

Home Affairs Committee

Oral evidence: [Drugs, HC 198](#)

Wednesday 18 May 2022

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Members present: Dame Diana Johnson (Chair); Ms Diane Abbott; Simon Fell; Carolyn Harris; Adam Holloway; Tim Loughton; Stuart C. McDonald.

Questions 35-117

Witnesses

[I](#): Professor Ornella Corazza, Professor of Addiction Science, University of Hertfordshire; Professor Joanna Neill, Professor of Psychopharmacology, University of Manchester; Professor David Nutt, Edmond J. Safra Professor of Neuropsychopharmacology, Imperial College London; Professor Stuart Reece, GP and Professor of Medicine, University of Western Australia and Edith Cowan University.

[II](#): Dr Owen Bowden-Jones, Chair of the ACMD and Consultant in Addiction Psychiatry and Honorary Professor, University College London; Dr Emily Finch, Co-Chair of the ACMD Recovery Committee and Clinical Director of the Addictions Clinical Academic Group and Consultant Psychiatrist, South London and Maudsley NHS Trust; Professor Roger Knaggs, Chair of the ACMD Technical Committee and Associate Professor in Clinical Pharmacy Practice, the University of Nottingham.

Written evidence from witnesses:

[Professor Jo Neil, Dr. Sara Tai and Dr. John Gigg \(DRU0062\)](#)

[Professor Stuart Reece \(DRU0026\)](#)

Examination of witnesses

Witnesses: Professor Ornella Corazza, Professor Joanna Neill, Professor David Nutt and Professor Stuart Reece.

Q35 **Chair:** Good morning, everybody. Welcome to the Home Affairs Committee. This is the second session of our inquiry into drugs. We are very grateful to all our witnesses who are with us this morning, both physically in the room and virtually. I will first ask the witnesses to introduce themselves, and to explain in what capacity they are speaking this morning. I will start in the room with Professor Nutt. Please introduce yourself.

Professor Nutt: I am David Nutt. I am a psychiatrist—a psychopharmacologist—at Imperial College. I am also chair of the charity Drug Science. I shall be speaking as both an academic and psychiatrist, and as the chair of Drug Science.

Professor Corazza: Good morning, everyone. My name is Professor Ornella Corazza. I am professor in addiction science at the University of Hertfordshire. I am also president of the International Society for the Study of Emerging Drugs, so I am looking for new brands on the illicit market.

Chair: Thank you very much. I ask our guests who are appearing virtually to introduce themselves, starting with Professor Neill.

Professor Neill: Good morning. I am Jo Neill, professor of psychopharmacology at the University of Manchester. I am also chair of the Drug Science medical psychedelics working group, and a trustee of Heroic Hearts Project UK, a combat veterans' charity. I am speaking today in my capacity as an academic.

Chair: Thank you. Professor Reece, I am not sure what time of day it is in Australia, but thank you for appearing before us today.

Professor Reece: Thank you. My name is Stuart Reece. I am a professor of medicine at the University of Western Australia and the Edith Cowan University. I am a GP and run one of the largest addiction clinics in the country, in terms of individual practices. I have just over 500 patients actively at present. I am speaking today as an academic.

Chair: Thank you very much. I am not sure what the noises are in the room. Perhaps we can get that sorted out. While we are doing that, I am sure that the panel will appreciate that, as Members of Parliament, not all of us have a scientific background. We would very much welcome it if you could speak in very straightforward terms that we are able fully to grasp and understand. That would be very helpful. I will ask Simon Fell to start us off with some questions.

Q36 **Simon Fell:** Thank you, Chair, and thank you to our witnesses for joining us. Please do speak in very simple terms, because some of us are not that bright, either. This is our second session looking at drugs, and the first



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one really challenged some of my relatively long-held beliefs about how we classify them and how we should be dealing with enforcement, so if I may, I will start with that first point, about classification. Do you think that the UK model is currently fit for purpose? Professor Nutt, I will start with you.

Professor Nutt: I think it is very clear that it is not. You heard in your last set of evidence that deaths from drugs are going up and use of drugs is going up. That has happened ever since, really, the Misuse of Drugs Act was introduced in '71, so, 50 years on, it is pretty clear that it has really not achieved its purpose. One of the reasons why it has not done what it was supposed to do is that it isn't based on evidence. The classification of drugs under the Misuse of Drugs Act has zero correlation with the harms of drugs, and that presents major problems.

It presents problems in education, because telling people about drug harms is almost an irrelevance if you use the Misuse of Drugs Act, because people know that is not evidence based. Of course, it also drives policies which—as you heard, again, last week—can be counterproductive. By trying to stop people using cannabis, you end up killing people because they move to a drug like Spice. At many levels, it has failed.

Simon Fell: Thank you. I will come back to you, but I would just like to take other views from panellists. Professor Corazza?

Professor Corazza: I would like to refer to the context in which especially the Psychoactive Substances Act was implemented. It is very important to go back to that specific moment in time, because the situation, the phenomenon—the rapid emergence of hundreds of novel psychoactive substances—really challenged the regulatory system nationally and internationally. Let's admit it: at that time, we were all unprepared, and we tried, often, to apply old models to completely new situations.

So far, we know that over 1,000 novel psychoactive substances have emerged in the illicit market—according to the early warning system of the United Nations and of the European Commission, the EMCDDA—in over 133 countries. It is a widespread and global phenomenon. It is driven, indeed, by globalisation, but also by the internet and technological development, and by the changing lifestyles in our society, because the drug market is dynamic; it is constantly changing.

In a way, we tried to apply old methods to completely new situations. I remember that, at the time, I had schoolteachers phoning the university and telling me, "We've got bags of white powder coming into the school. What should we do? Is this legal or not legal?" We had head shops, if you remember, selling all these drugs that we well know, as legal alternatives to illicit drugs. We had never seen anything like that before. At that time, the Government responded based on a situation of emergency, but since then, a lot of things have changed in terms of the drug market. I am mainly looking at the new—novel—trends. That is mainly my work. I would



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like to share with you, possibly, some highlights of the work that is emerging.

Chair: Could I just stop you there? We are going to have a section where we would like to discuss the psychoactive substances legislation that we have in this country, so I think we will come to that, if that's okay.

Simon Fell: May I move to Professor Neill, just to take your view on this as well?

Professor Neill: I completely agree with everything that Professor Nutt said. The classification system is not based on evidence and is clearly not fit for purpose. My main interest is in drugs that are currently illegal, like psilocybin, which is the active ingredient in magic mushrooms. It is a so-called psychedelic and has enormous therapeutic potential. It is a class A drug and also a schedule 1 drug.

I am hoping to talk about the barriers to research and innovation caused by these drugs being in schedule 1. That is a specific topic I would like to cover, if that is planned for today. That drug just exemplifies the fact that the current scheduling system is incorrect, because the definition for schedule 1 is that a drug has no medicinal value and it causes a great deal of harm, and psilocybin does none of those things. It has medicinal value, and it does not cause significant harm.

Q37 **Simon Fell:** Thank you. We will come on to some of those specifics later in the panel. Professor Reece, I realise that you are sat in Australia, but do you have a view on the UK classification framework?

Professor Reece: Yes, I do. My view would differ from that of some of the other panellists you have heard from. I think that the current system is probably a good one. I am particularly concerned about cannabis, as you would have noticed from my submissions to the Committee. Cannabis is very important because it is well established to be a gateway drug to other drugs, and one of the most prominent features of the pharmacology and toxicology research literature on cannabis is that it has exponential dose-response effects.

The details are different in Europe, America and Australia, but it is generally true that there are three changes that have happened in many places in the world. There are more people smoking weed due to the legalisation movement. There are more people smoking weed daily. The intensity has gone up; in the US, it has gone up 2.1-fold in the last 12 years. The THC concentration—in fact, the concentration of a lot of cannabinoids—has gone up enormously, as is well established.

The point is that you have three trends—a higher prevalence of use, a higher intensity of use and a higher cannabinoid concentration—all acting at the same time. The point is that the community is being relatively suddenly springboard catapulted up into the high genotoxic dose zone, and the genotoxicity of cannabis is virtually never discussed in public. It is a huge issue. It affects brain development, it affects the development of

every organ system in the body, and it is linked to numerous cancers, as our recent papers show.

The magic that the current regulatory system has done is to confine the community to a relatively low dose of cannabis use. We know that everywhere cannabis legalisation has been rolled out, including Colorado—there is a long list, but I will not bore the Committee with that—literally the wheels fall off. I am not sure if the Committee is familiar with the recent statistics coming out of Colorado—on every index, they are horrific.

By confining the community to a relatively low dose area of use, it is protecting the community from numerous harms that are directly related to cannabis pharmacology, so we think the current regulatory system, which is relatively tight compared with what is being proposed, is relatively successful, except that—this is a big exception—in our view, massive community education needs to occur so that everybody is on the same page about the risks.

Right now, there is a lot of talk, which is mostly hypothetical, and there are very few randomised controlled trials—which is the clinical gold standard, as I am sure you all know—for cannabis or any other illicit drugs. A lot of the harms are well established. Right now, the general discussion has got way out of kilter in terms of overemphasising the hypothetical “perhaps” benefits and underemphasising the known risks, especially in the case of cannabis: the genotoxicity, the exponential effect, and the fact that it applies to many of the common cannabinoids.

Q38 Simon Fell: Thank you. I will stop you there, because we will be coming back to this topic later and I am sure you will have a lot to say on it. The majority of you have issues with the current model, so I am curious to hear what you think would work. Is there anywhere around the world that has a classification model that is responsive, evidence-based and dynamic, and that we should be looking either to emulate or to take the best from? Professor Nutt, let me come to you.

Professor Nutt: Yes. There are two separate aspects to this. You can achieve important goals by changing the way you enforce prohibition on drugs. The most obvious example is decriminalisation, which has shown to be really quite effective with cannabis in countries such as the Netherlands. It reduced the gateway effects that cannabis might have had, which of course is not actually due to the drug but is due to where you get the drug from and the fact that, to get cannabis, you are almost always dealing with a dealer who will offer you other drugs.

You’ve got Portugal, where we have seen that the removal of drug users from the criminal system and putting them into the health system has dramatically reduced deaths from opiates. They have reduced their deaths by two thirds in the last 15 years; in the UK, ours have increased by two thirds in the last 15 years. Countries are now beginning to open up the utility, or change their regulations, so it is easier to study these drugs. As Jo Neill said, there is remarkable evidence developing on the clinical utility.



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My own view—and I am one of the leading researchers in this field—is that the last 50 years have been the worst censorship of clinical research in the history of the world: the opportunities we have wasted and lost in the last 50 years by essentially not allowing proper studies on cannabis and making it very difficult to study psychedelics like psilocybin and MDMA. We should be changing the regulatory system to make it more honest, and the classification system to make it more evidence based. The regulatory controls are, I think, the things that we really should be focusing on. It would be quite easy. As Rudi Fortson said at your last hearing, it is much easier to change the regulations to facilitate at least the medical profession having proper access to this.

Q39 Simon Fell: You have paid a political price over the years for speaking up on this. What is lacking in our country to stop us making that decision? Is it political will? If we pick on Portugal, for instance, what was the framework that allowed them to move to the model that they have now?

Professor Nutt: Well, it is interesting. If you look at Portugal, in many ways the main driver was economic. There comes a point where many countries that enforce regulation and try to stop drug use through criminalisation find that it is very expensive. In this country, we have doubled our prison population in the last 40 years, and that is all due to drug crime. You can work it out—that is billions and billions of pounds that have been wasted by putting people with drug problems in prison when they should have been treated outside. The Portuguese movement was really driven to try to reduce this enormous cost of policing, and it has been very successful.

Moving drug users from the criminal justice system into the health system means some very fundamental changes occur. For instance, they don't have to commit crime to get their drug because it gets prescribed, or they get into treatments where they don't use it at all, which dramatically reduces the cost of the criminal justice system. It improves outcomes. It reduces the collateral damage from drugs, with things like HIV and AIDS and so on. There are clear examples of how you can get enormous social and economic benefits from a more rational policy.

Chair: Carolyn Harris is now going to ask about the psychoactive substances that Professor Corazza started talking about.

Q40 Carolyn Harris: Can I take you back to before the Psychoactive Substances Act 2016? We will all have memories of seeing young people and videos of young people behaving in very strange and upsetting scenes. It was the time when they were known as "legal highs". It was not something that I ever thought should be legal. Has the Act reduced the number of people who are affected by psychoactive substances?

Professor Nutt: I doubt it. I don't think there is any good evidence that it has. What it has done is driven the purchase of these drugs from head shops. The Act was driven by the wish to get rid of head shops, really; I don't think anybody thought it would stop the use of recreational drugs. I think 50% or more of head shops have closed down, but the sale of these



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drugs continues on the black market and in the back streets, and that is the worst place of all, as we know, because the dealers don't really care about the life quality of the people who buy from them, whereas head shops were often run by people that use these drugs and could at least give people some direction.

Certainly, in the six years since the Act was introduced, we haven't seen a massive diminution in the use of synthetic cannabinoids or Spice and we have still seen some very toxic ones coming along, so I do not think there is any good evidence that it has helped at all. Ornella may have a different view.

Professor Corazza: I would like to build on that. Yes, it was successful in stopping the open sale of NPS—novel psychoactive substances—at the time. I remember that most of the head shops closed down overnight when it was implemented. The number of novel psychoactive substances has generally dropped over the past few years, but of course they are still a big challenge. We need to face the challenges of protecting against and monitoring the new substances that are coming out—because they are more and more toxic—as well as understanding patterns of use, and developing new and more appropriate public health approaches.

In particular, I refer to our study on the diffusion of drugs on the internet. We have seen a decline in the number of substances advertised on the open web, but we have seen an exponential increase of substances advertised and sold on what we call the dark net. What we normally see on Google is less than 1% of the amount of information and activity going on online. We are looking at a deeper level of the internet where the market of illicit substances is predominant. According to a recent EMCDDA Interpol report, the number of transactions has tripled in the past three years, and two thirds of the products offered on the dark net are drugs.

We also know that sellers are mainly from the United Kingdom, the Netherlands and Germany—so we play a big part in this criminal activity. According to a report by the United Nations, there are more than 95,000 drugs available for sale on the dark net. As you may know, payment on the dark net is with cryptocurrency, so it is extremely hard to detect transactions, and communication is anonymous, so it is extremely hard for us to study or intervene at that level.

We recently carried out a study, and I would like to share the key findings with you, because I think it is very relevant to policy making. It was on the availability of extremely dangerous drugs, like novel synthetic opioids such as carfentanil. Carfentanil is a novel synthetic opioid that is extremely toxic and powerful; it has been estimated that it is approximately 10,000 times more powerful than morphine. We are talking about very problematic substances being available. According to our systematic analysis of the dark net, we found 118 listings for this substance. This substance is available to buy for those who have access to the dark net.



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Something related to this is the fact that this novel class of synthetic opioids, because they are so powerful, are being used not only for recreational purposes but for chemical attacks. In an age of global insecurity, I would advise that more attention is paid to these types of substances and the illicit dark market. For instance, we know that a mixture of carfentanil and other substances was used by Russian forces in 2002 against Chechen separatists—the incident caused 125 fatalities. Traces of carfentanil were found in the clothes of two survivors. It is being used for this purpose. These substances are extremely toxic and dangerous, so I think more attention should be paid to them.

Q41 Carolyn Harris: Could I stop you there? Are you suggesting that the substances that were being used by the Russians against insurgents are available in this country to anybody who cares to search the dark net?

Professor Corazza: That is correct. We found 118 listings for this substance, by 63 vendors in 19 dark net markets, which is extremely worrying. I submitted evidence before to a different inquiry trying to highlight this situation. I think further concerns should be raised in this regard. The substances are so diverse; some may have potential use in therapy, but some are extremely toxic and potentially very dangerous for society.

Professor Nutt: It is important to note that fentanyl has been an illegal drug since, I think, 1966. It is not an NPS.

Q42 Carolyn Harris: My recollection is that, in the run-up to the 2016 Act, we had a lot of anecdotal evidence about prison officers becoming affected by prolonged exposure to this substance, which has been used prolifically in prisons. It was left to the trading standards organisations to monitor the head shops, as you called them, Professor Nutt. If what you say is true, none of the measures actually worked to control the addiction and the social ills that became part of that scene. What more should we do and what more can we do?

Professor Nutt: The only way you can deal with a problem like fentanyl is to have a regulated market for drugs that are less harmful so that people don't go on the black market to get it, and of course have a much wider roll-out of antidotes in case people accidentally take it, because it is not just being used as a heroin substitute; it is now being put into other drugs to give them a bit more kick and give people a bit more of a high.

I think last year there were 60,000 deaths from fentanyl in the States. They have tried prohibition and it has not worked. In fact, the reason we had the rise of fentanyl is because the Americans tried to eliminate other opiates, and the Mexican gangs realised that fentanyl was much cheaper to make than heroin. Again, it is one of the examples of prohibition leading to perverse consequences if people look for more potent substances.

The reality is that you need antidotes, therapy and a regulated market for things that people want to use. I don't think anyone really wants to use the toxic cathinones—the new cathinones—that have come out as a result of the head shops being closed. Before the head shops were closed, they



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were using weak drugs such as methiopropamine, which is like a strong caffeine. Now we have these super-strong cathinones, which have been made to avoid the law and might be 100 times more potent than the ones people were using before. They are not being used by people with any experience, so 18-year-olds at festivals are taking 100 mg of N-ethylpentylone and staying awake for three days.

The other way we could potentially deal with that is with better testing. If we do not have a regulated market, at the very least we should have open testing so that people know what they are taking and can be given guidance on what the safe dose is.

Q43 Carolyn Harris: Thank you. Would you like to add anything, Professor Corazza?

Professor Corazza: I do agree: the fact that these substances are now available on the dark net makes it very difficult for us to detect and prevent the harm, so a focus on prevention is key, along with the public health approach. Looking at the motivations behind such use is also crucial. The motivation behind drug taking is constantly evolving as the drug market evolves, so I think the law should be more flexible.

Q44 Chair: I would like to ask about fentanyl, as you have just had a discussion about that. I understand it is not within the discussion of psychoactive substances, but I heard last week that because of what has happened in Afghanistan, the Taliban are now saying that you cannot grow poppies in Afghanistan, and that will affect the world heroin market. I heard that fentanyl is coming down the track as the next big problem for the UK to deal with. Professor Nutt, I think you just made reference to the toxicity and the fact that people could overdose on it very easily. Is that what you worry most about, in terms of what drug problems are coming down the track?

Professor Nutt: Absolutely. The fentanyls are the biggest rising drug problem because they are so lethal. I mentioned carfentanil, which is a thousand times more potent than heroin. In fact, it is so potent that the people who sell it do not know how to measure it at a safe level, so they have to guess, and sometimes they guess wrong. The fentanyls, to my mind, are the biggest threat, particularly if there is a drought of heroin, as is likely, as we have seen previously when Afghanistan stops producing. In fact, we might not be able to stop it, anyway, because the economic returns from making the fentanyls are so much greater than from making heroin.

Q45 Chair: Just so I understand this, we are saying that under the current legislation, possession of that substance, because of the way the law is couched in terms of psychoactive substances—

Professor Nutt: No, they are all class A drugs.

Chair: Sorry, I am getting confused with carfentanil, I think. What was the one you described?



Professor Nutt: Carfentanil. There are at least 1,000 different molecule structures that are all like fentanyl. Fentanyl was developed as a synthetic alternative to morphine in the 1950s. It has a completely different chemical structure. You don't get it from poppy; you make it in the lab. Some variants of fentanyl have been used and are widely used in almost every operation in this country for pain control and sedation. They were pretty much contained within healthcare until about eight years ago, when there was some interruption of the heroin supply and the Mexican gangs realised that, actually, they could make fentanyl.

The original medical fentanyl, which is about 50 times more potent than heroin, can be made at about half the price of heroin. It is about 100 times more cost-effective. The new ones are maybe 1,000 times more cost-effective, so the field is morphing into fentanyl from opium-based opiates. Some of them, as I said, are so potent that the people who make them don't know how to measure it out in small enough amounts to be safe, which is why there were 60,000 deaths from fentanyls in America last year. If that comes to Britain, we will have a serious problem. It has been illegal ever since it was made.

Chair: Okay, thank you for that clarification. We will move on to Stuart.

Q46 **Stuart C. McDonald:** Thank you very much, Chair, and I thank our panel for their answers so far. On the issue of the 2001 regulations, Professor Neill and Professor Nutt, you have both touched on the scheduling system there, and I think have both been pretty critical of it already. Professor Neill, could you just give the Committee some examples of the types of research that you think have been restricted, limited or stymied, as it were, by those regulations? Could you also just say a little bit more about how they have this impact? What is it that scientists have to go through to try to get authorisation to carry out research, particularly for schedule 1 drugs?

Professor Neill: Having been through all this myself, I can tell you exactly what the barriers are; they are significant. Just to put this into context, I am an animal researcher. I have been working in drug discovery for 40 years, looking for better treatments for mental illness. In all that time, we have not enabled patients to access better medicines than the standard drugs, so I would say that psychiatry research has hit a brick wall.

Big pharma pulled out of this area about 15 years ago because this is a very difficult area to work in. I am now working on psilocybin because it has such enormous therapeutic potential, but it is extremely difficult for anybody in the UK—whether they are working in the NHS, in the pharmaceutical industry or, like me, in a university—to do this research, because psilocybin is a schedule 1 drug, as I have said.

There are four main issues here: huge costs, massive delays, bureaucracy and stigma. I will deal with each one, but first, the other thing to say is that we have exemptions to work with schedule 2 drugs such as cocaine, heroin, ketamine, phencyclidine, which is angel dust and does cause



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harm—I have used that in my animal model for 25 years. We do not need any special permission to hold or use those drugs, and we have all the systems in place to keep safe. Universities are full of dangerous chemicals, and we are all very well set up to keep them safely locked away. However, when it comes to a schedule 1 drug, we need special permission.

The Home Office says that everybody can apply for a controlled drugs licence to conduct schedule 1 research, but I found out that is only partly true. For me, I wanted to research cannabinoids and psilocybin. I applied pre covid and it cost me more than £3,000 for the licence itself. There are a number of additional security features that you need. You need locked, alarmed cabinets—we have all our drugs locked up anyway, but these need to be alarmed. You need to have a registered person, a pharmacist—I am lucky that I am in a school of pharmacy—to dispose of the drug safely. I have worked on new chemical entities all my career. We are used to disposing of potentially harmful substances, but we need extra supervision.

That was just the cost for the licence. I had to wait a year after the application went into the Home Office, and that was pre-covid. You must have an inspection from the Home Office and to renew the licence every year, which you have to pay for. Of course, you don't need any of that for a schedule 2 drug. The form is very difficult to fill in, so it is a bureaucratic nightmare. I have a lab manager and it took him a week to fill it in.

There is also a lot of stigma because these drugs are in schedule 1. When I wanted to research psilocybin in animals, the vet was particularly concerned, and we needed a lot of extra checks and balances, which meant I had to use more animals. I am very lucky because I conduct all my research in the same building, so the drug is held in the same place as the animals.

I decided to do a qualitative study on this, to interview researchers up and down the country, to see what their issues were, and whether they had similar problems to me. What I found surprised and horrified me. A colleague in London who was doing a clinical trial with psilocybin needed six separate controlled drugs licences. That is £3,000 for each licence, a huge delay for each one and the bureaucracy for applying for each one. It cost him £20,000 just for the licences before he was even able to get the drug into a patient. Every stage where the drug was blinded, put into capsules and where it was kept for the clinical study were all separate locations, which they have to be for a clinical study. That extremely disabled his research and cost him a lot of money out of his research budget.

Even more worryingly, when I interviewed people in smaller institutions, who do not have large research budgets, they wouldn't even consider doing this research. They said it is far too expensive. They don't have the manpower or the money. If I may, I would like to read you a quote from a researcher: "It's only very, very, very select people who have the potential to do schedule 1 research, the funding and the workforce. There are so many barriers that have been put up, you have to be a very specific few."



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You have to be particularly famous, and you have to have lots of grant money and philanthropy money behind you that they are willing to chuck millions at you. It is such an unavailable thing.”

That particularly affects smaller institutions. I am lucky that I am in Manchester. Imperial and King’s have been able to fight this to be able to do it. It has taken an awful lot of effort and money, which a lot of academics don’t have.

Q47 Stuart C. McDonald: In terms of addressing it then, you expressed a view that psilocybin in particular should not be in schedule 1. Even if something is in schedule 1, I am guessing that you will say that all of those different aspects have to be addressed. Do other countries do it in a completely different way? Do we need a radical overhaul, rather than just tweaks?

Professor Neill: As I said, psilocybin has enormous therapeutic potential. There are 40 clinical trials going on around the world at the moment. Actually, this is of huge economic value. The psychedelic research industry was worth \$2 billion last year, and is predicted to rise to \$10.7 billion by 2027. This is an emerging, growing market. People are developing new drugs, but they will all be in schedule 1 in the UK, unless we change the law.

People will not conduct their research here; companies will not come here. I am working with one company that has just opened a facility in Canada. There are lots of different countries. In the US—in Oregon and many cities—they have changed their laws, as they have in Canada and many parts of Europe, such as Spain, and, as we have heard, Portugal, to enable this research to happen. St Kitts has no restrictions in terms of developing drugs for patients, running clinical trials and doing all the basic research.

With psilocybin, the main indications at the moment are for severe illnesses—PTSD, depression and the anxiety and distress that occurs with a terminal diagnosis. I have brought a couple of testimonials with me from patients, if I get time to read those out. It is absolutely essential that we are enabled to do this research in the UK. Removing psilocybin from schedule 1 would enable that. As I have said, we do not have any restrictions—we do not need any special permission—to research schedule 2 drugs.

Q48 Stuart C. McDonald: If you could submit those testimonials in writing, that would be helpful. That would be brilliant. Professor Nutt, is there anything you want to add?

Professor Nutt: I am one of these fortunate people who has been around long enough to fight through the regulations. You have this absurd situation where I have to have a special safe in a special room with a camera to put my psilocybin in. I say to the Home Office, “Why can’t I store it alongside the fentanyl and heroin and cocaine that I work on?” That is in the pharmacy. You cannot do that because it is a schedule 1 drug. What is the logic in that? If anyone were to break in, they are not



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going to take the psilocybin—they are going to take the fentanyl and the rest.

The simplest thing you could do immediately would be simply to say that all universities and all hospitals are schedule 1 exempt, as they are schedule 2 exempt. That would be something you could just do at a stroke—I don't think that needs an Act of Parliament even—but I would certainly think we should also be looking more specifically at moving drugs. We have clear medical evidence now. Probably 1,000 patients have been treated with psilocybin now, for a range of disorders. It is in many ways the most effective treatment we have ever seen for severe depression. What more evidence do you need that it should be studied as a medicine? But the studies are being delayed, particularly in the UK.

We pioneered the use of psilocybin in depression—we published the first paper six years ago. There are 40 companies now doing research based on that discovery, but very little of it is happening in Britain, because every single site—every pharmacy, every hospital, every academic—needs to get a licence, and it is too expensive and too time-consuming.

Q49 Adam Holloway: I am sure you find psilocybin in virtually any farmer's field, from time to time. An observation: I have a friend called Matthew who goes to the Netherlands to microdose on this stuff, and it has pretty much fixed his depression.

It does seem very odd; it is almost like we are superstitious about this stuff. What is it about us that we create these great regulations on respectable researchers such as yourselves?

Professor Nutt: Well, I think you need to answer that rather than me. From my perspective—

Q50 Adam Holloway: You have been the victim of it for many years. What do you think the root of it is?

Professor Nutt: It is several things. The psychedelics were banned by America, because the anti-Vietnam war movement was also associated with the use of LSD. They couldn't ban protests against the war, but they could ban LSD, so America banned LSD in 1967. They sucked in pretty much all the other psychedelics like psilocybin. Our drug laws are largely the same as the Americans. The Misuse of Drugs Act was driven by America. Basically, everything we have done has been to comply with their attitudes.

Why are they against these drugs? It started off political; it ended up being much more puritanical and hostile to drug users generally. There is no logic to it—none at all—but you get into this cycle where people are terrified of changing the drug laws.

Some of you will remember the debate about cannabis. Cannabis once was a schedule A or schedule B drug, depending on its form. Then it was downgraded by David Blunkett to C. The hysteria about changing the position of something in the Misuse of Drugs Act was bizarre, both in here and in the media. A lot of it is about not wanting change. In the medical



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profession, there is also a resistance to admitting they were wrong. People still say to me, "Of course, if it's a schedule 1 drug, it must be very harmful." I say, "What is the evidence of that?" and they say, "Well it must be, because it's schedule 1, and it must be addictive." But it's not addictive—it is anti-addictive, but we can't use its anti-addictive properties because we cannot study it.

The other thing about the Netherlands is that the Netherlands were very clever. In fact, we were quite clever to start with. We didn't ban the mushroom until 2005. We banned the drug—the active ingredient, psilocybin—but the mushrooms were legal until 2005. Then there were political machinations, with David Cameron goading Tony Blair that he was soft on drugs. That persuaded Blair to make the mushrooms illegal alongside the active ingredient, psilocybin. The Dutch were different and realised that this whole thing was pretty absurd. In the same way as they freed up cannabis in a regulated fashion, they kept the truffle legal. The truffle is the bit that goes under the ground. That is why you can go and get the truffles in Holland, because they are not illegal in the Netherlands. It is a huge business for them as well.

We have put 60 people through trials with psilocybin. Many of them have done very well but, for some of them, the depression has come back. They say, "Can you give me another dose?" I say, "I can't give you another dose, because I don't have a trial going. I can only use it in a trial." So we say, "Maybe go to the Netherlands and try it there." It is seen as a serious business. My top therapist is now working largely in the Netherlands, because she cannot work here. There is no work for her here.

Q51 Tim Loughton: Professor Reece, can we come back to cannabis? You mentioned earlier that it is a gateway drug. Professor Nutt made the interesting comment that it is a gateway drug because of how you get hold of it rather than the impact it has on individuals. What are the potential medical harms that it can cause? You cited three dangers: greater concentration, greater usage and more regular usage by those who use it. Can you go into a bit more detail about the actual medical harms? You touched on cancer. I believe cannabis burns at a much higher temperature, which can do more damage to lungs and so forth. Can you give us some details on that?

Professor Reece: That is a very large subject; thank you for your question. Cannabis obviously has a lot of effects on the brain, as there are a lot of cannabinoid receptors in the brain. As you say, it is smoked up and hits the lungs. It can cause chronic inflammation in the lungs and chronic bronchitis. It is linked to a higher residual volume, which is a medical term—it is the sine qua non of emphysema and its increased respiratory symptoms. It is known to affect the reproductive tract. It is very active in the liver and perpetuates liver inflammation, and it is a known liver carcinogen, so it causes cancer in the liver. It affects the brain and is linked with mental health issues.

You understand that inside every cell, there are genes, which have a control system. The body has thousands of different kinds of cells. The



DNA in each cell is essentially the same, but the cells themselves are very different, so it must be that the way the genes are controlled and used in each cell is different. The medical word for the control system for genes is epigenome, which means “upon the genes”, “after the genes” or “on top of the genes”. Think of it like a computer: if you get a new computer, you get the hardware and you get the software that runs the computer. Cannabis has a very big epigenetic footprint, which is part of its overall genotoxicity. The toxic effects I just mentioned—including driving, which is part of the neurotoxicity—are what we call the classical picture of cannabis toxicity.

The first study on cannabis genotoxicity was published in 1969, so this is a well-established area and there are lots of papers on it in the literature. But we have conducted studies recently to say, “Okay, cannabis has a well-established genotoxic effect in the lab. What are its effects in people—in the clinic—when the stuff has been widely available?” We heard earlier about Portugal, Spain and parts of France where cannabis is widely used, and the Netherlands is well known internationally. But these countries are also top of the pops, if you like, within Europe, and we have papers just published, and more papers coming up, that show that inherited congenital birth defects in babies—on the brain, the heart, the bowels—are much higher in countries such as the Netherlands and Belgium, and in parts of Spain.

Q52 Tim Loughton: Professor, it is obviously a very big subject. I can see some frustration from Professor Neill, so she might want to come in after in response to some of those points. A lot of what you have described is the impact of smoking cannabis. Presumably, some of the genetic and other impacts that you have described are a result of ingesting cannabis, in whatever form, into the body. So, are there much safer ways of consuming cannabis and are there levels at which you can say that there are medicinal benefits—particularly for people with the three classes of ailments where we know there may be some medicinal benefits—that can outweigh that harm to the various parts of the body that you have described? What I am driving at is this. Is there a way of people taking cannabis with only minimal harmful effects but with potentially rather more positive medicinal impact on conditions that they may have?

Professor Reece: That is also a good question, sir. As you know, cannabis can be eaten in cookies. It may be that that would reduce some of the toxicity on the lungs, the throat and the upper airways. That may be the case. I am not sure that there is any particular research on that. The effects on the brain, the liver, the ovaries, the testicles, the heart and the arteries are not related to the inhaled route of cannabinoids; they are just related to the actual pharmacology of cannabinoids themselves. The three key hallmarks of genotoxicity are ageing, cancer and birth defects, and we have found very strong signals in all those three key areas. There is a recent paper, using state-of-the-art epigenetic clocks, that showed that at the age of 30, cannabis users were 30% older than normal. They have only one time point in that study; they do not know whether people are 30% older at all ages or whether it is 40% at 40 years or 50% at 50 years. We do not know; the research has not been done. But just that



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datum point—30% older at 30 years—with the state-of-the-art epigenetic clocks has horrifying public health implications. If you roll that out across your population, you have an unsustainable health budget.

- Q53 **Tim Loughton:** Presumably there is evidence that will show that contemporary use of cannabis, which tends to be much stronger now—the skunk compared with the weed, or whatever we want to call it, back in the '60s—is far more damaging in those areas, as well as the higher incidence of people who do smoke or take cannabis doing it on a much more regular basis. So people are being impacted far more now than they would have been 40 years ago, with a different type and a lesser use of cannabis. There is evidence to show that, yes?

Professor Reece: Yes, that is what the data shows; that is correct, sir.

- Q54 **Tim Loughton:** Thank you. Professor Neill, do you want to come back on some of those comments that you were frowning at?

Professor Neill: Sorry, I was just trying to concentrate. I am really not a cannabis expert, but I have done some work. We did work for GW Pharma on numerous cannabinoid molecules—CBDA, CBDV, THCV, CBD and THC—in animals. GW brought to market two products containing cannabis. They must have done extensive toxicology studies in animals. We did a lot of work. It was all to test whether they were likely to work. They must have a lot of information. I would have thought the drug would never have got to market if there were genotoxic effects that they had seen, certainly in all the animals. I know from my experience in drug discovery that that work in animals—in rats and in dogs—is extremely extensive before any drug gets to market. But I think Professor Nutt is much more of an expert on cannabis than I am.

Professor Reece: Excuse me: the registered prescribing information for Sativex and Epidiolex has the genotoxic warnings if you read it, because, as I said, this stuff has been known for decades and it has been confirmed many times. If you read the stuff, you can see the warnings about use in pregnancy and use in breastfeeding, and “Don’t take this if you are going to have a family.” These are classic genotoxic warnings. Ma’am, your information is only fragmentary on that point.

- Q55 **Tim Loughton:** Can we come to Professor Nutt and Professor Corazza on that? Are there clear medical benefits from cannabis use in regulated circumstances? And why is it—again, I am not an expert on this—that most people who use cannabis still smoke it even though the prevalence of smoking tobacco is coming down and everybody agrees that it is not good for you? So why has there not been a bigger move across to everybody having hash brownies or whatever it is—

Adam Holloway: Hash gummies.

Tim Loughton: To different ways of using it, which I am not aware of. Why do people still choose to smoke it, for whatever reason?



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Professor Nutt: The advantage of smoking is that it gets in very quickly. I want to correct one thing. Cannabis burns at a lower temperature than tobacco and is less harmful to lungs.

Q56 **Tim Loughton:** My understanding is that skunk, and much higher concentrated cannabis now, burns in the lungs at a much higher temperature than cannabis—weed—used to. Is that not the case?

Professor Nutt: I would be interested to see the data; I do not think that is true. There are some variants, some ways you can manufacture strong THC, which might be different, but the leaf of the cannabis plant burns at a lower temperature than a tobacco leaf. In fact, that is research that the ACMD did when I was still part of them.

The reason people smoke recreationally is because you get an immediate effect. Clinically, that is also very important. The way we provide rapid onset for medical cannabis for people in pain is to use a new kind of vapouriser, so you don't burn the leaf, you heat it so that the active ingredients go in. That is the first thing. We can actually reduce the risk to the lungs by vaping; not putting it in liquid, but heating it through a special vapouriser.

As you may know, Drug Science now has 3,000 patients in a trial—an audit—of medical cannabis. We are encouraging as many people as possible to move from the heated products to oils, because they have a better time profile, and you do not run the potential risks from getting hot vapour into your lungs.

There is one thing I really want to say about this. This project is showing a lot of fascinating data. We have now analysed about the first 500 people who are using medical cannabis for chronic pain. One of the most intriguing things is that 44% have stopped using opiates. They have stopped using opiate painkillers—44%. We didn't ask them to stop; we just monitored what they were doing. Because cannabis provides such a significantly better control for their pain than opiates. That fits in with other research we have done.

Q57 **Tim Loughton:** Do you want to add anything on medical benefits, Professor Corazza?

Professor Corazza: I don't think I have anything else to add on that. I am not an expert on medical cannabis.

Q58 **Ms Abbott:** I want to ask a little bit about drug addiction and treatment. I think most normal people, unless they spend a lot of time reading the tabloid press, are more concerned about drug addiction and how to treat it than anything else. Do you have any observations to make on that, Professor Nutt? Also, has treatment for drug addiction become more effective over time, or has it stayed the same, in the numbers of people helped?

Professor Nutt: The effectiveness of treatment has declined. I think Emily Finch on the next panel will talk about that, because she is very much on the frontline there. That has largely been driven by the reduction



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in funding. There has been a significant attenuation of funding for addiction services over the past 10 years. Thankfully, I think that is going to change with the Black report, which will put us back to where we were. There is no question that there has been an unfortunate hiatus in terms of appropriate funding.

In terms of treatments, there has been relatively little innovation in new treatments in a very long time. We are still using drugs such as buprenorphine for opiate addiction, or methadone. Those drugs were invented in the '60s. One reason that I and Jo Neill think it is important that we facilitate access to drugs such as psilocybin is that there is some evidence that they can be used to treat addiction.

Currently, there are studies going on with ketamine, which is a schedule 2 drug. There is definitely preliminary data suggesting that, for tobacco smoking and alcohol addiction, psilocybin may be even better. That is the study that I want to do next, but the limitations of the schedule 1 status make life difficult.

Q59 Ms Abbott: As you indicated, the 10-year drugs strategy promised to invest, I think, £780 million, to rebuild drug treatment and recovery services in England and Wales. Is that enough?

Professor Nutt: No, that will put us back to where we were in 2010. We probably should double that, particularly in terms of funding research. My biggest criticism of the new strategy is that it did not explicitly dedicate funding for research. There is an opportunity for serious innovation in addiction treatment now, using these illegal drugs.

Q60 Ms Abbott: Are there types of treatment that are not currently practised in the UK that you would recommend adopting?

Professor Nutt: I wouldn't recommend adopting but I would definitely recommend researching. For instance, internationally there is a lot of use of ibogaine to treat heroin addiction, but it has never been publicly studied. I cannot tell you if it works or not, or if it is safe. I want to study ibogaine, but, again, it is a schedule 1 drug and therefore very difficult for me to study. If it wasn't, I could study it.

Q61 Adam Holloway: I want to ask you, Professor Reece, because to you seem to be a lone voice here, what you think Britain should do to reduce the harm caused by these drugs?

Professor Reece: As I mentioned earlier, I think we need much better public education on the harms. Touching on a point that was just discussed, about rehab, detox and helping treatment, there has been a change recently in Australia where cannabis is more freely available, and with that the demand for cannabis treatment has plummeted. We used to do a fair number of detoxes for cannabis, which is straightforward medically. Now, people just say, "Oh, it is medical, I will just jump on the medical programme and that way the law can't touch me." I think it is very important that the Committee have a clear understanding that the illegal status of drugs is one of the motivating forces to enter detox and



treatment. A lot of patients are very ambivalent about whether they want treatment, so the fact that there are restrictions and legal sanctions against it is one of the major factors that tips the balance in favour of treatment.

I think education, especially on cannabis, is important. The genotoxic health impacts of cannabis are not understood. If you think that a huge percentage of children exposed in utero are going to develop autism or have serious birth defects in their brain or heart, or limblessness—as we recently reported—then the whole picture takes on a totally different tone altogether. I think one of the big issues in this whole addiction and drug field is that people are not on the same page. I think the research, which is being increasingly brought to bear and made evident, needs to be much more widely known in the community so that everyone can be on the same page, and we can sit down and have a rational discussion.

Q62 Adam Holloway: Forgive me, but everyone in this room knows that drinking alcohol is not particularly good for you, yet I am guessing that most of us in this room drink too much. What you are saying isn't the answer, is it? We know that doesn't work with alcohol, but what we are not doing with alcohol is creating an illegal market. It is a medical issue, not a criminal justice one. How does that fit with what you have just said about educating people?

Chair: I am going to ask you to be very brief because we are running out of time.

Professor Reece: I think we need much better education in this area. To touch on another point, earlier you were talking about fentanyl and carfentanil on the dark internet. The law that you talked about from 2016 sounds very successful; the head shops were closed. What you have there is a cyber-security issue, and you need to involve cyber-security experts to intervene in the dark net.

Chair: I am going to hand over very briefly to Stuart McDonald.

Q63 Stuart C. McDonald: I want to ask Professor Nutt to come back on two or three of the points that Professor Reece has raised. On the idea that it is the illegality of drugs that drives people to seek treatment, most of the written evidence that we have received seems to suggest the opposite—that it is actually a barrier to people seeking treatment. Secondly, on the idea of cannabis as a gateway drug, it seems that in the countries where cannabis has at least been decriminalised or regulated, people have less access to other drugs from the source of their cannabis. Finally, what is your view on whether cannabis should be class B or class C, and do you think that possession be decriminalised altogether?

Professor Nutt: Starting with the last question, I think it should be decriminalised because the criminalisation of cannabis users has led to enormous social problems. You have hundreds of thousands of young black men with criminal records for possessing cannabis—it is outrageous. Does the law facilitate treatment? You are right: it doesn't. In fact, as Nobel prize-winning economists have said, the black market is by far the

best market. It keeps people in addiction, it denies access to treatment and it doesn't give Governments any kind of taxation. What was your middle question?

Stuart C. McDonald: The gateway point.

Professor Nutt: The gateway argument is interesting. It has been very powerful. However, the reality is that when you deconstruct it, you discover that the Dutch were right. The reason the Dutch set up the cannabis coffee shops was to separate the cannabis market from the heroin market. They didn't want their young people to be offered heroin, and it was a remarkable success. They have lower use of cannabis among their young people than we have, because there is no black market driving it, and they have way, way lower use of heroin than we do. It was a perfect solution, and we should definitely adopt it here.

Chair: Thank you very much. I thank everyone who has given evidence in this part of our session this morning. It has been very stimulating and we have all learned a lot. Thank you very much for your time. We will now move on to our second panel.

Examination of witnesses

Witnesses: Dr Owen Bowden-Jones, Dr Emily Finch and Professor Roger Knaggs.

Q64 **Chair:** Good morning. This is the second panel of this morning's evidence session. As with the first panel, could everyone introduce themselves and say in what capacity they are speaking? I will start with Dr Bowden-Jones.

Dr Bowden-Jones: Good morning. My name is Owen Bowden-Jones and I am chair of the Advisory Council on the Misuse of Drugs.

Dr Finch: My name is Emily Finch. I am joint chair of the recovery committee of the Advisory Council on the Misuse of Drugs.

Professor Knaggs: My name is Roger Knaggs. I am a council member of the Advisory Council on the Misuse of Drugs and chair of the technical committee.

Q65 **Chair:** Thank you. As I said to the previous panel, it would be very helpful if everybody could use simple and straightforward language, as we are not all scientifically trained on this Committee. Dr Bowden-Jones, what is your assessment of the classification model we have been discussing this morning? In your view, is it fit for purpose in terms of controlling drugs?

Dr Bowden-Jones: I will preface that by outlining the role and the limitations of the work of the advisory council. We are an independent scientific advisory council with a statutory role under the Misuse of Drugs Act 1971. We are a group of 23 experts drawn from a range of different disciplines. We make recommendations to the Government on issues such as scheduling and classification and a range of other topics, which I imagine we will touch on today. What we do not do is develop policy or

undertake direct research ourselves. It is important to be clear about that right from the beginning.

The classification system is not something that we have studied. We have not undertaken research or examined the classification itself, so it is really difficult for us to comment on the classification and how it works. What I can say, though, is how we make decisions with respect to recommending that a certain drug go into one class or another. We have published this because we felt it was really important that people were clear on how we reach decisions. We have a very clear description of how we seek evidence, how we synthesise that evidence and how we present that evidence.

Also included in that document, which we are very happy to send to the Committee, are the health and social harms matrices. This is really important, because what it allows us to do is to be very systematic in how we look at a drug and the harms it might cause. We go through the health and social harm matrices in detail, making sure that we have not missed anything, and that also allows us to do a clear and comprehensive review of each substance we look at.

That is the process we go through. We then make a formal recommendation in writing to the Government. It is then the Government's decision whether they choose to accept that or not.

Q66 Chair: Would you like the power to be able to look at and take evidence about the system that you are operating in, whether that is the best system and whether it could be improved? Would you like that opportunity?

Dr Bowden-Jones: We have not been commissioned directly by the Government to look at this.

Q67 Chair: No, but as the chair, do you think that would be a good thing for you to be able to do?

Dr Bowden-Jones: We do actually have a process by which we can self-commission work, and in fact we do self-commission work regularly. The process by which we do that is an annual meeting where we look at all the priorities, then we develop a list, and then we choose the ones we feel are most important.

In terms of the things that have come top of that list, our main focus has been on drug-related deaths. The focus of the reports we have self-commissioned has very much been in that space. To give you examples, we have done reports on naloxone. We have done work on the sorts of substances you were hearing about in the first session, which are added into heroin supplies—for example, novel benzodiazepines. We have also done a lot of work on different vulnerable groups to try to understand and explain to the Government the science behind some of those vulnerabilities.

Q68 Chair: So there is the possibility in the future that your organisation could



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look at the classification model, if it wanted to.

Dr Bowden-Jones: Yes.

Q69 **Chair:** That is interesting to note. I expect you are very clear that you are there to provide the recommendation and the evidence base to Ministers, and Ministers make the final decision.

Dr Bowden-Jones: Yes, that is our role.

Q70 **Chair:** And that is clear? Obviously, in the past, it has been difficult for your organisation. There have been certain tensions between politicians and chairs of the committee.

Dr Bowden-Jones: I think the role is really very clear and it is described very clearly in the Misuse of Drugs Act. We are an independent scientific advisory committee. When we function well, we are providing the science and synthesising that in a way that Ministers can clearly understand what the science says. It is very much for the Government then to decide what to do with those recommendations.

Q71 **Carolyn Harris:** We heard in the last session about the prevalence of the dark web and the damage that that is doing in allowing people to access psychoactive substances. With your work, looking at social harms, what more can we do to prevent that and support people to come away from that environment?

Dr Bowden-Jones: This is a very concerning area. It is an area that we have already initiated a report on. We have a working group at the moment looking at internet-facilitated drug markets. Obviously, I can't comment on the findings of that report yet, but it is a high priority.

What I would say about many of our reports is that there is a theme that comes across, which I think is important to mention. What we tend to find when we look at the evidence is that no single intervention on its own tends to be enough. What our reports tend to be suggesting when we look at the evidence is that there is a range of different approaches that you have to look at and take together as a package.

A really good example of this is our GHB report. GHB is a substance that was associated with a number of very high-profile sexual assaults and murders in the UK. The Home Secretary asked us to look at the classification and the scheduling of that substance and that group of substances. When we looked at the evidence, we found very clearly that no single intervention was likely to be sufficient to reduce the harm. Alongside the recommendations we made around classification and scheduling, we made a lot of additional recommendations looking at treatments, the training of clinicians, the information that is given to people who use these drugs, harm-reduction information, information on toxicology and how you might measure the harms that are caused. We were very clear—and this is a theme across many of our reports—that a single intervention will probably not lead to a reduction in the harm, but that this broader approach where you knit together lots of different evidence-based interventions is the way to go.



Q72 **Carolyn Harris:** So when you advise Government on the methodology that you say would be most effective, are you knocking on an open door?

Dr Bowden-Jones: There is a working protocol in place between the ACMD and the Government that outlines how this relationship works. All our recommendations are put to Government in writing. They are all published on our website, so everybody can see them. The Government respond to recommendations in writing as well. Some recommendations are accepted and some are rejected, and there is a clear process in the working protocol about how we manage that. When the Government reject a recommendation, the working protocol is clear that they need to write to us explaining the reasons for that rejection. Typically, what will happen is I will meet with Government and discuss that face to face as well. That is the sort of framework that governs our interaction.

Q73 **Chair:** Is there a timeframe around that process? One concern we have is that things often take an inordinately long time in the Home Office. Do you have a timescale for each bit of that process?

Dr Bowden-Jones: The working protocol suggests that we should receive a response within three months of submitting our recommendations.

Q74 **Chair:** Do you?

Dr Bowden-Jones: We don't always. We do acknowledge that sometimes we write, as I have described, recommendations that are aimed at more than one Department. We will quite regularly write recommendations to several different Government Departments. I acknowledge that the more complexity we present the Government with, perhaps the longer it will take them to respond. One of my roles as chair is to encourage Government to respond in a timely manner. That is sometimes difficult. I don't think the pandemic has helped with some of the responses, but there still is, as I say, a clear timeframe within the working protocol.

Q75 **Chair:** Okay, but it sounds like it is breached more than it is observed?

Dr Bowden-Jones: I would have to go back and look. Some of the reports and recommendations have certainly breached three months.

Q76 **Stuart C. McDonald:** Thanks to the panel for coming along this morning. I suspect my questions would probably be best directed at Professor Knaggs, but if anyone else wants to come in, please do.

On the previous panel, Professor Nutt and Professor Neill expressed considerable concern about aspects of the 2001 regulations, the system of scheduling drugs and the impact that that has on research. Is it your view that the way drugs are scheduled—it is now schedules 1 to 5—reflects the potential harms of all of those drugs? Is the system fit for purpose?

Professor Knaggs: Dr Bowden-Jones has described our approach to classification and making decisions regarding classification. One piece of work that the ACMD has undertaken over the past couple of years has looked at the process and the criteria as to why specific substances may be scheduled within the different schedules in the misuse of drugs regulations. That document is freely available, and we would be happy to



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share it with you to show the considerations we look at when considering making a decision regarding scheduling.

- Q77 **Stuart C. McDonald:** By way of an example, psilocybin was one of the complaints of the two professors. Are you able to give us a brief summary of how psilocybin ended up in the first schedule?

Professor Knaggs: The first thing to remember is that many scheduling decisions were made a long time ago. The schedules that drugs are currently in are historical decisions that may have been made many years ago, and as new evidence comes to light, they may well be reviewed.

- Q78 **Stuart C. McDonald:** You have mentioned new evidence as a trigger, but should there be some sort of automatic process of reconsidering the scheduling of drugs if somebody like Professor Nutt or Professor Neill makes a submission that they are in the wrong place, rather than just leaving them there? What I am getting from you, really, is that there are things that are wrongly scheduled now. Shouldn't there be some sort of automatic review process?

Professor Knaggs: One of the key defining features between schedule 1 and schedule 2 within our document relates to the availability of licensed medicinal products. Obviously, through the Medicines and Healthcare products Regulatory Agency, there is a process regarding licensing of medicines, and that is one of the key factors that distinguishes between schedule 1 and schedule 2.

- Q79 **Stuart C. McDonald:** I am venturing into territory where I am not remotely knowledgeable, but isn't there a risk of a chicken-and-egg situation there? How are you going to get a licence under the MHRA's system if you are not able to undertake the research—if all these burdens are preventing research from happening in the first place?

Professor Knaggs: There is a very clear process for undertaking research, and the MHRA does allow research with schedule 1 drugs for investigational purposes. There is also the ethical approval process through the health research that is required in order to undertake clinical studies.

- Q80 **Stuart C. McDonald:** The evidence from Professor Nutt and Professor Neill was that if they want to do research in relation to schedule 1 drugs, they have significant expense, significant bureaucracy and significant delay, which is having a really detrimental overall impact on the research they and many others want to do, which could bring enormous health and, indeed, economic benefits to this country. Are you quite relaxed about the system as it is just now, or do you have some sympathy with the complaints they are making?

Professor Knaggs: Barriers to research is an issue that has been on the ACMD agenda for several years now. This began, and was highlighted to the ACMD as an issue, following a generic definition regarding the synthetic cannabinoids, and we have been working to understand those barriers over the past two or three years. In summer 2021, we published a report on barriers to research specifically relating to the synthetic



cannabinoids, and last year we had a call for evidence regarding barriers to research more generally, particularly schedule 1 controlled drugs. This is a piece of work that we are currently working on.

Q81 **Stuart C. McDonald:** When do you expect that to be available?

Professor Knaggs: As you can imagine, this is a very complex area. We are looking at all stages of the discovery process, from drug discovery in types of laboratory-based research through to the development of new medicines, and also clinical trials. The issues are probably slightly different in each of those areas. As I say, this is an area that we are currently working on, and we hope to be able to publish a report this year.

Q82 **Stuart C. McDonald:** Thank you. I don't know whether Dr Bowden-Jones or Dr Finch want to add anything. At a very simple level, Professor Nutt spoke about the storage of psilocybin in a safe with a camera looking at it. He asks why they can't just keep it in the cabinet next to other drugs, which would be far more attractive to anyone trying to break into a pharmacy. Surely there has to be another look at these rules.

Dr Bowden-Jones: If I may make a comment, we are absolutely aware that schedule 1 puts extra burdens on research. We are very sympathetic to people who are trying to do research. It is critical that legitimate research occurs in the easiest way possible. There is a balance, of course, between allowing legitimate research to occur and these safety checks and balances that you would expect over substances that have been put in schedule 1, typically for a reason.

As Professor Knaggs has described, this is an issue we have been working on for a long time, and it is very, very complicated because there are different types of research under way and the problems are different for the different groups. We are very committed to this. We have, as Professor Knaggs said, already provided recommendations to Government around the synthetic cannabinoid receptor agonists. We are now moving to look at all schedule 1 drugs and, as Professor Knaggs said, we are very much hoping to come back with recommendations by the end of the year that might then find a way around this issue. We recognise it is an issue and we want to try and find a way round it.

Q83 **Tim Loughton:** May I follow up on that? You said earlier, Dr Bowden-Jones, that you are looking at drugs in terms of their health and social harms. We have heard that you will look at rescheduling a drug only if there is new evidence. Clearly, there is new evidence for not just health but social harms emerging all the time, as well as the way other countries have chosen to reclassify or reschedule their drugs in whatever system they use. So is there not a case, as we heard just now, for a routine analysis every x years to make sure that everything is in the right schedule, rather than slightly randomly allowing some new evidence in whatever form to come along before you actually look at it?

Dr Bowden-Jones: The advisory council has a watching brief on drug harms. We have various committees and sub-committees that keep an eye on emerging drug harms. We have lots of different metrics that we look at



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to try to identify emerging harms. Similarly, on the medicinal side, particularly around the scheduling, the MHRA will inform us if new medicines are being brought to market and if those need scheduling. So there is a process by which, as new medicines appear, we are alerted via that system. But I do agree with you: the idea of having a more systematised approach to review would be helpful.

Q84 Tim Loughton: Would there need to be legislation to change that? Would the Minister have to authorise that? Or could you change your own processes? How would that come about?

Dr Bowden-Jones: As I said, we do have processes in place to have a continued review of emerging drug harms. That is already in place.

Q85 Tim Loughton: So you could just change your practices, effectively?

Dr Bowden-Jones: As I say, we feel that our practices do pick up emerging harms. If I have understood you correctly, the question you are asking is: what about the things already in the schedules?

Q86 Tim Loughton: That is exactly my point. I have prescriptions for various long-term conditions and my doctor will routinely, each year, look at whether they are still fit for purpose—whether I still need that drug, or whether they should change the dosage and such. It just seems odd that you are at a much higher level, regulating some of those things, and are not routinely seeing whether your advice and scheduling classification is still fit for purpose.

Dr Bowden-Jones: We do review emerging harms, as I have said. For example, if we suddenly started hearing that there were harms associated with a drug that has been classified, that would be something we would go back and review. We have reviewed drugs at fairly regular intervals over the years, but I think it is an interesting point. It would be something I would be interested in taking back to the council to discuss.

Q87 Tim Loughton: Okay. Dr Finch, let us hear from you. Can we come on to cannabis? You will have heard the comments earlier about the medical harms of cannabis. Picking up on your approach that looks at health and social harms, what are the health and social harms as regards cannabis and cannabis alternatives?

Dr Finch: The ACMD hasn't looked at cannabis since 2008, I think, which was before my time on the ACMD. We haven't been commissioned by Government to look at the harms of cannabis. We also haven't self-commissioned ourselves. We have focused on the areas that Owen was talking about. We haven't reviewed the scientific evidence for 15 years.

Q88 Tim Loughton: So your scientific review is 14 years, potentially, out of date?

Dr Finch: That is right, yes.

Q89 Tim Loughton: And you have to be prompted to look at that by Government? You cannot just instigate it yourself?



Dr Finch: We could, in theory. As Owen said, we have a process by which we decide the various things we look at. From my point of view on the recovery committee, we focused that review on particular vulnerable groups. Different drugs have come up, but we have focused those reviews on homelessness, for instance, and other forms of reducing harm. We haven't looked at cannabis.

Q90 **Tim Loughton:** Do you not think there is a case for looking at this again? Obviously, we have heard that the medical impact of cannabis is being used and there is more research and availability commercially of certain drugs, which can be seen to help.

Dr Finch: We have looked at cannabis-derived medications. We haven't looked at the use of illicit cannabis. What we have looked at is around the provision of medicinal cannabis, which we have done a significant amount of work on.

Q91 **Tim Loughton:** Right. In terms of illicit cannabis, we have heard from Professor Reece about the very damaging impact it can have on all parts of your body, and that it is stronger now and taken more regularly by the users and so on. In terms of the social harm impact, surely quite a lot has changed over at least the last 14 years. Do you not think you should be able to have a proper look again at the illegal, illicit use of cannabis?

Dr Finch: Yes, there is a case for it, but we have a lot of other priorities. The increase in drug-related deaths is an example. We have other treatment priorities from the recovery committee's point of view. We have just talked about the barriers to research. We have a limited amount of resource to perform our work programme. It is something we could consider.

Q92 **Tim Loughton:** So it is a resource issue?

Dr Finch: Perhaps, but it is also a prioritisation issue.

Q93 **Tim Loughton:** Okay. What is your view? If resources were not an issue, do you think that you should be looking at the scientific evidence around the health and social harms of illicit cannabis on the basis that your evidence could now be 14 years out of date?

Dr Finch: I think we would have to look at other issues and prioritisations for the whole work programme in order to make that decision.

Q94 **Tim Loughton:** That is slightly fudging the question, if I may say so. Everything is a priority. How big an issue do you think this is, given that cannabis is the most common form of legal drug that is taken?

Dr Bowden-Jones: Perhaps I can come in.

Q95 **Tim Loughton:** Can we look at the social impact? I was interested that you said you look at health and social harms. Social harms covers a multitude of sins—it goes into the crime stats that we heard about earlier—so I am slightly concerned that your evidence is 14 years out of date. This is a big and growing problem.



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Dr Bowden-Jones: One way to think about this is in the context of the drug problems in the UK at the moment. The clear challenge that we see is drug-related deaths. Very few people, to our knowledge, die from cannabis, but very large numbers of people die from opioid-related substances, so we have been putting enormous energy in trying to marshal the scientific evidence around drug-related deaths and things that are contributing to them to inform the Government of the science behind that. There are always important and interesting issues that need to be and could be discussed, but in the context of what is going on in the UK at the moment with respect to drug-related deaths, it is quite appropriate that the ACMD is placing its resource into looking at that issue.

Q96 **Tim Loughton:** Do you not buy the argument that cannabis is a gateway drug into harder drug use, which does result in drug-related deaths?

Dr Bowden-Jones: That was not a particular feature of our 2008 report, so there wasn't much science related to that. Again, the group of people we are seeing who are experiencing harm from drug use at the moment tend largely to be opioid users. This is a huge and devastating problem, and it is getting worse. We feel very comfortable focusing our energies looking at things like naloxone provision and why that is not happening properly, opioid substitution treatment and giving evidence on that, and new adulterants to heroin markets and the harm they are causing. That is an absolute priority for ACMD, and I am very comfortable with it.

Q97 **Tim Loughton:** Professor Knaggs, did you want to add anything?

Professor Knaggs: No, thank you.

Q98 **Chair:** You were talking about reviewing and the opportunity to look again at things. I notice that in your 2020 report on fentanyl, you basically said that you didn't think it was much of a risk to public health in the UK at that time. I think you were in the room when I said that fentanyl is now seen as a real problem because of what has happened in Afghanistan. Has that report been accepted by the Government? How do you raise the fact that there has been a change in circumstances, and that perhaps a new approach is needed? How does that work?

Dr Bowden-Jones: We keep a watching brief on issues such as drug-related deaths, crime survey data on prevalence, and treatment presentations. We have a way of keeping an eye—what is described in the Act as a watching brief—on drug harms. That is how we do it.

Q99 **Chair:** So you will wait until fentanyl is in the country and people are dying, and then you will say, "We need to do something."

Dr Bowden-Jones: Not at all. As you will have seen, we have written a report on fentanyl with a number of recommendations, which highlights how concerning this is. In fact, we are working on a further report looking at different synthetic opioids. One of our roles is absolutely to get ahead of the harm, look at the evidence and explain what that might be to Government. We have seen enormous harm from fentanyl and fentanyl analogues in North America, and it is a great concern that that could come



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here. Our report is written very much in the way of prompting the Government to think about these issues in advance.

Q100 **Chair:** Have they accepted the recommendations you made to them?

Dr Bowden-Jones: We are still waiting for them to respond.

Chair: Sorry, it was 2020 that you wrote the report and gave it to the Government. It is now 2022 and you are waiting for a response. Okay, thank you.

Q101 **Ms Abbott:** I was very interested to hear you say that reviewing cannabis is not a priority for you. I think the public might be amazed that it is 14 years since you last looked at it. The point about cannabis, as we heard earlier, is that it is a gateway drug in a particular sense; the dealer you get your cannabis from may be the same one you get your opioids—or other more harmful drugs—from. Are you confident that you can justify not looking at cannabis and not regarding it as a priority? Do you really think you can justify that?

Dr Bowden-Jones: Just to clarify, we are not saying it is not a priority.

Ms Abbott: It is not a priority for you.

Dr Bowden-Jones: There are many, many priorities, and we have to work out which we are going to do first.

Q102 **Ms Abbott:** I understand that, but it is the most commonly used controlled drug and, whether physiologically or in trading terms, it is a gateway drug to opioids, yet public money is being spent on an advisory council that does not consider reviewing cannabis after 14 years—it has been 14 years since we last looked at it. Public money is being spent on a council that does not regard reviewing cannabis as a priority. That is what you are telling me.

Dr Bowden-Jones: Just to respond to that, the majority of our commissions come from Government, and we have not been commissioned by Government to look at that. That is an important point because, typically, if something is a priority for the Government, they will be asking us to do it.

Q103 **Ms Abbott:** Yes, but you did say that not all of your commissions come from Government, so you could choose to look at cannabis if you considered it a priority.

Dr Bowden-Jones: We could. As I said, we do have a process for looking, each year, at what we think are the key things that we need to focus on, and other things have come before a review of cannabis. That is the situation: we focus on drug-related deaths because we feel that is the most urgent issue for us to be looking at.

Q104 **Ms Abbott:** Parents might also consider it urgent to look at the use of cannabis because, so often, their children go on from using cannabis to accessing more serious drugs. But I will leave you with your assertion that it is not a priority.



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As you will know, in 2021, the Information Commissioner upheld the Home Office's decision to refuse the publication of your 2016 report, in which I understand you recommended the decriminalisation of drug possession for personal use. Is it the case that you recommended that in your 2016 report?

Dr Bowden-Jones: That is not the case. We have a variety of internal discussions, which is only healthy in a council such as ours, and we produced our final report, which was looking at the interaction between the Psychoactive Substances Act and the Misuse of Drugs Act. That is published on our website.

Q105 **Ms Abbott:** Do you think that the Home Office's decision not to publish the 2016 report is conducive to fostering a practice of transparent policy making?

Dr Bowden-Jones: I am glad you asked about transparency because this is a very important issue to me.

Ms Abbott: That is why I asked it.

Dr Bowden-Jones: It is critical that people can look at the recommendations we make and understand how we have made them. That is why we have published in detail how we collect, analyse and produce our recommendations; that is why we have been so clear about putting out our health and social harms matrices, so you can see exactly the metrics we are looking at to try to reach a conclusion; and that is why we published a summary of how we reach scheduling decisions, so that it is very clear to people how we are reaching those conclusions.

Q106 **Ms Abbott:** Okay. Finally, let me put this to Dr Finch, because I note that you have responsibility for addiction services across Lambeth, Bexley, Greenwich and Wandsworth. To what extent does your practical experience of addiction services confirm your view that cannabis is not a priority?

Dr Finch: In addiction services, it very much confirms my view. In addiction services, the people who present for treatment are mainly opioid users. The ACMD has looked at that in a lot of detail. We looked at things like opiate substitution treatment, and at other things to prevent drug-related deaths, such as using naloxone. Those are very relevant to current treatment. I think the ACMD hasn't looked at where and how cannabis users can present. They tend to be a different group, so we have looked at them very separately and done various reports about what the most effective treatments would be.

Q107 **Ms Abbott:** Are you saying that, in your capacity as someone who is responsible for addiction services in Lambeth, Bexley, Greenwich and Wandsworth, you have not looked at how cannabis users present?

Dr Finch: I am here in my capacity as chair of the recovery committee at the ACMD.

Q108 **Ms Abbott:** Yes, but you have other roles. Are you saying that in those



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other roles, you have not looked at how cannabis users present?

Dr Finch: I don't think it is fair to comment on my other roles.

Ms Abbott: Okay.

Q109 **Chair:** Can I go back to the point that Diane Abbott raised about the report produced in 2016? It was reported that the ACMD recommended the decriminalisation of drug possession for personal use. What is the current position of the ACMD on that point? Are you able to say that?

Dr Bowden-Jones: Can you ask that again? I am not quite sure I understand.

Chair: My understanding is that it was reported—the report has not been published, so we do not know—that the report recommended the decriminalisation of drug possession for personal use. We do not know what was in that report, but I am asking you, as the chair of the ACMD, what your position is. Is that what the ACMD is saying should happen?

Dr Bowden-Jones: Do you mean under the Misuse of Drugs Act or the Psychoactive Substances Act?

Chair: I have not seen the report, so I do not know what was in it, but what is the position of the committee today?

Dr Bowden-Jones: The discussion was really around temporary class drug orders—TDCOs, as they are known. The question was really whether they should be retained or not. The internal discussion was really about trying to understand that, where things fitted, and how the two Acts interfaced. We came up with recommendations around retaining the TDCO—sorry to use technical terms—within the Misuse of Drugs Act.

Q110 **Chair:** So there was no recommendation to decriminalise?

Dr Bowden-Jones: No, we have never published—finalised—any sort of evidence around that.

Chair: Okay. It is unfortunate that we have not been able to see the full report, because it was reported that that was what was in it.

Dr Bowden-Jones: Just to be clear, all our final conclusions are published. Anything on which we reach agreement as a council is published. There will, of course, be internal discussions, and it is right and proper that we can test out different ideas. All our final recommendations are available on our website.

Q111 **Chair:** But the Home Office decided to refuse the publication of the 2016 report. That is correct, isn't it?

Dr Bowden-Jones: I am not sure that is correct, in the sense that that is not a published ACMD position. It may be an internal document—a discussion paper.

Q112 **Chair:** Okay. Perhaps we will get clarification of exactly what it was that



was not published. May I just ask you one other question? There has been quite a lot of criticism about the provision of cannabis-based products for medicinal use being restrictive. What do you say about that? Do you agree?

Dr Bowden-Jones: This is a complex area. I think the way to frame it is to be clear about the two broad types of available products. The first group of available products are licensed cannabis-based medicines. They are medicines that have been submitted for market authorisation by the companies that make them. One is called Sativex and is in schedule 4, and one is called Epidiolex and is in schedule 5. To be clear, any doctor can prescribe them, and they are approved for certain conditions by NICE, which is the gold standard that many clinicians look towards. We think about 800 people a year are in receipt of one of those licensed cannabis medicines.

The second group are unlicensed cannabis-based products for medicinal use. These are products for which the manufacturers have chosen not to apply for market authorisation through the normal regulatory framework. They lie in schedule 2 because there is less clarity about their safety, efficacy and content. We have made a number of reports over the last couple of years about how these products could be more helpfully introduced into the health system. As it stands, this second group can be prescribed only by specialists on the General Medical Council register and they are not supported by NICE at the moment, although—we have talked about reviewing evidence—these things do get reviewed.

Q113 Chair: And there aren't any that are being used under that second category.

Dr Bowden-Jones: There are very few prescriptions in the NHS. There are more prescriptions, I understand, in the private sector. The data is quite hard to get hold of. In 2019, we produced a report summarising the impact of the rescheduling. In fact, coming back to the point about reviewing things, we are actually coming back to look at this again, because we feel that the data may have changed over time.

Chair: Okay. Thank you very much. We are very short of time, so I will take Stuart McDonald and then we will conclude.

Q114 Stuart C. McDonald: It is a big topic and there is obviously not enough time to cover it in depth, but you touched on harm reduction measures—in particular, the use of naloxone. I think opiate substitute treatment was also mentioned. Is it your view that this country is offering enough of that type of treatment? Could I mention drugs testing and drug consumption rooms as possibilities as well?

Dr Bowden-Jones: There was quite a lot there to cover quickly. Again, as a scientific advisory council, our job is to look at the evidence and see where the science says things work. We have very strong evidence that opioid substitution is a highly effective treatment. We have good evidence showing that naloxone is an important thing to provide. We have made recommendations around drug consumption rooms. That is the point: we



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say, "This is what the science says," we put that in recommendations and we hand them to the Government, who then decide what to do with those.

Q115 **Stuart C. McDonald:** What, in summary, were your recommendations in relation to drug consumption rooms?

Dr Bowden-Jones: We made a recommendation that there should be a pilot of a drug consumption room in an area of high injecting prevalence.

Q116 **Chair:** When did you make that recommendation?

Dr Bowden-Jones: It was made in 2016 as part of our drug-related deaths report.

Q117 **Adam Holloway:** Do you feel ignored by Government?

Dr Bowden-Jones: Not at all. We receive an enormous number of commissions from Government—some of them are often very urgent—so Government gives us a lot of work to do.

Ms Abbott: But they ignore your recommendations—that's the point.

Dr Bowden-Jones: May I finish? We don't feel ignored. There are of course situations where we will make recommendations and, as you say, they may not be accepted, but it is about coming back to understanding what the purpose of the council is. We are a scientific advisory council. Our job is not to write policy; our job is to provide Government with the science. It is then Government's job to decide what to do with that.

Chair: I think we are very clear on that. Thank you very much for your time today. If there are any questions that we have not been able to put to you, we might write a letter to you, asking for some further clarification, but thank you so much for your time.