

Fiddling Whilst Rome Burns? The significance of changes and debates over the evidence-base in the UK drug classification system

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Abstract

Issues relating to the efficacy of the UK drug classification system have dominated public debates in UK drug policy since the turn of the millennium. Despite this, there is actually widespread apathy towards the drug classification within the drug the policy community, many of whom see drug classification debates as at best, a nuisance, and at worst, an irrelevance. Drawing on data from the author's own research, including qualitative interviews with a range of policy actors, this paper looks at what lessons, if any, can be learned from this turn to drug classification for UK drug policy as a whole.

Introduction

Issues relating to the efficacy of the UK drug classification system have dominated public debates in UK drug policy since the turn of the millennium. Despite this, there is actually widespread apathy towards the drug classification within the drug the policy community. This is because there are other (more pressing) concerns such as; a) the impact that the increasing criminalisation of drug policy is having on 'harm reduction' approaches; b) that the prohibition of substances has not solved the drug problem, but has actually made it worse and; c) that drug prevention interventions seem to be falling by the wayside in current policy initiatives. In these scenarios, then, ambivalence is not only understandable but is perhaps to be expected.

Drawing on findings from the author's own research, it is suggested that debates over the evidence-base for drug classification can and do have a bearing on wider drug policy debates, especially in contextualising the thorny nature of 'harm' as well as shedding some light into the problematic nature of making evidence-based policy-making (Monaghan, 2008a). In effect, policy lessons can be learned from one area of policy for another. As a consequence, the paper is organised in the following way. First, discussion focuses on the prominence of drug classification issues in contemporary drug policy; this is followed by a brief methodological overview of the wider study from which the current discussion draws. The widespread apathy of the drug policy community towards drug classification is then introduced. Debate then turns to the possible lessons that can be learnt from this turn of events. Finally, some concluding comments are given.

The Centrality of Drug Classification Debates in Contemporary UK Drug Policy

Since the nineteenth century, there has been widespread debate amongst drugs researchers and policy-makers alike about the direction of British drugs policy. These have tended to focus on the whether drug use or misuse is a moral, medical or criminal justice issue. These debates are unresolved and are ongoing, but generally take the form of a power-struggle between the criminal-justice and medical professions over ownership of the problem (Barton, 2003; Blackman, 2004). Since the 1980s, a new direction for drug policy can be witnessed which is tied into the increasing criminalisation of all social policy in light of a perceived loss of confidence in liberal welfare models (e.g. Garland, 2001, Rodger, 2008). The creeping criminalisation of drug policy and the implications this has for the last vestiges of the so-called 'British system' is indicative of this.

Central to the British system of drug control was a view that drug addiction was inherently an illness or a disease that could be treated medically, for example through the controlled supply of drugs, mainly heroin and more recently methadone to those in need. Drug prescription was consolidated as a staple part of UK drug control since the meeting and report of the Rolleston Committee in 1926. Named after its Chairman, Sir Humphrey Rolleston, President of the Royal College of Physicians, this committee stated that morphine and heroin 'addiction' did not and should not necessarily mean drug 'abuse'. The committee recommended allowing for the prescription of heroin and morphine to enable gradual withdrawal or to 'maintain' a regulated supply to those judged unable to break their dependence, or those whose lives would otherwise suffer serious disruption (South 1997:927-8). Ultimately, this created a system of drug control which differed from the American stance of outright criminal prohibition (Barton 2003; Shiner 2003; Stimson and Lart 1994) and was lauded by dissident scholars in the USA (e.g. Alfred Lindesmith) for its humanity and progressive nature.

On reflection, scholars have come to increasingly question whether the British system was actually a benign expression of humanity. In actual fact operated alongside other legislation that served to criminalise drugs and drug users. It is not necessary to go into all these here but suffice it to say that there had always been a desire to push British drug control down the route of American criminalisation and this became a reality in the midst of the World War one. It was at this time that the origins of drug prohibition emerged. Commentators such as Smart (1984:35) have remarked that the 1916 Defence of the Realm Act established 'British drug prohibition' because for the first time, it was 'a criminal offence to be in possession of drugs without professional authorisation'. Although a law-and-order initiative, authorisation of possession could only be granted from responsible individuals within the medical profession. In time, however, it became a pre-requisite for prescribing doctors to register their activities with the Home Office. Questions have, therefore, been raised about whether this system is actually a 'myth' (Blackman 2004). Indeed, Lart (1988) questions the extent to which there has been a dichotomy between the two institutions, suggesting instead that these are two sides of the same regulatory coin.

The policy goal of prescribing heroin to those in need has waxed and waned over the years, recently falling out of favour as methadone maintenance programmes became the *modus operandi* of the drug treatment firmament, particularly from the late 1980s onwards. This was in light of the threat of HIV/AIDS and its links with injecting drug users. It was then offered hope of reprieve as the Government updated its previous drug strategy (Home Office, 2002), but with a twist. Bringing the debate up to the present, similar issues as those discussed above are taking place under the aegis of the criminalisation of many areas of public policy. The creep of criminalisation has been well documented (e.g. Garland 2001; Rodger 2008), although in UK drug policy there is little agreement on its causes (Stevens, 2007; Seddon et al, 2008). Criminalisation here refers to the way various aspects of policy that once had discreet functions have become enlisted in the fight against crime and the protection of communities. Interestingly, one bi-product of this has been the creation of confusion over what one of the central premises of British drug control actually is. In effect, there is now mystery surrounding the concepts of 'harm reduction' and drug treatment and what these actually mean and entail (Webster, 2007). This is because there is little agreement over what the concept of 'harm' is. Who or what is being harmed by drugs? How is this harm being manifested and with what consequences?

There are no easy answers to these questions and inevitably any attempt to do so depends on one's ideological standpoint. Stimson and Metrebian (2003) illustrate the problems at hand when evaluating the Government's commitment in their updated drug strategy (Home Office, 2002:11) to improve access to prescribed heroin for those with 'clinical need', as another possible measure in curbing the drug problem:

While the willingness of the government to favourably consider the idea of prescribing heroin is to be welcomed, a major stumbling block is the lack of evidence of what might constitute 'clinical need'. It appears that doctors have one goal of treatment (the health of the drug user and their freedom from addiction) and policy makers hold different goals (the needs of society as a whole), hence their interest in providing heroin as a risk-reduction strategy and more recently to reduce crime (Stimson and Metrebian 2003: 39-40)

Leaving aside, for the moment, the issue of whether heroin prescription is efficacious in any way¹, as these debates remain unresolved, attention more recently has turned to the overall legislative framework that governs drug control in the UK. This is the tri-partite (A,B,C) drug classification system as laid out in the 1971 Misuse of Drugs Act (MDA). Since the turn of the millennium with the publication of the Police Foundation's (2000) *Independent Inquiry in the Misuse of Drugs Act* (also known as the Runciman Report), there has been much debate about whether this is fit-for-purpose. Two separate Parliamentary Select Committee's (Home Affairs Committee, 2002; Science and Technology Committee 2006) have addressed the issue, the latter commissioning its own independent research (Levitt et al, 2006). In

¹ For a contrary view to that of Stimson and Metrebian (2003) see McKeganey (2006) and McKeganey (2008)

addition, the Royal Society of Arts (2007) set up a commission analysing current UK drug policy and its impact on communities. Part of its gaze covered the efficacy of the MDA. Running alongside these, senior members of the Government's Advisory Council on the Misuse of Drugs (ACMD) also conducted research into the tri-partite system. They developed a new 'matrix' on which the dangers of drugs could be more accurately measured and from which appropriate punishments should be ascertained (Nutt et al, 2007).

Primary amongst debates about the MDA, however, has not been a concern with heroin, but consternation over the legal status of cannabis. Initially listed as a class B substance, it was reclassified as to class C in 2004 before returning to class B in 2009. In this time the ACMD themselves conducted three separate investigations into its correct location in the current classification system (ACMD, 2002, 2005, 2008). The 2004 reclassification of cannabis signalled a subtle, but nonetheless significant, change to UK drug policy, acting as a stimulus for the on-going debate over the nature of drug classification.

Media reports following the reclassification illustrated that in light of the change, arrests initially dropped by a third (BBC 2005) and, similarly, findings from the British Crime Survey suggested that cannabis use had actually decreased (Roe 2005). More recent figures suggest that since reclassification in 2004, the numbers of people using cannabis has fallen from 24 per cent to 21 per cent (Guardian 2007). On this measure, it would appear that the change had 'worked'. Caution is required, however, as no Key Performance Indicators (KPIs) were identified by the Home Office through which to gauge its impact. Consequently, although more cannabis was being seized, this was a product of more interactions between the police and the public relating to cannabis, making the success of the policy change hard to measure. The absence of KPIs also contributed towards the subsequent confusion over the purpose of the policy change. Moreover, it ensured that drug classification issues remained firmly on the political agenda for some time.

Another significant development following reclassification was the (re)discovery by various charities and academics of the link between cannabis use and mental illness. This association has a long, but uncertain, history (Mills 2003). Such was the public and media attention of this issue that in March 2005, the then Home Secretary Charles Clarke announced that the reclassification, undertaken by his predecessor David Blunkett, would be placed 'under review'. In doing so, Clarke asked the ACMD to return to the issue. In January 2006, the ACMD (2005) published its review, stating that the initial reclassification should remain, thus maintaining cannabis as a class C substance.

In the aftermath of the cannabis reclassification and review, several other significant events occurred. This process started with the Parliamentary debate over the passing of the 2005 Drugs Act. Towards the end of 2006 and into 2007, the debate between various constituencies concerning the efficacy of, and evidence for, the tri-partite structure of 1971 MDA, became more widespread as mentioned. Later in 2007, cannabis once again became a

pressing, media dominated issue. Within weeks of assuming office, the Prime Minister Gordon Brown announced that, in light of continuing interest in the link between cannabis use and mental health (e.g. Moore, et al. 2007), and as part of the run-up to the review of the 2008 Drug Strategy, the classification of cannabis would be referred back to the ACMD (Woodward 2007).

In May 2008, against the prevailing advice of the majority of the ACMD, the Government signalled its intention to reclassify cannabis back up to a class B drug, stating that this would send a message out to users and potential users about the dangers of the drug (BBC 2008). The most recent review by the ACMD (2008:33-5) concluded that although the Council was 'still very concerned about the widespread use of cannabis amongst young people' as it poses a 'real threat' to the health of users, the harms caused by the use of cannabis to individuals and society were not considered to be 'as serious as those of drugs in Class B'. This was premised on the fact that although there is recognition of a 'consistent (though weak) association, from longitudinal studies, between cannabis use and the development of psychotic illness', there was little evidence of the social harms associated with cannabis use, particularly its association with 'acquisitive crime and anti-social behaviour'.

It was another recommendation of this latest ACMD study that the cannabis classification issue should remain 'under review', with the Council returning to the issue in 2010. This is a product of the likelihood of new data emerging over the next few years. In November 2008, numerous scientists wrote a letter to the *Guardian* newspaper in support of a motion introduced by Baroness Meacher in the House of Lords to stop the re-reclassification until the ACMD 2010 report. This was unsuccessful and the change was effective as of January 2009. These later developments highlight how issues relating to the classification of substances in the UK are currently an almost permanent fixture on political and media agendas. Despite this, as recent research conducted by the author testifies classification issues are treated with a degree of antipathy by those involved in drug policy-making debates. It is to these issues that we now turn.

Overview of the (Original) Study

Using recent and ongoing developments in UK drug classification policy as a case-study, this research investigated the tumultuous relationship between evidence utilisation and policy making in this area. The overall aim was to produce an explanatory framework to illustrate the complex role and nature of evidence in heavily politicised policy areas. One unintended consequence of this research provides the present focus; the high levels of apathy towards drug classification debates. Undoubtedly, this apathy is related to the fact that drug policy is a divisive issue, as illustrated above. Issues of prohibition and its failure, drug treatment, enforcement and prevention were the dominant concerns of members of the drug policy community and attitudes towards one or more of these provided the lens through which they understood 'evidence-based policy-making' in this context.

To explain this, a methodological approach that could account for the role of conflicting beliefs and the way these impinge on policy was required. A modified version of the Advocacy Coalition Framework (Sabatier and Jenkins-Smith 1993) was employed to this end. Coalitions are characterised by a three-tiered belief system of “deep core,” “policy core” and “secondary aspects.” The deep core are “basic ontological and normative beliefs,” in essence, a world-view. These corresponded with the primary concerns listed above. In the middle-range, lies the “policy core,” “basic normative commitments and causal perceptions of the specific problem” (Sabatier and Jenkins-Smith 1999:122), in this case whether cannabis reclassification was ‘evidence-based.’ This forms the glue which holds coalitions together. Finally, the secondary aspects constitute a large set of narrowly held beliefs, or ‘appreciations’ (Vickers 1965) of the subsystem, often not shared by all coalition members, and which may (or may not) overlap with other coalitions (Sabatier and Jenkins-Smith 1999:122). Modification was made as ‘perspectives’ were favoured over coalitions with the former not resting on the same degree of ‘coordinated activity’ on behalf of members as is the case with the latter, but still sharing similar views on the nature of the issue at hand. In essence, perspectives allows for a scale of beliefs to be held within one group often making the boundaries between them fuzzy.

This modified ACF allowed for a range of data-collection methods to be used, including observation and documentary analysis of Parliamentary Select Committee hearings alongside qualitative, ‘elite’ interviews with a wide-range of key policy actors involved in the decision-making process and in evidence production for government and parliamentary bodies. Those interviewed included MPs and civil servants along with Directors and senior figures of drug agencies and NGOs and representatives of law enforcement agencies were among those interviewed. Different participants had differing degrees of involvement in the policy process. None were involved in direct decision-making but most were involved in consultation, either directly or via their organisation. Selection was made on the grounds of their knowledge of the evidence and policy relationship, in relation to the MDA. Their views were canvassed on the nature of evidence-based policy-making with regard to the UK drug classification system. In all 24 semi-structured interviews were carried out between June 2006 and April 2007, 22 face-to-face and two telephone-based. A question guide was used to structure discussions.

The turmoil of evidence was explored by ascertaining from each respondent appreciations of whether the reclassification was ‘evidence-based’ (policy core) and what evidence was or should have been used in the decision-making process (secondary aspects). These allowed for the emergence of three different perspectives, labelled; the ‘radical’, ‘rational’ and ‘conservative’. These had differing appreciations over what constituted ‘evidence-based policy’ in the milieu of this subsystem, stemming from, amongst other things, conflicting understandings of the nature of drug harm. These issues will be explored subsequently. It is fair to say, though, that one area of consensus across the subsystem was apathy towards the classification system as a whole and its centrality to UK drug policy.

Ambivalence

It has been suggested that debates over the efficacy of the current MDA and its associated evidence-base now represent the 'new rules of engagement' in UK drug policy debates (Monaghan, 2008b). This is generally much to the chagrin of the drug policy-making fraternity who tend to treat it with a degree of apathy. This can be witnessed in oral evidence-sessions in the aforementioned Science and Technology Committee's report into the Government's drug policy. In response to a question (No. 442, from Mr Brookes Newmark, MP), inquiring whether there is actually a valid argument to be for for improving the evidence-base on how drug classification decisions are made, it was the view of one leading member of a drug law reform NGO that:

Steve Rolles: I think in terms of young people and the classification system, I do not think it makes any difference really; it is much more based on their personal knowledge and information they get from their peers about risks and so on. I certainly do not think that young people are leafing *Hansard* before they go out on a Saturday night. If anything they will ignore it completely. In terms of a criminal justice tool I think it is actively counter productive (Science and Technology Committee 2006: 91)

Alongside this, there was clearly ambivalence over the centrality of drug classification debates to wider drug policy issues on behalf of the drug policy community researched. The deep core view of the radical group holds that drug use is an inevitable aspect of society for certain people. The most effective way of reducing drug related harm, for this group, is via a humane and useful regulatory system of drug control, culminating with the abolition of prohibition. According to a senior figure in an organisation advocating drug law reform, in relation to the classification system:

...the debate about the classification of cannabis and the scientific evidence for that really suits the government because we've been arguing this boring bull shit debate about cannabis classification for years now, you know, it dominates the media....If you use it [cannabis] the wrong way, it is going to harm you, but in the meantime, whilst we have been arguing over this - the tiniest policy tweak - the reclassification of cannabis hasn't made much difference at all, or not a particularly significant one. The bigger picture...is the apocalyptic failure of prohibition and all the harm it causes.

We see here how prohibition represents the prime concern. The deep core beliefs of the rational group also see drug use as an inevitable part of everyday life for many, but advocate the promotion of human rights and public health, which places treatment at the centre of the drug strategy. In this context, the rational perspective is generally more favourable towards the operation of a drug classification system, based on a hierarchy of drug harms with associated legal penalties, as in the MDA. Their main concern is ensuring the system is internally valid, where the correct drugs are in the correct class, as failure here affects its efficacy as a deterrent. This involves using up-to-date evidence to inform policy by ironing out existing anomalies in the

framework. There is a sense, though, that classification debates are political and not scientifically driven which undermines this; as a Director of leading drug-treatment QUANGO indicates:

I occasionally get interested in it [the classification system] and then I back off it because I think it is tedious actually. I think they have tried to get the classification system more in line with evidence, except for stupid, bloody reactionary stuff like magic mushrooms, which is a clear, absolutely clear reactionary piece of bollocks really...

It is the politicised nature of the classification debate that renders in 'tedious' here. The conservative group, by contrast, start from the view that drug use is not an inevitable aspect of daily life. Here, the aim of drug policy should be the promotion of drug free healthy and wholesome lifestyles through drug enforcement, prevention and education. They also display significant ambivalence towards the drug classification issue. According to one senior academic and current advisor to the Scottish Parliament:

I think that one can envisage that the classification system is something that should be much more evidence-based. Devoting an enormous amount of time to placing drugs in their right position, in their right relative position as well as their right absolute position...in a sense...is rather fiddling while Rome burns...Actually the classification system is neither here nor there. Whether it is right or wrong, it is something of an irrelevance in terms of the choices and decisions that people make over whether to use or not use illegal drugs.

The ambivalence towards the current classification system is clear. To reiterate, for the individuals quoted above and indeed for most members of the policy subsystem, there were much more significant problems in UK drug policy, whilst the debate over classification raged. It is suggested here that these debates have been subsumed by two inter-related developments that are, as mentioned *de rigueur*: a) the increasing criminalisation of drug policy and; b) knock-on effect this has for understanding the nature of harm in the context of drug policy. It is also maintained that the tendency to view classification debates as somehow separate from wider discussions in drug policy misses the point that light can be shed on the problematic nature of harm as attempts have been made precisely to operationalise this in the discussions over drug classification.

The nature of harm in debates about the evidence-base for the drug classification system

The concept of drug harm is a significant, even defining feature, of the perspectives' positions on the efficacy of the MDA. This can be illustrated by highlighting the various perspectives' appreciations of the efficacy of the Act itself, as a means of addressing the drug problem. At present, the Government, and the majority of Parliament, are alone in arguing that the MDA has withstood the test of time and that the tri-partite structure is currently fit for purpose. As was the case with the initial cannabis reclassification, there are noticeable differences between perspectives and their view of evidence in

the wider classification system (Monaghan, 2008a). The central concept of drug harm in relation to the classification system is indicative of this. In a neat synopsis of what follows, a Local Government Officer in the South East of England, with an interest in drugs education, suggested that:

...it is this definition of harm that has been fought over so very much. Harm from the social point of view? Harm from the physical point of view? Harm from a mental point of view? Harm from an emotional point of view? Everyone clearly comes at this from a different perspective.

The Radical Perspective

As illustrated, central to this perspective is the view that it is not the intrinsic properties of substances themselves that produce the greatest harm, but the manner in which they are regulated. Moving the debate on to consider the wider drug classification system, when asked about the relationship between evidence and policy in this sense, it was the view of a Director of Research for a leading drug treatment NGO that:

There are also lots of messages in there...the idea that a three-category system [based on drug harm] is meaningful has proved a dubious enterprise in its own right so there is a weak relationship – but obviously there is some area of ramification with cannabis at one end and heroin at the other end – there is something in that.

In terms of drug harms, the key point here is that in its present guise, there is some semblance of order to the MDA, but that within this, certain drugs are misplaced. Looking at the bigger picture, for the radical perspective, the framework is rendered meaningless by excluding alcohol and tobacco; the drugs that cause the most harm.

There is a lack of clarity about harm because people don't distinguish between the harm caused by prohibition and the harm caused by drugs and I think this is skewed rather by alcohol...In terms of drug harm, what most people see in real life is alcohol, leery people fighting in the street, but because the assumption is that alcohol is safe because it is legal and all other drugs are worse than alcohol, then there is an assumption that all these other drugs are very dangerous and harmful in the way that alcohol is, except worse. And in public health terms, alcohol is really quite conspicuously harmful and the harm caused by cocaine, for example, is really hard to identify... So I think that drug harms are radically misperceived because of the illegal activities associated with them.

A further manifestation of 'harm' intrinsically linked to the criminalisation of drug policy, can again be witnessed in oral evidence from the Science and Technology hearings. The following excerpt is between Liberal Democrat committee member, Dr Evan Harris, MP and the chairman of the ACMD:

Q188 Dr Harris: In this matrix you include under “social harms” intoxication, health care costs, and other social harms. Included under “other social harms” do you include the harm that stems from criminalisation itself?

Professor Sir Michael Rawlins: Yes.

Q189 Dr Harris: You do not spell that out but that is understood?

Professor Sir Michael Rawlins: Yes and whether this leads to acquisitive crime... (Science and Technology Committee 2006:72)

For the radical perspective, this is the crux of the reason as to why the current classification system is not evidence-based. According to one respondent from a leading NGO advocating drug law reform:

There is this bizarre... circularity and [the next question] basically said “well why don't you classify alcohol, it's a dangerous drug that kills loads of people” and the response was “well you know the problem is we tried that in America and loads of gangsters took over and everyone was selling hokey moonshine and people were dying of it” and the chairman [Phil Willis] was going well “isn't that what happened with all the other drugs?” And Rawlins (sheepishly) goes “well now you mention it, yeah it is”. Their (ACMD) failing on my part is that they haven't challenged the system that I think they deep down know is flawed... They work in the system and they are too scared to challenge it... Our role is to be that voice that challenges by asking those difficult questions and saying, you know, “hang on, if the system that you are advocating is creating the harms that you then use to define the system, is that not a bit weird?”.

We see in the following quotation the centrality of the issue of prohibition and the impact this has on the nature of drug harms. In effect, for the radical group, drug harms are caused primarily by the legal status of the drugs themselves. As we shall see, this is in contrast to all other members of the drug policy community and the Government. In relation to the overall classification system, the above respondent continues:

All drugs are harmful especially if you have mental health problems before you do them. Or, you are fourteen and you are smoking bonges everyday for breakfast, yes of course cannabis is bad for you... But we knew that anyway.... Any drug, if you use it the wrong way, it is going to harm you... The bigger picture... is the apocalyptic failure of prohibition and all the harm it causes....

For the radical perspective, the notion of drugs harms are illustrated below:

If you look at the various vectors of drug harms, in terms of different types of users, different drugs, different drug using patterns, modes of administration, different users predispositions, different doses, it's actually incredibly complex and there is a whole series of variables which are translated into a whole series of short, medium and long term harms for the individual, or for the community. To boil all that down for an individual drug into A,B,C, I really do think is almost completely meaningless. If you're a potential drug user or a current

drug user, if you want proper, useful information on drugs, about how harmful they are, or about how to reduce risk or anything like that, ABC gives you no information at all – none.

Consequently, how the perspective views the efficacy of the overall system has a knock-on effect for drug harm, which contrasts with all other perspectives. This is most apparent in the different appreciations of what constitutes 'harm reduction'. The concept of harm reduction, for this perspective, involves removing the damage caused by the legal status of the drug. In effect, then, harm reduction becomes legalisation.

The Rational Perspective

Again to recap, it is the deep core belief of this group that drug use is an inevitable part of everyday life for many and evidence should be used to inform policy by ironing out anomalies of existing legislative framework, with drugs remaining prohibited. The thorny issue of drug harm is approached from a particular angle within this perspective, which focuses more on the properties of the drugs themselves, rather than their legal status. The following quotation serves to clarify the issue. In reply to a question asking about the overall efficacy of the current classification system, it was the view of a Director of an international drug treatment NGO:

Well, I think one of the problems is how we decide what the harms are and what causes the harms. Because if you take an argument that a lot of the harms stem from the control mechanisms themselves, so you take some of the control mechanisms away and regulate the market then that is easy...At another level, you can say what are the inherent harms and I suppose on a health basis that would be pretty easy to do, once you start looking at social harms you are then in a bit of a circle because it is hard to decide where the social harms originate, whether they are inherent in the drug itself? Well, certain drugs possibly, yes, because certain drugs have a deleterious effect on behaviour but very often culture mediates those behaviours and very often there is a risk environment, which is a whole constellation of things coming together which determines whether people suffer harms or not so that becomes rather complex to tease out.

Unlike the radical perspective, it is not thought by the rational perspective that the legal status of substances has a significant bearing on the nature of harm. Part of the rationalising process involves introducing 'science' into the control of substances, by attempting to equate levels of harm with levels of punishment. In effect, this constitutes 'evidence-based policy' for members from this perspective. This was consolidated in 2007 with the publication of the Nutt et al. matrix. According to one member of the ACMD technical committee:

It's only since we've taken on board the risk assessment processes in the last six years or so that we've really made any effort in changing that early policy [MDA], because all the time that the Act has been in existence, very few substances have been removed and very few substances have been reclassified. Some that were removed had to

go back in again later because misuse then grew once they came out of the act and so the feeling with time was that it was dangerous to tinker with the Act because it caused all sorts of problems, so the feeling was that we should leave things where they were, or at least other people felt that. It's only been in the last few years to say that the scientific base doesn't really support the classification we've got today, I feel that very strongly now.

There is, here, a clear indication of a general acceptance that the ranking of drugs in some form of scale of harm is a desirable enterprise and is thus central to the general understanding of evidence. The Nutt, et al. matrix is an example of this. This research has its genesis in the Police Foundation Report (2000). The research positions the main illicit substances alongside alcohol and tobacco in terms of their harmfulness. This is based on a risk assessment over nine domains, as illustrated in Table 1 below. Three each relating to: a) physical harm – damage to organs or systems; b) dependence – the propensity of the drug to produce dependent behaviour and; c) social harm – the myriad of ways drugs harm society, through the various effects of intoxication and anti-social behaviour, for example. Each drug was scored on a 0-3 scale with a value for each drug derived from which a rank order of harm was produced (Nutt, et al. 2007). The results are shown in Table 2, below.

Table 1: Harms in the Nutt et al, Matrix

Parameter		
Physical	One	Acute
	Two	Chronic
	Three	IV Harm
Dependence	Four	Intensity of pleasure
	Five	Psychological Dependence
	Six	Physical Dependence
Social Harms	Seven	Intoxication
	Eight	Other social harms
	Nine	Health-care costs

(Adapted from Nutt et al, 2007)

The general understanding of drug harms does revolve around the substances themselves in this perspective, but this has numerous dimensions as stated. Reducing drug harm, however, does not require a radical overhaul of the current framework, but can be achieved by keeping it in tact and making it more internally valid. It suggests that by accurately depicting the

harmful nature of drugs, in relation to one another, within the framework, drug users should be able to make informed choices about the risks they take. For those that do come into difficulties, drug treatment in some guise is a means of reducing the harms associated with drug use instead of some form of legalisation or more emphasis on prevention as these are policy goals seen as unrealistic for members of this perspective, but the latter in particular operates on the premise that drugs are not an inevitable aspect of life for many people.

Table 2: Hierarchy of Drugs Harms in the Nutt et al, Matrix

Mean harm scores for 20 substances (Max = 3.0)		
	Mean Overall Score	Class in MDA
Heroin	2.77	A
Cocaine	2.30	A
Barbiturates	2.08	B
Street Methadone	1.94	A
Alcohol	1.85	Not Controlled
Ketamine	1.74	C
Benzodiazepines	1.70	C
Amphetamines	1.66	B
Tobacco	1.62	Not Controlled
Buprenorphine	1.58	C
Cannabis	1.33	C
Solvents	1.27	Not Controlled
4-MTA	1.27	A
LSD	1.23	A
Methylphenidate	1.18	B
Anabolic Steroids	1.15	C
GHB	1.12	C
Ecstasy	1.09	A
Alkyl Nitrates	0.92	Not Controlled
Khat	0.80	Not Controlled

(Adapted from Nutt et al, 2007)

The Conservative Perspective

The key feature of the conservative deep core belief revolves around a specific concern with the deleterious properties of the drugs themselves. This is consistent with the commitment to promoting wholesome and healthy lives through abstinence. In this sense, the conservative perspective stands in

contrast to the radical and rational positions for whom abstinence is an unrealistic goal. There is, furthermore, a sense that the initial implementation of the MDA has done little to address the drugs problem. If understood as a policy intervention, in causal terms, the intervention has not achieved what it set out to do and that is solve the 'drug problem'. For the conservative perspective, however, it is not the philosophy of the Act itself that produces the problem *per se*, as it is with the radical group. Indeed, the overarching criminal justice philosophy is generally considered to be sound, but more enforcement is needed and more emphasis should be placed on prevention, in this sense drug policy goals should be more proactive and less reactive as they currently are.

In terms of drug harm, then, the current framework does not target the correct areas and a three-tiered, ABC structure only confuses the issue. Consequently the concept of drug harm becomes distorted and, for the conservative group, the publication of the Nutt et al matrix confounds this. This is because introducing any system with a hierarchy of harms assumes that some drugs are more harmful than others, a dangerous position to adopt in their eyes. As a retired Customs Officer and Independent Anti-Corruption Consultant for the UN stated:

I think that whole thing about that new list [Nutt, et al. matrix] is a con job...Where is the advantage in discussing it? I would just rather have they are legal or they are not legal and the hierarchy of harm...it is used by law enforcement and it is used by the Courts but I actually think that a better determinant would be scale and size of operation and profitability and I think we have got ourselves locked in a debate splitting hairs.

A similar viewpoint is reiterated from a former UK government, and current adviser for the Scottish Parliament:

I don't actually have a huge degree of sympathy with the investment of considerable effort in trying to work out where certain drugs sit within the classification system. I think it is a bit outmoded actually and I don't know that it serves any more useful function, for example, to seek to differentiate between heroin and cannabis but that is where the classification system takes you.

In public debates about the relationship between evidence and policy, with regard to the drug classification system, it has been precisely the endeavours of Professor Nutt and colleagues that has come to assume a dominant status. For those who adhere to the conservative standpoint, this is problematic because it seeks to differentiate between drugs in terms of harm rather than relaying a consistent message that all drugs are harmful. In addition, respondents from the conservative were more concerned that the understanding of harm within the drug policy debate was actually too narrow. Thus, according to one Director of a leading Drug Prevention Organisation:

People are not measuring all the harms when they are assessing or not how harmful a particular drug is. We do know, if you take, for

example, siblings and other relatives, in the drug agency work we did - face to face work with alcohol and street drug abusers - time and again it came up that it was the people around the user who were suffering more or were harmed more. Until the drug or alcohol user got to the real stage of addiction, then they were suffering a lot, but up until that point they were fine. They were getting all the stuff they wanted and they weren't getting 'nicked' by the police because they were lucky and they had ways of getting it or maybe they had a job.

These harms are generally considered to be 'social harms' but, for the conservative perspective, they are downplayed in the current way that classification decisions are made. In contrast to the rational perspective, there is clear scepticism concerning the utility of basing policy on a rationally developed scale of harm, precisely because they doubt the actual rationality of the scale and because the notion of a hierarchy of harm is particularly misleading. To summarise, the key point is that the intervention of the MDA unnecessarily complicates drug policy, and that tweaking the mechanism internally does not get to the route of the problem. This means that the MDA actually has little utility. In essence, drug classification does not accurately depict that all drugs are dangerous and should be given equal weighting in the legislation.

Discussion - The Misuse of Drugs Act: A Small, but Significant Cog?

Based on the data presented above, it is clear that there is not only apathy towards the MDA as a policy tool but also a degree of incredulity. We have also witnessed how in contemporary UK drug policy, there has been a pre-occupation, particularly in media and political circles, over the nature of the UK classification system as outlined in the 1971. By contrast, in wider policy circles issues relating to the nature of current manifestations of harm reduction, or the increasing criminalisation of drug policy or the declining significance of drug prevention schemes, are more serious concerns for the drug policy community.

There is an implicit suggestion that these are separate issues. It is maintained here, by contrast, that this is not necessarily the case. The development of a scientific scale to measure the harms of all substances; the 'Nutt, et al. matrix' has been a significant occurrence. It was developed in light of the increasing significance of risk management in contemporary drug policy. In this sense, debates over the classification system are not completely divorced from other concerns identified in UK drug policy. A good argument can be made that risk management now underpins most, if not all, drugs and crime policy-making. As Garland (2001:12) points out: 'Today, there is a new and urgent emphasis on the need for security, the containment of danger, the identification and management of any kind of risk'.

Debates over drug classification (and the associated evidence-base) have revolved precisely around these debates. The 'Nutt et al matrix' was precisely an attempt to introduce issues of risk management into drug classification debates and the decision-making process. This is significant as, for many critics of UK drug legislation, it is this kind of analysis that has been

missing since the implementation of the MDA in 1971 when it was something of a mystery as to why certain drugs were placed in certain categories. That not everyone agrees with the endeavour should not detract from its significance and it seems somewhat churlish to dismiss the debates as an irrelevance as has been the want of many members of the drug policy community.

As has been the case in recent years with the increasing criminalisation of drug policy, debates over the nature of harm have become confused and murky. The case of whether heroin prescription to those in need would be an efficacious policy development is indicative of this. It is suggested again here that lessons can be drawn from the classification debates again from the development of the scientific-scale to measure harm. This is a more inclusive measurement that is more than just protecting the health of the drug user; it also takes into account social and community issues. Regardless of one's feelings towards the validity of the Nutt et al matrix this was one of its main goals; a worthy one at that. Even though this scale is not a completed project, it can act as a reference point for other debates and can thus avoid the talking at cross-purposes that has become more widespread recently.

Conclusion

In terms of the significance of the drug classification system itself, it is claimed here that the degree of apathy expressed towards it by the members of the drug policy community are understandable in light of the normative positions outlined regarding the debates over its evidence-base. It is suggested here that downplaying or even separating classification issues from wider issues in drug policy is not advisable given that the debates over the nature of harm – that are integral to it – are also integral to all debates in drug policy at the moment and that there is little to be gained from the separation. It is not suggested that drug classification debates can and should provide the answers to other debates occurring at this time, but they can give helpful insights into how risk and harm can be contextualised and that alone is reason for them not to be ignored.

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