ACMD

Advisory Council on the Misuse of Drugs

Annual Report

Accounting Year 2009 - 2010

Secretariat
Advisory Council on the Misuse of Drugs
Science and Research Group
3rd Floor, Seacole Building
2 Marsham Street
London SW1P 4DF

Foreword from Professor Les Iversen

The annual report from the Advisory Council on the Misuse of Drugs (ACMD) provides an overview of our work in 2009/10 and summarises our on-going commitment to ensure that we provide Government with high quality advice concerning drug misuse and harms in the UK.

In January 2010, the then Home Secretary appointed me as interim Chairman of the ACMD. I believe that this represented an important step in ensuring continuity of the Council's work so that it may continue to carry out the important function of advising the Government.

I was honoured to take up the position and wish my predecessor, Professor David Nutt, all the best for his future work. I would also like to take this opportunity to thank those members who recently stood down from the ACMD for their hard work and dedication to the work of the Council.

The events around the dismissal of Professor Nutt were destabilising for the Council, however, soon after the Council had the opportunity of meeting with the Home Secretary and agreeing a way of working collaboratively in the future. The joint statement between the ACMD and the Home Secretary (available at http://drugs.homeoffice.gov.uk/Joint_Statement_-_ACMD__HSec.pdf) is the culmination of our meeting of 10 November 2009. This document represents a very positive step forward for the provision of advice to Ministers and is an approach that we believe should be taken forward in subsequent years.

The events surrounding the membership of the ACMD should not overshadow the considerable body of important advice that we have provided. During the last year the ACMD has advised the Government on a range of important issues. In particular has been the growing public concern around the compounds colloquially known as 'legal highs'. The ACMD have been considering a number of these groups of compounds. Over the last year we have advised on the synthetic cannabinoid receptor agonists (including 'Spice') and 1-benzylpiperazine (BZP) including other piperazines. In both cases the ACMD provided Government with generic definitions so as to ensure the provision of durable legislation. The ACMD were pleased to see that the government was swift to control these harmful drugs.

One major area of work has been the consideration of the cathinones which include the drug mephedrone. The ACMD provided advice to Government on the 29th March 2010. The ACMD recommended that the cathinone compounds be brought under control of the Misuse of Drugs Act 1971 in Class B, Schedule I by way of a generic definition. Based on the evidence and by analogy with the amphetamines, the ACMD considered that the harms associated with the cathinones most closely equated with other compounds in Class B.

In the last year, and in response to a commission by the previous Home Secretary, we have initiated work to consider: Cognitive Enhancing drugs; Poly-Substance Use and the use of information streams to provide better early warning of new potentially harmful drugs and those drugs, currently illegal, where we see trends that are of concern. In addition the ACMD are looking to convene a working group to consider the field of drug treatment.

The ACMD has continued its work looking at the factors around the hazardous use of alcohol, tobacco and drugs among young people with the publication of Pathways to Problems: A follow up report on the implementation of recommendations from *Pathways to Problems (2006)*. The report notes the good progress that Government has made – particularly around the control of tobacco and increased recognition of the roles of parents and schools. However, the ACMD recognises that there is further work to be done, chiefly around young people's exposure to alcohol (see also section 2.3).

The ACMD recently announced a review of cocaine to take place in 2010/11. The ACMD have concerns that there is an erroneous perception of cocaine being a 'safe drug'. There is an underlying trend in the use of cocaine increasing across a wide social demographic. It is important to be clear that the final report will not advise on the classification of cocaine since the ACMD believe that cocaine is, and should remain, a Class A drug. The ACMD propose to carry out a thorough review of the harms associated with cocaine and provide ministers with recommendations for tackling these.

Over the past year the ACMD has received considerable input from experts to its ongoing work. I would like to thank all those who have freely given their time to contribute to the work of the ACMD for their contributions during the year.

Professor Les Iversen
(ACMD Chairman)

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Annexes

1. Introduction

The Advisory Council on the Misuse of Drugs (ACMD) is a statutory and non-executive Non-Departmental Public Body, which was established under the Misuse of Drugs Act 1971.

This Annual Report provides an overview of the ACMD's work, in accordance with both the Office of the Commissioner for Public Appointments Code of Practice for Ministerial Appointments to Public Bodies[1] and the Code of Practice for Scientific Advisory Committees[2]. This report gives a summary of the main issues the ACMD considered between April 2009 - March 2010 as well as information about its Terms of Reference, Committees and Working Groups and membership and administrative arrangements.

Any enquiries about this Annual Report or any aspect of the work of the Advisory Council should be addressed to:

The Secretariat to the Advisory Council on the Misuse of Drugs
Science and Research Group
HOME OFFICE
3rd Floor, Seacole Building (SW)
2 Marsham Street
LONDON
SW1P 4DF

Tel: 020 7035 0454
Email: ACMD@homeoffice.gsi.gov.uk

Will Reynolds
Secretary to the Advisory Council on the Misuse of Drugs
April 2010

[1] http://www.ocpa.gov.uk/upload/assets/www.ocpa.gov.uk/codeofpractice_aug05.pdf
[2] http://www.berr.gov.uk/dius/science/science-in-govt/advice-policy-making/codeofpractice/page9483.html

2. Committees and working groups meeting in the accounting year 2009 – 10

2.1. Technical Committee

The Technical Committee is a standing body of the Advisory Council on the Misuse of Drugs. The Committee's primary purpose is to consider and make recommendations to the Advisory Council about classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations.

The Technical Committee had its last meeting on 25th March 2010..In the last year the Technical Committee has considered a number of issues including;

- Evidence for the use of foil as a harm reduction intervention (with reference to the current legislation under Section 9A of the Misuse of Drugs Act 1971)
- The synthetic cannabinoid receptor agonists (including 'Spice')
- The Cathinones
- 'legal highs'
- Anabolic steroids
- The mixing of medicines
- The provision of Naloxone

2.2. Cognition Enhancers Working Group

The Cognition Enhancers Working Group (CEWG) was convened in response to the Home Secretary's commission of March 2009 (see http://drugs.homeoffice.gov.uk/ACMD_Letter_to_Home_Secreta1.pdf).

The Working Group held it first meeting on 8th October 2009; at which it discussed terms of reference, the scope and areas of work.

The Working Group has undertaken to investigate the harms associated with the use of CEs (Cognition Enhancers), including physical, psychological, and social harms. The Working Group agreed to focus on the three enhancers that are most widely cited;

- Adderall[3]
- Ritalin (Methylphenidate)[3]
- Modafinil

The Working Group will advise the Government on whether the harms necessitate some form of regulation and/or control. If this is proposed, the Working Group will need to consider whether the same regulation/control applies

[3] It is noted that Adderall and methylphenidate (Ritalin) are already controlled under the Misuse of Drugs Act 1971.

to the whole class of drugs or needs to be differentiated according to harms and use.

The Chair of the CEWG resigned in late November 2009. A new Chair of the Working Group is being sought.

2.3. Pathways to Problems Implementation Group

This is a working group of the ACMD that was set up to assess progress against the ACMD's recommendations published in *Pathways to Problems* (2006); how they are being taken forward and implemented.

This group published its report on 29 March 2010. The report is available on the ACMD's website.

2.4. Anabolic Steroids Working Group

The ACMD set up the Anabolic Steroids Working Group in June 2008 to consider the ACMD's concerns around Anabolic Steroids misuse – the report will not focus on the use of anabolic steroids in elite sport. The purpose of the report will be to provide ministers with advice on anabolic steroids and associated harm reduction measures.

The Anabolic Steroid Working Group intends to report its advice to the ACMD which will report to ministers later this year.

2.5. Simultaneous poly-substance misuse working group

The simultaneous poly-substance misuse working group was convened in response to the Home Secretary's commission of March 2009 (see http://drugs.homeoffice.gov.uk/ACMD_Letter_to_Home_Secreta1.pdf).

The 'Simultaneous Poly-Substance Misuse' Working Group (SPWG) had its first meeting on 30th September 2009. This Working Group was set up following the Home Secretary's correspondence to the ACMD about Government priorities.

At its first meeting on the 30th September, the Working Group considered the terms of reference for the group. The Group proposed that it was termed the Simultaneous Poly-Substance Misuse' Working Group so that alcohol was implicitly included.

The Working Group agreed, to cover some of the following work areas:

- Harms
- Pharmacology and chemistry
- Prevalence
- Population segments

- Secondary prevention advice

It was envisaged that the Working Group would report in the form of a formal report in late 2010.

All current external work on the Working Group is suspended until further notice. A new Chair needs to be appointed.

2.6. New Psychoactive Substances Working Group

The New Psychoactive Substances Working Group (NPS) held its first meeting on the 8 December 2009. The new psychoactive substances working group was convened in response to the Home Secretary's commission of March 2009 (see http://drugs.homeoffice.gov.uk/ACMD_Letter_to_Home_Secreta1.pdf).

One of the aims of this Working Group was to provide advice to Government on the synthetic cannabinoid receptor agonists (that includes 'Spice') (see section 3.1) http://drugs.homeoffice.gov.uk/publication-search/acmd/acmd-report-agonists?view=Binary; this advice was delivered to the Home Secretary in August 2009.

The group also considered the cathinones. However, after the resignation of Dr Les King (group Chair) in November 2009 the work was subsumed into that of the Technical Committee.

2.7. Early Warning System

The Early Warning System working group was convened in response to the Home Secretary's commission of March 2009 (see http://drugs.homeoffice.gov.uk/ACMD_Letter_to_Home_Secreta1.pdf).

The early warning work of the ACMD is not intended to duplicate any present systems but rather serve as a working checklist against which the ACMD would maintain a standing brief. The ACMD can then advise Government at the earliest opportunity of developments within the field.

2.8. Treatment Working Group

The Treatment Working Group was established by the ACMD to consider and to determine:

1 Goals, outcomes and indicators of what constitutes 'successful' treatment for drug users.

2 Review evidence for effective ‘clinical’ treatment interventions ie psychosocial and pharmacological to determine where evidence is strong, and to identify gaps.

3 On the basis of the strength of evidence accrued, to inform the debate on a balanced approach to harm reduction and abstinence, and thus improve implementation of effective interventions.

The group will report in 2011.

3. Summary of ACMD Recommendations and Advice 2009-10

3.1. Classification and control of the synthetic cannabinoid receptor agonists

In July 2009 the ACMD proposed generic legislation to control the synthetic cannabinoid receptor agonists as Class C substances. This advice was accepted by the Home Secretary. The report is available at: http://drugs.homeoffice.gov.uk/publication-search/acmd/acmd-report-agonists.html.

3.2. Mixing of medicine in clinical practice: MHRA and CHM reviews

The ACMD was approached by the MHRA to consider proposals for the 'mixing of medicine' in clinical practice to enable Nurse and Pharmacist Independent Prescribers to specially prepare products for their individual patients and direct nurses and pharmacists who are not prescribers to mix drugs prior to administration. At the same time, enabling doctors to direct nurses and pharmacists to mix on a similar basis, was recommended by the MHRA and approved by the ACMD. The MHRA is now approaching the Home Office with the Commission's recommendations that corresponding amendments are made to the Misuse of Drugs Regulations.

3.3. Use and prescribing of Naloxone for opiate overdose treatment:

The ACMD welcomed the National Treatment Agency's (NTA) pilot scheme which provides family members and carers with training and supplies of Naloxone for heroin users in the event of an overdose. Naloxone is an opiate antagonist that prevents (or reverses) the effects of opioids including respiratory depression, sedation and hypotension. The ACMD believe that, where appropriate, this represents a step forward in tackling the high numbers of fatal opiate overdoses but consider that provisions should be extended to cover others who may be in contact with drug users. The ACMD would also recommend that it should be made possible for (suitably trained) drug service providers such as needle exchanges and outreach programmes to be able to hold/carry a stock of Naloxone for use in an emergency. The ACMD wrote to the MHRA accordingly.

3.4. Cathinones and Legal Highs:

Following on from a request by the Home Secretary the ACMD has been gathering evidence about the harms of the so called 'legal highs' the Cathinones – including Mephedrone and will present its findings in the near future.

4. Consultation responses

The ACMD has responded to 3 consultations in the last reporting year.

4.1. Department for Transport's review: The North Review of Drink and Drug Driving Law

The ACMD's response to the Department of Transport review is available at Annex E. In addition, the Chair of the ACMD's Pathways to Problems Working Group attended a review meeting, held by Sir Peter North, and submitted a memorandum (also available at Annex E).

4.2. Department for Children Schools and Families: Drug Guidance for Schools

The ACMD's response to the Department for Children, Schools and Families guidance is available at Annex F.

4.3. Review of the principles applying to the treatment of independent scientific advice provided to government - Science and Technology

The ACMD's response to this consultation can be found at Annex G.

5. Recruitment and Reappointment

5.1 Under the terms of the Act, members of the Advisory Council - of whom there should be not less than 20 - are appointed by the Home Secretary. There is a statutory requirement that they must include representatives from the practices of medicine, dentistry, veterinary medicine and pharmacy, the pharmaceutical industry, and chemistry other than pharmaceutical chemistry; and people who have a wide and recent experience of social problems connected with the misuse of drugs.

5.2 Appointments are ordinarily limited to a term of three years and made in accordance with the guidance issued by the Office of the Commissioner for Public Appointments (OCPA).

5.3 Due to resignations of a small number of Council members during the year including four from statutory positions the Home Office initiated a recruitment campaign.

5.4 A list of current members as at March 2010, together with their professional background is set out in Annex B.

6. Forward Look

6.1 The ACMD will write to the next administration setting out the present work programme and priorities.

6.2 Cocaine Review
Following on from discussions at a meeting between the Home Secretary and the ACMD Chair it has been decided to conduct a review of cocaine. This is set against an increased use of this drug amongst a broad social demographic, a fall in purity levels, and the popular but erroneous perception that Cocaine is a ‘safe drug.

7. Meetings in the accounting year 2009 – 10

Committee / Group	Date
ACMD Full Council	14th May 2009* 19th June, 2009 (Awayday) 10th November 2009 14th December 2009 29th March 2010*
Anabolic Steroids Working Group	1st April 2009 1st October 2009
Pathways to Problems Implementation Group	10th June 2009
Technical Committee	6th July 2009 29th October 2009 22nd February 2010 25th March 2010
Cognition Enhancers Working Group	8th September 2009 8th October 2009
Simultaneous Polysubstance Misuse Working Group	30th September 2009
New Psychoactive Substance Working Group	8th September 2009 8th October 2009

*denotes open meetings

Annex A. Terms of Reference

The terms of reference of the Advisory Council are set out in Section 1 of the Misuse of Drugs Act 1971 (the Act) which states as follows:

" It shall be the duty of the Advisory Council to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem, and to give to any one or more of the Ministers, where either Council consider it expedient to do so or they are consulted by the Minister or Ministers in question, advice on measures (whether or not involving alteration of the law) which in the opinion of the Council ought to be taken for preventing the misuse of such drugs or dealing with social problems connected with their misuse, and in particular on measures which in the opinion of the Council, ought to be taken:

a) *for restricting the availability of such drugs or supervising the arrangements for their supply;*
b) *for enabling persons affected by the misuse of such drugs to obtain proper advice, and for securing the provision of proper facilities and services for the treatment, rehabilitation and after-care of such persons;*
c) *for promoting co-operation between the various professional and community services which in the opinion of the Council have a part to play in dealing with social problems connected with the misuse of drugs;*
d) *for educating the public (and in particular the young) in the dangers of misusing such drugs and for giving publicity to those dangers; and*
e) *for promoting research into, or otherwise obtaining information about, any matter which in the opinion of the Council is of relevance for the purpose of preventing the misuse of such drugs or dealing with any social problem connected with their misuse".*

A further duty is placed on the ACMD by the Act to consider any matter relating to drug dependence or the misuse of drugs which may be referred to them by any one of the Ministers concerned, and in particular to consider and advise the Home Secretary on any communication which he refers to the Advisory Council which relates to the control of a dangerous or otherwise harmful drug and which is made to Her Majesty's Government by any organisation or authority established by treaty, convention or other agreement or arrangement to which Her Majesty's Government is a party.
Under the terms of the Act the Home Secretary is obliged to consult the ACMD before laying draft Orders in Council or making regulations.

Annex B. Membership (as of 31st March 2009 to 31st March 2010)

Under the terms of the Act, members of the ACMD - of whom there should be not less than 20 - are appointed by the Home Secretary. There is a statutory requirement that they must include representatives from the practices of medicine, dentistry, veterinary medicine and pharmacy, the pharmaceutical industry, and chemistry other than pharmaceutical chemistry; and people who have a wide and recent experience of social problems connected with the misuse of drugs.

Appointments are ordinarily limited to a term of three years and made in accordance with the guidance issued by the Office of the Commissioner for Public Appointments (members may be re-appointed twice upon appraisal).

A list of current members as at 31st March 2009 together with a note of their professional background is set out in Table 1. Table 2 gives those members who stood down within the reporting year.

Table 1. Members of the ACMD as of the 31st March 2010

Members	Professional Background	Date took up appointment
Professor Leslie Iversen FRS	Professor of Pharmacology, University of Oxford	13th January 2010 (member since 1st December2004
Dr Dima Abdulrahim	Senior Researcher, Research Briefings Manager, National Treatment Agency	1st January 2002
Lord Victor Adebowale CBE	Chief Executive, Turning Point	1st January 2002
Mr Martin Barnes	Chief Executive, DrugScope	1st December 2004
Dr Margaret Birtwistle	Specialist General Practitioner, Senior Tutor – Education and Training Unit, St George's Hospital and Forensic Medical Examiner	1st January 2002
Commander Simon Bray	Commander, Metropolitan Police	1st January 2008
Mr Eric Carlin	Chief Executive, Mentor UK	1st January 2008
Ms Carmel Clancy	Principal Lecturer in Mental Health and Addictions Middlesex University	1st January 2002

Professor Ilana Crome	Academic Director of Psychiatry, Professor of Addiction Psychiatry, Keele University	1st January 2002
Ms Robyn Doran	Mental Health Nurse and Director of Operations, North-West London Mental Health Trust	1st January 2002
Mr Patrick Hargreaves	School Inspector, Drugs and Alcohol Adviser, County Durham Children and Young People's Services	1st October 2005
Ms Caroline Healy	National Adviser for the commissioning of mental health services for children in secure settings, Department of Health	1st December 2004
Dr Matthew Hickman	Reader in Public Health and Epidemiology, Department of Social Medicine, University of Bristol	1st December 2004
Mr David Liddell	Director, Scottish Drugs Forum	1st January 2008
Dr Fiona Measham	Senior Lecturer in Criminology, Department of Applied Social Science, Lancaster University	1st January 2009
Mr Trevor Pearce QPM	Director of Enforcement Serious Organised Crime Agency	1st January 2002
District Judge Justin Philips	District Judge, Drugs Court	1st January 2008
DCC Howard Roberts	Deputy Chief Constable. Nottinghamshire Police	1st December 2004
Mr Richard Phillips	Independent consultant in substance misuse	1st January 2008

Dr Mary Rowlands	Consultant Psychiatrist in Substance Misuse, Exeter	1st January 2002
Ms Monique Tomlinson	Freelance consultant in drug misuse	1st January 2002
Mr Arthur Wing	Assistant Chief Officer, Sussex Probation Area	1st December 2004

Dr Polly Taylor	Veterinary surgeon, Cambridgeshire	1st January 2002 – October 2009

Table 2. Members of the ACMD that stood down in the year 2009-10.

Members	Professional Background	Dates
Professor David Nutt FRCP, FRCPsych, FMedSci	Edmud J Safra Professor Neuropsychopharmacology and Head of the Department of Neuropsycholpharmacology and Molecular Imaging at Imperial College London	1st March 2000 – 30th October 2009
Dr Leslie King	Adviser to the Department of Health and the European Monitoring Centre for Drugs and Drug Addiction	3rd April 2008 – October 2009
Dr Anita Nolan	Consultant , Honorary Senior Lecturer in Oral Medicine, Dundee Dental Hospital, NHS Tayside	1st January 2009 – October 2009
Mrs Marion Walker	Pharmacist and Clinical Director, substance Misuse Service, Berkshire Healthcare NHS Foundation Trust	1st January 2008 – October 2009
Dr Simon Campbell CBE, FRS, FMedSci	Scientific consultant. Formerly Senior Vice President for Worldwide Discovery and Medicinal R&D Europe, Pfizer	3rd April 2008 – November 2009
Dr John Marsden	Reader in Addiction Psychology	1st January 2002 – November 2009
Peter Martin	Independent Consultant in Substance Misuse	1sr January 2002 – 11th November 2009

Ian Ragan	Executive Director of European Brain Council; formerly Executive Director Neuroscience Reserch, Eli Lilly UK	6th February 2008- 16th November 2009

Annex C. Departmental Officials

Departmental officials observe the Council's discussions, input as required on the government's priorities and provide feed back on advice to Government and subsequent progress against actions/recommendations.

Mr John Farina	Jersey: Alcohol and Drugs Service
Mr John Lenaghan	Welsh Assembly
Ms Margaret O'Reilly	Isle of Man Representative
Mr Rob Phipps	Northern Ireland Assembly
Mr Joe Griffin	Scottish Executive
Mr Patrick Deller	HMRC
Dr Mark Prunty	Department of Health
Mr John McCracken	Department of Heath
Mr David Chater	Department for Children Schools and Families
Mr Matthew Scott	Department for Children Schools and Families
Ms Angela Scrutton	Home Office, Drug Legislation

Annex D. Administrative Arrangements

Finance
The ACMD is financed by the Home Office and had a total budget of £152,000 in the accounting year 2009/10. Their costs were associated with the provisions of facilities for meetings of the ACMD (and its Committees and Working Groups), expenses of members properly incurred, and commissioned research. The ACMD generated no income of its own. Members of the ACMD are not remunerated.

Administrative arrangements
Administrative support to the ACMD has been provided by a Secretariat made up of staff from the Home Office Science and Research Group, and any queries regarding this annual report, or any other aspect of the ACMD's work, should be directed to the Secretariat using the contact details at the front of this report.

Annex E. Consultation response to Department for Transport's review: The North Review of Drink and Drug Driving Law

ACMD

Advisory Council on the Misuse of Drugs

3rd Floor (SW), Seacole Building
2 Marsham Street
London
SW1P 4DF

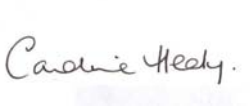
14th January 2010

Dear Sir Peter,

Please find attached a memorandum prepared by the ACMD regarding its recommendation that the blood alcohol concentration (BAC) for young drivers be reduced from its present level. This is in addition to the response to the DfT consultation regarding drink and drug driving as submitted by the ACMD of 16 March 2009 which we have sent to your team.

The recommendation, by the ACMD, concerning the BAC originally appeared in the 2006 ACMD report: *Pathways to Problems*. Ahead of the publication of *Pathways to Problems: A follow up report on the implementation of recommendations from* Pathways to Problems (2006), the ACMD is pleased to attach a summary of its key findings.

Yours sincerely,



Caroline Healy
Chair of the Pathways to Problems Working Group

Professor Les Iversen, PhD, FRS
Spokesperson to the Advisory Council on the Misuse of Drugs

MEMORANDUM
DRINKING, DRIVING AND YOUNG PEOPLE

Recommendation 13
Given the poorer driving skills and higher accident rates among inexperienced young drivers, the Government should give consideration to reducing the maximum legal blood alcohol rate for drivers under 25 years of age to 50mg per 100ml. If successful, this could be extended to drivers of all ages.
Action: *Department for Transport.*

- The ACMD acknowledges the THINK! drink-driving advertising campaign, launched in 2007, which targets young men up to the age of 30.

- The evidence shows that 20% of drink-drive fatal accidents involve a driver aged 20–24 (16% aged 25–29) (DfT, 2008b). The data (for 2006) shows that, of the 920 car drivers who were killed/seriously injured and who were over the alcohol limit, 360 were aged 16–24. For motorcyclists, the corresponding figures are 340 casualties, 140 of them aged 16–24.

- The Department for Transport (DfT) has published a consultation on road safety compliance, which includes proposals to reduce drink-driving (DfT, 2008a). The consultation commits to keeping the present blood alcohol concentration (BAC) limit under review, but describes any change in the prescribed BAC to below the current 80mg per 100ml as 'a significant change of strategy'. The problem identified is that there is insufficient evidence to predict changes in drinking behaviour if the limit were reduced. The consultation document specifically notes that a lower limit for 'novice' drivers 'would convey the wrong message at the wrong time', as it would allow a higher BAC limit for drivers once they ceased to be 'novices'.

- The current BAC limit is 80mg per 100ml. The evidence shows that most drivers who are prosecuted are well over this limit. Set against this statistic is the decreasing number of people killed or seriously injured. In a response to the DfT consultation, the ACMD considered that there are four options to further reduce the number killed or seriously injured:

    • greater public awareness campaigns;
    • increased enforcement response;
    • lower BAC – possibly split age group; or
    • a combination of the above.

- The ACMD believes that the current statistics for accidents among the younger age groups provide a good reason for considering legislation changes that could better safeguard those accumulating age-related experience. The ACMD does not believe that such a change would send a message to young drivers that it is acceptable for them to drink more once they reach a certain age, but it would be a measure that would target those most at risk.

- In responding to the consultation, the ACMD reiterated to government that it should consider reducing the legal BAC to 50mg per 100ml or less for drivers under the age of 25. Lowering the BAC would bring the UK more into line with other European countries (see Foreign and Commonwealth Office website 'Travel advice by country').

- In 2007, the Transport Select Committee recommended that there was a case for introducing a 20mg per 100ml BAC limit – 'which in practice is effectively zero' – for 'novice drivers' (i.e. those with less than three years' driving experience). While drivers under the age of 20 are, by definition, novice drivers, the recommendation was not specific to this age group (House of Commons Transport Committee, 2007).

- The Chief Medical Officer for England, in his 2007 annual report, recommended that the legal blood alcohol rate for drivers aged between 17 and 20 years should be reduced to zero (Donaldson, 2008).

- The ACMD does not believe there are any practical problems with enforcement, such as calibration of alcohol detection devices and verification of age. The ACMD does not believe that concerns regarding roadside verification of age are an obstacle to enforcement of such a policy, particularly as there is an expectation that proof of age is a requirement before purchase of alcohol. In addition, the ACMD understands that alcohol detection devices could be calibrated to different thresholds, and that there is provision within the Road Traffic Act for verification of age to take place at the roadside.

- Studies in both New Zealand (Kypri *et al.*, 2006) and the USA (Voas *et al.*, 2003) provide evidence in support of more stringent alcohol-purchasing legislation for younger drivers and the impact of such a move on reducing traffic crash injuries. The US study concluded that 'the policy of limiting youth access to alcohol, through minimum legal drinking age laws and reinforcing this action by making it illegal for underage drivers to have any alcohol in their system, appears to have been effective in reducing the proportion of fatal crashes involving drinking drivers' (Voas *et al.*, 2003). While the ACMD is not advocating an increase in the minimum age at which alcohol may be purchased, these studies clearly demonstrate the effectiveness of restricting alcohol availability to young people.

- The ACMD considers action against this recommendation to be inadequate. There is evidence to support a reduction in the BAC for novice drivers. Both the Transport Select Committee and the Chief Medical Officer for England support this position. However, the Government has, to date, chosen to retain the current BAC levels for all drivers, and has not accepted the potential benefits to young people (as novice drivers) of a reduction in the BAC levels.

References

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ACMD

Advisory Council on the Misuse of Drugs

Chair: Professor David Nutt
Secretary: Will Reynolds

3rd Floor (SW), Seacole Building
2 Marsham Street
London
SW1P 4DF
Tel: 020 7035 0454
Email: ACMD@homeoffice.gsi.gov.uk

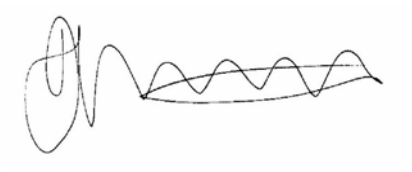
16th March 2009

Dear Mr Fox,

The Advisory Council on the Misuse of Drugs (ACMD) are pleased to contribute to the Department for Transport consultation paper on road safety compliance.

We have responded specifically to those sections of the consultation that are within our expertise, namely: drink driving and drug driving.

Yours sincerely,



Professor David Nutt FMedSci

The Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to Government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations. It considers any substance which is being or appears to be misused and of which is having or appears to be capable of having harmful effects sufficient to cause a social problem.

The ACMD also carries out in-depth inquiries into aspects of drug use that are causing particular concern in the UK, with the aim of producing considered reports that will be helpful to policy makers and practitioners.

Responses from the Advisory Council on the Misuse of Drugs to questions for consultation

Drink Driving

6. **Do you have any comments on the use of targeted checkpoint testing for drink drivers?**

This question requires comment and evidence outside of the ACMD's locus of expertise.

7. **Do you think we should withdraw the statutory right to a blood or urine test as an alternative to a breath test?**

This question requires comment and evidence outside of the ACMD's locus of expertise.

8. **Please comment on three options in respect of the proposal to take away cover for High Risk Offenders (HROs) to drive after submitting a re-application for a licence, while medical procedures are being carried out:**

    - **We move now to implement the change provided for in the Road Safety Act 2006 on the basis that we are satisfied that existing procedures allow ample time for medical examinations before a disqualification expires; or**

    - **We develop further powers either to require an HRO to submit a medical report with their re-application for a licence or to give them that option, to be implemented probably after we have removed the cover to drive; or**

    - **We defer implementing the change provided for in the Road Safety Act until we alos have powers either to require HROs to submit a medical report with their re-application for a licence or give them that option.**

This question requires comment and evidence outside of the ACMD's locus of expertise.

9. **Do you agree that the costs of implementing and enforcing a judicial alcohol ignition interlock scheme would be disproportionate?**

This question requires comment and evidence outside of the ACMD's locus of expertise.

10. What priority do you think should be given to a change in the prescribed alcohol limit for driving?

The current BAC limit is at 80mg/100ml. The evidence notes that most drivers that are caught are well over the present limit. Set against this statistic is the decreasing numbers of people killed or seriously injured. The ACMD consider that there are four options to further reduce the number killed or seriously injured:

1. Greater public awareness campaigns
2. Increased enforcement response
3. Lower BAC – possibly split age group
4. Combination of the above

The ACMD believes that the current campaigns are well resourced. In addition, greater detection, by enforcement, may not be cost effective if, from evidence presented in the consultation, it is a small minority that are determined to flout the law.

Evidence demonstrates that there is no BAC above 0 that is free from impairment and, although the statistics show the numbers killed or seriously injured are decreasing, the numbers are considerable.

The ACMD recommends, as in its *Pathways to Problems* report 2006 (see Recommendation 13), there should be opportunity for legislation to change, as it has in other European countries, particularly around the maximum BAC that a young person can have, when driving. The ACMD recommends that the Government should consider reducing the legal Blood Alcohol Concentration to 50mg/100ml or less for drivers under the age of 25. Lowering the BAC would bring the UK to being more in line with other European countries.

The ACMD does not believe there are any practical problems for enforcement: calibration of alcohol detection devices and verification of age. The ACMD understand that alcohol detection devices could be calibrated to different thresholds, and that there is provision within the Road Traffic Act for verification of age [at the roadside] to take place.

The consultation makes reference to a special limit for young drivers (paragraph 3.65) as suggested by the Transport Select Committee. The ACMD believe that the current statistics of accidents among the younger age groups should be reason to consider legislation changes that could better safeguard those accumulating age-related experience. The ACMD does not believe that such a change would create an impression (send a message) that it is acceptable for young drivers to drink more when they reach a certain age but would be a measure to reduce those who are most at risk (see *Pathways to Problems*, 2006; p11 recommendation 13).

11. What evidence are you able to offer – and what further evidence do you consider should be obtained – to support a fully-considered decision whether or not to change the limit.

The Transport Select Committee, in their 7th report, propose a BAC of 20mg/100ml. This report was based on evidence from a number of other countries and presented evidence from international reports (e.g. OECD).

It is important to re-iterate the Committee's statement that:

'If the Department introduces a lower permitted blood alcohol concentration for novice drivers it must be assiduous in countering any impression that it is acceptable for more experienced drivers to drive under the influence of alcohol.'

The ACMD would support the consideration of evidence led policy in this area, with, as above, due consideration given to the concerns of 'conveying the wrong message'.

Drug Driving

12. Do you agree that a new offence of driving with an illegal drug in the body is required to make the regulation of drug driving more effective?

It is important, from the outset, to iterate two issues. Firstly, that driving under the influence of any drug, prescribed or otherwise, has the potential to impair driving ability. Secondly, any impairment of driving ability will be irrespective of whether the drug being used is illegal or not. In the form that the consultation is constructed, separating illegal and prescribed drugs is not addressing the primary drug driving offence but rather appears to target illicit drug users.

There are several issues that need to be addressed if a new offence of driving with an illegal drug in the body was made legislation. These are set out below.

As far as the ACMD are aware, the technology is not currently available to provide roadside testing of the full suite of illegal drugs. Furthermore, analytical laboratory testing of biological samples may not allow the positive identification of the actual drug originally used.

However, analytical methods for drugs are many and varied and are often specific to the drug. In some cases there is a need to analyse for metabolites (breakdown products of the original drug in the body) to properly estimate the original drug. The ACMD have concern that the positive identification of metabolites of a given drug may not consider the full range of legal substances that could have been potentially used and produce the same metabolite.

The ACMD do not consider that the evidence base is sufficiently developed to support a framework of thresholds for individual drugs that is related to their impairment of driving a motor vehicle. To determine dose-related impairment of driving would require extensive research. It must be borne in mind that the taking of an illicit drug does not necessarily confer an impairment of driving ability, and indeed may improve it e.g. stimulants under conditions of fatigue.

Published evidence shows that the panoply of available drugs (licit or illicit) are often taken in combination (polydrug use). Therefore, there are substantial difficulties in determining the level of impairment against the threshold of any given drug in a person's system. In such cases, thresholds for individual drugs may not be as relevant as the sum total of their effects.

Many drugs can be prescribed that would otherwise be illegal (under the Misuse of Drugs Regulations). If enacted, the proposal in 12) could result in very mixed outcomes: for example, an individual may be prosecuted for impaired driving with an illegal drug in their body. However, another individual that has taken the same drug, but on prescription may not be prosecuted for the same offence. The ACMD believe it is important that the DfT maintain focus on the driving offence committed, by virtue of taking a substance, and not the legality of the substance itself – the possession and supply is already provided for under the Misuse of Drugs Act 1971.

For those people that take prescribed drugs that would otherwise be illegal such new legislation would require them to maintain records of their prescriptions (or return to their prescriber).

13. Do you think that such a new offence should apply to illegal drugs only, and not those that have been legally prescribed or obtained?

The ACMD has grave doubts about this suggestion. A punitive policy for illegal drug users only fails to recognise the primacy of the road traffic offence being committed. As described in our response to question 12) above, the key point of any new legislation in this area would be whether the driver is competent to drive i.e. are they a danger to themselves and/or others whilst in control of a motor vehicle; question 13), as posed, does not address this issue.

It is important to recognise that there are many drugs that are illegal which may be prescribed and therefore may be legally taken. Changes to the legislation would require very careful consideration and could be very expensive to investigate and prosecute.

Furthermore, current drug policy is focussed on supply and possession not use; users are prosecuted for having the drug in their possession for personal use or supply. It is not, and never has been an offence to have taken an illicit drug. If this suggestion was brought into law it would be a watershed in policy that could have broad, complex and currently unknown secondary consequences.

The ACMD has concerns that penalties for use may have unintended consequences that need to be considered e.g. users switching to those drugs that are eliminated from the system more quickly. The DfT will wish to note that many of the drugs that are most quickly eliminated from the system are some of the most harmful e.g. Gammahydroxybutyrate (GHB) and ketamine.

The ACMD does not believe that the question posed in 13) has any merit or scientific basis.

14. How do you think we should identify the drugs that would be the subject of the proposed offence? How should we incorporate new drugs under the proposed offence?

Please see our response to 12).

15. Do you have any other comments about the proposed new offence?

Please see our response to 12).

16. Do you have any other comments about our drug driving proposals?

None.

Annex F. Consultation response to Department for Children, Schools and Families: Drugs: Guidance for Schools

Drugs: Guidance for Schools

Consultation Response Form

The closing date for this consultation is:
15 February 2010
Your comments must reach us by that date.

THIS FORM IS NOT INTERACTIVE. If you wish to respond electronically please use the online or offline response facility available on the Department for Children, Schools and Families e-consultation website (http://www.dcsf.gov.uk/consultations).

The information you provide in your response will be subject to the Freedom of Information Act 2000 and Environmental Information Regulations, which allow public access to information held by the Department. This does not necessarily mean that your response can be made available to the public as there are exemptions relating to information provided in confidence and information to which the Data Protection Act 1998 applies. You may request confidentiality by ticking the box provided, but you should note that neither this, nor an automatically-generated e-mail confidentiality statement, will necessarily exclude the public right of access.

Please tick if you want us to keep your response confidential.

Name	N/A
Organisation (if applicable)	Advisory Council on the Misuse of Drugs (ACMD)
Address:	c/o Secretariat Advisory Council on the Misuse of Drugs 3rd Floor(SW), Seacole Building 2 Marsham Street London SW1P 4DF

If your enquiry is related to the policy content of the consultation you can contact Holly Turner on:

Telephone: 01325 392256

e-mail: holly.turner@dcsf.gsi.gov.uk

If your enquiry is related to the DCSF e-consultation website or the consultation process in general, you can contact the Consultation Unit by e-mail: consultation.unit@dcsf.gsi.gov.uk or by telephone: 0870 000 2288.

If you have a query relating to the consultation process you can contact the Consultation Unit on:

Telephone: 01928 794888 Fax: 01928 794 311

e-mail: consultation.unit@dcsf.gsi.gov.uk

Please select one category which best describes you as a respondent.

☐ Teacher	☐ Local Authority/PCT	☐ Health Professional/Organisation
☐ School (Please state whether Primary, Secondary or Special	☐ Governor	☐ Parent or Carer
☐ Voluntary Sector Organisation/Charity	☐ Young Person	☐ Pupil Referral Unit
✓ Other (Please specify)		

Please Specify:

The Advisory Council on the Misuse of Drugs (ACMD) is a statutory and non-executive Non-Departmental Public Body, which was established under the Misuse of Drugs Act 1971.

Introduction

1 Is the introduction helpful?

✓	Yes		No		Not Sure

Comments:

The ACMD endorses the definition of **"Drugs"** as referring to all drugs **including medicines, volatile substances, alcohol, tobacco** and **illegal drugs**.

It would be useful to start off with a description of a school drugs policy, what it should cover and how and by whom it should be developed.

It should be noted that a school's remit goes beyond 'curriculum and a drugs policy' and also extends to pastoral care, monitoring absence and changes in behaviour, all of which may be attributable to alcohol or drug misuse.

There is a need for consistency throughout the whole document regarding the use of terminology – e.g. "use", "misuse". Also, terms like "school community" used throughout the document are too imprecise.

1.2 A comment focussing on the benefits to pupils would be useful.
It would also be useful to strengthen the last point to say that it is relevant for pupils. We believe that many pupils in the independent sector, for example, receive little or very limited drugs education but they are still at risk.

1.2 (bullet point 7) Parent Support Advisors should be added to the list.
There is also repetition of the previous bullet at the end.

1.3 Terminology (see question 13). Mention should be made here of "legal highs"/new psychoactive substances. The term "drugs" is used throughout this document to refer to all drugs.

1.4 The ACMD believe it is probably not useful from here on to continue to distinguish between legal and illegal, unless referring to a specific drug. 1.3 has defined what we're talking about.
The reference to "users of drugs for medicinal purposes" is ambiguous. Is it referring to the *misuse* of medicines or the use of illicit drugs to self-medicate?
Also the list here excludes "legal highs" which are often misused by young people.

1.5 The ACMD considers it unfortunate that the Alcohol Strategy's terminology uses the word "safe" rather than "less risky", in line with WHO guidance and the Youth

Alcohol Action Plan.

Section 2: What is drug education and what should be taught

2 Is section 2 helpful in setting out the context of drug education and what should be taught?

☐ Yes	☐ No	✓ Not Sure

Comments:

2.1 The aims are confused and contradictory and could lead to unrealistic expectations. We suggest removing the entire first paragraph.

2.2 In the 1st line the last segment should be amended to “It should aim to:”

2.3 "drug education" and "drug and alcohol education" are referred to in the same paragraph. Terminology is not standard throughout the document.

2.4 The "whole school approach” message is helpful as is the explicit link to behaviour and sexual health (2.5) and the use of cross curricular links.

2.5 This section would benefit from bullets of what should be taught at each key stage, as expanded upon in 3.2.1.

2.6 When explaining how drugs are classified, it is stated that "classification of substances may change from time to time **to reflect the latest available evidence**". It should here be acknowledged that classification takes into consideration a wide range of issues, not just the intrinsic harms of a specific drug. The ABC classification system is a reflection of the parliamentary decisions based on many knowledge inputs. The ABC system gives the present legal penalties rather than a direct indication of harms. Public health advice on individual drugs information should be sought from FRANK and other sources.

2.6.1 The CMO’s guidance is at odds with the legal position and common parenting practice in the UK and elsewhere.

2.6.1 Effects. The paragraph after the bullet points does not seem to make sense.

2.6.2 It is not clear what precisely the guidance is directing schools to do re-focussing on “community and family based interventions to denormalise smoking”.

In the penultimate paragraph of this section the immediate effects of smoking are rightly identified as a more effective deterrent for young people. We would add also add the environmental damage caused by the industry (e.g. deforestation, pollution, litter) together with the exploitation of workers and the marketing of tobacco to children in the developing world as being additional avenues worth exploring with young people.

2.6.3 Reference should be made to the ACMD’s most recent report on Cannabis – *Cannabis: classification and public health (2008)*. Available at: http://drugs.homeoffice.gov.uk/publication-search/acmd/acmd-cannabis-report-20082835.pdf?view=Binary

2.6.5 States that "Class A drugs are considered the most likely to cause harm". The Home Office has set out in a command paper to Parliament (Ref) the full range of criteria that are considered when considering the class of any given drug. It is therefore inaccurate to directly link the classification of a drug with its harms.

The ACMD are also concerned at the recent reported rises in the use of “new psychoactive substances” or “legal highs” and their potential harms. The following paragraph details those substances which are already classified and controlled under the Misuse of Drugs Act (1971) following the ACMD’s recommendations.

2.6.6 This information is now out of date - the substances listed here are now controlled under the Misuse of Drugs Act (with effect from 23/12/09). The synthetic cannabinoids contained in “Spice” are now a Class B. GBL, BZP and 15 anabolic steroids are now Class C. However, other psychoactive substances such as mephedrone and salvia are reported to be becoming more popular in the ever evolving ‘’legal highs” market.

There has also been a growth in prevalence of "smart drugs" or nootropics such as methylphenidate or modafinil which are increasingly being used by the healthy to augment cognitive ability. Off-label use of prescription medicines will increase and whether the prohibition of these cognition enhancers can be effectively enforced is doubtful.

Young people also need to consider the added issues around illicit (counterfeit or bootleg) alcohol, a major market for them.

As far as education is concerned, the recent NICE guidance on alcohol is much clearer than the CMO's, i.e. "There are no national guidelines on what constitutes safe and sensible alcohol consumption for children and young people so the recommendations focus on:

- encouraging children not to drink
- delaying the age at which young people start drinking

- reducing the harm it can cause among those who do drink".

This provides a simpler message, less open to misuse and misinterpretation than the one recommended in the Young People and Alcohol consultation:

"If 15 to 17 year olds consume alcohol they should do so infrequently and certainly on no more than one day a week. Young people aged 15 to 17 years should never exceed recommended adult daily limits and on days when they drink, **consumption should usually be below such levels**".

In the WHO's draft alcohol report (December 2009), it states that:

"The secondary supply of alcohol, for example from parents, needs to be taken into consideration in measures on the availability of alcohol".

"Policy options and interventions include increasing legal age limits for purchase or consumption of alcoholic beverages in order to raise barriers against consumption of alcoholic beverages by adolescents."

Put simply, alcohol is harmful. The younger you are, the more you drink and the more often you drink, the more harmful it is.

Section 3: Planning and teaching of drug education

3 Is Section 3 helpful in setting out the range of processes that need to be in place and the roles that different partners have in planning and teaching effective drug education?

✓	Yes	☐	No	☐	Not Sure

Comments:

The importance of the spiralling curriculum, with young people revisiting the topic year on year, is rightly highlighted.

The underlying principles in 3.2.2 are excellent as are those in the remainder of section 3. However, in 3.2.2 the diversity section only gives race examples and alludes to "some groups of the population" but doesn't say who they are which is not helpful.

3.3 "Pupils vulnerable to drug misuse..." section - are not all pupils potentially vulnerable?

3.9.1 The role of PSAs and family learning provision could be mentioned. In 3.4 ground rules and signposting through the CAF are highlighted.

3.10.2 The evaluation section is very weak – this is somewhat disappointing and needs to be substantially expanded. Drug education provision needs to be evaluated. The evaluation aims are wrong and too narrow; according to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA):

Evaluation should address:

What is the nature and scope of the problem?

Which interventions can affect the problem?

Which group will the intervention target?

Does the intervention reach the target group?

Is the intervention being implemented as planned?

Is the intervention effective?

Evaluation methods might include:

Baseline audits, Document analysis, Financial information, Questionnaires, Interviews, Progress audits, Focus groups, Analysis of Media coverage

Reference:
http://www.emcdda.europa.eu/attachements.cfm/att_78087_EN_EMCDDA-manuals1-en.pdf

3.11.2 States "it is essential that all school staff have general drug awareness". This is

true of anybody working with or bringing up children and young people and further emphasises the importance of work with parents.

Parents' sessions are best run within the context of a 'Health' event where other issues may be included (healthy eating, bullying, physical activity etc) which is also how any programme should be outlined to parents.

Particular issues re the use of ex-users to deliver in a universal provision.

4 Do you find the table at section 3.2.1 helpful in setting out some of the key issues we suggest are explored with pupils? Are there other issues that should be explored with pupils as part of drug education?

☐ Yes	✓ No	☐ Not Sure

Comments:

The National Curriculum Key Stage table may be over-prescriptive e.g. why do children only learn how to challenge bullying and discrimination and how to resist pressure at Key Stage 4? Why are children only taught what to do in an emergency at Key Stage 2?

In 3.2.2 much emphasis is rightly placed on the importance of needs analysis and personalised learning which may be at odds with such a table.

There does not appear to be any place for debate around prohibition and the law and its efficacy in substance misuse prevention and control; the chain of misery, suffering and exploitation that drug use leaves in its wake particularly in poorer nations nor the implications for young people of living in a society where drugs are available.

Section 4:

5 Is Section 4 helpful in setting out good practice in relation to school drug policies? We would particularly welcome comments on what issues should be added to the policy framework.

✓ Yes	☐ No	☐ Not Sure

Comments:

Excellent.

4.3.1 Pupils should not just be consulted; they should be involved in developing, implementing and reviewing the school policy and practice. Likewise parents and governors.

4.8 This section is useful.

The next three questions relate to Section 5: Good management of drugs within the school community

6 Is Section 5 helpful in setting out good practice in the management of drugs within the school community? Are there any other areas of particular concern to schools that should be covered in the guidance?

✓ Yes	☐ No	☐ Not Sure

Comments:

5.1.1 The listing should also include: young people who have mental health issues (including self harm), physical health problems, those with poor educational achievement, parental mental health (apart from substance misuse) difficulties, conduct disorder, unsupportive, dysfunctional or chaotic family background.

5.5 Begins "Illegal drugs have no place in schools". ACMD recommend it should read "No drugs, legal or otherwise, have any place in schools other than ...." or simply "Unauthorised substances have no place in schools".
The difference between prescribed medicines and over the counter medicines should be noted. Staff need to be aware that young people may become addicted to over the counter medicines e.g. codeine based medications, so that even if they are not administering those medications, they could still cause harmful effects.

5.6 “Legal” drugs? What does it mean that police will not normally need to be involved? e.g. Alcohol is illegal for under-18s to buy.

Vulnerable groups – As well as ‘vulnerable groups, the ‘settings’ in which young people at risk might present should be listed. It should include parents with mental or physical

health problems and young people with physical health issues because they present to Accident and Emergency.

Risk factors – divided into personal, environmental (see attachment)
– for example, where has it been demonstrated that a strong partnership between parents and schools is protective? Where is the reference?
What does 'successful' school experience mean? Does it mean academic achievement?

There is a Home Office document on this (attached) which should be considered. It might also be helpful to include something about resilience.

It should not be assumed that all readers will understand the meaning of "extended school" or "extended services around schools" and this terminology should be explained within the document.

More information should be included on "Hidden Harm" (Parental substance misuse).

7 Is the guidance on confiscation and disposal of illegal and unauthorised drugs workable?

☐	Yes	✓	No	☐	Not Sure

Comments:

5.7 This section is very unclear regarding disposal of illegal substances. Can the school dispose of them? The police will not always "collect it" but may ask staff to deliver it. On no account should staff take a suspected illegal substance off the premises.

If suspicious powders, tablets or capsules are encountered in schools they should be confiscated and if it is necessary to identify the presence of any drug this should be done by a forensic laboratory via the police.

School trips: schools should be advised that staff should not drink alcohol while on school residential trips, even if "off duty".

5.8 Why should parents/carers be given the opportunity to collect alcohol or tobacco? Can they collect confiscated "legal highs"?

5.9 It would be better to recommend that all schools have sharps containers on-site.

8 What are your views on the guidance relating to the use of drug dogs in schools? How could the guidance be improved in this area?

Comments:

As we stated in our *Pathways to Problems* report (2006) and reiterated in *Pathways to Problems: A follow up report on the implementation of recommendations from* Pathways to Problems (2006),we believe schools should be strongly discouraged from using sniffer dogs. This is an approach we believe to be inherently flawed.

In County Durham a protocol has been agreed (copy attached), drawn up between the Drug and Alcohol Adviser and the police, which the police will go through with a school on receiving a request for passive drugs dogs to be deployed. It is not until all these conditions are satisfied that the request will be considered. This check list could be included here as an appendix. It is easier to use than the current Appendix 7 which is more narrative in style.

Section 6: Responding to drug incidents

9 Is Section 6 helpful in setting out good practice on responding to drug incidents?

✓	Yes	☐	No	☐	Not sure

Comments:

Confidentiality cannot be emphasised enough.

6.2 How else would a 'medical emergency' be dealt with except by summoning medical assistance? Clarification is needed as to whether this means summoning the school nurse, a doctor, dialling 999 or going to an Accident and Emergency department.

6.3 Would school staff be trained in how to behave in this circumstance?

What does the following statement mean?:
''All schools have a responsibility to identify the pupils who have drug related 'needs'."

The school needs to specify 'which local professionals' will be able to conduct a screening process. Which tool is being discussed here?

6.4 The phrase 'learn from mistakes' is not a very helpful interpretation of the multiple complex problems that some of these young people have.

We would question whether the legality or illegality of the substance should be necessarily given too much weight. The nature and extent of the problem (including whether supply is involved) is more important.

6.4.2 Referral - Child and Adolescent Mental Health Services (CAMHS) seem to have been ignored when they are highly relevant services for many young people with complex needs.

Adult substance misuse and mental health services are also important where parents have problems.

6.4.8
There should be a section on the Role of Specialist Substance Misuse and Mental Health Services (as there is about the police).
We believe more attention needs to be paid to outlining the types of treatment interventions which are effective, and which should be available and whether they are accessible in a particular area. These are 3 different aspects, all of which need to be clearly outlined by schools in any policy. Otherwise the likelihood is that little or nothing will be done apart from the criminal justice response.
This is a vital component, because schools and families need to realise that help is

effective if it is accessible.
Support may need to be intensive and long term even for those young people (and their parents) who are not using regularly or much.

Regarding 6.4.9, the ACMD believe that permanent exclusion for a drug related incident may not always protect others in the school population. Although this reason is often cited for such an action, there is a risk that the offender will be able to continue and indeed increase their activities without the control of the school.

The next two questions relate to Case Studies

10 Case studies have been included. Are they sufficient or do we need to cover other areas? Do you have any case studies that can be included?

Comments:

Just for a Laugh project - young-person centred drama project (outline and evaluation attached).

11 What mechanisms have schools successfully used to engage with parents/carers, particularly those who are harder to reach, on issues related to drugs? Do you have any case studies of successful engagement?

Comments:

Take Care Not Risks - family learning project (the outline which refers to use in schools) is attached. This resource is now being used by family learning partners as a tool for collaborative learning with carers and youngsters.

The next question relates to the Appendices

12 Can you suggest any improvements to the appendices? Please state clearly the number of the appendix which you are commenting on.

Comments:

App 1 - enhanced healthy schools programme?

App 2 - should tobacco not be 18 throughout the tobacco laws section?

App 3 - add Teen Life Check, D-World, Teenage Health Freak, Youthinformation.com.

FRANK web link does not appear to work?

App 7 - See 8 re: protocol on deployment of passive drugs dogs

13 We have used the term "drugs" throughout to refer to all drugs including medicines, volatile substances, alcohol and tobacco and have put a note in the terminology section of the introduction and a footer on each page explaining this. Is the use of the generic term useful? If not what would be more helpful?

✓	Yes	☐	No	☐	Not Sure

Comments: Yes, if it was used consistently.

See 1.3. Terminology is not consistent because "drugs", "drugs and alcohol", "substance use", "illegal drugs" etc. are used.

14 Are there any particular issues the guidance needs to add/highlight?

✓	Yes	☐	No

Comments:

The guidance should note that:

- Everything from paracetamol to heroin is potentially harmful.
- There are illicit versions of legal substances (medicines, tobacco and alcohol) which clearly carry additional health threats from contaminants and toxic substances.

There needs to be more on how to assess young people's needs.

Schools should be guided not to go down the route of permanent exclusion if avoidable; according to Newburn T. et al (2005) *Dealing with Disaffection: Young people, mentoring and social inclusion* (Cullompton: Willan Publishing), just under three quarters of primary school-age children who are permanently excluded are never successfully re-integrated into full-time education. Only 15% of secondary pupils permanently excluded return to mainstream schooling. According to the same source, exclusions also happen disproportionately to the following:

- Boys
- African-Caribbean pupils (x 5 compared to White pupils),
- Young people with special educational needs
- Young people from lower socio-economic groups,
- Young people with disturbed or disrupted family circumstances,
- Looked-after young people.

This benefits neither the excluded pupil nor the community.

It would be helpful to have a template for a school policy rather than bullet points in the text.

Young people really seem to be lacking from the document. The draft guidance appears to be all about procedure; some quotes throughout the document from young people about what's helpful/not helpful would be useful.

The ACMD welcome the section on engaging with families, carers and parents as it is crucial that parents have the opportunity to understand the facts around substance misuse, how to set boundaries, how to identify symptoms of substance misuse and how to advise and guide children to make the right choices. It may be useful to give examples of practice in this area to illustrate how it can be done as it is an area that many schools will be reluctant to engage with.

15 We will provide an index. How could the document be improved to make navigation easier?

Comments:

Contents page and index should be added.

It is too long and needs an Executive Summary.

Colour-coding of different sections could help with navigation. Design it in ways that people can easily pick out the bits that are most useful for them.

It would be helpful to have exemplar policies or a framework for policy rather than bullet points in the text. Could/should there be guidance to prompt schools to include a young person's statement in their drug policy. But the exemplar policies should not be a crib sheet.

The document needs to be designed and published to link with other PSHE curriculum guidance.

16 If you have further comments to make on the content of this draft or on how we might publish and disseminate the final document, please give them below.

Comments:

The ACMD suggests that the guidance should explicitly include establishments that are holding children in secure settings, particularly as Local Authorities will soon be responsible for the provision of education into Youth Offender Institutes, Secure Children's Homes and indirectly, to Secure Training Centres.

The lack of specific information about medical support for physical, psychological and substance misuse problems i.e. what treatment is there, who provides it, how do you get to it is lacking particularly in comparison to all the material on police services.

Hard copies to be distributed to all schools.

Request for partners to display electronic version on websites.

Thank you for taking the time to let us have your views. We do not intend to acknowledge individual responses unless you place an 'X' in the box below.

Please acknowledge this reply X

Here at the Department for Children, Schools and Families we carry out our research on many different topics and consultations. As your views are valuable to us, would it be alright if we were to contact you again from time to time either for research or to send through consultation documents?

PROTOCOL FOR POLICE DOGS

The following is a checklist schools should address prior to considering an operation including Police dogs.

		Yes	No
1.	Is your school drugs policy up to date and does it include incident management procedures which reflect current County Durham Guidance – Hitting the Target?		
2.	Is the Governing Body aware of the proposed operation?		
3.	Does your school already have an active communication and liaison process with the Police including planning ways Police can assist schools with drug-related issues?		
4.	Have you set out clear criteria aims and objectives for the operation and are these documented?		
5.	Have you consulted with other agencies (Children and Young People's Services Drugs and Alcohol Advisor, Durham Constabulary, School Nurse, School Counsellor) and has a planning meeting been arranged/undertaken?		
6.	Have you liaised with the passive drugs dog handler and considered the following: (i) The range of drugs that may/may not be identified by the dog. (ii) The operational procedures regarding the search. (iii) The location of the operation. (iv) The target age group. (v) A pupil may have been exposed to drugs in the environment. (vi) A pupil may swallow substances or conceal them and abscond.		
7.	Have you considered the possible outcomes of such an operation?		
8.	Have you a strategy in place for searching, with possible outcomes?		
9.	Have you established evaluation criteria for the operation?		
10.	Have you briefed all school staff on the details of the operation?		
11.	Will staff be required to participate in the exercise? If not, why not and if so have all relevant unions been consulted?		
12.	Have you considered a course of action should a member of staff, contractor or visitor be identified?		
13.	Are parents aware of the proposed operation, and have you obtained consent for their child to participate in the operation?		
14.	Have you a procedure in place for the removal of pupils for whom consent is not given?		
15.	Have you considered what to do regarding pupils who are absent or truanting?		
16.	Have you taken into account the right of privacy of pupils who may be identified because they are taking prescription medicines or have been exposed to an environment where others have used drugs?		
17.	Have your agreed a strategy for follow-up support for staff, pupils and parents?		
18.	Have you considered the consequences of media interest/involvement and have you prepared a press statement?		
19.	Have you considered how to answer the possible criticism that such an operation may compromise the trust between school and student body?		
20.	Have you considered how the 'need' for such an operation might be avoided?		

✓ Yes ☐ No

All DCSF public consultations are required to conform to the following criteria within the Government Code of Practice on Consultation:

Criterion 1: Formal consultation should take place at a stage when there is scope to influence the policy outcome.

Criterion 2: Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Criterion 3: Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

If you have any comments on how DCSF consultations are conducted, please contact Donna Harrison, DCSF Consultation Co-ordinator, tel: 01928 794304 / email: donna.harrison@dcsf.gsi.gov.uk

Thank you for taking time to respond to this consultation.

Completed questionnaires and other responses should be sent to the address shown below by 15 February 2010

Send by post to: Consultation Unit, Area 1A, Castle View House, East Lane, Runcorn, Cheshire, WA7 2GJ.

Send by e-mail to: DrugsGuidance.CONSULTATION@dcsf.gsi.gov.uk

Annex G. Consultation response to Review of the principles applying to the treatment of independent scientific advice provided to government - Science and Technology

ACMD

Advisory Council on the Misuse of Drugs

Chair: Professor Les Iversen
Secretary: Will Reynolds
3rd Floor (SW), Seacole Building
2 Marsham Street
London
SW1P 4DF
Tel: 020 7035 0454
Email: ACMD@homeoffice.gsi.gov.uk

Lord Drayson
Government Office for Science
1 Victoria Street
London SW1H 0ET

9th February 2010

Dear Lord Drayson,

The ACMD very much welcome the review of the relationship between government and advisory bodies. Although the review has wider significance, the recent difficulties around the ACMD make this of particular interest to our members and the Council as an advisory body.

As you are aware, since the dismissal of Professor David Nutt the ACMD met with the Home Secretary, Professor John Beddington and senior Home Office officials at a meeting of 10 November to discuss these issues. The joint statement that resulted from these meetings has allayed many of the concerns that the ACMD had regarding these issues. I have appended the joint statement to this response as submitted evidence to your consultation. The ACMD believe the joint statement represents a strong platform from which fruitful working relationships can develop with the Government.

In the present consultation document we note that there is some distance between the statement of principles communicated by the Royal Society and the revisions proposed. The ACMD have addressed these issues in its attached response. From the outset we must express our concern that the proposals are in places ambiguous and at best fall short of our expectations.

In summary we have four principal concerns around: 1) the Government pre-judging advice; 2) the Government demonstrating it has given adequate time for the consideration of advice; 3) clarification of academic freedom; and, 4) independence of an advisory body. We have addressed these in our attached response.

I welcome the opportunity to meet with you on the 22nd February 2010 to discuss the ACMD's response.

Yours sincerely

Professor Les Iversen FRS
ACMD Chair

ACMD response to consultation on Guidelines on Scientific Analysis in Policy Making:

Introduction

The ACMD do not believe that the proposals, as drafted, fully reflect the role of independent advisory bodies and nor do they adequately set out the terms of engagement of such bodies with ministers of Government. We believe that the principles that the Royal Society set out in their recent communication to the Prime Minister more fully addressed our primary concerns. Below, we have detailed our consideration of the consultation document.

Response

Trust and Respect

These terms were not included in the original Royal Society statement of principles document, and the ACMD feel that too much emphasis has been placed on these concepts, neither of which is capable of objective measurement.

Although over stated, we do concur with the first two paragraphs of this section. However, the final bullet point that suggests that the government and its advisors should seek to reach a 'shared position' is ambiguous, and unacceptable in its present form. Independent advisory bodies must reach their position entirely independently of government and focus on the science and expert evidence, rather than considering how politically agreeable the findings may be. Advisory bodies and the Government should, of course, work together to reach a position of mutual trust.

It is fully accepted that advisory bodies should respect the democratic mandate of government; there is a need to distinguish between advice and decision making responsibilities. The counter balance is that the government must allow dissenting interpretations of evidence to be aired and that this should not be seen to indicate a lack of trust or respect. This does not come across in the drafting.

Independence

We agree with the principles in this section, however, a key commitment regarding independence is missing. We feel strongly that the government should not pre-judge advisory group recommendations before or at the time of publication. This has been one of the most problematic issues of recent years, from the point of view of the ACMD, and the principle should apply to all advisory committees.

By way of example, Sir Michael Rawlins wrote to the Prime Minister on 10th January 2008. He voiced the ACMD concerns that media reports indicated that ministers (including the Prime Minister) were pre-judging advice and suggesting a direction of travel whilst the ACMD were considering the outcomes of a review that ministers themselves had commissioned.

We have concerns that by pre-judging advice and creating further media speculation on the outcomes of advice there is the potentially damaging consequence that the Government makes decisions that are not founded on, or fully consider, the evidence base.

It therefore follows that Government should give due consideration to advisory reports and their recommendations; allowing some interval between receipt of the report and an announcement of their response (see section in consultation document on transparency and openness, bullet 3).

Transparency and openness

The points in this section are generally well made and will provide assurance that Ministers have given appropriate consideration to an advisory body's reports and recommendations. However, the final point in this section should be strengthened. The ACMD believe that where a Government is minded not to accept the advice of an advisory body it is essential that the reasoning for non-acceptance be discussed with the Chair in advance of these comments being made public. It is also essential that the Chair has adequate time to discuss the issues with other advisory body members. This procedure should apply whenever Government decides not to accept the advice of an advisory body, not only "in matters of significant public interest".

General comments

The proposal almost entirely refers to 'scientific' advice, although the ACMD along with several other committees is composed of a diversity of expertise, many of which may consider themselves 'non-scientists'. The document might usefully refer to 'scientific and expert advisory bodies'. The independence of these groups could also be emphasised more strongly.

We welcome the statements about engagement with the media, thereby maintaining actual and perceived independence.

Role of the chair

The ACMD believe that it is reasonable that there are slightly different expectations of the Chair compared to other members regarding such issues as the freedom to express dissenting views. This does however deserve further consideration by the Chairs of advisory bodies and Government to ensure that each has a shared understanding of their responsibilities. It is disappointing that this has not been addressed during the current review, as this leaves some ambiguity for current chairs.

Conclusions

The ACMD welcomes the review that has been undertaken and the move to clarify the relationship between government and advisory bodies. However, we note that there is some distance between the statement of principles

communicated by the Royal Society and the revisions proposed in the present consultation document.

We look forward to seeing a further, strengthened, draft.