associated with NPS (Figure 3) and the establishment of considerable barriers to scientific research, the outcome of which would have provided an essential evidence base for better understanding NPS, and how to treat harms associated with them. Four years after the introduction of the Act, deaths associated with NPS were at an all-time high 56. A study of university students following introduction of the Act found that users were sourcing NPS from street dealers and the darknet while health/risk related information remained low 128. Furthermore, since the enactment of the PSA, it appears that the increased number of NPS-related deaths are associated with an increase in their potency on the market and/or a loss of the protective factors associated with the legal sale of NPS 129,130. Even in custodial settings the Act has not prevented the violence and health harms incited by NPS use, reports of serious incidents continue to rise 130,131 and the number of deaths associated with NPS in custodial settings tripled between 2015 and 2019 132. While it may appear counterintuitive at first glance, the availability of legal highs can result in a reduction of harm to users and society through

the availability of information, more certainty of what is being consumed, and the non-escalation of the potency of the drug 133.

The UK's Psychoactive Substance Act of 2016 is emblematic of the repercussions when expert advice is sidelined in policy-making. Despite clear warnings from the ACMD about potential pitfalls, their insights were largely ignored. This oversight led to alarming consequences: the emergence of more dangerous synthetic drugs in the market, undue strain on the NHS, and a spike in drug-related emergencies. The case of mephedrone further exemplifies this, where misguided regulations led to a surge in stimulant-related deaths. Additionally, a generic ban on cathinones stymied potential medicinal breakthroughs. The neglect of the ACMD's guidance not only resulted in dire public health outcomes but also hampered scientific progress. It's a compelling lesson on the importance of heeding expert advice for informed policy-making.

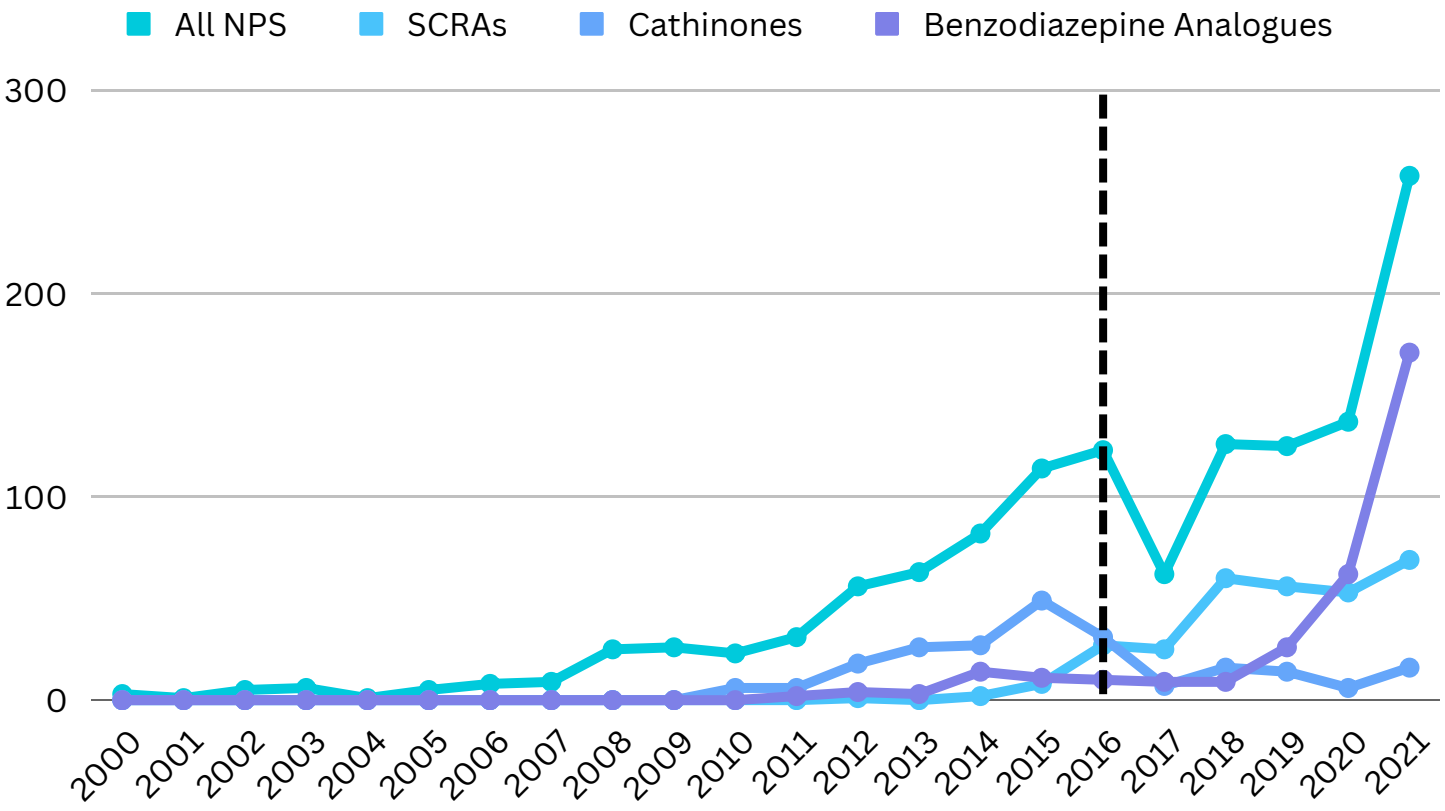


Figure 3. Drug Related Deaths in England and Wales cause by NPSs increased following the 2016 PSA. Following the introduction of the Novel Psychoactive Substances Act in 2016 drug related deaths associated with NPS increased, more than doubling in 5 years. Data was obtained from ONS.

Nitrous Oxide

Nitrous Oxide (N2O) is a colourless gas with a slightly sweet taste primarily used in medical settings as an analgesic/anaesthetic, in cooking as a propellant, or in industry as an oxidizer. N2O gained popularity on the UK recreational drug market around 2010 and from 2018-2020 was the third most consumed drug 55. Traditionally being sold in single dose sized canisters of 8g, which are intended for use in cream whippers, in more recent years larger canister sizes of 600g or 2000g began appearing 134. These larger canisters offer illegitimate users easier refilling of the balloons which are generally used to inhale the gas, a cheaper price per dose, and avoid having to carry around a large quantity of paraphernalia. However, they also promote more frequent and heavier use. As noted in

the ACMD's report, heavy use of N2O can lead to inactivation of vitamin B12 thereby reducing the activity of the enzyme methionine synthase which is crucial in the metabolism of fatty acids in the central nervous system and the synthesis of myelin (the insulating sheath around nervous cells) 134. As noted by the ACMD, there is no data on the number of patients undergoing harm linked with N2O use, and there were 56 deaths linked to N2O from 2001 to 2020 in England and Wales (i.e. 0.0853% of the total drug related deaths over the same period 56). Nonetheless, it is undeniable that illegitimate nitrous oxide use is linked to the littering of metal canisters in the streets of the UK. This appears to be the government's main gripe with the substance given it was classified as part of the Antisocial Behaviour Action Plan. Indeed on March 26th the government announced that nitrous oxide will be reclassified as Class C drug for the first time on a BBC Sunday show 135, then in writing to the ACMD 136 and in its Anti Social Behaviour Action Plan to parliament on March 27th 136. In itself, it is against the working protocol between the Home Office and the ACMD for the government to have announced the banning of N2O ahead of formal written notice to the ACMD 9, although this has been denied in WPQs by the Home Office 137. Conspicuously, in the date inscribed on the government's response the specific date which was originally included has since been removed from the document, however an analysis of the webpage's analytics shows that it was published on March 27th, 2023.

The ACMD was commissioned twice to conduct a review of the classification and harms of N2O, and both times concluded that its harmfulness does not warrant control under the Misuse of Drugs Act 134,138. In 2015 the ACMD noted at the conclusion of its report that N2O use was increasing, as were the sales of the drug for illegitimate purposes and the diversion of large canisters from medical settings 138. In order to combat this, the ACMD advised the government to collaborate with retailers to understand and monitor the supply chain, especially indications of misuse like bulk buying and the sale of 'crackers' (used to dispense the gas from 8g canisters). Local Councils were asked to address issues related to anti-social behaviours such as littering, while NHS PROTECT were asked to keep medical facilities updated on the misappropriation of gas cylinders, reviewing guidelines as necessary. The Department of Health was also urged to detail audit processes countering misuse in medical settings 138. In October 2021, the ACMD was asked to conduct an updated review of the harms and classification of N2O, and subsequently asked to expedite its review. In the time between the two reviews N2O use remained stable, and even reduced between 2021 and 2022 134. Regarding use in young people, the NHS digital survey noted that around 4.0% had consumed N2O in 2016-2018, whereas only 1.8% reported using the N2O in 2021 134. Furthermore, the ACMD noted that "*While every drug-related death is a tragedy, the current number of annual deaths related to nitrous oxide remains low when compared to other drugs and comparable to other volatile compounds and solvents. In 2020 there were 3 deaths associated with nitrous oxide, 62 with benzodiazepines (Class C), 3 with solvents and 19 with fuels.*" 134. At the outcome of this report the ACMD recommended a comprehensive approach, urging the government to explore strategies used for other substances and to implement measures addressing non-legitimate nitrous oxide supply and educating both the public and healthcare professionals about its risks, as no isolated intervention would suffice. The ACMD provided extensive recommendations on nitrous oxide, emphasising its regulation under the Psychoactive Substances Act 2016 was sufficient given its harms, restricting

non-legitimate supply, promoting public and professional education on its harms, enhancing inter-departmental partnerships to reduce social harms, monitoring related health and social impacts, understanding its legitimate uses through consultation, and assessing the recommendations' impact three years post-implementation [134]. However, as noted above, the government rejected the ACMD's recommendation that N2O should remain solely under the Psychoactive Substance Act (2016) on the grounds that there was an anecdotal reports of increased harm, drug driving and littering, announcing its classification as a class C drug [136]. Following the announcement of the ban in Parliament by the Home Secretary who cited "emerging evidence" and taking a "broader view" in her decision to ban N2O [139], the Home Office was unable to provide said emerging evidence nor substantiate the "broader view" in WPQs [140]. Furthermore, the Home Secretary cited the need "*to criminalise possession, so that there is a deterrent and a meaningful consequence for people who break the law by using nitrous oxide*." [139]. As has been elaborated upon several times in this report, there exists no evidence for a deterrent effect of criminalisation [11–17], therefore her approach is misguided. It is noteworthy that this ban was also criticised by experts across the field and internationally [141].

The urgency with which the government banned N2O following the ACMD's report (against its expert advice), the law within which the ban will be instituted (i.e. the Antisocial Behaviour Action Plan), the way the ban was announced to the public (on the BBC by Michael Gove, preceding formal notification of the ACMD), the lack of evidence for the harms of N2O, the ensuing social media campaign promoting strong action against antisocial behaviour, and the lack of economic analysis of the ban set against other drug policy priorities strongly together suggests that the ban was a politically motivated move, designed to demonstrate the government's stance on a form of drug use which is evident to the public (by the pollution of metal canisters). Unfortunately, this politicisation and weaponization of drug policy has been used for decades with severe consequences for the populations they target and little impact on the demand and use of drugs [142,143].

The decision to ban nitrous oxide presents a myriad of potential negative repercussions. Drawing parallels with the aftermath of the Psychoactive Substances Act (PSA), there's a looming threat of the black market stepping in to fulfil demand. This illicit market may supply gases tainted with contaminants, made using easily accessible recipes found on platforms like YouTube. Furthermore, the ban is likely to result in reduced oversight on the trends in sale and consumption which are vital in estimating the size of the problem. The Home Office has not provided a tangible means to hold itself accountable for its decision or to monitor and evaluate N2O use in the wake of the legal shift. The widespread availability of hazardous synthesis methods for nitrous oxide online poses a heightened risk not only to the health of users, who may consume impure or toxic products, but also to public safety due to the potential for explosive accidents. While it might be premature to definitively determine the ramifications of this policy, historical evidence consistently suggests that prohibitive measures tend to amplify, rather than alleviate, associated harms.

Recommendation for Decriminalisation

In 2016, the ACMD made a proactive recommendation in a report to the Home Office recommending the repeal of the subsection of the Misuse of Drugs Act (1971) which criminalises the possession of drugs without the intent to supply 46,62. However this report was never released to the public. The exact recommendations made remain unclear and the report was subject to a 3-year freedom of information challenge where the tribunal ruled in favour of the Home Office to keep the report suppressed. The Home Office argued in court that it was not subject to Freedom of Information laws given that the report's recommendations are currently under consideration 46,144, an unlikely claim given the hard-line prohibitionist approach consistently taken. This demonstrates the validity of concerns regarding the transparency of the proceedings between the Home Office and the ACMD raised in the reports of both the House of Commons Science and Technology Committee (2006) and Sir David Omand's review (2010). Indeed the ACMD operates on a fundamental presumption of openness 24, and for good reason; if policymakers are ignoring advice from experts, constituents have a right to know.

Moreover, this guidance from the ACMD serves as a significant instance of fulfilling its mandate to actively assess the detriments arising from drug misuse in the UK. Given the Council's lack of resources and the voluntary basis upon which it operates, this report surely represents a policy change the experts deem essential for the country. In addition, the reputable and extremely well-evidenced work published by the ACMD in the past, suggests the recommendation was thoughtful and of high quality. To suppress the report represents a disrespect to the Council and its members, a lack of transparency on behalf of the government, and a missed opportunity to address a pressing public health concern in a comprehensive and evidence-based manner.

Submissions to the Home Affairs Select Committee inquiry on drugs by a former member of the ACMD begins to elucidate the nature of the report and the substantial body of evidence which supports it 62. Of particular importance is the renewed observations that various inquiries have found little to no evidence of the deterrent effects of the Classification system for possession and use of drugs 11,12,14–16, and the utility of aligning the Misuse of Drugs Act and the Psychoactive Substance Act on the issue of simple possession.

Decriminalization offers a range of benefits that warrant serious consideration. First and foremost, it presents an opportunity to align the Psychoactive Substance Act (2016) with the Misuse of Drugs Act (1971), establishing a more coherent policy framework. This alignment not only simplifies the legal landscape but also allows for a more streamlined approach to drug-related matters. By decriminalising drug possession, law enforcement efforts and budgets can be directed where they are most needed: targeting criminal organisations involved in drug trafficking and prioritising prevention and treatment. This strategic allocation of resources stands to significantly improve the effectiveness of law enforcement initiatives, reducing the burden on minor drug possession cases and allowing a concentrated focus on combating serious drug-related criminal activity.

Decriminalisation is not only beneficial but also eminently implementable. International

examples from 30 countries worldwide provide compelling evidence for the efficacy of similar initiatives, as well as lessons to be learned for how decriminalisation should be implemented 145. These nations have decriminalised drug possession to some extent and have demonstrated positive outcomes, such as reduced rates of drug-related harm and improved focus on treatment and recovery initiatives rather than criminalization 146.

Furthermore, decriminalisation would not put the UK at odds with its international institutions. The approach adopted by Portugal, involving decriminalisation in conjunction with the augmentation of public health strategies, has been endorsed by the International Narcotics Control Board “as a model of best practices" 147, and the UN Chief Executives Board for Coordination has explicitly endorsed the “decriminalisation of drug possession for personal use” 148.

Both the Health and Social Care Committee (2019), the Scottish Affairs Committee (2019), and the Scottish Government (2023) have joined the ACMD in recommending decriminalisation. Despite the mounting evidence and recommendations from reputable sources advocating for decriminalisation, the government's stance remains resistant. Unsurprisingly, the government has stifled these recommendations, despite mounting evidence that decriminalising possession can significantly attenuate the harms caused by drugs, be cost-effective and does not increase drug use 149–152. It is imperative that the government heeds the guidance and expertise of its Council of experts, not only to minimise the harms associated with drug misuse and save valuable resources, but also to position the country as a forward-thinking global leader in evidence-based drug policy.

The examples outlined above underscore the significant ramifications that ignoring the Advisory Council on the Misuse of Drugs can have on the UK's economy, public health, and bioscience sector. As a statutorily-appointed panel specialising in substance abuse issues, the ACMD comprises visionary experts capable of anticipating the unintended outcomes of various drug policies. These experts also possess the foresight to identify emerging challenges in the swiftly evolving landscape of psychoactive substances. Their assessments are conducted independently, free from the distortions of political or media influence that could compromise the integrity of their findings. The cyclical nature of history makes it crucial to heed the lessons learned and take decisive action. This would ensure that the ACMD's counsel is taken into account, preventing the repetition of past errors.

3. FUNDING AND OPERATIONAL ISSUES BETWEEN THE ACMD AND THE HOME OFFICE

The relationship between the Advisory Council on the Misuse of Drugs (ACMD) and the Home Office has been complex and fraught with significant concerns. Crucial issues encompass the apparent influence and oversight the Home Office has over the ACMD, potentially undermining its independence. This includes the worrying decline in self-commissioned work by the ACMD, consistent repression of the Council's proactive recommendations, and concerns over a shift towards more political influence on drug policy. The Secretariat's potential bias as a Home Office employee, funding cuts linked to controversial decisions (such as the dismissal of Chair David Nutt), and the lack of implementation of the ACMD's advice, have all contributed to the uneasy relationship. Calls for independent oversight, recurring reviews, and proper resource evaluation have often been stalled or ignored. This scenario has led to perceptions of unaccountable influence and possible suppression of evidence-based policy by the Home Office, setting the stage for a more in-depth examination and analysis of the ACMD's past reports and newly collected survey data in the subsequent sections of the report.

Working Protocol Between the Home Secretary and the ACMD

In 2011 a working protocol was developed to establish a framework for collaboration between the Home Secretary and the ACMD 9. This document may have been prompted by the dismissal of Prof David Nutt and his perceived stepping out of line by the government. The working protocol delineates the roles and responsibilities of the Government and the ACMD in providing and receiving advice on matters related to drug misuse, guided by evidence-based policy making. The protocol supports the ACMD's duties under the Misuse of Drugs Act 1971, including both advice sought by Ministers and consideration of issues by the ACMD independently.

As part of this working protocol, the ACMD commits to aligning with the Government's communicated priorities, responding to specific requests, and considering other work within its resources. The ACMD will be guided by Ministerial priorities in formulating a 3-year work program and will inform Ministers of its plans and timelines. If difficulties arise in providing or prioritising advice, the ACMD Chair will discuss the reasons with Ministers. The ACMD will publish its advice concurrently with presenting it to Ministers, unless there are pressing reasons to withhold it, such as national security or public health. The Chair will report annually on progress and ensure that substantive matters related to drugs policy are brought to Ministers' attention before making public statements.

On the other hand, when commissioning advice from the ACMD Ministers commit to considering the ACMD's current program, including self-initiated work. The protocol further stipulates that Ministers will not prejudge ACMD's advice and will engage in

regular and annual meetings with the ACMD Chair and Council. Responses to the ACMD's advice must be considered appropriately, and if recommendations are rejected, Ministers will discuss with the ACMD Chair and provide written reasons before public comment. A decision and response on recommendations are expected within 3 months, with flexibility depending on the nature of the advice and interdepartmental consultation. The ACMD will be informed if there are delays. Additionally, the Home Office will continue to provide the ACMD with professional government information services, ensuring the preservation of the ACMD's independence in areas such as media handling.
Despite the well-defined working protocol between the ACMD and the Government, there have been instances where the agreed-upon guidelines seem not to have been respected. For example, there have been perceptions of advice being prejudged, as seen in the handling of matters related to cannabis and nitrous oxide, where governmental decisions appeared to be made prior to thoroughly considering the ACMD's advice. Furthermore, some reports, such as the one concerning CBD for consumer products, have not been responded to within the stipulated timeframe, if at all, indicating a disregard for the protocol's responsiveness clause. Additionally, the ongoing issue of inadequate funding for the Council has severely hindered the ACMD's ability to commission independent research, limiting their efficacy and potentially undermining the intended collaborative and evidence-based approach to policymaking.

The Drug Policy Ratchet Problem

The "drug policy ratchet" describes the tendency of drug policies to become progressively stricter and more punitive, rarely being relaxed or reversed 153. This phenomenon can be attributed to several factors. Politicians, often under public pressure to appear decisive, may adopt stringent drug measures in response to media coverage, high-profile incidents, or prevailing public sentiments, even if such measures aren't always in the long-term public interest 5,11,154. Media outlets, through their sensational portrayal of drug-related stories, can amplify public fears and drive demands for more punitive measures. Once enacted, these strict policies become difficult to roll back, as politicians may fear being labelled "soft on drugs" or may believe that relaxing laws sends the wrong message 153. Furthermore, the policies themselves can be reactionary, prioritising moralistic stances over evidence-based approaches 155. This reactive nature can lead to a self-perpetuating cycle: as stricter policies might spur increased black market activities or other unintended consequences, these very problems can then be cited as reasons to tighten policies even further. In essence, like a ratchet tool that only turns one way, drug policies, once made stricter, prove challenging to moderate or reverse, even in the face of evidence suggesting the benefits of a more lenient approach 153.

The "drug policy ratchet" effect is notably evident in the context of the UK's drug policies 156. Historically, the UK has tended to adopt increasingly stringent drug measures in response to episodic moral panics, media frenzies, or particularly high-profile incidents, rather than being guided primarily by scientific evidence or harm reduction principles. One notable example is the classification of cannabis. Despite scientific evidence suggesting its harm was comparatively low, cannabis was reclassified from Class C to Class B in 2009, largely in response to media campaigns and perceived public

sentiment 11. This was against the repeated advice of the Advisory Council on the Misuse of Drugs (ACMD).

Furthermore, the introduction of the Psychoactive Substances Act 2016, aimed at curbing the use of 'legal highs', has been critiqued for its broad scope, which criminalises a vast array of substances without clear evidence of their harm. The Act also shifted the paradigm from banning known harmful substances to prohibiting all psychoactive substances by default, unless specifically exempted.

The challenge in the UK, as with the ratchet problem universally, is that once a drug is classified or a policy is tightened, political pressures make it difficult to revert or relax the stance. Politicians often fear the potential backlash of appearing lenient or complacent. This political conservatism, often influenced by sensationalist media narratives, has sometimes placed the UK at odds with more progressive, evidence-based drug policies observed in other European nations. Importantly, the drug policy ratchet disregards scientific evidence and continues to maintain the same policies despite evidence of their harms 157.

Stevens and Measham provide a historical analysis of the ACMD's recommendations in their 2014 paper on the drug policy ratchet. They observed that up until 2014, the ACMD's advice on drug specific reports had been for the most part heeded by the government 153. However they note that in the instances where the ACMD's advice had been explicitly rejected by the government it was in the case of drug policies where the ACMD recommended less stringent controls than those implemented by the government (e.g. regarding the control of cannabis in 1978 and 2008, MDMA in 2009 and khat in 2013)153. Further analysis of the ACMD's drug specific reports posted online since 2014 10 indicate a similar trend. Indeed since 2014 the ACMD has made 2 recommendations to not classify a drug under the Misuse of Drugs Act (e.g. Sunosi and Nitrous Oxide). In 50% of those cases the government has rejected the ACMD's recommendations. It is noteworthy that when the government decides to increase the classification of a substance, this action takes precedence over all other recommended measures, such as enhancing monitoring and education, as seen in the response to nitrous oxide and GHB. Furthermore, it should be highlighted that since 2014, no review has been commissioned by the ACMD to assess the classification of any compound with the intention of declassifying it.

Survey of Past and Current Members of the ACMD

An online survey was carried out to better grasp the inner workings of the Council, its independence, and gauge the extent to which ACMD members felt their advice was heeded. This effort was carried out by the All-Party Parliamentary Group for Drug Policy Reform. The survey was distributed to both current and former ACMD members. Of the 22 respondents, 71.4% had served as past members, and both groups exhibited similar rates of completion for the 23-question survey, which included a mix of multiple-choice and written responses.

The survey responses shed light on several key strengths of the ACMD in its capacity to

advise the government on drug policy. Participants consistently highlighted the ACMD's substantial expertise and the dedicated commitment of its members to conducting meticulous evidence reviews on a voluntary basis. However, there were recurring concerns raised regarding the Council's independence, with some respondents noting that the ideal of independence is not always fully realised in practice. Moreover, while the ACMD was acknowledged for its multidisciplinary composition, including academics, clinicians, and practitioners, there were indications of perceived challenges in translating its recommendations into tangible policy actions. This disconnect was attributed to a perceived lack of implementation of the ACMD's advice by the government.

Additionally, respondents raised significant concerns about the Council's funding limitations, which were seen as a substantial impediment to its overall efficacy. The ACMD's pivotal role in informing drug policy was recognized, yet its potential was constrained by inadequate financial support. Despite its exceptional expertise and adaptability, the ACMD's ability to effectively address pressing drug policy issues was hindered by these notable obstacles. Efforts to enhance the council's independence, ensure the implementation of its recommendations, and secure adequate funding were identified as critical steps toward optimising its impact on shaping effective drug policies.

Recommendation 7: Enhance Political Expertise on the Council

In light of the perceived challenges in translating the ACMD's evidence-based recommendations into tangible policy actions, it is recommended to bolster the council with increased political expertise. By including members with a deep understanding of the legislative process and political landscape, the council can bridge the gap between evidence and law. This addition will enable the ACMD to formulate recommendations that are not only scientifically robust but also practically feasible within the existing political framework. Such an approach will strengthen the council's influence and ensure that its vital insights are more effectively integrated into drug policy legislation.

ACMD Independence and Authority

Survey respondents identified several areas where they believe the ACMD lacks independence or faces interference, affecting its effectiveness. These include concerns about independence erosion, particularly due to pre-emptive substance classifications and reduced autonomy in exploring matters. Restrictions on public expression were highlighted as well, emphasising the need for fair and independent private advice. Additionally, respondents mentioned expertise barriers, such as disqualifying qualified experts based on social media posts, the need for more diverse expertise, and better secretarial support. The lack of an independent research budget was identified as a hindrance to producing evidence-based reports. Finally, worries were expressed about political interference, with concerns about ministerial oversight leading to interference and intimidation to align with government positions.

Importantly, 94% of respondents said the ACMD’s recommendations are not adequately

considered and implemented by the government. Several reasons were identified as causing the lack of implementation of advice. These factors include political expediency, where political considerations and the perceived need to act quickly often override evidence-based recommendations and decision-making processes. Planned rejection of recommendations was also highlighted, suggesting that the government sometimes rejects the advisory group's recommendations due to predetermined decisions, political motivations, perceived public perception, or preconceptions. Furthermore, respondents expressed concerns about the lack of government responsiveness, believing that the government does not adequately listen to or consider the advice given by the advisory Council, or does so in an untimely manner. Underfunding of the advisory Council was mentioned as a contributor as well, leading to concerns about the wrong people being on the committee and a consequent lack of impact or effectiveness. Finally, frustration was expressed regarding unaddressed recommendations, especially when less contentious but important recommendations concerning populations affected by drug harms are not followed up.

Recommendation 8: Establish a Formal Oversight Body for Accountability

Given the substantial concerns regarding the lack of implementation of the ACMD's recommendations, as well as the need for greater accountability and responsiveness from the government, we recommend the formation of a formal independent oversight body. This body should be tasked with the following key responsibilities:

Follow-up on Agreed Recommendations: Regularly monitor and assess whether the government is implementing the ACMD's recommendations that it has accepted. This will ensure that evidence-based advice is translated into actionable policy.

Evaluate Rejected Recommendations: Analyse and publicly report on the consequences of the Home Office's decisions when it chooses to reject the ACMD's recommendations. Such evaluations will provide transparency and may reveal whether political motivations or other non-evidence-based factors have influenced the decisions.

Enhance Accountability and Independence: Act as a safeguard against political interference, intimidation, and other factors that have been identified as undermining the ACMD's effectiveness and independence.

Report on Implementation and Consequences: Produce regular reports outlining the status of implementation of the ACMD's recommendations and the consequences of the government's decisions. These reports should be publicly accessible, thereby fostering transparency and accountability.

By forming this oversight body, the government will demonstrate a commitment to respecting and acting upon expert advice, thereby strengthening the trust between the ACMD, the government, and the public. This recommendation aims to bridge the gap between evidence-based policy recommendations and political decision-making, ensuring that the vital work of the ACMD translates into impactful drug policy.

Survey respondents are overwhelmingly in favour of transitioning the ACMD's sponsorship from the Home Office to another governmental department, with 72% advocating this change. The Department of Health and Social Care (DHSC) emerges as the preferred alternative, reflecting a desire for a health-focused approach to drug policy rather than conviction. Although the Home Office's lead role in drug-related matters is acknowledged, there is consensus that a placement under the DHSC can more effectively address drug-related harm from a public health perspective. The Scottish Government's similar shift is cited as a precedent, and some suggestions also extend to possible cross-departmental arrangements involving the Department for Digital, Culture, Media & Sport. Emphasis on maintaining science-based, non-political guidance from the ACMD is consistent. Moreover, when considering the ACMD's potential for greater impact, 50% of participants expressed support for the Council to possess legislative power to enhance the implementation of its advisory role.

Clearly, both former and present Council members perceived their autonomy to be compromised in the hiring process, overseen by the Home Office. When queried about the Home Office's impact on member selection for the ACMD, 64.7% highlighted a dual concern—undue influence and an underlying agenda (Figure 4).

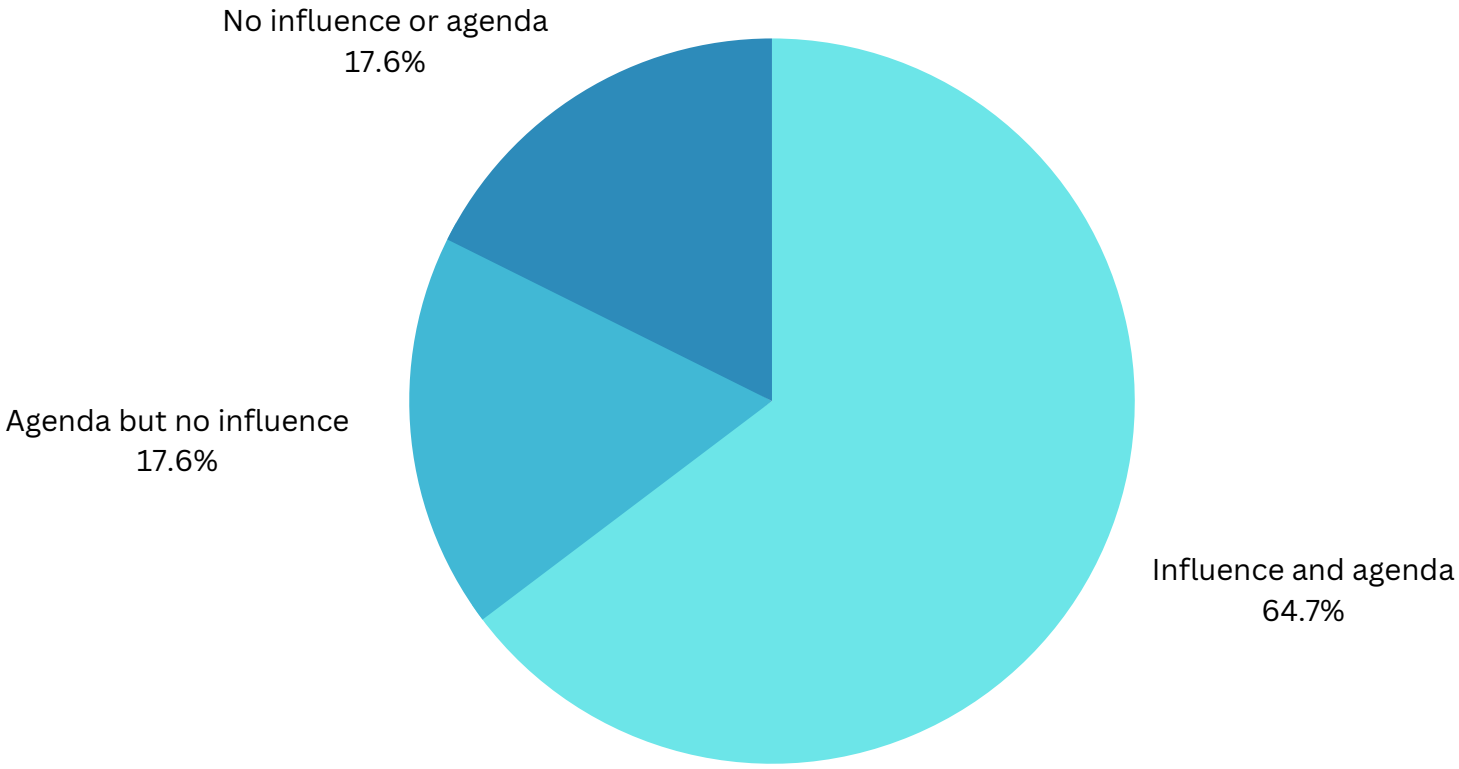


Figure 4: Most respondents perceived that the Home Office has undue influence and an agenda when conducting appointments to the ACMD.

Recommendation 9: Decentralization of Appointment Authority

Transition of Sponsorship: Given the importance of a health-focused approach to drug policy, it is recommended that the oversight of the Advisory Council on the Misuse of Drugs (ACMD) be transferred from the Home Office to the Department of Health and Social Care (DHSC).

Inclusion of Multiple Ministries: To mitigate concerns of undue influence and political agendas in member selection, the appointment process for new ACMD members should be a collaborative effort involving ministers from the DHSC and the Department for Digital, Culture, Media & Sport with equal decision-making powers.

Democratization of Chair Selection: To enhance the autonomy and scientific integrity of the ACMD, it is recommended that the selection process for the new Chair include input from both the outgoing Chair and the Council members at large.

Collaboration and Stakeholder Engagement

The ACMD was perceived as communicating very effectively with the Home Office and other relevant departments (5.56% responded extremely effectively; 61.11% responded very effectively; 16.67% responded moderately effectively). An overwhelming consensus emerged from the survey, with 94.12% of respondents advocating for enhanced international collaborations and initiatives for the ACMD. This sentiment underscores the perceived need to facilitate knowledge exchange, bolster research endeavours, and harmonise policy strategies in the domain of drug misuse. Several key suggestions were put forth to strengthen international ties and collaborations. While acknowledging the potential benefits of such engagements, some respondents noted resource limitations that could impede effectiveness. Brexit was cited as a factor affecting liaison with certain international bodies, and there was a call to pool resources and expertise, particularly with organisations like the EMCDDA. Additionally, respondents emphasised the advantages of forging stronger connections with counterparts in the United States, United Nations, Europe, and Australia. There was an urging to explore avenues such as joint reviews of new psychoactive substances and cross-border working groups. The shared sentiment was that broader international collaboration holds immense potential, contributing to a comprehensive and globally informed approach to drug policy and mitigation.

The level of engagement between the Council and non-governmental stakeholders, including third-sector organisations and experts, for the purpose of gathering diverse perspectives on the issues under consideration, was assessed to be of moderate quality (Figure 5).

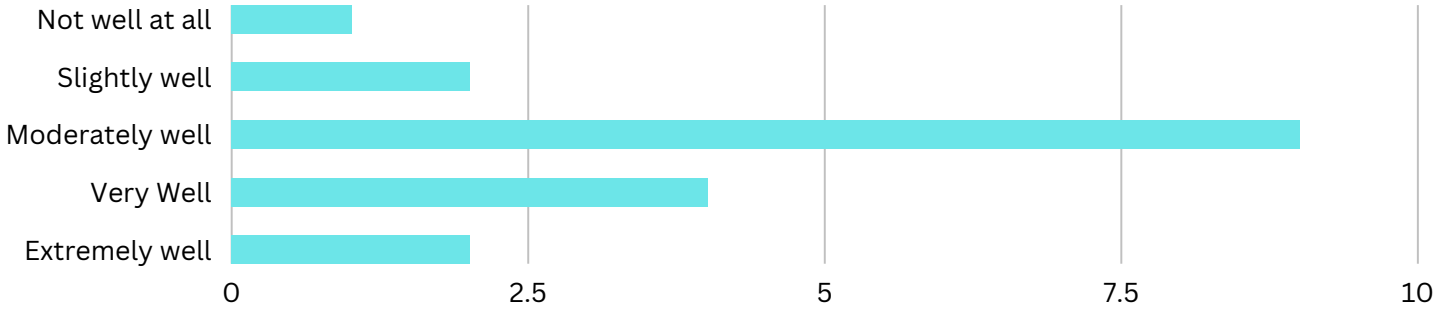


Figure 5. The ACMD is perceived by past and current members as engaging moderately well with other stakeholders and the public, and gathering diverse perspectives when formulating policy recommendations

Recommendation 10: Establish a Memorandum of Agreement with the EMCDDA (or the newly formed EU Drugs Agency)

In alignment with the strong sentiment expressed by survey respondents advocating for enhanced international collaborations, and recognizing the specific call for closer ties with organizations like the EMCDDA, we recommend the establishment of a formal Memorandum of Agreement (MoA) between the UK and the EMCDDA (or the newly formed EU Drugs Agency).

The objectives of this MoA would include:

Fostering Stronger Relationships: Facilitate ongoing dialogue, collaboration, and trust between the two organizations, building a solid foundation for shared initiatives.

Knowledge Sharing: Enable a fluid exchange of research, data, and best practices in the domain of drug misuse. This will enhance both the evidence base and the policy-making process in the respective jurisdictions.

ACMD Involvement: Engage the ACMD in the process of formulating and implementing the MoA, capitalizing on their expertise and ensuring alignment with the national context and priorities.

Collaborative Efforts: Explore joint reviews of new psychoactive substances, cross-border working groups, and other cooperative initiatives that leverage the strengths of both parties.

Brexit Considerations: Address and mitigate any barriers arising from Brexit that might affect liaison with the EMCDDA, ensuring a seamless and effective partnership.

By formalizing this collaboration through an MoA, the UK can tap into a rich vein of international expertise and perspective. This will not only contribute to a globally informed approach to drug policy but also underscore the UK's commitment to a comprehensive and collaborative strategy in addressing drug misuse.

Effectiveness and Adaptability

In terms of its ability to navigate the swiftly evolving terrain of drug policy, the Council garnered diverse perceptions. A notable 44.44% of respondents voted for a moderate level of adeptness, while 33.33% lauded its proficiency as "very well." An additional 5.56% went so far as to endorse an "extremely well" rating. Conversely, 16.67% of participants expressed reservations, deeming the Council's adaptability "not well at all."

Likewise, the ACMD's capacity to tackle emerging trends and novel substances in the realm of drug misuse was met with varying degrees of assessment. The perception of its readiness spanned a spectrum, with 22.22% perceiving a moderate level of preparedness. Overall 38.89% held the view that the ACMD was "very well" equipped and 27.78% attributed an "extremely well" rating to its capabilities. Nevertheless, 11.11% of respondents indicated scepticism, believing that the Council's readiness in this aspect was lacking.

Accountability and Transparency

The survey elicited noteworthy recommendations for enhancing accountability and transparency within the ACMD. Respondents advocated for more accessible documentation, suggesting that minutes, agendas, and discussions be readily available to the public. To mitigate potential biases, there was a proposal to reduce leading discussions by the chair and working group chairs, with the alternative of annotated minutes prepared by the Secretariat. A key theme emphasised the necessity of transparency, urging that all ACMD reports be made publicly accessible and that the government responds to these reports in a timely manner. An intriguing proposal put forth was the potential integration of the ACMD within the offices of the Chief Medical Officer (CMO) or Chief Scientific Officer (CSO), coupled with a call for securing an adequate budget to support rigorous evidence reviews. These insights underscore a collective aspiration for a more open, responsive, and credible advisory process in shaping drug policy.

Improving the ACMD and UK drug Policy

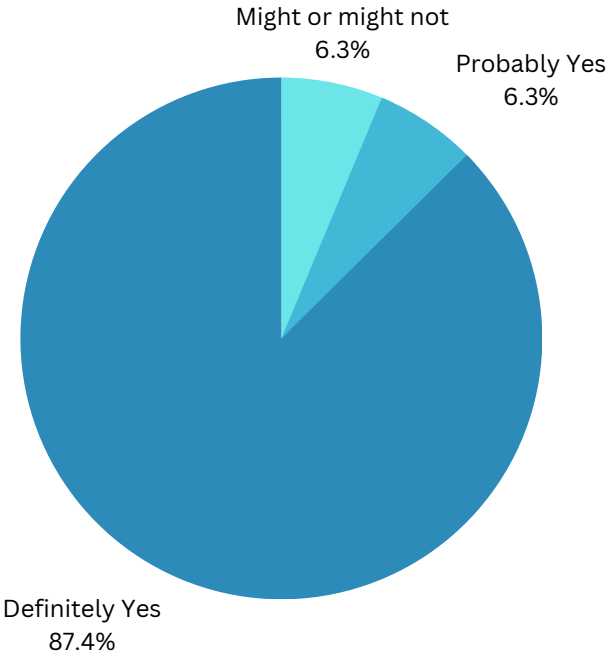
The survey responses revealed a range of pressing concerns and recommendations for reform in the realm of drug policy, indicating areas of urgency and potential improvement for the ACMD's focus. Many respondents highlighted specific issues they believed warrant immediate attention. A notable suggestion was for the ACMD to be entrusted with reviewing the efficacy of medical uses of currently controlled substances, and aligning policy decisions with scientific evidence. The discrepancy between sentencing and classification for drugs like cannabis was emphasised, with a call for formalising classification and revisiting past recommendations.

With regards to enhancing the functioning of the Council, survey participants underscore the need for enhanced resources and support to bolster the Advisory Council on the Misuse of Drugs (ACMD)'s research capabilities and enhance the quality of its advisory role. When asked whether the ACMD would benefit from additional funding, 87.5% of respondents said: “Definitely yes” (Figure 6).

Decriminalisation of cannabis emerged as a recurring theme, alongside the need for better regulation of drug possession. Respondents stressed the importance of assessing the cost and harms of drug criminalisation and urged the ACMD to consider updated guidelines. Addressing opioid-related deaths, revisiting previous recommendations, and catering to vulnerable groups were also urged.

The implementation of drug consumption rooms and engaging with European Governments on cannabis legislation were suggested. Calls for updated clinical guidelines, reform aligned with international practices, and intensified research efforts were prevalent. Respondents underscored the significance of primary care involvement, the need for a fundamental review of national drug policy, and the consideration of licensing less harmful substances. Uniformity in prescribing practices, reevaluation of the Misuse of Drugs Act, and a shift away from knee-jerk prohibition were also cited. These multifaceted recommendations collectively emphasise the need for a comprehensive and adaptable approach to drug policy reform, underlining potential avenues for the ACMD to enhance its role and impact in improving the current landscape.

Central to improving the ACMD is the proposal for the Council to have its own dedicated research budget, enabling it to conduct independent and rigorous research activities. The lack of a research budget and capacity is identified as a current limitation, prompting the call for allocated funds for literature reviews, consultations, and evidence reviews similar to established policy units like NICE or NIHR. Respondents emphasise the significance of a more robust secretariat and a dedicated team of researchers to assist in report preparation and evidence gathering. Furthermore, the idea of postdoctoral fellows to aid in labour-intensive tasks and support the ACMD's activities gains traction.



Do you believe the ACMD would benefit from additional funding?

Figure 6. The vast majority of past and current members of the ACMD believe the ACMD would benefit from additional funding.

The importance of engaging a wider range of perspectives is also highlighted, with suggestions for improved selection of council members and the engagement of affected communities and service providers. There is a notable call for increased engagement and collaboration with various government departments to ensure a comprehensive and well-rounded approach to drug policy. Greater resourcing of the secretariat, longer terms for council members, and enhanced engagement practices within the ACMD itself are among the strategies recommended to bolster the Council's research capabilities and advisory functions. Overall, respondents emphasise the necessity of a dedicated research budget, expert staffing, and comprehensive engagement strategies to elevate the ACMD's research prowess and enhance the quality of its advice.

Recommendation 11: Equip the ACMD with a Dedicated Research Budget and Staff Support

To augment the ACMD's capacity to conduct independent and rigorous research activities, we recommend the following measures:

Establish a Dedicated Research Budget: Allocate a specific budget to the ACMD for conducting independent research, including literature reviews, consultations, and evidence reviews. This budgetary provision will enable the ACMD to commission its own research, akin to established policy units like NICE or NIHR, thereby enhancing its autonomy and analytical capabilities.

Create a Dedicated Research Team: Form a team of researchers, analysts, and postdoctoral fellows specifically assigned to assist the ACMD. This team would be responsible for conducting comprehensive literature reviews, gathering evidence, preparing reports, and analyzing emerging trends in the field of drug misuse.

Strengthen the Secretariat: Provide robust support to the ACMD's secretariat to ensure streamlined operations, coordination, and oversight of research activities.

Regularly Evaluate Needs and Resources: Implement a periodic assessment to ensure that the ACMD's research budget and staff resources are aligned with its evolving needs and objectives.

By implementing these measures, the ACMD will be equipped to pursue in-depth analysis, develop evidence-based recommendations, and respond proactively to emerging challenges in the domain of drug misuse. This approach reinforces the ACMD's role as an independent and authoritative body, aligns it with best practices in policy research, and supports a holistic and responsive drug policy framework in the UK.

Analysis of the ACMD's past reports

Systematic Review of the ACMD's Publications available online

To systematically assess the interaction between the Advisory Council on the Misuse of Drugs (ACMD) and the Home Office, a comprehensive examination of all publicly available ACMD reports was conducted. The gov.uk search function was employed to identify relevant reports, with the search criteria specifically targeting publications authored by the ACMD 10. This search yielded a total of 281 reports. These were subsequently catalogued in a spreadsheet for further scrutiny. Manual inspection was then undertaken to eliminate duplicate reports, annual reviews, calls for evidence, and other correspondence directed to the ACMD. This curation process resulted in a selection of 136 original reports and letters produced by the ACMD, encompassing a timeframe from 2003 (the date of the earliest identified online publication) to July 2023 (when the search was conducted). In addition to cataloguing ACMD-authored reports, efforts were made to locate corresponding government responses for each publication. This involved a combination of Google search and direct navigation through the gov.uk website, ensuring a comprehensive analysis of the interactions between the ACMD and the Home Office. This systematic approach facilitated a robust evaluation of the communication and engagement between these two key entities in UK drug policy governance.

Findings

Part of the ACMD's remit states that the Council has the responsibility "*to give to any one or more of the Ministers, where either the 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*" 8. As such, it is crucial that the experts on the Council be equipped to proactively recommend policy changes to Ministers. This enables them to adequately address emerging drug trends in the country that might not be immediately apparent or concerning to those who are not experts in the field. However, the ACMD's ability to fulfil this role has been questioned due to its limited resources, as highlighted by the triennial review of NDPBs and responses to our survey. Analysis has revealed that the rate of self-commissioned reports by the ACMD has been on a steady decline over time (Figure 7) with a total average of 37%. This trend underscores the need for a critical evaluation of the Council's capabilities and resources to ensure it continues to effectively fulfil its vital role in drug policy.

One factor which may contribute to the lack of proactive reports by the ACMD is the lack of implementation of their advice when it was not commissioned, or even a lack of response. Indeed while the average non-response rate for commissioned reports was 28%, for self-commissioned reports the non-response rate of the government was 37%. Another factor which may contribute is the lack of resources of the Council as noted in a review of the ACMD in which the annual reports were not even being published owing to a lack of resources of the secretariat. Furthermore, self commissioned reports which the government does not agree with may be stifled, as was a report advocating for the

decriminalisation of possession of small quantities of drugs.

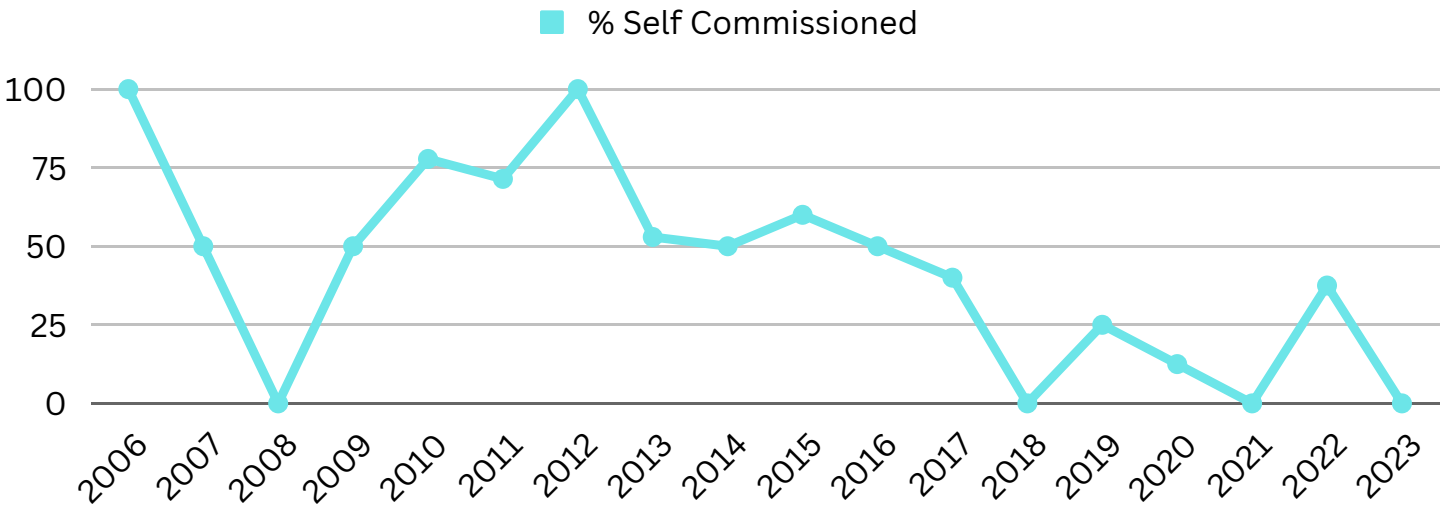


Figure 7. The proportion of self commissioned reports published by the ACMD has been decreasing in the last 10 years. Reports were retrieved from the government's website 10 The downward trend underscores potential challenges in the council's capacity to independently evaluate and respond to emerging drug-related issues.

Overall the rate of government response to the ACMD's reports is severely lacking. The ideal response rate of 100% was attained only in one year since the introduction of the 2011 code of practice. This occurred in 2017 and was followed by a severe dip in 2018 (Figure 8). The average % of reports formally responded since 2011 to is 66.99%.

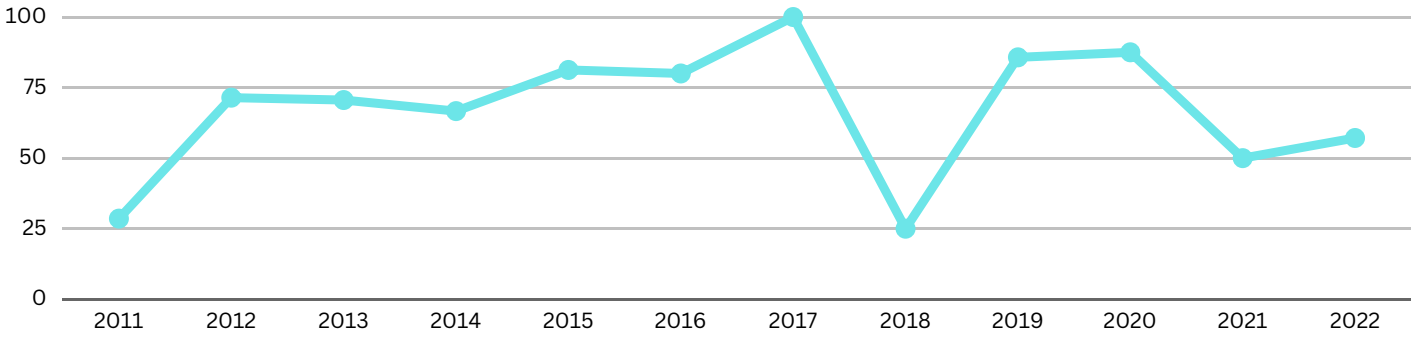


Figure 8. The Government consistently fails to formally respond to the ACMD. These values represent the average percentage response rate for all ACMD reports published in a given year

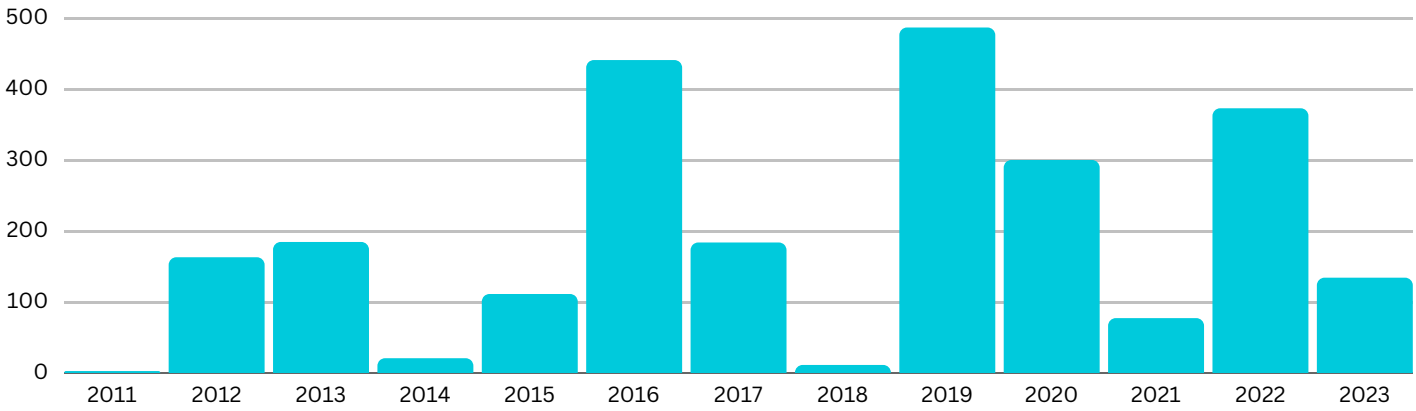


Figure 9. The Government consistently fails to formally respond to the ACMD's reports in the agreed upon time frame of 3 months. These values represent the average response for all ACMD reports published in a given year. Red line indicates the agreed upon 90 days response time, analysis shows that the government fails consistently to meet the agreed upon response time to ACMD reports. It is of note that in years when the government respected the agreed timeline, few reports were responded to (e.g 2011 = 28.5%; 2014 = 66.66%; 2018 = 25%) see figure 8.

In terms of the average response time, the government also consistently fails to meet its commitments. This is particularly concerning given the rapid changing pace of the drugs field and the need for rapid response to stop problems in their tracks. Indeed Figure 9 above shows that the yearly average response time for ACMD reports published only achieved the agreed upon deadline of 90 days on 3 occasions. This in itself may be misleading however. In 2018 where the average response time was 10 days the response rate was only 25% (4 reports published, one responded to). Furthermore, in 2021 where the government's average response time was 76 days, the yearly response rate was only 50% (2 reports published, one formally responded to). Finally in 2011, when the code of practice was published, the response rate was 1 day, however out of the seven reports published only 2 were responded to.

Structural Changes in UK Drug Policy

The current UK drug policy framework has been found to lack a clear focus on evidence-based solutions and effective monitoring and evaluation processes 43. While independent and governmental reviews have identified this issue, little has been done to address it. The solution lies in structural reform, not just individual policy changes. The ACMD can play a key role in ensuring that evidence-based advice is considered and implemented, but there needs to be improved effectiveness in the relationship between the ACMD's advice and resulting policies. Additionally, political motivations must be removed from the decision-making process in order to focus on evidence and create a delivery model that is able to compromise between competing needs, admit uncertainty, find flexibility, and be adaptive to new evidence or evaluations of existing programs. Below two suggestions are made for structural reform which would increase the independence and decision making power of the ACMD, thereby strengthening the role of evidence in the design of UK drug policy.

Reforming the ACMD: Learning from the Bank of England's Independence Model

David Nutt, a former Chairman of the ACMD, has put forth a progressive proposal that draws parallels between the structure of the Bank of England and how the ACMD should function. He suggests that, just as the Bank of England was reformed to independently handle financial decisions such as setting interest rates and monitoring risks in the financial system, the ACMD should also be afforded a similar level of autonomy in making drug policy decisions. This would enable the Council to operate independently of government influence, potentially leading to more evidence-based and unbiased decision-making processes 158.

In 1997, the Bank of England was granted operational independence to set interest rates, a power previously held by the Chancellor of the Exchequer. This reform led to the creation of the Monetary Policy Committee, responsible for setting the official Bank Rate, with a primary objective of achieving price stability through meeting the government's inflation target. The shift was aimed at depoliticising interest rate decisions, enhancing the credibility and transparency of monetary policy, and aligning the UK with the practice of central bank independence found in other major economies 159. The change is seen as contributing to a more stable economic environment in the UK 160. Crucially,

although it is independent, the Bank of England is overseen by a board of Directors and is accountable to Parliament and the public 159.

As has been noted throughout this report, politics can have a negative impact on the development of drug policy, as it can skew the focus towards self-defeating goals and perpetuate flawed notions rooted in stigma, fears of public perception, and media sensationalisation. Political motivations can also interfere with evidence-based decision making and result in a lack of clarity on principal policy goals and sensible metrics. This can lead to unintended consequences and maintain the same focus on ineffective policies. It may therefore be useful to establish a Council responsible for drug policy decisions which can operate independently of government, thereby minimising the risk of political interference and biases. Structuring the Council similarly to the Bank of England's Monetary Policy Committee could foster a more evidence-based, transparent, and health-focused approach to drug policy. Such a move would align drug policy with public health objectives rather than political ones, leading to more effective interventions and regulations. This independent Council could be responsible for assessing the current state of drug-related issues, setting clear strategies, and recommending evidence-based policies. Being overseen by a board of directors and accountable to Parliament and the public, it would ensure an ongoing commitment to transparency, credibility, and a more holistic approach to addressing drug-related harm in the UK. Similar to the Bank of England's reform, this structural change could contribute to a more stable and well-considered framework for drug policy, reducing the influence of political agendas and allowing for a more coherent, scientifically grounded strategy.

Empowering the ACMD: From Advisory to Executive Role

The ACMD currently serves as an advisory non-departmental public body (NDPB), but its effectiveness in shaping drug policy is often hampered by political considerations. A proposed transformation of the ACMD into an Executive NBPD could alleviate this issue

Advisory NDPBs are primarily established to provide independent, expert advice to Ministers and are often set up administratively, with members appointed for their individual skills. Although they may be supported by civil servants, their main function is to provide advice, and Ministers have the authority to wind them up. In contrast, Executive NDPBs carry out administrative, commercial, and regulatory functions at arm's length from ministers, often established in bespoke legislation. Their structure includes independent boards and CEOs, and they have varying degrees of operational autonomy and independence. Unlike Advisory NDPBs, they manage their budgets, may generate additional income, and actively engage in implementing specific functions. The transformation from an Advisory NDPB to an Executive NDPB represents a significant shift from providing advice to a role of implementation, administration, and regulation, accompanied by greater autonomy and independent functionality. This shift illustrates a move from a more consultative role to one with direct power and responsibilities, reflecting a substantial change in mandate and operational structure.

An Executive NDPB is headed by a board comprising an independent, non-executive chair, and a majority of non-executive members. The board appoints a CEO with

day-to-day responsibility for managing the body, and the CEO and staff are not usually civil servants. These bodies may receive funding from their home department but are accountable for their own budget, publishing their annual report and accounts. Many also generate additional income through other sources, and some are funded by levies of particular sectors, receiving no central funding.

Transforming the ACMD from an Advisory NDPB to an Executive NDPB would represent a firm stance against drug-related issues, demonstrating a commitment to taking stronger measures and aligning with public desires for a more evidence-based and responsible approach. Furthermore, it would relieve ministers of the highly politicised task of deciding drug policy, placing decision-making in the hands of experts.

The transformation of the ACMD into an Executive NDPB would empower it with executive authority, enabling it to produce sustainable changes in drug policy that reflect scientific evidence and public health considerations. By distancing drug policy from political influence and ensuring that recommendations are both evidence-based and implemented, this change would lead to more effective interventions and regulations. The proposed transformation offers a promising pathway towards a more stable, transparent, and evidence-based framework for addressing drug-related issues in the UK.

Recommendation 12: Adopt Structural Reforms to Enhance the ACMD's Independence and Decision-Making Power

Given the critical limitations in the current UK drug policy framework and the key role that the Advisory Council on the Misuse of Drugs (ACMD) can play in shaping more evidence-based, effective approaches, it is imperative that structural changes be made to the council's operational model. Two promising avenues for reform have been identified:

1. Reforming the ACMD to function similarly to the Bank of England's Monetary Policy Committee would grant the council operational independence from governmental influence, thus fostering a more evidence-based, transparent, and public health-centered approach to drug policy.

2. Transforming the ACMD from an Advisory Non-Departmental Public Body (NDPB) to an Executive NDPB would imbue the council with executive authority, distancing drug policy from political sway and ensuring that evidence-based recommendations are not only made but also implemented.

Either of these structural changes would greatly enhance the independence and decision-making power of the ACMD, ensuring that the role of evidence is strengthened in the design of UK drug policy. This would, in turn, minimize the impact of political and media influences on drug policy decisions. Therefore, it is recommended that the UK government seriously consider adopting one of these structural reforms to ensure that the ACMD can more effectively serve its role in guiding the nation toward more effective and humane drug policies.

4. CONCLUSION

In light of the comprehensive analysis presented in this report, it is unequivocally clear that the ACMD plays a critical role in shaping drug policy in the United Kingdom. Given its statutory establishment in the first section of the Misuse of Drugs Act 1971, the proper functioning of the ACMD is not merely advisable, but integral to the legislative framework that governs drug policy in the UK. However, the Council's effectiveness has been substantially compromised by factors ranging from limited financial resources to ongoing disregard of its expert recommendations by governmental bodies and undue interference by the Home Office.

This concerning state of affairs does more than just undermine the ACMD's mandate; it has serious repercussions for public health, the economy, and the nation's standing in the field of biosciences. A deficient drug policy not only leads to inefficient allocation of resources but also compromises the wellbeing of UK citizens and stagnates innovative research in the realm of psychoactive substances.

This report has examined the myriad challenges and limitations facing the ACMD in its role as a critical influencer of drug policy in the United Kingdom. Based on this evaluation, a comprehensive set of recommendations is offered, aimed at rejuvenating the ACMD's efficacy, transparency, and impact.

Drug Classification System: It is crucial that the UK revamp its drug classification system to make it a truly scientific tool. This entails a systematic review and validation of existing drug classifications, led by the ACMD, to align them strictly with the relative harms and medical utilities of substances. A periodic review process should also be established to reflect ongoing research.

Transparency and Accountability: To rectify the long-standing issue of limited transparency in ACMD proceedings, meeting minutes and all the Council’s reports should be regularly published online. The implementation of regular reviews, as well as accountability mechanisms for both accepted and rejected ACMD recommendations, will serve to enhance the Council's credibility and operational effectiveness.

Funding and Resources: The Home Office must allocate increased funding to the ACMD, thereby enabling essential research and an expansion of the council's staff. Moreover, this funding should be transparently managed and audited to ensure that it is effectively utilised. ACMD members should also receive fair remuneration for their efforts, and the funding strategy should consider the broader economic benefits of effective drug policy.

Oversight and Research: Establishment of a formal oversight body is recommended for monitoring and accountability. A dedicated research budget should also be allocated to the ACMD, along with a committed research team to aid in its activities.

Decentralisation and Democratisation: The transition of oversight to the Department of Health and Social Care is recommended, along with a democratised appointment process that includes multiple ministries. This ensures a health-focused and multidimensional approach to drug policy.

Structural Reforms: To mitigate the risk of political influence, the UK government should consider structural reforms that enhance the ACMD's operational independence, perhaps modelling it on the Monetary Policy Committee of the Bank of England or transitioning it to an Executive Non-Departmental Public Body (NDPB).

As we move forward, it is crucial to empower the ACMD to act as an effective advisory body, free from the constraints that have hobbled it in recent years. Only by taking these vital steps can we ensure that UK drug policy is grounded in evidence-based science and best practices, fostering a safer, healthier, and more prosperous future for all. By implementing these targeted recommendations, the UK has the opportunity to reform the ACMD into an institution that is not only scientifically rigorous but also socially responsible and fiscally sound. This would mark a significant step towards developing a drug policy that is truly aligned with the principles of public health, scientific evidence, fiscal responsibility and help the UK attain the goals set out in the 10-year drug strategy; namely breaking the drug supply chain, delivering a world-class treatment and recovery system, and achieving a generational shift in the demand for drugs. As such, it is imperative that these recommendations be given serious consideration for the betterment of drug policy in the United Kingdom.

APPENDIX A: RECOMMENDATIONS

Recommendation 1: Reform and Validate the Drug Classification System

- **Commit to Accurate Representation**: Ensure that the Classification system functions solely as an indicator of the relative harms of drugs. The system should not be used to "send messages" to the public but must focus on a scientifically validated representation of harm.

- **Systematic Validation of Classifications**: Engage the ACMD in a thorough review of all current classifications and schedulings, aligning them with scientifically determined relative harms and medical utility. The review must be conducted objectively and transparently, free from political interference using reproducible and scientifically validated measures.

- **Regular Review and Alignment:** Implement a periodic review process, supervised by the ACMD, to ensure that both classification and scheduling according to the Misuse of Drugs Act and Misuse of Drugs Regulations accurately reflect ongoing research and understanding of substance-related harms.

By embracing these measures, the UK can cultivate a Classification system that is consistent, scientifically grounded, and reflective of the actual harms posed by different substances. This alignment would promote a more rational and effective approach to drug regulation, penalties, and societal understanding.

Recommendation 2: Increased Transparency in the ACMD Proceedings

- **Enhancing Transparency**: The Advisory Council on the Misuse of Drugs (ACMD) and the Home Office should commit to regularly posting meeting minutes online. This commitment will foster greater transparency and public trust, allowing stakeholders and the general public to have insight into the council's deliberations, recommendations, and the rationale behind their decisions. Ensuring consistent and timely access to this information would not only align with principles of openness and accountability but also contribute to a more informed public discourse on drug policy in the UK.

In light of the fact that the ACMD's minutes have not been posted since 2015, it is imperative to enhance transparency regarding the council's workings and decision-making processes.

Recommendation 3: Adequate Funding and Remuneration for the ACMD

The analysis of the ACMD's budget, responsibilities, and current limitations illustrates a pressing need for appropriate funding and support.

The following recommendations are proposed:

- **Increase Funding:** The Home Office should significantly increase the funding allocated to the ACMD. Adequate funding will enable the council to hire additional staff, conduct essential research, commission relevant studies, and fully fulfill their wide-ranging remit. This investment in the ACMD should be seen as a vital aspect of evidence-based and health-centered drug policy design and implementation, which has been proven to be cost-effective and beneficial to public health.

- **Remunerate Members:** Considering the important role that the ACMD members play, they should be fairly remunerated for their contributions. Providing compensation will allow members to commit more time and resources to the council, enhancing their ability to make proactive and informed recommendations.

- **Transparency and Accountability:** To ensure that the funding is used effectively, there should be clear and transparent guidelines regarding how the ACMD obtains and utilizes funds from the Home Office. Regular reviews and audits should be conducted to prevent undue influence or limitations imposed by the Home Office.

- **Align Funding with National Savings:** It should be recognised that a properly funded ACMD, operating with evidence-based principles, could lead to significant national savings in the overall cost of addiction and drug misuse. The investment in the ACMD should be seen in this broader economic and societal context.

By implementing these recommendations, the UK can ensure that the ACMD is empowered to act as a robust and independent advisory body, capable of shaping a drug policy that is grounded in scientific evidence, public health best practices, and fiscal responsibility.

Recommendation 4: Regular and Independent Reviews of the ACMD

- **Conduct Regular Independent Reviews:** To foster continuous transparency, effectiveness, and accountability within the ACMD, it is recommended that regular reviews of the ACMD be conducted at least every 5 years. These reviews should be carried out by an independent body, assessing the council's operations, decision-making process, communication with Ministers, and overall functioning. The findings and recommendations should be publicly available and actively implemented to address identified shortcomings or areas for improvement. A clear accountability structure must be established, and details of the review process, schedules, findings, and changes should be consistently published on official channels.

By adhering to this recommendation, the UK can ensure that the ACMD remains an effective and accountable public body in its proceeding with the Home Office, aligned with its objectives and the broader principles of public life.

Recommendation 5: Accountability for Implementing ACMD Recommendations

To ensure that the advice and recommendations of the ACMD are not only heard but acted upon, it is recommended that a clear mechanism be instituted to hold the Home Office accountable for implementing agreed-upon recommendations. This mechanism should include transparent processes, timelines, and regular updates, allowing both the ACMD and the public to track the progress and outcomes of implemented recommendations. Such an approach will reinforce trust, enhance collaboration between the ACMD and the Home Office, and foster a more responsive and evidence-based approach to drug policy in the UK.

Recommendation 6: Accountability for Rejected ACMD Recommendations

When the Home Office chooses to reject a recommendation made by the ACMD, it is vital that this decision is not made lightly or without transparent justification. Therefore, it is recommended that the Home Office be held explicitly accountable for the outcomes of decisions to reject ACMD recommendations. This accountability should include a detailed explanation of the reasons for rejection, the expected outcomes of the alternative approach, and ongoing monitoring and reporting on the effects of the decision. By ensuring that such rejections are carefully considered, justified, and tracked, the UK can foster greater transparency, accountability, and integrity in its approach to drug policy, and uphold the importance of evidence-based decision-making.

Recommendation 7: Enhance Political Expertise on the Council

In light of the perceived challenges in translating the ACMD's evidence-based recommendations into tangible policy actions, it is recommended to bolster the council with increased political expertise. By including members with a deep understanding of the legislative process and political landscape, the council can bridge the gap between evidence and law. This addition will enable the ACMD to formulate recommendations that are not only scientifically robust but also practically feasible within the existing political framework. Such an approach will strengthen the council's influence and ensure that its vital insights are more effectively integrated into drug policy legislation.

Recommendation 8: Establish a Formal Oversight Body for Accountability

Given the substantial concerns regarding the lack of implementation of the ACMD's recommendations, as well as the need for greater accountability and responsiveness from the government, we recommend the formation of a formal independent oversight body. This body should be tasked with the following key responsibilities:

- **Follow-up on Agreed Recommendations:** Regularly monitor and assess whether the government is implementing the ACMD's recommendations that it has accepted. This will ensure that evidence-based advice is translated into actionable policy.

- **Evaluate Rejected Recommendations:** Analyse and publicly report on the consequences of the Home Office's decisions when it chooses to reject the ACMD's recommendations. Such evaluations will provide transparency and may reveal whether political motivations or other non-evidence-based factors have influenced the decisions.

- **Enhance Accountability and Independence:** Act as a safeguard against political interference, intimidation, and other factors that have been identified as undermining the ACMD's effectiveness and independence.

- **Report on Implementation and Consequences:** Produce regular reports outlining the status of implementation of the ACMD's recommendations and the consequences of the government's decisions. These reports should be publicly accessible, thereby fostering transparency and accountability.

By forming this oversight body, the government will demonstrate a commitment to respecting and acting upon expert advice, thereby strengthening the trust between the ACMD, the government, and the public. This recommendation aims to bridge the gap between evidence-based policy recommendations and political decision-making, ensuring that the vital work of the ACMD translates into impactful drug policy.

Recommendation 9: Decentralisation of Appointment Authority

- **Transition of Sponsorship:** Given the importance of a health-focused approach to drug policy, it is recommended that the oversight of the Advisory Council on the Misuse of Drugs (ACMD) be transferred from the Home Office to the Department of Health and Social Care (DHSC).

- **Inclusion of Multiple Ministries:** To mitigate concerns of undue influence and political agendas in member selection, the appointment process for new ACMD members should be a collaborative effort involving ministers from the DHSC and the Department for Digital, Culture, Media & Sport with equal decision-making powers.

- **Democratisation of Chair Selection:** To enhance the autonomy and scientific integrity of the ACMD, it is recommended that the selection process for the new Chair include input from both the outgoing Chair and the Council members at large.

Recommendation 10: Establish a Memorandum of Agreement with the EMCDDA (or the newly formed EU Drugs Agency)

In alignment with the strong sentiment expressed by survey respondents advocating for enhanced international collaborations, and recognizing the specific call for closer ties with organizations like the EMCDDA, we recommend the establishment of a formal Memorandum of Agreement (MoA) between the UK and the EMCDDA (or the newly formed EU Drugs Agency). The objectives of this MoA would include:

- **Fostering Stronger Relationships:** Facilitate ongoing dialogue, collaboration, and trust between the two organizations, building a solid foundation for shared initiatives.

- **Knowledge Sharing:** Enable a fluid exchange of research, data, and best practices in the domain of drug misuse. This will enhance both the evidence base and the policy-making process in the respective jurisdictions.

- **ACMD Involvement:** Engage the ACMD in the process of formulating and implementing the MoA, capitalizing on their expertise and ensuring alignment with the national context and priorities.

- **Collaborative Efforts:** Explore joint reviews of new psychoactive substances, cross-border working groups, and other cooperative initiatives that leverage the strengths of both parties.

- **Brexit Considerations:** Address and mitigate any barriers arising from Brexit that might affect liaison with the EMCDDA, ensuring a seamless and effective partnership.

By formalizing this collaboration through an MoA, the UK can tap into a rich vein of international expertise and perspective. This will not only contribute to a globally informed approach to drug policy but also underscore the UK's commitment to a comprehensive and collaborative strategy in addressing drug misuse.

Recommendation 11: Equip the ACMD with a Dedicated Research Budget and Staff Support

To augment the ACMD's capacity to conduct independent and rigorous research activities, we recommend the following measures:

- **Establish a Dedicated Research Budget:** Allocate a specific budget to the ACMD for conducting independent research, including literature reviews, consultations, and evidence reviews. This budgetary provision will enable the ACMD to commission its own research, akin to established policy units like NICE or NIHR, thereby enhancing its autonomy and analytical capabilities.

- **Create a Dedicated Research Team:** Form a team of researchers, analysts, and postdoctoral fellows specifically assigned to assist the ACMD. This team would be responsible for conducting comprehensive literature reviews, gathering evidence, preparing reports, and analyzing emerging trends in the field of drug misuse.

- **Strengthen the Secretariat:** Provide robust support to the ACMD's secretariat to ensure streamlined operations, coordination, and oversight of research activities.

- **Regularly Evaluate Needs and Resources:** Implement a periodic assessment to ensure that the ACMD's research budget and staff resources are aligned with its evolving needs and objectives.

By implementing these measures, the ACMD will be equipped to pursue in-depth analysis, develop evidence-based recommendations, and respond proactively to emerging challenges in the domain of drug misuse. This approach reinforces the ACMD's role as an independent and authoritative body, aligns it with best practices in policy research, and supports a holistic and responsive drug policy framework in the UK.

Recommendation 12: Adopt Structural Reforms to Enhance the ACMD's Independence and Decision-Making Power

Given the critical limitations in the current UK drug policy framework and the key role that the Advisory Council on the Misuse of Drugs (ACMD) can play in shaping more evidence-based, effective approaches, it is imperative that structural changes be made to the council's operational model. Two promising avenues for reform have been identified:

1. Reforming the ACMD to function similarly to the Bank of England's Monetary Policy Committee would grant the council operational independence from governmental influence, thus fostering a more evidence-based, transparent, and public health-centered approach to drug policy.

2. Transforming the ACMD from an Advisory Non-Departmental Public Body (NDPB) to an Executive NDPB would imbue the council with executive authority, distancing drug policy from political sway and ensuring that evidence-based recommendations are not only made but also implemented.

Either of these structural changes would greatly enhance the independence and decision-making power of the ACMD, ensuring that the role of evidence is strengthened in the design of UK drug policy. This would, in turn, minimize the impact of political and media influences on drug policy decisions. Therefore, it is recommended that the UK government seriously consider adopting one of these structural reforms to ensure that the ACMD can more effectively serve its role in guiding the nation toward more effective and humane drug policies.

APPENDIX B: SECTION 1 OF THE MISUSE OF DRUGS ACT 1971 (REPRODUCED)

1 The Advisory Council on the Misuse of Drugs.

(1) There shall be constituted in accordance with Schedule 1 to this Act as Advisory Council on the Misuse of Drugs (in this Act referred to as "the Advisory Council"); and the supplementary provisions contained in that Schedule shall have effect in relation to the Council.

(2) It shall be the duty of the Advisory Council to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem, and to give to any one or more of the Ministers, where either the 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—

1 - for restricting the availability of such drugs or supervising the arrangements for their supply;

2 - for enabling persons affected by the misuse of such drugs to obtain proper advice, and for securing the provision of proper facilities and services for the treatment, rehabilitation and after-care of such persons;

3

3 - 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 such drugs;

4 - for educating the public (and in particular the young) in the dangers of misusing such drugs, and for giving publicity to those dangers; and

5 - 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.

(3) It shall also be the duty of the Advisory Council to consider any matter relating to drug dependence or the misuse of drugs which may be referred to them by any one or more of the Ministers and to advise the Minister or Ministers in question thereon, and in

particular to consider and advise the Secretary of State with respect to any communication referred by him to the Council, being a communication relating to the control of any dangerous or otherwise harmful drug made to Her Majesty's Government in the United Kingdom by any organisation or authority established by or under any treaty, convention or other agreement or arrangement to which that government is for the time being a party.

(4) In this section "the Ministers" means the Secretary of State for the Home Department, the Secretaries of State respectively concerned with health in England, Wales and Scotland, the Secretaries of State respectively concerned with education in England, Wales and Scotland, the Minister of Home Affairs for Northern Ireland, the Minister of Health and Social Services for Northern Ireland and the Minister of Education for Northern Ireland.

APPENDIX C: MEMBERS OF THE ACMD (AS OF APRIL 2023)

Chair: Dr Owen Bowden-Jones, Consultant Psychiatrist, Central North West London NHS Foundation Trust

Professor Judith Aldridge, Professor of Criminology at University of Manchester

Dr Kostas Agath, Consultant Psychiatrist (Addictions), Change Grow Live Southwark

Dr Anne Campbell, Senior lecturer in social work at Queens University Belfast

Mr Mohammed Fessal, Chief Pharmacist for Change Grow Live

Dr Emily Finch, Clinical Director of the Addictions Clinical Academic Group and a Consultant Psychiatrist at South London and Maudsley NHS Trust.

Professor Sarah Galvani, Professor of Social Research and Substance Use at Manchester Metropolitan University

Lawrence Gibbons, Head of Drug Threat (Intelligence Directorate, Commodities) at National Crime Agency

Dr Hilary Hamnett, Senior Lecturer in Forensic Science and Forensic Toxicologist at the University of Lincoln

Professor Graeme Henderson, Professor of Pharmacology at the University of Bristol

Dr Carole Hunter, Lead pharmacist at the Alcohol and Drug Recovery Services at NHS Greater Glasgow and Clyde and Doping Control Officer for UK Antidoping

Professor Roger Knaggs, Associate Professor in Clinical Pharmacy practice at the University of Nottingham

Professor Tim Millar, Professor of Substance Use and Addiction Research Strategy Lead at University of Manchester

Mr Rob Phipps, Retired Head of Health Development Policy Branch, Department of Health, Social Services and Public Safety (Northern Ireland)

Harry Shapiro, Director of DrugWise

Dr Richard Stevenson, Emergency Medicine Consultant at Glasgow Royal Infirmary

Dr Paul Stokes, Reader in Mood Disorders and Psychopharmacology at King's College London

Dr Ann Sullivan, Consultant Physician in HIV and Sexual Health and National co-lead for HIV Surveillance, Public Health England

Professor Matthew Sutton, Professor of Health Economics at the University of Manchester

Professor David Taylor, Director of Pharmacy and Pathology at the South London and Maudsley NHS Foundation Trust and Professor of Psychopharmacology at Kings College London

Professor Simon Thomas, Consultant Physician and Clinical Pharmacologist at Newcastle Hospitals NHS Foundation Trust and Professor of Clinical Pharmacology and Therapeutics at Newcastle University

Dr Derek Tracy, Consultant Psychiatrist and Clinical Director at the Oxleas NHS Foundation Trust and Senior Lecturer at King's College London

Rosalie Weetman, Public Health Lead (Alcohol, Drugs and Tobacco) at Derbyshire County Council

Dr David Wood, Consultant physician and clinical toxicologist, Guys and St Thomas' NHS Trust

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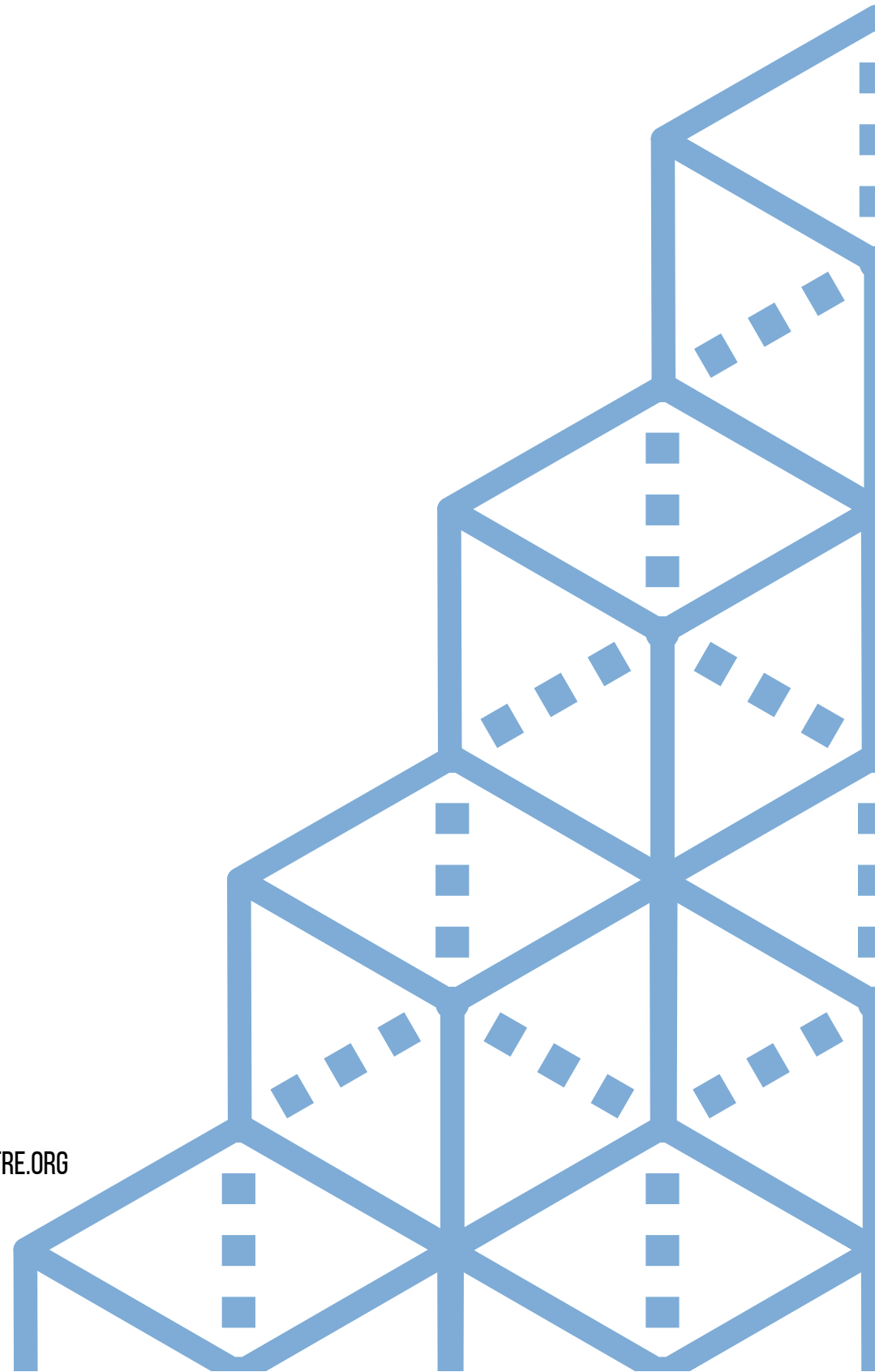

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