Report of the 2010 NDPB Review of the Advisory Council on the Misuse of Drugs

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Commissioning of the Review

1 Following the announcement by the Minister for the Cabinet Office regarding improving the efficiency of Non-Departmental Public Bodies (NDPBs)[1], the Home Office requested the continuation of the review of the Advisory Council on the Misuse of Drugs (ACMD), a non-executive, scientific advisory statutory committee set up under section 1 of the Misuse of Drugs Act 1971 (henceforth 1971 MDA). Following the reference to the ACMD in the Coalition Agreement, the Council was listed by the Minister for the Cabinet Office in his statement as an NDPB that would be retained and has strongly supported its work[2]. The intention to review this body had been announced by the previous government before the General Election but work was suspended when the chair, Professor David Nutt, and seven other members of the ACMD resigned in the autumn of 2009[3]. The ACMD was subsequently reformed under its interim chair, Professor Les Iversen, and an independent recruitment process under OCPA guidelines started in autumn 2010 for a substantive chair. The ACMD will therefore be entering a new phase of its existence at the beginning of 2011.

2 The overall aim of the review is to satisfy Ministers that the Advisory Council on the Misuse of Drugs (ACMD), for which they are accountable, can discharge effectively the function that it was set up to deliver and that it represents continuing value for money for the public. As described below, consultation as part of my review has evoked sharply contrasting views amongst those outside Government who work and advise on drug abuse issues about the present role, and the past effectiveness, of the ACMD. I have considered all these views with care in formulating my recommendations. My commission for this review excludes re-examination of the content of the advice, some of it controversial, that the ACMD has produced in the past and indeed from consideration of the legislation itself under which the ACMD operates. This report has nevertheless been written in the hope that it will help the 2011 ACMD establish a strong sense of direction, and will help remind government of the support it must provide for the ACMD in order that it can carry out its necessary work.

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[1] Francis Maude, House of Commons, 14 October 2010

[2] "This Government is committed to an evidence-based approach. High quality scientific advice in this complex field is therefore of the utmost importance. This is why we value the work and independent advice of the Advisory Council on the Misuse of Drugs (ACMD), which has experts from fields that include science, medicine, law enforcement and social policy. We are committed to both maintaining this expertise and ensuring the ACMD's membership has the flexibility to respond to the accelerating pace of challenges. the proper consideration of that advice is at the heart of enabling us to deliver this strategy, including the reforms required to tackle the problem of emerging new psychoactive substances ('legal highs')". http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary, page 9.

[3] Professor David Nutt then set up the Independent Scientific Committee on Drugs (ISCD), http://www.drugscience.org.uk/ accessed 6 December 2010

Conduct of the Review

3 The review has been conducted by Sir David Omand GCB[4], assisted by Dr Iain Williams, Head of Science Secretariat, Home Office. The review has considered:

a) the status of the advice of the ACMD;

b) the functioning and processes of the ACMD;

c) how the ACMD's agenda is set, and how decisions on what to investigate are made;

d) the composition of the committee and the roles of members, secretariat and officials;

(e) Temporary Banning Powers and research funding;

(f) the resources available to ACMD and the costs in undertaking their duties;

(g) the overall effectiveness of the ACMD.

4 The Home Office asked that the review not assess or revisit specific advice made by the ACMD nor review the legislation under which the NDPB is established. This exercise has therefore been conducted against the existing Terms of Reference of the ACMD that are set out in the legislation, and reproduced for convenience in Annex A together with Schedule 1 of the 1971 MDA that sets down how the ACMD should operate. Annex A gives the full remit given in the legislation.

5 During the process of the review, the views of the ACMD Interim Chair and members were sought together with those of the relevant Home Office and Department of Health policy and professional staff. The views of other key stakeholders and interested parties were sought through a consultation request placed on the web-site of the ACMD. Written responses to the external consultation were helpfully received from a number of organisations and professionals active in the area (listed at Annex E) and these have been taken into account in the review and in the recommendations made in this report.

The statutory position of the ACMD

6 The Misuse of Drugs Act 1971 controls drugs that are "dangerous or otherwise harmful" either to individuals or to society when they are misused. The unauthorised possession, supply etc. of these "controlled drugs" is prohibited and a criminal offence. The Act establishes a three-fold classification system, the primary purpose of

[4] Sir David Omand GCB is a retired civil servant: Permanent Secretary of the Home Office from 1997 to 2000 and in the Cabinet Office from 2002 to 2005. He is a Visiting Professor at King's College London.

which is to prescribe maximum penalties to each of the 3 drug classes. Examples are given below (source: Home Office web-site):

Penalties for possession and dealing

		Possession:	Dealing:
Class A	Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms, amphetamines (if prepared for injection).	Up to seven years in prison or an unlimited fine or both.	Up to life in prison or an unlimited fine or both.
Class B	Amphetamines, Cannabis, Methylphenidate (Ritalin), Pholcodine.	Up to five years in prison or an unlimited fine or both.	Up to 14 years in prison or an unlimited fine or both.
Class C	Tranquilisers, some painkillers, Gamma hydroxybutyrate (GHB), Ketamine.	Up to two years in prison or an unlimited fine or both.	Up to 14 years in prison or an unlimited fine or both.

7 There are currently over 250 substances classified under the 1971 MDA.

8 The 1971 MDA gives the ACMD the duty of keeping under review the situation with respect to drugs likely to be misused and that are capable of having harmful effects sufficient to constitute a social problem. The ACMD also has an important role in advising on the misuse of drugs regulations concerning healthcare provision. The legislation is framed in terms of the United Kingdom and decisions on drug classification have UK-wide effect.

9 The Council must respond to requests for advice from Ministers but also has under the 1971 MDA the important duty of offering advice on its own initiative on measures (whether or not involving alteration of the law) that the Council thinks ought to be taken for preventing the misuse of such drugs or dealing with social problems connected with their misuse. The Act asks the Council to be prepared to give advice in particular on measures for restricting the availability of such drugs (in practice, through the system of drug classification) or supervising the arrangements for their supply; on measures for enabling drug misusers to obtain proper advice, and on measures for securing the provision of proper facilities and services for their treatment, rehabilitation and aftercare.

10 The 1971 MDA also places a duty on the ACMD to promote co-operation between the various professional and community services

dealing with social problems connected with the misuse of drugs; and for educating the public (and in particular the young) in the dangers of misusing such drugs and for giving publicity to those dangers; and for promoting research into preventing the misuse of drugs or dealing with any social problem connected with their misuse. Reports from the ACMD are submitted to relevant ministers, published and are available to the public on the ACMD web-pages.

11 Decisions on the advice submitted by the ACMD, including the monitoring of compliance and the enforcement of standards, remain with the government. The Home Office is the sponsor department for the ACMD, and Home Office Ministers account to Parliament for its work. Where relevant, reports are submitted by the chair of the ACMD to the Heath Secretary as well as the Home Secretary. Decisions on the control and classification of drugs, taking advice from the ACMD, are for the Home Secretary, supported by her officials as the Department of State responsible for the implementation of the MDA. The 1971 MDA does not set out specific measures of impact or effectiveness for the ACMD against which its performance can be objectively assessed. It is left therefore to the government of the day to provide guidance on how it wishes to frame the objectives of its policies under the Act (in terms, for example of harm reduction or of increased abstinence from drug misuse).

12 The statutory independence of the ACMD is reinforced by having the Secretariat support for its work provided from the staff of the Home Office Chief Scientific Adviser, Professor Bernard Silverman, and not from the drugs policy area of the Department. This arrangement was introduced following past criticism from a Parliamentary committee (House of Commons Science and Technology Select Committee).

13 The UK is a signatory to various United Nations conventions on controlled drugs. The Home Office is the UK's competent authority for the purposes of these conventions. The Unit also issues licences for those who work with controlled drugs, including:

a) companies and other organisations that intend to work with controlled drugs and precursor chemicals;
b) prescribing certain drugs to addicts;
c) people taking their prescribed controlled drugs abroad.

Findings of the Review

14 The main findings of the review are summarized in the sections below. Supporting detail where necessary is contained in the Annexes. **A summary of the principal conclusions and recommendations is given at Annex F.**

(a) The status of the advice of the ACMD

15 The ACMD is a statutory Non Departmental Public Body that exists to provide government with independent professional advice. That advice

rests, and should continue to rest, on a mix of scientific judgments (from both physical and social sciences) and professional and practitioner experience from those who have worked to manage the harm from the misuse of drugs from a number of perspectives that include criminal justice (judges, magistrates, lawyers, police and probation), education, medical and community treatment services and their users.

16 For most of the subjects covered by the scientific advice of the ACMD the Home Office does not maintain internal expertise. The ACMD should itself already have taken into account in formulating science-based advice any divergence of academic opinion there may be in the relevant scientific communities. Where the evidence does not allow precise estimation or unambiguous judgment then the expectation is that the scientific advice submitted will be properly caveated and differences of view exposed. As a general principle, professional scientific advice is submitted to government in the expectation that it will not then be ignored, quoted out of context or 'cherry picked', lightly set aside or contradicted by officials. The Home Office Chief Scientific Adviser, although not sitting as a member of ACMD, will be made aware of any relevant scientific debate and can have the opportunity before the ACMD reports to Ministers to contribute if required. Ministers are then entitled if they accept ACMD advice to rest publicly on the argument that they have relied on the ACMD as having provided the scientific basis for policy.

17 There is to be an update of the 'Code of Practice for Scientific Advisory Committees' (CoPSAC) developed by the Government Chief Scientific Adviser; a draft was published for consultation in during the process of this review. The revised CoPSAC will incorporate the Principles for Scientific Advice in Government. The Principles were published by the Government in March 2010[5] and are reflected in the Ministerial Code. They set down the key principles applying to the treatment of independent scientific advice provided to government, including academic freedom, independence of operation and proper consideration of advice. Those principles clearly already apply to the ACMD and the revised SAC Code of Practice should cover the advice of the ACMD.

18 In addition, the ACMD has been operating under a protocol or 'concordat' agreed with the previous Home Secretary to govern its work. This 'Ways of Working' code is under revision with current Ministers and is expected to re-issue shortly. It is expected to incorporate the understandings reached[6] following the resignation of Professor Nutt in October 2009 concerning the need to uphold the independence of scientific advice and academic freedom and for government not to prejudge the ACMD's advice in advance of receiving and considering a report.

[5] Lord Rees's letter to the Government Chief Scientific Adviser, Professor John Beddington, enclosing 'The Principles for the Treatment of Independent Scientific Advice'.
[6] Joint Statement from the Home Secretary and the ACMD, issued by the Home Office on 10 November 2009

19 As a number of external submissions to this review have emphasised, the ACMD's statutory remit extends much further, however, than the provision of specialist advice based on the relevant sciences. The ACMD has the duty to assess the likely effectiveness of policies on the prevention, management and treatment of drug misuse and on the wider personal, familial and social harm that drug misuse can cause. The use of Khat by the Somali and other communities in the UK is a current case in point[7]. Such wider ACMD advice will rest on the collective judgment of its members, taking account of the practitioner and professional experience of the relevant ACMD members in the field, as well as specific stakeholder views that have been gathered. For example, the ACMD has advised the coalition government in its response to the Drug Strategy Consultation (November 2010) that there is an opportunity to be more creative in dealing with those who have committed an offence only by possession of drugs for personal use by being diverted into drug education/awareness courses or other more creative civil punishments rather than being processed through the criminal justice system. On such matters it is to be expected that external professional and voluntary sector bodies, think-tanks, and lobby groups will have strong and sometimes contrasting views. Officials have emphasized to me that the ACMD's advice in this regard has always attracted considerable respect within the Home Office and the Department of Health, and is regarded as having a different status from other sources of view because of its statutory remit. That spirit needs to be captured in the concordat referred to above.

20 The ACMD has invested in developing methodology for the future to allow an explicit multi-criteria approach of harm[8] and thus provide a more scientific basis for its judgments. It is, however, early days in the use of such a technique and the evidence base may well be insufficiently rich today to allow such methods to be used or to enable sufficient discrimination between alternative hypotheses that might explain observed behaviours and thus illuminate potential policy options. In the absence of robust explanatory theories tested on sound evidence, it is bound to be case that the relative weighting given to factors identified as affecting policy will be at least partially subjective. In such a politically charged policy area such as drug misuse, it is likely to be the case that where you stand on the issue is where you sit. The Coalition Government drugs strategy[9] is different in its underlying assumptions from the previous Government's strategy. Current Ministers have already indicated that their approach differs in giving more weight to the objective of recovery and abstinence as opposed to emphasis on harm reduction from drug misuse.

21 It could therefore be that occasionally a different opinion to that of the ACMD on policy might legitimately be reached by Ministers (advised by

[7] The ACMD produced a report in 2005 recommending that it not be classified as a drug under the Act. The Coalition Government has (2010) asked the ACMD to revisit that work.
[8] ACMD, Consideration of the Use of Multi-Criteria Decision Analysis in Drug Harm Decision Making, 28 July 2010 available at http://www.homeoffice.gov.uk/drugs/acmd/ accessed 6 December 2010
[9] Published on 8 December 2010, http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/

Departmental policy officials), even where there is no disputing the science. Ministers also have to weigh their support on a controversial issue and their ability to carry the day where Parliamentary approval for new measures is needed. In such circumstances I consider it essential for public confidence that Ministers inform in advance the chair of the ACMD if they are minded not to accept a recommendation and give their reasons, allowing a discussion to take place. In the end, and subject to the will of Parliament, the Minister's decision is then final.

22 The previous Home Secretary made a commitment to the ACMD that if he was minded not to accept their advice then the Home Secretary would meet with the Chair of the Council to discuss the issue and if the decision was not to accept the advice the Home Secretary would write to the full Council setting out his reasons for rejection ahead of any public comment on the matter. This seems very sensible, and should be incorporated into the revised 'Code'. The original advice of the ACMD will, usually, have been published at the time of its submission to Ministers and Ministers must be prepared to justify their rejection of it.

23 Ministers are of course entitled to ask the ACMD to look again at findings submitted to them and to commission further work. In the case of the 2007/08 review of cannabis classification, for example, the Home Office undertook research into cannabis potency and a public consultation (as part of a wider then drug strategy consultation); the ACMD conducted a MORI poll of public opinion. All findings were shared as appropriate, considered by the ACMD and incorporated into its own report. In those cases to keep within the spirit of the Act the commissioning of additional work should be done openly and the ACMD given the opportunity to comment on any alternative views obtained before final decisions are taken.

24 I have considered whether there would be any merit in this context of a separation of the ACMD's strictly scientific 'technical' advice (for example on substance pharmacology) from their consideration of wider issues of prevention and harm reduction to the individual and society. All those I have consulted believe it to be an advantage of the current structure that the ACMD membership includes both scientific and practice-based professionals. For example, when discussing advice based on pharmacological issues, impacts on (say) education for young people are discussed at the same time as formulating the advice. This 'holistic' approach to advice is considered a strength. All the views I have heard have stressed how important it is for sound policy-making that ACMD advice – not just its hard science component - continues to be seen by all concerned as representing the best independent judgments available, consistent with the available facts.

25 Ministers in the present government have already committed themselves[10] to look to the ACMD under the 1971 MDA and be guided

[10] see footnote 2.

by its advice. Whilst final decisions on ACMD recommendations on drug classification in particular are for Ministers, for which Ministers are accountable to Parliament, I consider it important that they are able to demonstrate that in reaching their decisions Ministers have paid proper regard to the independent professional advice of the ACMD, and be prepared to explain to Parliament when for wider reasons it has not accepted and acted upon the advice.

(b) The functioning and processes of the ACMD

26 The interim chair of the ACMD is Professor Les Iversen, who was appointed in January 2010. A selection process is under way for a new substantive chair. The membership of the ACMD as at December 2010 is set out in Annex B. There are, apart from the interim Chair, at present 26 members who are appointed by Ministers in accordance with OCPA guidelines for an initial term of three years extendable for two further three year terms. In addition, the ACMD has been able to draw on the expertise of co-opted members for specific studies, helpfully expanding the range of expertise available.

27 The main Council of the ACMD ordinarily meets twice a year. The current pattern is for the morning session to be open to the public, and the afternoon to be a closed session. After each main ACMD meeting the Secretary draws up a detailed action sheet, and assigns tasks to members of the Secretariat and to individual members. The ACMD carries out most of its work by means of sub-committees and working groups (a list of these is Annex C) since it has been found helpful given the technical and sometimes controversial nature of the work to have discussions in depth in smaller groups. The ACMD has used 'away-days' in the past to develop and decide on work priorities and its groups have often held hearings at which scientific experts and practitioners alike who are not on the ACMD can present their views and be questioned on them. It is important therefore that the ACMD work programme continues to be available on its web-site and that open calls for evidence and research findings are published. The only exception should be where an urgent classification exercise, such as for a 'legal high', is underway (or in future, advice on a temporary ban) where advance knowledge could lead to wholesale level stockpiling of the substance in anticipation of a ban.

28 Once a piece of work of a sub-committee or working group has been accepted by the main committee, the Chair submits the results – which can be a letter offering advice or a longer report – to the Minister. Any declared conflicts of interest that ACMD members may have declared in relation to the subject must be included in the advice. As is the case at present, members with conflicts of interest must recuse themselves at the outset from a study and inform ACMD members. In accordance with best practice, the Secretary maintains a standing register of members' interests, and this is placed on the web-site. It is important that ACMD members are periodically reminded to keep this register up to date.

29 The Technical Committee is a standing body of the ACMD whose primary purpose is to consider and make recommendations to the Council about control or classification under the MDA 1971 and its scheduling under its and its regulations of any substances which is being or appears to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to cause a social problem. The Technical Committee will often establish working groups to carry out in-depth reviews of specific drugs, including their classification. The chair of the Technical Committee should normally not also be chair of the ACMD in order to avoid any impression that the key classification recommendations emerging from the Technical Committee have not engaged the full participation of the Council as a whole (exceptionally both posts are currently held by Professor Les Iversen).

30 A point put to me from an external stakeholder is that there is a case for the ACMD reviving standing Committees on criminal justice and prevention aspects of drug harm reduction. I consider this point in para 43 below.

31 The ACMD usually, in recent times, publishes its advice concurrent with its presentation to the Home Secretary. There are, however, exceptions to this when a time lapse between advice and consideration of that advice may be detrimental to public health or safety (e.g. the stockpiling of a drug prior to it being made illegal). Memories are still alive of a few occasions in the past on which previous Ministers had made it publicly evident that they had already made up their minds on an issue on which the ACMD was to report. An example was the classification of ecstasy. In the joint statement issued in November 2009 the then Home Secretary emphasized that he would not pre-judge the ACMD's advice in advance of receiving a report. It is essential for good government that this principle is upheld.

32 The ACMD Interim Chair is strongly in favour of transparency for the work of the ACMD. Those to whom I have spoken have noted the importance of the committee continuing to have face-to-face meetings with key stakeholders. The Interim Chair has held a number of these and there may be scope for more committee members to be involved. I received differing opinions on the value of the open meetings that the ACMD holds. Having attended one, which included a lively debate with members of the Somali community on the use of khat, which will lead to evidence from the community being submitted to the ACMD as input to its review of khat, I endorse their value to the work of the ACMD. They are not however a substitute for government sponsored programmes of targeted public information on the harms of drug misuse.

33 The Home Office web-site has a section[11] for the ACMD. There are good value for money reasons to use the Home Office site to host the ACMD web-presence, but there is no reason why the ACMD pages

[11] http://www.homeoffice.gov.uk/drugs/acmd

themselves should not be clearly distinguished in heading and layout from those of the Home Office, as is the case for other NDPBs. It is important for the perception of independence that visitors to the web-site are aware that the ACMD is not part of the Home Office. The ACMD web-site includes its reports, but is not up to date on minutes of meetings and does not include full details of current working groups and work programme. The Home Office web-site page for the ACMD at present gives only a part of the ACMD terms of reference and it would be better to provide the full statement. A better-presented and more up-to-date website that clearly reflects the independent status of the ACMD would be welcomed by stakeholders.

34 The remit of the ACMD includes giving advice on 'educating the public (and in particular the young) in the dangers of misusing such drugs and for giving publicity to those dangers'. Unlike some other scientific advisory NDPBs, the ACMD does not however have a direct educational engagement strategy with the public, and does not produce material for educational use. With no infrastructure of its own, apart from a very small secretariat, and no resources to speak of, it is evidently impossible for the ACMD to do more than cover in its advice the educational implications of its recommendations. Given the scale of effort of the voluntary sector in combatting drug misuse, and the role that government public health campaigns can play (for example on the dangers of AIDS transmission), I see no pressing need for the ACMD to attempt to engage directly in general public education. It should, however, interpret its remit as including advising government on the adequacy of the efforts of others as part of its general advisory remit.

35 Specialist media handling advice is provided to the ACMD by the Home Office communications staff (whose members belong to the Government Information and Communication Service, GICS). Members of the ACMD, and some external stakeholders, have raised the question of whether this arrangement could, at least in theory, lead to a conflict of interest and a perception that the ACMD is not truly independent. Some NDPBs employ their own media advisers precisely to avoid such a perception. Funding for this would have to come from the Home Office – but if any additional funds were available then I would strongly advise that they be devoted first to expanding the direct scientific secretariat support for the work of the ACMD Committees and Working Groups (see para 68 et seq). Although I have not found any evidence of a problem, the potential risk of a perception of conflict of interest could be reduced if the ACMD 'concordat' with the Home Office explicitly made clear that GICS staff when working on an ACMD topic take their operational direction from the chair of the ACMD (in practice through the ACMD secretary) and not from Home Office officials.

(c) How the ACMD's agenda is set, and how decisions on what to investigate are made

36 Under the 1971 MDA, the ACMD is empowered to set its own agenda as an independent NDPB and can choose topics within its wide remit that it wishes to investigate and advise on. An indication of the range of the ACMD's work can be seen from the list at Annex B.

37 The ACMD's current priority is work on new psychoactive substances ('legal highs') and it has set up a New Psychoactive Substances Working Group. It has also set up a Polysubstance Use Working Group given the evidence of the increasing problem of combinations of drugs, including alcohol, being misused. The ACMD also considers that there is a pressing need to look at treatment and its Treatment Working Group is considering the goals, outcomes and indicators of what constitutes 'successful' treatment for drug misusers, reviewing the evidence for effective treatment interventions and on the basis of strength of evidence to identify the optimal balance of different treatment interventions.

38 In addition, the ACMD has recently decided that it would like to produce fresh advice for the government on cocaine use, given the rapid increase in misuse of this substance, the practice of cutting the drug with dangerous substances, and an increase in polydrug use involving cocaine. That will be a major study.

39 The ACMD also has the duty under the 1971 MDA to respond to requests for advice from Home Office Ministers, notably to advise on control or classification of substances and time must be set aside for such commissioned work. The Minister for Crime Prevention has for example already asked the ACMD for an update of advice on khat misuse given the concerns over the harms caused to individuals and the societal harms in the affected UK Somali, Yemeni and Ethiopian communities. This exercise will also be a major piece of work involving a comprehensive review of the available evidence, an updating of its earlier report in 2005[12] and advice both in relation to control under the 1971 Act and a wider response. It will not given present resources be possible for the ACMD to carry out the cocaine and khat reviews in parallel. The government will set out its view on priorities shortly.

40 In addition to these reviews, the ACMD expects to receive a growing number of immediate, reactive requirements for classification advice on compounds newly taken up by drug misusers. Once a temporary banning power is available to government[13] these pressures will likely increase.

41 The expectation of the ACMD, which I share, is that these short-term pressures in addition to the major studies referred to above will severely restrict the effort that can be put into longer term, more

[12] ACMD, *Khat (Qat): Assessment of Risk to the Individual and Communities in the UK,* London: Home Offcie 2005

[13] A provision seeking this power is included in the Police Reform and Social Responsibility Bill, http://www.homeoffice.gov.uk/media-centre/press-releases/police-reforms accessed 10 Dec 2010

strategic studies into prevention, treatment and post-treatment issues. One stakeholder put to me that as a result the ACMD is in danger of not being able to fulfill its wider duties under Act and drew my attention to the importance in terms of developing new policy of earlier wider ACMD studies such as its 2006 Pathways to Problems report[14]. The treatment and recovery work of the ACMD is considered particularly important by external stakeholders as this is an opportunity to provide advice that could have considerable impact.

42 Officials have also told me that they would continue to welcome in future additional thematic and broader pieces of advice (over and above that on individual substances) such as that currently being undertaken by the ACMD on cocaine, new psychoactive substances, treatment and recovery and polysubstance misuse (including alcohol as part of the misusers' mix). There is therefore a conflict between the current capacity of the ACMD and the aspirations of government and the external stakeholders.

43 I have examined in the light of these indications of expected future demand for advice whether the ACMD could in practice expand its effort. The current recruitment exercise for ACMD members has revealed considerable enthusiasm from experts in the field to contribute to ACMD studies. My inquiry reveals that over the next few years the limitation on ACMD work is therefore more likely to be shortage of Secretariat support than availability of members and co-opted experts. As part of the government-wide deficit reduction plans, the ACMD secretariat is expecting to be reduced in size. As recommended below in the section on resources, the Home Office must ensure proper support for the ACMD and I recommend that these plans are reconsidered. One idea that I believe should also be explored is the provision by the Department of Health of a suitably qualified official to act as Assistant Secretary to the ACMD, thus also helpfully increasing the linkage of the ACMD to that Department.

44 It is evident, however, that in any event there will be limitations on the resource available to the ACMD to run its programme, and for supporting research and for the launch of new policy initiatives. There is therefore over the next few years of public sector austerity no alternative to rigorous prioritization by the ACMD of its work programme.

45 The Coalition Government's Drugs Strategy[15] should provide the ACMD with a better feel for priorities as seen by the government as a whole. Under the previous administration specific guidance on the work programme was provided by the Home Secretary in a letter to the then chair of the ACMD. I understand that the Coalition Government intends to follow this precedent and either confirm that the previous

[14] A follow-up report was issued in July 2009, ACMD, http://www.homeoffice.gov.uk/publications/drugs/acmd1/acmd-pathways-to-problems-report?view=Binary accessed 6 Dec 2010

[15] see footnote 2.

list of tasks continues to have high priority for the Home Office, Department of Health and other departments or re-order them in the light of its own sense of priorities. The ACMD can then take that guidance into account – but it is important that Ministers recognise that the ACMD must in the end take responsibility for its own work programme, balancing the different demands upon it. The ACMD should in particular try to ensure that there is capacity in its programme for it to provide advice on its own initiative on new or emerging risks of drug misuse drawing on the expertise of its members in order to help the departmental policy-makers keep ahead of the curve of changes in drug use in society.

46 There are areas that the ACMD has not examined in detail for many years, such as the effectiveness of criminal justice sanctions and enforcement measures aimed at restricting the supply of controlled substances to the general public, for example through border controls and other interdiction of supply. A point put to me from an external stakeholder is that there is a case for the ACMD reviving standing Committees on criminal justice and prevention aspects of drug harm reduction. On the other hand, government has been active over the last decade in examining issues around enforcement as part of its overall drugs strategy and it has other specialist sources of advice on interdiction, work at the border and the impact of sentencing guidelines. I do not see these areas as a current priority for the ACMD, but it would help the ACMD if the government were to confirm this in their statement of priorities for the future ACMD work programme and to indicate how alternatively they plan to obtain independent advice to guide their drugs strategy in these areas if not from the ACMD. The choice of which standing committees to set up should then be a matter for the new chair of the ACMD to consider when appointed.

47 Resource pressures increase the importance of having the means of keeping the ACMD programme under review and for forward planning the time demands on ACMD members. I recommend that ACMD adopts a more structured approach, with a rolling three year programme of work aligned to the financial year. The ACMD holds a meeting in November each year where the work programme for the following year could be discussed and the 3 year programme updated. This would also help the Secretariat and the chair consider well in advance what co-opted support might be needed. I would expect the outcome of the November meeting then to form a logical agenda for a forward-looking discussion with the Minister. I have found general agreement that it would be valuable to external stakeholders to have a clearer sense of the ACMD's own thinking on priorities. A published (on the ACMD web-site) three year programme would provide a vehicle for this.

48 The ACMD contributed a written response to the consultation exercise on the Coalition Government drugs strategy after convening a one-day strategy meeting in September 2010. The response made clear that the ACMD believes that the drugs strategy should be based on the

understanding that addiction is viewed as a chronic and relapsing brain disorder. The ACMD should be prepared to provide further views to the Secretary of State on the impact of the Drug Strategy after it has been in operation for sufficient time, and drawing on the ACMD's own work, including its 'Treatment Working Group'.

(d) The composition of the committee and the respective roles of members, secretariat and officials

Balance of membership

49 A strength of the ACMD's advice on a topic is that its expert membership is competent to evaluate, where it is available, scientific evidence (for example on the chemistry or pharmacology of the substances concerned or on the interpretation of statistical findings concerning drug misuse and treatment). The ACMD has for example advised on drugs brought under the MDA for the first time such as Ketamine, GBL, synthetic cannabinoids and the cathinones).

50 The wording of the 1971 MDA in schedule 1 does however lay down in legislation requirements on membership in terms of providing a list of some (but not the only) areas of 'core expertise' that must be represented on the ACMD - there are other professions such as social sciences, treatment and law enforcement experts who would also have a good reason to be represented if the Act was being passed today. The view of the ACMD is that this 40 year old list of statutory positions does not correlate with what is required today and that, depending on the circumstances, there is a risk that the Council could lack a quorum if any one of these posts fell vacant and that it would provide for more flexibility if the Act was amended although the core expertise represented by these professions should continue to be represented. I accept this argument for greater flexibility but regard it as essential in that case that for the future credibility of the ACMD each government should publish afresh the non-statutory protocol between the Home Office and the ACMD[16] and identify in it the most relevant areas of expertise that should, under normal circumstances, be represented directly on the ACMD with an undertaking in the House of Commons that it will abide by it in terms of ensuring sufficient scientific expertise. Otherwise, as has already been misunderstood this month by critics[17], there will be suspicion that over time the scientific credibility of the ACMD might erode.

51 I share the view expressed to me by the Interim Chair that once the current recruitment exercise for members of the ACMD is complete the overall balance of membership on the committee should be appropriate for its planned work programme.

52 Recruitment to the ACMD takes place following OCPA guidelines as for other NDPBs and that will remain important for the perception of

[16] See para 18
[17] The Times, News, Monday December 6 2010

independence from government. New members currently receive an induction to the Council from the Chair, secretariat and Home Office officials. Given the size of the ACMD and relative formality of full Council meetings, it is vital that this process continues so help new members become effective and involved in the work of the ACMD as soon as possible.

Relationships with Home Office Ministers and policy officials

53 Relations between government and the ACMD are now much improved. Good relations between the interim Chair and the new Ministerial team following the general election were quickly established, and there is the necessary access to Ministers and their offices when required. The previous Home Secretary expressed the intention to meet with the ACMD chair on a regular scheduled basis and to meet with the full Council annually. As noted above, the more structured relationship between Ministers and the ACMD developed over the last few years needs to continue, with a clear Ministerially endorsed statement of Departmental priorities to feed into the ACMD's development of their own work programme. I understand that work on a letter from the Home Secretary representing the views on priorities of the Home Office and other government departments is in hand.

54 Officials from the Home Office Drugs Legislation team and Department of Health attend main Council meetings and some sub-committee meetings (particularly the Technical Committee meetings). Having spoken to the relevant officials, I am clear that they understand both their role in representing the Department's and Ministers' views and the independence of the ACMD. Experience has shown that it is very helpful for the ACMD to have officials present who can speak to the current position or view of their respective departments on any issue and to the previous history of policymaking on a topic.

55 The quality of the ACMD's advice is considered to be very high. Its approach to reports is considered thorough and methodologically correct. Officials regard advice on individual substances as carrying great weight and the provision of advice, when requested on specific substances, as timely. An example, was provided in the use of the OGIL (Open General Import Licence) to bring an immediate restriction on the import of mephedrone. The use of OGIL had not previously been considered before, but its use, as an option to reduce supply of a substance, was brought to the attention of the ACMD by Home Office officials. The ACMD were under no pressure or obligation to recommend the use of OGIL, but did so following careful consideration. Regarding recent issues relating to new substances, I note that government had asked the ACMD to provide advice on increasingly shorter timeframes and that the ACMD has so far been able to respond appropriately.

56 The move of the ACMD secretariat to the Science and Research Group within the Home Office was considered by those I consulted to be positive and to have sent the right signals about the importance attached by the government to the ACMD as being seen as independent. It is a relationship that works well, with the right balance of maintaining the independence of the Council and interaction between policy officials. As one external stakeholder commented, however, care will be needed to ensure a strong link will remain for the future with Home Office policy staff, especially given the likely reduction in staff numbers.

57 I concur with the Interim Chair and the Secretary of the ACMD in believing therefore that there is a positive and effective working relationship between the ACMD and policy officials, and that this has improved further over the course of the year.

Consideration and implementation of ACMD reports

58 A major concern of stakeholders is the (lack of) speed with which government responds to ACMD advice. An example is the ACMD Report on ecstasy submitted in February 2009 that included a recommendation that ecstasy be reclassified as a Class B drug. Whilst a response has been provided on 2 of its recommendations, a full response to the other 11 is still await awaited. Long delays do harm to the integrity of the relationship between the ACMD and its parent department. If for any reason the government does not wish to act on a recommendation, as appears to be the case with Ecstasy, then common courtesy would suggest a meeting with the ACMD chair at which the government's reasoning can be explained, and the ACMD reassured that its advice has been carefully considered even if the government in the end decided not to act. Ministers should make decisions on ACMD recommendations within a reasonable time (6 weeks is suggested), or if this is not possible to inform the ACMD of the reasons.

59 In the past, not all ACMD advice that has been accepted appears to have been vigorously acted upon – even when official responses from the Home Office and other Departments concerned accepted the thrust of the recommendations from the ACMD. There is a feeling among ACMD members that the ACMD provides its advice into the Home Office without a clear mechanism for tracking follow-up and providing feed-back to the Committee. ACMD should also not feel constrained in investigating on its own initiative how far accepted recommendations have been translated into action on the ground. The ACMD Secretary should therefore agree with the relevant department and policy unit a procedure that tracks the follow-up of a recommendation being taken forward and a reporting mechanism to the ACMD. The Secretary should also consider whether it would be possible to word the ACMD's recommendations more carefully to make it easier for the government to identify who should be responsible for

overseeing the action, and thus provide a clearer line of sight for implementation.

60 It may help officials in preparing advice on complex issues for the ACMD to highlight the (probably small) number of key recommendations so that these can be given priority. Having 20-30 recommendations a few of which may require complex interdepartmental negotiation may introduce unnecessary delay in getting on with more straightforward matters. The ACMD should also be clear when making a recommendation whether it is affirming continuing current practice or recommending a new action to government.

Relationships to other Departments and the devolved administrations

61 Work on the Coalition Government's Drug Strategy has been overseen by the Inter Ministerial Group on Drugs chaired by James Brokenshire MP, the responsible Home Office Minister, reporting to the Home Affairs Cabinet Committee (chaired by the Deputy Prime Minister) and the Public Health Cabinet Sub-Committee chaired by the Health Secretary. This structure has worked effectively and if made a standing arrangement then this would provide the necessary framework into which the independent advice of the ACMD would fit. It would also provide the necessary government-wide strategic direction for the senior officials' Drug Strategy Group chaired by the Home Office Director for Drugs and Alcohol Policy.

62 The Department of Health has a very major stake in the work of the ACMD (for example, the recent major ACMD report on Foil Use[18] was submitted jointly to the Health Secretary as well as the Home Secretary). Drug misuse represents a major challenge for health outcomes and contributes significant costs to the health budget. A number of bodies provide advice on related issues for the Department of Health, including research by the National Treatment Agency for Drug Misuse (NTA)[19], NICE and health expert groups. It is in the interests of the Health Department that the ACMD remains fully effective as the government's independent advisory group in this area. Although relationships between the ACMD and Department of Health were considered to be positive by policy officials, I consider that there will be a need for even closer coordination on advice on policies for drug misuse. One simple way to improve communication would be for the Department of Health to provide a suitable official to the ACMD Secretariat and for the Secretariat to see itself working for both the Home Secretary and for the Health Secretary. Another Department that may have in future a greater interest in the work of the ACMD is the Department of Communities and Local Government (DCLG) given the Coalition Government's wish to see greater responsibility exercised

[18] ACMD, *The Use of Foil as a Harm Reduction Intervention,* London: Home Office, 10 November 2010
[19] For example, into the post-treatment recovery journey over four years of drug users, http://www.nta.nhs.uk/new-hope-for-drug-addicts.aspx

at the local level for public health issues. The ACMD Secretary should therefore keep in touch with DCLG as policy in this area develops.

63 The 1971 legislation is framed in terms of the United Kingdom and decisions on drug classification have UK-wide effect. The ACMD therefore has an important role in considering the drugs situation in the devolved administrations and membership from these countries is important. Since the MDA was passed in 1971 the relevant health and social services, administrative and treatment services concerned have become the responsibility of the devolved administrations in Scotland, Wales and Northern Ireland. Recent meetings have taken place with the Welsh Advisory Panel on Substance Misuse (APOSM) and the Scottish Drugs Strategy Delivery Commission. The ACMD also has a positive relationship with the authorities in the Channel Islands and the Isle of Man. These relationships appear to work well.

64 It was put to me that the ACMD works much faster than European bodies and allows the UK to legislate and respond more rapidly, addressing issues that have arisen specifically in the UK, than if it relied on such bodies for assessments of substances. For example, the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) has only recently produced its report on mephedrone, something the ACMD produced over nine months ago. The work of ACMD is well regarded overseas and can be deployed to good effect by officials in European and UN discussions.

(e) Temporary Banning Powers and research funding

65 A major development that will affect the future work programme of the ACMD is the proposal to have a temporary banning power[20]. The coalition government proposal is for a Temporary Banning Power for 12 months over substances, such as new psychoactive substances (so-called 'legal highs') where swift action to prevent harm is the imperative but the evidence is not available at that point to justify full and permanent control under the MDA. The ACMD has provided advice to the Home Office on new procedures in anticipation of this new legislation, based on the ACMD being advised in advance that Ministers are considering use of a temporary ban on the precautionary principle where there is prima facie belief that serious harm may be caused but insufficient time for the ACMD to provide an evidenced recommendation on classification. The ACMD would then complete a full report to allow a final decision before a sunset clause in the legislation forced the order to lapse after 12 months. In exceptional cases a further interim order may be possible but clearly meeting the requirements for timely advice within the government's preferred timetable will represent a significant challenge for the ACMD. Procedures must be detailed in the new 'Ways of Working' protocol to ensure that the chair of the ACMD is aware in advance of the advice going to Ministers on a temporary ban, and as discussed below the work programme will need to be able then to accommodate the work

[20] See footnote 13.

to provide considered advice in good time for permanent classification of the substance in question.

66 It is becoming increasingly evident, given the viral spread of knowledge among drug misusers of new 'legal highs', that the ACMD needs to have access to a suitable 'early warning' system to provide alerting (for example from A&E Departments) of new patterns of use. A research framework is needed for this purpose. The Temporary Banning Power will also require some basic test purchases or seizures of branded products that scientific testing can show contains the chemical in question. Funds for such research will need to be made available either from within the Home Office research budget or from Department of Health sources. The ACMD does not itself have a research budget or any way of accessing the necessary funds itself. If funds were available then I am sure that the ACMD would be able to guide a suitable research programme and provide appropriate research questions into issues relevant to their statutory functions.

67 The funding of this work should be considered a matter of priority by the Home Office-led Drug Strategy Research Group (DSRG) chaired by the Programme Director, Crime, Drugs and Alcohol Research in the Home Office and on which the chair of the ACMD sits. The remit of the inter-departmental DSRG is to act as the strategic lead for the work of government departments in developing the evidence base for drugs policy and to facilitate and encourage wider coordination of drugs research across government and other relevant research bodies. The DSRG reports to the Inter-ministerial group on substance misuse through the Drug Strategy Group. The need for research to support the Temporary Banning Power must be brought to the attention of the DSRG and a plan developed and put to the Ministerial Committee for how the necessary research is to be funded.

68 A number of external stakeholders also commented to me on the present absence of a research fund at the disposal of the ACMD to commission research. The government has accepted the need for investment in developing the evidence base against which drug policy analysis and programmes can be evaluated. Rather than press for the ACMD as an independent body to have its own fund, which would inevitably be small in current circumstances, I consider it will be more productive for the ACMD to seek to leverage funds across government and the research councils. The remit of the DSRG is precisely that, although I do not sense that it has so far been able to fulfill it. The DSRG should be guided by the ACMD in setting priorities since providing such advice is a statutory duty of the ACMD (see 2(e) of Annex A). The chair of the ACMD will wish to ensure that the ACMD has the opportunity to consider research priorities and that its views are strongly represented to the DSRG.

***(f)* The resources available to ACMD and the costs in undertaking its work**

69 The details at Annex D reveal how little it costs the Home Office to have this source of expert advice. I am in no doubt that with an annual extra cost of only £150,000 the ACMD represents exceptional value for money for the taxpayer. ACMD members, including the chair, are not paid. Members and co-opted experts give their time voluntarily and pro bono – in the case of the chair this amounts to 2 – 4 days a month working on ACMD business. By comparison, as was pointed out to this review, the government estimate of the costs of Class A drug misuse is some £15billion.

70 It is incumbent on the Home Office to recognize the value of this public service by providing adequate secretariat support for its work. The Home Office should review the future resource needs of the ACMD in the light of the work programme that Ministers wish carried out together with the necessity to provide sufficient effort to allow the ACMD to fulfill at least at a minimum level its statutory duty.
It is clear to me that government needs independent scientifically based advice and that if the ACMD did not exist it would be necessary to invent something very similar. All the obvious alternatives to that end would be very much more expensive with no certainty of being more effective.

(g) The overall effectiveness of the ACMD

71 It is generally accepted that the ACMD has had significance influence over its 40 year history measured by advice mainly accepted and, in large parts, implemented. I have nevertheless received widely differing views on the overall effectiveness of the ACMD in relation to its statutory remit.

72 On the one hand, there are some critics who point out that although since the 1971 Act successive governments have followed the advice of the ACMD with few exceptions we see a continuing (and in some respects growing) problem of the misuse of legal and illegal drugs in the UK, in which the UK is seen as faring less well than comparable nations in tackling the problem. For these critics, there has been something amiss with the advice offered by the ACMD. Here too we see a divergence of view on why this might be so. There are those who think the ACMD was over-influenced by pro-user groups, and those with a pro-legalisation agenda, and cite in particular the ACMD reports on Cannabis and Ecstasy/MDMA as in their view under-estimating the mental health problems of recreational drug use. There are also those who feel that with its emphasis on pharmacology in support of MDA classification the ACMD has failed to address sufficiently wider social issues including treatment of substance misuse (which it has not looked at for some years) and policy has therefore been too narrowly focused and therefore has not been as effective as it might have been.

73 On the other hand, there are commentators who see the past work of the ACMD as highly effective precisely because grounded in evidence, and expect its independent scientific/expert analysis to continue to be

almost universally accepted. Some do warn, however, against a shifting centre of gravity of influence away from the ACMD as the provider of wider advice. These critics express a worry that there will be a shift towards more overt 'political' imperatives shaping policy. The recent controversy[21] over the Government's intention to relax the statutory requirements for various professions to be represented on the ACMD shows how sensitive this point is. The Government response to the Science and Technology Committee 2006 Report about the drug classification system is seen in that light as raising questions about the future utility of a scientific and expert advisory committee in such a political arena.

74 Most commentators do however accept that in general the ACMD has been over its life largely independent, systematic, objective and comprehensive in the way it has gone about its business. Some point to the international recognition it has achieved as a model of good practice. For these commentators the ACMD has done well to maintain a broad consensus throughout its existence on issues where there are fundamentally differing political, ideological or moral positions held.[22].

75 In terms of advice on wider issues, the record is largely positive although as noted earlier in some cases it is not clear how far implementation of recommendations accepted in principle was carried through into action on the ground. Particularly influential reports included The Treatment and Rehabilitation Report, the HIV/AIDS Reviews, the series of Reports on the Criminal Justice System, Hidden Harms and the Pathways to Problems (copies of most past reports can be downloaded from the ACMD web pages). Even where ACMD reports may have been unpalatable to government at the time, they have helped to create fresh thinking, for example the ACMD's work on AIDS.

76 Some of the divergent views on the ACMD stem from differing expectations. In 1971 when the Act was passed the ACMD filled a gap in an under-developed policy market. Now there are many more official and voluntary sector advisory bodies with a stake in the subject with which the ACMD needs to liaise and work. There is the National Treatment Agency for Substance Misuse. There is also the Sentencing Guidelines Council that will be concerned with the guideline penalties, and aggravating and mitigating factors for sentencing for drugs offences and drug related crime. There are new international bodies, processes and requirements that impact on the ACMD's work and that have to be taken into account. And government has expanded its drugs policy capability, including briefly having a 'Drugs Czar' in the Cabinet Office and an Inter-departmental

[21] BBC News, 6 December, *Politics v Science, Yet Again*, http://www.bbc.co.uk/blogs/thereporters/markeaston/2010/12/politics_v_science_yet_again.html, accessed 6 December 2010

[22] The only classification recommendations that were not accepted and acted upon by government were in 1978 (Cannabis from B to C) and 2009 (Cannabis to stay at C and Ecstasy from A to B)

Ministerial Group on Drugs chaired by the relevant Home Office minister, which still meets. As noted earlier, I consider it sensible for the Home Secretary with the Health Secretary (and in future, possibly also the Communities and Local Government Secretary) to give the ACMD guidance on where their advice would be most likely to add value to other work being commissioned by government. The ACMD can then adjust its programme and, in addition to meeting specific remits from the government under the 1971 MDA, the ACMD should not shrink from continuing to fulfill its duty of providing to government independent advice on its own initiative, including those times when the advice may not initially be particularly welcome.

77 The wide spectrum of expertise on the ACMD is considered a strength, with ACMD reports bringing all evidence into the open in a disciplined and rigorous manner. The fact that the ACMD, as an organisation independent of government, examines evidence carefully and demonstrably takes it seriously, should be seen as helpful to government given the polarised nature of public views on the subject and the strong views held by many stakeholders.

78 I conclude that the ACMD has been effective within the resources made available in fulfilling its statutory remit of providing independent advice on the harms caused by the misuse of drugs. It represents excellent value for money. In particular, for as long as the 1971 Act framework remains, the ACMD represents an essential authoritative cost-effective source of scientific advice on the classification of substances.

Acknowledgments

79 I am very grateful to Dr Iain Williams for assisting me with this review, and to Professor Les Iversen, the Interim Chair of the ACMD and to Will Reynolds, the Secretary of the ACMD, for giving so generously of their time in discussing their experience of the work of the committee and in providing background information.

Sir David Omand GCB
Visiting Professor, King's College London
December 2010

Terms of Reference of the ACMD

From the Misuse of Drugs Act 1971, Chapter 38

"(1) There shall be constituted in accordance with Schedule 1 to this Act an Advisory Council on the Misuse of Drugs…

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

(3) It shall also be the duty of the Advisory Council to consider any matter relating to drug dependence or the misuse of drugs which may be referred

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

Schedule 1 of the MDA 1971 states:

"Constitution etc of Advisory Council on the Misuse of Drugs

1.

(1) The members of the Advisory Council, of whom there shall be not less than twenty, shall be appointed by the Secretary of State after consultation with such organisations as he considers appropriate, and shall include:

(a) in relation to each of the activities specified in sub-paragraph (2) below, at least one person appearing to the Secretary of State to have wide and recent experience of that activity; and

(b) persona appearing to the Secretary of State to have wide and recent experience of social problems connected with the misuse of drugs.

(2) The activities referred to in sub-paragraph (1)(a) are-

(a) the practice of medicine (other than veterinary medicine)

Members of the Advisory Council on the Misuse of Drugs

(as at December 2010)

Members	Appointed	term end	Sector
Dr Dima **Abdulrahim**	01-Jan-02	**01/01/2011**	NHS
Dr Margaret **Birtwistle**	01-Jan-02	**01/01/2011**	GP
Ms Carmel **Clancy**	01-Jan-02	**01/01/2011**	Principal Lecturer in Mental Health and Addiction
Professor llana **Crome**	01-Jan-02	**01/01/2011**	Professor of Addiction Psychiatry
Ms Robyn **Doran**	01-Jan-02	**01/01/2011**	Mental Health Nurse/Service Director
Mr Trevor **Pearce**	01-Jan-02	**01/01/2011**	SOCA
Dr Mary **Rowlands**	01-Jan-02	**01/01/2011**	Consultant Psychiatrist
Ms Monique **Tomlinson**	01-Jan-02	**01/01/2011**	Freelance Consultant in drug misuse
Lord Victor **Adebowale**	01-Jan-02	**01/01/2011**	Charity Turning Point
Mr Martin **Barnes**	01-Dec-04	**01/01/2011**	Charity Drugscope
Mr Arthur **Wing**	01-Dec-04	**01/01/2011**	Director of Interventions Surrey & Sussex Probation Trust
Mr Howard **Roberts**	01-Dec-04	**01/01/2011**	Retired Deputy Chief Constable
Ms Caroline **Healy**	01-Dec-04	**01/01/2011**	Children's Service Adviser
Professor Leslie **Iversen**	01-Dec-04	**01/01/2011**	Professor of Pharmacology
Mr Patrick **Hargreaves**	01-Oct-05	**01/01/2011**	Advisor for Drugs and Alcohol
Commander Simon **Bray**	01-Jan-08	**01/01/2011**	Commander / Metropolitan Police
Mr David **Liddell**	01-Jan-08	**01/01/2011**	Director of Scottish Drugs Forum
District Judge Justin **Philips**	01-Jan-08	**01/01/2011**	District Judge / Magistrate's Courts
Mr Richard **Phillips**	01-Jan-08	**01/01/2011**	Independent Consultant
Dr Fiona **Measham**	01-Jan-09	**31/12/2011**	Social Scientist
Mrs Gillian **Arr-Jones**	26-Mar-10	**25/03/2013**	Pharmacist/Care Quality Commission
Professor **Simon Gibbons**	26-Mar-10	**25/03/2013**	Chemist
Mr Hew **Matthewson**	26-Mar-10	**25/03/2013**	Dentist
Dr Roger **Brimblecombe**	07-Jun-10	**06/06/2013**	Pharmaceutical Industry
Professor Raymond **Hill**	07-Jun-10	**06/06/2013**	Pharmacuetical Industry
Mr Graham **Parsons**	07-Jun-10	**06/06/2013**	Pharmacist
Dr Jason **Aldiss**	07-Jun-10	**06/06/2013**	Veterinary Surgeon

ANNEX C

ACMD Sub Committees and Working Groups and recent reports
(as at December 2010)[23]

Technical Committee

Working Groups

- New Psychoactive Substances Working Group (NPSWG)
- Treatment Working Group
- Polysubstance Working Group

Advice and reports: November 2009 – 2010

- Consideration of the use of foil, as an intervention, to reduce the harms of injecting heroin (Nov 2010)
- Advice on 2-DPMP ('Ivory Wave') (October 2010)
- Advice on controlled drug licence fees (October 2010)
- Response to the 2010 Drug Strategy Consultation (October 2010)
- Consideration of the Anabolic Steroids (Sep 2010)
- Advice on Amineptine (July 2010)
- Advice on Mixing Medicines in Clinical Practice (July 2010)
- Advice on Tapentadol (July 2010)
- Multi Criteria Decison Making Analysis Report (July 2010)
- Napthyl pyrovalerone analogues (including Naphyrone) Report (July 2010)
- Consideration of the Cathinones report (March 2010)
- Pathways to Problems - Follow Up report (March 2010)
- Guidelines on Scientific Analysis in Policy Making – response to Lord Drayson consultation (February 2010)
- DCSF drug guidance for schools consultation (February 2010)
- Letter to Home Secretary - Mephedrone and related Cathinones (Dec 2009)

[23] Membership of the Sub Committees can be found at http://ACMD.homeoffice.gov.uk/reference/ACMD0602.pdf

Also see Annual report (available on website).

ACMD: Home Office Costs

Approximate running costs for the ACMD were £152,000 in 2009/10. Costs were associated with the administration and provision of meeting facilities (for the ACMD and its working groups), travel and subsistence expenses of members and the recruitment of new members.

Salaries for the ACMD Secretariat are met by the Home Office. The Secretariat consists of staff provided as part of the Home Office Science Secretariat.

ANNEX E

List of views obtained and submissions received

Jim Dobbin MP
Dame Ruth Runciman and Roger Howard, UK Drugs Policy Commission
Professor Andrew Parrott, Swansea University
Professor David Nutt, ex-Chair of the ACMD
Professor Woody Caan, Department of Child and Family Health, Anglia Ruskin University
Kathy Gyngell, chair of the Prisons and Addiction Forum, Centre for Policy Studies
Steve Rolles, Transform Drug Policy Federation
David Raynes, Executive Councillor, National Drug Prevention Alliance UK
Darryl Bickler, Drug Equality Alliance
Casey William Hardison
Mary Brett, former vice-President of Eurad (Europe Against Drugs)
Kenneth Hamer, lawyer

The Interim Chair and members of the ACMD
Will Reynolds, Secretary of the ACMD
Professor John Beddington, Government Chief Scientific Adviser
Professor Paul Wiles, formerly Home Office Chief Scientific Adviser
Professor Bernard Silverman, Home Office Chief Scientific Adviser
Home Office policy officials
Department of Health policy officials

Principal Conclusions and Recommendations

1. The ACMD has been effective within the resources made available in fulfilling its statutory remit of providing independent advice on the harms caused by the misuse of drugs. It represents excellent value for money. In particular, for as long as the 1971 Act framework remains, the ACMD represents an essential authoritative cost-effective source of scientific advice on the classification of substances. (para 79). In addition to meeting specific remits from the government, the ACMD should not shrink from continuing to fulfill its duty under the 1971 MDA provisions of providing on its own initiative independent advice to government, including on those occasions when the advice may not initially be particularly welcome. (para 77) This need must be accommodated in the ACMD work programme. (para 46)

2. Ministers have a duty to give the most careful consideration to the advice they receive from the ACMD under the 1971 MDA and to be guided by it unless there are overriding reasons to the contrary, and to explain their reasons to Parliament should they be unable to accept the advice. (para 25) Ministers should make decisions on ACMD recommendations within a reasonable time (6 weeks is suggested), or if this is not possible inform the ACMD of the reasons. (para 59)

3. The ACMD Secretary should establish with Home Office and other departmental policy units a procedure for tracking the follow-up to ACMD recommendations and a reporting mechanism to the ACMD. (para 60)

4. The ACMD should be governed by the new 'Code of Practice' for Government Science Advisory Committees. (para 17)

5. The ACMD should continue to provide a mix of independent scientific and expert practitioner based advice in meeting its remit under the 1971 MDA. (para 19). The composition of the ACMD should reflect this mix.

6. Consequent on the amendment to the 1971 MDA being passed, the need for appropriate scientific representation on the ACMD should instead be included in the revised 'Ways of Working Document' to be agreed between the Home Secretary and the chair of the ACMD. (para 50). The Document should incorporate the previous understandings by the Government that it would respect the special status of the ACMD's advice under its statutory remit (para 19), and that it upholds the independence of scientific advice and academic freedom and would not prejudge the ACMD's advice in advance of receiving and considering a report. (paras 18 and 31). The

Document must also specifically describe the future arrangements for consulting the ACMD and seeking advice in relation to the Temporary Banning Power. (para 65)

7. The ACMD should continue to identify where there are any relevant differences of scientific and expert opinion in their reports. (para 16)

8. Where the Government is minded not to accept or to amend a recommendation from the ACMD then the chair of the ACMD should be informed in advance to allow a discussion to take place between the chair and Home Secretary before a final decision is taken (para 21). This should be done by the Home Secretary writing to the full Council setting out the Government's reasons ahead of any public comment on the matter. (para 22). Ministers should then make their reasoning public (para 22).

9. The Coalition Government should provide the ACMD with a coordinated set of priorities, whilst respecting the independence of the ACMD to carry out work and to submit advice under its statutory authority, including in relation to new emerging harms. (para 45)

10. The choice of which standing committees to set up should be a matter for the new chair of the ACMD to consider when appointed. I do not see interdiction and law enforcement areas as a current priority for the ACMD, but it would help the ACMD if the government were to confirm this in their statement of priorities for the future ACMD work programme and to indicate how alternatively they plan to obtain independent advice to guide their drugs strategy in these areas if not from the ACMD. (para 46)

11. The Home Office should review the level of secretariat support for the ACMD and ensure that it is sufficient to allow the ACMD to meet their priorities and to discharge its responsibility under the 1971 MDA.

12. Home Office Ministers and officials should develop further the relationship with the Department of Health, and other relevant Departments such as DCLG, in sponsoring and supporting the work of the ACMD. (para 62) The Department of Health should be invited to provide an Assistant Secretary for the ACMD. (para 44)

13. The processes of the ACMD are generally fit for purpose. (paras 27-29) The ACMD should continue to publish its advice concurrent with its presentation to Ministers (unless there are good public health, or other, reasons for not doing so). (para 31)

14. The ACMD should agree annually a three year rolling programme of work aligned to the financial year, and the chair should use this as the basis for an annual discussion with the Home Secretary. (para 47) The work programme should be placed on the ACMD web site.

15. The new chair of the ACMD should, when appointed, consider whether there should be standing committees on criminal justice and prevention aspects of drug harm reduction. (para 30)

16. The ACMD web pages hosted on the Home Office site should be redesigned so as to emphasise the independent status of the ACMD. (para 33). The web pages should give the full terms of reference of the ACMD, and be kept up to date with the minutes, the current work programme and organization of working groups of the ACMD. The ACMD Secretary should maintain a standing register of members' interests and place this on the ACMD web-site. (para 28)

17. The ACMD should continue its practice of holding open sessions (para 34) but should not, itself, attempt to run programmes of targeted public information on drug harms or attempt to engage directly in general public education. It should, however, interpret its remit as including advising government on the adequacy of the efforts of others as part of its general advisory remit. (para 34)

18. In the interests of economy, the ACMD should continue to look to the Home Office for assistance with professional government information services including in support of the publication of ACMD reports. The 'Ways of Working' document should, however, include an agreed statement that Home Office press officers thus engaged on ACMD business will look to the ACMD chair and secretary for operational direction.

19. The interdepartmental Drug Strategy Research Group should consider as a matter of urgency how best to ensure the necessary funding of research following Temporary Banning Power, and generally to support the work of the ACMD. (paras 67-69)