ACMD

Advisory Council on the Misuse of Drugs

Standard Operating Procedure for using evidence in ACMD reports

Intended purpose of this Standard Operating Procedure

This Standard Operating Procedure (SOP) is a central document developed by the Advisory Council on the Misuse of Drugs (ACMD) to allow the Council to follow a consistent mechanism to prepare evidence-based advice.

This document describes the process by which the ACMD collects, analyses, summarises and presents different types of evidence in a consistent and transparent manner to lead to the formulation of recommendations.

Chapter 1: Identifying and approving a report theme

Proposals for new ACMD projects should follow a consistent mechanism of being considered and approved centrally by the ACMD Full Council before being taken forward by an ACMD Standing Committee or working group. This will ensure that the projects are governed by the ACMD Full Council and will allow ACMD members to contribute to the scope of the proposed areas of work.

1. Identifying the scope of a new report

- The origin of the report needs to be stated, i.e. whether this was commissioned by Government, or self-commissioned by the ACMD's membership.
- The scope of the report needs to be described with clear and defined questions, and an explanation of what is and is not covered within the report.

2. Process for approving the initiation of a new report

ACMD members have the opportunity to present and discuss potential proposals at away days - however, a proposal for a new project can be submitted to the ACMD Full Council for consideration via the ACMD's Secretariat at any time.

A Project Initiation Document (PID) outlining the aims of the project along with a brief description of the strength of evidence available on the topic will be presented to the ACMD's Full Council for consideration. The ACMD Full Council will then collectively decide on whether to approve the project.

Structure of an ACMD project initiation document (PID)

Proposals should include:

1. Project title

2. Topic background & key issues

3. Overview of the strength of available evidence in the area. Projects are unlikely to be approved if there is insufficient evidence upon which to draw recommendations.

4. Project aim

5. A consideration of membership, Chair and possible co-option

6. Proposed timescale for completion

7. Whether the proposal would be likely to require the commissioning of further work (if this is possible to foresee). This will help with the allocation of resources.

Chair of proposed committee/working group

Traditionally, the Chair of the chosen inquiry is the ACMD member who proposed the subject area. However, this is not always the case and members who have proposals but who are unable to Chair the group should not be discouraged from submitting a proposal.

Chapter 2: Collecting, analysing and presenting evidence

The ACMD uses evidence from a wide range of sources to develop its recommendations - examples include peer-reviewed research, published reports and expert opinion. Assessing the quality and relevance of different types of evidence is a critical part of the ACMD's work.

Collecting evidence to answer the identified questions

For each question, the working group should identify:

(i) specific keywords to help answer the question, then search appropriate databases using these keywords.

(ii) organisations/individual experts who should be approached.

Table 1: Sources of data

Sources of data	***Examples of types of data***
a) Published research literature	Peer reviewed journals
b) Conference papers/abstracts, 'grey' literature	(e.g. unpublished/not peer reviewed)
c) Evidence from Government departments and devolved administrations	(e.g. reports from Home Office, National Crime Agency, Public Health England, Department for Health and Social Care, Office for National Statistics and other datasets)
d) Evidence from other UK organisations	(e.g. NPSAD, NPIS, WEDINOS)
e) Evidence from non-UK organisations	(e.g. European Monitoring Centre for Drug and Drug Addiction including focal point)
f) Expert opinions and stakeholder opinions	
g) Other sources	(e.g. media, user fora)

Analysing evidence

Once evidence has been collected a bespoke analysis will be agreed by the Working Group. The chosen method of analysis will depend on the purpose of the report and the identified questions. The Working Group may choose to finalise the specific methodology once it is clearer what evidence is available.

The Chair of the Working Group will be responsible for deciding the methodologies used.

Presenting the quality of evidence in reports

Each ACMD report should include an appendix describing the methods used in data collection and analysis, for example:

a. Range of evidence sources;
b. Quality of evidence (design, limitations, bias);
c. Applicability to report questions;
d. Determination of causality (using for example the Bradford Hill criteria).

Where possible, the annex should discuss the strength of the evidence supporting individual recommendations.

Presenting recommendations

Each ACMD report should include specific and targeted recommendations, including:

a) Who the recommendation is intended for;
b) A measure of implementation (i.e. likely indicators to show that the recommendation has been carried out);
c) Metrics for assessing the intended effect (i.e. how one could measure the intended (or unintended) effect of the recommendation).

- Identified gaps in evidence (or where there is weak or contradictory evidence) should be highlighted and where appropriate, a recommendation for further research made.

Quality assurance for ACMD reports

The ACMD's secretariat will be responsible for undertaking a quality assurance step prior to final draft advice being presented to ACMD Full Council for approval. At this stage of the approval process, the Secretariat will detail the quality assurance process followed for the report to the ACMD Chair and the respective committee/working group chair(s).

Checklist for ACMD projects

a) Has the scope of the workstream been identified?
b) Has the Working Group agreed the terms of reference with clearly defined questions that need to be answered?
c) Has the collected evidence answered the identified questions?
d) Does the report include in the annex:
   - a description of the methods used in data collection, search criteria and analysis?
   - the organisations and experts approached?
e) Has the methodology for analysing the evidence changed as a result of the evidence?
f) Does the report clearly state the sources of the data and types of data?
g) Do each of the recommendations indicate the strength of evidence?

Chapter 3: Consideration of health and social harms

Introduction

This summary outlines the process the ACMD follows for assessing the health harms and social harms associated with a drug when developing recommendations.

All ACMD reports which assess the overall harms of a drug should use the health harms matrix (Table 2) and social harms matrix (Table 3) to consider and identify potential harms across a range of domains to inform that assessment. The matrices are not intended to be prescriptive but instead provide a relatively simple mechanism to ensure that drug-related health and social harms are described comprehensively and consistently, to support literature searching, evidence review and decision making.

Health harms are classified by health professionals using a range of different approaches. These metrics include type of harm (physical versus psychiatric), time of occurrence (acute versus chronic), body system involved (e.g. cardiovascular, respiratory) and disease process (e.g. infection, trauma).

Social harms may emerge as a direct consequence of drug use or indirectly from drug use or through policy and enforcement responses to drug use. Many of these harms are predictable, but others may be unexpected and/or unintended.

Part of the complexity of describing drug-related harm is that it can occur across multiple systems and with poorly understood underlying mechanisms. The distinction between a health harm and a social harm is not always very clear. Many drugs will cause harms across several harm domains.

Drug-related harm may also be experienced by those who are not using drugs themselves. Relatives, friends, the wider community and the environment are examples. These have been described in the matrices under the section ‘harm to others’.

Definitions

For the purposes of ACMD’s work:

Health harms can be defined as “a negative effect on health resulting from drug use, whether direct or indirect”.

Social harms can be defined as “damages to human welfare, security and autonomy that occur in the relations between individuals, communities and institutions of society”.

There are multiple bearers of drug-related harm. These should be identified in reports and are broadly categorised as:

- The individual who uses drugs;
- Others affected by drug use, such as family and peers;
- Communities and social structures.

Methodology and development of the matrices

Two working groups of the ACMD developed the matrices for health harms and social harms, having considered the methodologies utilised for assessing both.

The methodology for assessing health harms reviewed existing work already carried out in this area, existing models and frameworks, including classifications used by the National Institute for Health and Care Excellence (NICE), the Medicines and Healthcare products Regulatory Agency (MHRA), Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5 (APA, 2013)) and International Statistical Classification of Diseases and Related Health Problems (ICD 10/11 (WHO,1992; WHO, 2018)). None were suitable for the needs of the ACMD and were not able to encompass the range of harms a drug could cause to an individual or others.

We also considered other ways which drug harms have been considered such as the "multi criteria decision analysis model" (Nutt, 2010) but again this set out to compare drug harms and rank harm which is not the goal of the ACMD's work.

The methodology for assessing social harms has been adapted from the work of Greenfield and Paoli (2013) on the assessment of the harms of crime, and the EMCDDA (2009) operating guidelines on the risk assessment of new psychoactive substances.

The properties of a drug and characteristics of the user

It is useful to consider factors related to (1) the drug's properties and (2) characteristics of the drug users.

Drug properties

- Routes of administration
- Dose
- Potency
- Purity and risks of adulteration
- Frequency of use
- Pattern of use
- Length of use
- Potential for dependence
- Potential interactions with other drugs/alcohol

Characteristics of the drug user

- Age
- Sex
- Physical health (e.g. liver and renal function, underlying heart or lung disease)
- Psychiatric/psychological health (e.g. depressive episode)
- Social health (e.g. disrupted social networks)
- Genetic factors (e.g. vulnerability to drug dependence)

Presenting conclusions

Through structured discussion, a subjective conclusion on overall harm should be drawn by an ACMD sub-committee or working group, taking into account the domains and the bearers of the main harms identified.

Associated recommendations should be justified by indicating, where appropriate, how the recommended action is considered to reduce the identified harms. Similarly, where the report has shown that there is a risk of indirectly increasing harm through recommendations, ameliorating actions should also be identified.

The ACMD did not find any evidence that the use of formal quantification or scoring in a harms assessment was likely to be more meaningful than structured descriptions, therefore the use of harm metrics in this process is not recommended.

Health harms matrix (Table 2)

Harm domain	Harm Example	Data source example
Harms to user		
1. Physical health harms		
1.1. Mortality	acute overdose, misadventure, drug-impaired fatal road crashes	Mortality statistics (ONS NRS, NISRA, NPSAD) Coroners' reports Confidential enquiries Fatal accident inquiries
1.2. Neurological	drug-induced coma, seizures	Case reports Case series studies Service user feedback Treatment trials Clinician feedback HES data MHRA Yellow Card scheme (for licensed medicine) NPIS data Congenital anomaly registries UK Teratology Information Service
1.3. Cardiovascular	acute cardiac arrhythmias or MI, venous thrombosis from injections, health harms associated with injecting crushed tablets	
1.4. Respiratory	respiratory depression, lung disease associated with smoking drugs	
1.5. Hepatic/ gastroenterological	drug-induced hepatitis, drug-induced vomiting, constipation	
1.6. Genitourinary/ renal	ulcerative cystitis, nephropathy, drug-induced glomerulosclerosis	
1.7. Blood/ nutrition/ endocrine	clotting abnormalities, drug-induced disseminated intravascular coagulation, drug-induced SIADH, indirect nutritional deficiencies	
1.8. Reproductive	early labour, adverse foetal effects of drug use, testicular atrophy	
1.9. Musculoskeletal	drug-induced rhabdomyolysis	
1.10. Immunological	immunosuppression	
1.11. Ear, Nose & Throat (ENT)	septal damage from drug snorting	
1.12. Dermatological / dental	skin abscess and necrosis secondary to injecting, oral cancer, dental decay from long-term drug use	

1.13. Multiple	issues related to repeated non-lethal overdoses, health harms related due to routes of administration covering direct and indirect effects (e.g. blood-borne virus)	
2. Mental health harms		
2.1. Intoxication		Case reports Case series studies Service user feedback Treatment trials Clinician feedback HES data MHRA Yellow Card scheme (for licensed medicine) NPIS data
2.2. Delirium	acute confusional states	
2.3. Psychosis	drug induced psychosis, persecutory thinking	
2.4. Mood disorders	including suicide risk	
2.5. Memory disorder	dementia and other memory deficits, short term memory loss, cognitive impairment	
2.6. Anxiety		
2.7. Psychological dependence and addiction	Including tolerance, withdrawal symptoms and craving	
Harms to others		
3. Physical health harms		
3.1. Infective process	blood borne virus (BBV) transmission	Surveys of BBV Public Health England and Devolved Administrations
3.2. Other physical harms to others	road traffic accidents whilst intoxicated, violence whilst intoxicated	Department for Transport

Social harms matrix (Table 3)

Harm domain	Notes and examples	Notes on data sources
Harms to User		
4. Loss of tangibles		
4.1. Education	including exclusion from education, educational disengagement, and under achievement (qualifications)	Drug and alcohol related permanent and fixed period pupil exclusions (DfE; Devolved Administrations)
4.2. Employment	including loss of employment; lack of and under-employment; loss of income and low wages; and tangible losses through workplace discrimination (identification as a person who uses drugs)	UK labour market data does not include reason for loss of employment. Organisations such as the Health and Safety Executive, Unions, employers' associations and sector bodies occasionally publish the findings

		of surveys and enquiries into substance use in the workplace
4.3. Housing	Loss of accommodation as a direct or indirect consequence of drug use, including loss of employment, imprisonment or break down in relationships	Ministry of Housing, Communities and Local Government homelessness statistics; PHE drug treatment (and equivalent bodies in devolved administrations) includes data on housing status; homelessness and housing charities/third sector organisations, and housing associations periodically commission research into this topic.
4.4. Crime	direct harms may include loss of autonomy and liberty as a result of sanctions (e.g. imprisonment, supervision orders, licence conditions), whilst indirect harms may include loss of other tangibles (e.g. employment, housing, travel) as a result of disclosure of penalties (e.g. imprisonment, police/court caution). There may also be secondary escalation of criminality (and drug use) through involvement in criminal justice system. This category also includes harms related to being a victim of drug-related crime.	Ministry of Justice (and equivalent bodies in devolved administration) datasets on arrests for recorded crime, prison population; local analyses of orders including DTTO, DRR; bespoke analyses of NDTMS; nature of crime Module from the CSEW ('the victim believed the perpetrator(s) to be under the influence of drugs')
5. *Loss of relationships*		
5.1. Personal relationships	Loss of relationships with children and other family members, friends and social support networks and the wider community. As positive social relationships are considered important forms of social capital and a component of recovery capital, loss of these may compound drug-related harm. Similarly, a narrowing of social relationships and social identity around drug-use may promote harm.	Public Health England Profiles (indicator Parents in drug treatment (rate per 100,000 children aged 0-15))
6. Other harms to the user		
6.1. Sexual exploitation and violence	Including exploitative sex work to pay for drugs, sexual violence, and human trafficking. Children and young people may	HO Annual report on modern slavery; PHE young people treatment data on service users reporting experiencing sexual

	be provided with drugs as part of sexual exploitation practices by adults, involvement in 'county lines'	exploitation; Sexual violence and grooming data (MoJ recorded crime data) does not include breakdown by offences related to substance use; NSPCC annual reports on child safety may include exploitation themes; Barnardo's reports.
6.2. Stigmatisation	Stigmatisation may lead to prejudice and discriminatory practice and behaviour towards both people who use drugs and associated groups (e.g. siblings, children of people who use drugs). This can lead to negative (self) labelling, prejudice, exclusion, and discrimination, which may undermine the provision, access, and the quality of support, and which serves to reproduce and reinforce broader health and social inequity.	Scottish Government Public attitudes towards people with drug dependence and people in recovery research 2016. Stigma frameworks (Stangl et al, 2019) can assist in identifying relevant domains for analysis; Social Media review/ survey.
Harms to others		
7. Injury		
7.1. Violence (general)	Including psychopharmacological, economic-compulsive, and systemic violence	Nature of crime Module from the CSEW ('the victim believed the perpetrator(s) to be under the influence of drugs'); Offending, Crime and Justice Survey
7.2. Intimate partner violence	Including harm resulting from aggression, sexual coercion, psychological abuse and controlling behaviours	Intimate violence Module from the CSEW - victims of partner abuse in the last year are asked whether they thought the offender (or offenders) was under the influence of alcohol or illicit drugs at the time of the incident. In addition, they are asked whether they (the victim) were under the influence of alcohol or illicit drugs at the time of the incident.
8. Accidents		
8.1. Traffic *8.2. Industrial* *8.3. Personal*	Including harms related to fatal and non-fatal accidents, property damage, loss of earnings, social costs of injury direct costs (e.g. emergency and health services, courts, traffic delay expenses)	Ministry of Justice (and equivalent bodies in devolved administration) datasets on arrests for recorded crime; Department for Transport Reported Road Casualties Great Britain self-reported drug driving tables; British Social Attitudes

		Survey; NatCen Omnibus Survey Driver behaviour Module; DVLA data on number of individuals who have been disqualified from driving after a drug-driving offence; Health and Safety Executive (HSE)
8.4. Foetal harm	Long term social harms to children resulting from pre-natal effects of drugs, poor maternal health and wellbeing during pregnancy, or harmful environments during pregnancy. These are distinct from developmental harms	
8.5. Developmental	Including family adversity, economic and emotional wellbeing, and harms resulting from adverse childhood experiences (ACEs) directly and indirectly related to parental/family drug use. Indirect adverse childhood experiences include physical abuse; sexual abuse; emotional abuse; physical neglect; emotional neglect; witnessing intimate partner violence; household mental illness; parental separation or divorce; imprisoned household member. ACEs may cluster and they have been associated with substance use, and behavioural and social problems later in life (including economic costs)	Local routine ACE enquiry data; National ACE Survey Public Health Wales
8.6. Crime against others	Social harms to victim of crime; loss of economic support for family members; increase in acquisitive crime, growth in serious and organised crime, fear of crime leading to a loss in confidence in formal criminal justice structures; fraud and money laundering; corruptions of public official and public office	Ministry of Justice (and equivalent bodies in devolved administration) datasets on arrests for recorded crime; Nature of crime Module from the CSEW ('the victim believed the perpetrator(s) to be under the influence of drugs'); Offending, Crime and Justice Survey
8.7. Environmental damage	Harms resulting from the production of drugs including environmental contamination, deforestation, land (re)appropriation, and	

	unsustainable agricultural and production practices	
8.8. Economic costs to society	Including costs from reduced productivity, loss of productive life years; healthcare; police; prisons; probation; courts; crown prosecution service; implementation of legislation; social services; customs; insurance; societal and personal costs of victims of crime	Academic papers; Government reports
8.9. Community costs	Harms resulting from the impact of drug use, drug markets, and legislative responses on social cohesion, community reputation, perceptions of community safety, and stigmatisation	Local authority Land and Environmental Services routinely collect data on call out responses for needle pickups. These trends give a useful proxy measure of public nuisance associated with drug related litter. National and local trading Standards.
8.10. Global harms	Harms that are borne by producer and transit countries because of drug use in consumer countries and global legislative responses. These include all of the harms described in other categories, destabilisation of government, economies and infrastructure; violent conflict; exploitation and people trafficking. These are harms that may disrupt achievement of the goals of the UN's 2030 Agenda for Sustainable Development	Sustainable Development Goal Indicators (ONS; 2030 Agenda for Sustainable Development) Information from the World Health Organisation and UNODC.

Chapter 4: Scheduling SOP

Definitions of Schedules of the Misuse of Drugs Regulations (MDR) 2001

Schedule 1*: Drugs in Schedule 1 do not have a UK marketing authorisation as a medicine and may not therefore lawfully be prescribed, except under a Home Office Licence. They do not usually have any legitimate medicinal**, veterinary*** or non-medicinal**** use. Compounds in Schedule 1 may lack supporting safety data and/or have a high potential for abuse or physical harm such that the highest level of restrictions or control are considered necessary.

Schedule 2: Drugs in Schedule 2 have demonstrated medicinal or veterinary use but have the greatest risk of abuse, dependence and/or physical harm in the absence of restrictions on their availability. The risk of diversion from legitimate use is very high in the absence of controls over importation/exportation, possession, storage, prescribing and supply. All drugs within Schedule 2 must be stored according to Safe Custody requirements.

Schedule 3: Drugs in Schedule 3 may lead to moderate or low degrees of physical dependence. They are generally less likely to cause physical harm than drugs in Schedule 2. Risk of diversion from legitimate use is moderate or high in the absence of controls over importation/exportation, possession, storage, prescribing and supply. A subset of Schedule 3 drugs is exempt from Safe Custody requirements as a result of having a lower risk of diversion and/or for reasons of operational practicality.

Schedule 4 (Part I): Drugs in Schedule 4 (Part I) – historically but not exclusively from the benzodiazepine class – are usually considered to be associated with a lower risk of physical dependence and a lower potential for misuse than drugs in Schedule 3. The risk of diversion is moderate in the absence of controls over importation/exportation, or in the absence of controls over possession, prescribing and supply. Drugs in Schedule 4 (Part I) are exempt from Safe Custody requirements as a result of having a lower risk of diversion.

Schedule 4 (Part II): Drugs in Schedule 4 (Part II) are mostly anabolic steroids, growth hormones and nonsteroidal anabolic agents. They are exempted from the prohibition on possession. They are also excluded from the application of offences arising from the prohibition on importation or exportation when imported or exported in person by that person for administration to him or herself.

Schedule 5: Preparations in Schedule 5 are differentiated from every other Schedule as they are characterised by their formulation – they are low concentration or low strength preparations of compounds scheduled elsewhere. The Controlled Drug has a concentration level or total amount per dosage unit set a specified maximum and/or is compounded with another material so as to prevent recovery or misuse of the active compound. Because of their formulation, Schedule 5 preparations are considered to have the lowest potential for misuse, the lowest risk of physical dependence and the lowest risk of diversion.

Schedule 5 preparations are exempted from the prohibition on importation, exportation and possession and are subject to only limited record-keeping requirements. The destruction of Controlled Drugs requirements do not apply. They are the only Scheduled preparations that may be classified as Pharmacy Only Medicines. When classified as Prescription Only Medicines, the duration of validity of prescriptions is not restricted to 28 days, as it is for other Scheduled drugs.

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Notes

**** Recommendations for Schedule 1 of the MDR may require an additional clarification under the Misuse of Drugs (Designation) Order 2015.***

Misuse of Drugs (Designation) (England, Wales and Scotland) Order 2015

The clauses of Section 7(3) of the Misuse of Drugs Act 1971 permit medical use of Controlled Drugs, subject to Regulations, unless this is specifically outlawed by Section 7(4). The 2015 Designation Order and its amendments list the materials which are covered by Section 7(4).

Within the Designation Order, Part 1 of Schedule 1 specifies which materials are affected by reproducing the wording of the relevant control clauses of the MDA/MDR.

As these include some generic controls, the scope of which covers legitimate medical pharmaceuticals, there is also a Part 2 of the Schedule which lists particular materials to be exempted from the Part 1 control so that they can remain available for medical use.

*****the Human Medicines Regulation defines a 'medicinal product' as:***

a) any substance or combination of substances presented as having properties of preventing or treating disease in human beings; or

(b) any substance or combination of substances that may be used by or administered to human beings with a view to—
(i) restoring, correcting or modifying a physiological function by exerting a pharmacological, immunological or metabolic action, or
(ii) making a medical diagnosis.

******the Veterinary Medicines Directorate (VMD) has noted that a Veterinary Medicinal Product (VMP) is legally defined as:***

- *any substance or combination of substances presented as having properties for treating or preventing disease in animals*
- *any substance or combination of substances that may be used in, or administered to, animals with a view either to restoring, correcting or modifying physiological functions by exerting a pharmacological, immunological or metabolic action, or to making a medical diagnosis*

******* Non-medicinal use could include, for example, usage in industry or agriculture***

Factors to consider in scheduling decisions

1. **International control** – is the UK, as a signatory to the UN International Drug Control Conventions, obliged to control the drug? If so, what level of control is mandated by the drug's scheduling under these conventions?

   Consider that the UK usually follows international scheduling decisions.

2. **Status as a medicine** in humans or animals – does the drug have a UK Marketing Authorisation, or is it permitted to be manufactured as a pharmaceutical Special?

   Consider that drugs without UK Marketing Authorisation will usually be placed in Schedule 1.

3. **Use in industry, agriculture, cosmetics** – is the drug used in these or any other non-medical/veterinary fields?

   Consider the ramifications of scheduling on the use of such compounds in commercial, non-medicinal environments.

4. **Classification under the Misuse of Drugs Act** – is the drug currently classified under the MDA or is it likely to be?

   Consider that there are some broad conventions in respect to classification. Class A and B drugs tend to be in Schedules 1 and 2. Class C drugs tend to be in Schedules 3 and 4 (Parts I and II).

5. **Safety** – is safety established in short- and medium-term clinical trials and in post marketing surveillance? Is knowledge of safety derived only from observation of illicit use? How safe is the drug known to be?

   Consider that lack of knowledge of safety usually means that drugs are placed in Schedule 1. Where safety is known, consider that the dangers presented by the drug contribute to the determination of its listing in Schedules 2, 3 or 4; the most dangerous (in respect to adverse effects in clinical use and overdose

potential and mortality) being placed in Schedule 2 and the least in Schedule 4.

6. **Toxicity** – is the acute, chronic and overdose toxicity known? How dangerous is the drug in respect to physical and mental health?

   Consider that the toxicity of the drug contributes to the determination of its listing in Schedules 2, 3 or 4; the most dangerous being placed in Schedule 2 and the least in Schedule 4. Factors to consider in determining dangerousness include clinical tolerability, medium and long-term adverse effects and overdose toxicity

7. **Behavioural effects** – what is known of the effect of the drug on behaviour? Is the drug known to provoke dangerous, impulsive or aggressive actions?

   Consider that the behavioural toxicity of the drug contributes to the determination of its listing in Schedules 2, 3 or 4; the most toxic being placed in Schedule 2 and the least in Schedule 4.

8. **Dependence potential** – how readily do people become dependent on the drug? Is the drug physically or psychologically addictive, or both? Is the drug prone to misuse? What is known about antisocial or criminal behaviours associated with the drug or with drug-seeking behaviour? What is the likelihood of recovery from dependence on the drug? How unpleasant and physically dangerous is withdrawal from the drug?

   Consider that the dependence potential and dependence severity of the drug contribute to the determination of its listing in Schedules 2, 3 or 4; the most addictive being placed in Schedule 2 and the least in Schedule 4.

9. **Diversion potential** – How likely are people to attempt to obtain the drug by diversion from legitimate sources, for personal use or to sell on?

   Consider that the diversion potential of the drug contributes to the determination of its listing in Schedules 2, 3 or 4. Safe custody requirements of the different schedules should be appropriate to the potential for diversion

10. The need for **controls on importation/exportation** – do the above factors mean that importation should be controlled so as to limit, identify, and allow seizure of shipments of the drug? How likely are people to attempt to obtain the drug by importation, for personal use or to sell on? How likely are people to attempt to profit from the exportation of the drug?

    Consider that the potential for uncontrolled import/export of the drug contributes to the determination of its listing in Schedules 2, 3 or 4. Controls on import/export of the different schedules should be appropriate to the potential for import/export.

    Consider that possession, importation, and exportation of drugs in Schedules 2, 3 and 4 Part I are offences under the Misuse of Drugs Act. There is no possession offence for drugs in Schedules 4 Part II and Schedule 5, and there is no importation/exportation offence for drugs in Schedule 5.

    Importation/exportation of drugs in Schedule 4 Part II is not an offence where the importation/exportation is carried out in person for administration to that person. However, unaccompanied importation (e.g. on-line purchases) and importing with intent to supply is still an offence. Most drugs in Schedule 4 Part II are typically Class C drugs. The exemption from possession (for personal use) regulations for Schedule 4 Part II drugs makes controls over importation/exportation of singular importance.

    Consider, the likely effects of criminalisation and the need for control on importation/exportation via on-line orders? Would the absence of a possession offence (alongside public health measure) be more effective than criminalising users? How likely are people to attempt to obtain the drug by importation via on-line purchases? How likely are people to attempt to profit from the exportation of the drug via on-line sales?”

11. Is the medicine **prescribed widely or frequently**, or is there likely to be a requirement for immediate accessibility, such that restrictions on storage or supply could cause important operational problems?

    Consider that the factors listed above and below need to be balanced against operational needs in practice.

12. **Chemical structure and pharmacological action** of the drug – is the drug a benzodiazepine and/or benzodiazepine receptor agonist? Is the drug an anabolic steroid; does it have anabolic properties?

    Consider that historically benzodiazepines (with some exceptions) have been placed in Schedule 4 part 1, and anabolic steroids in Schedule 4 part II.

13. **Formulation** of the drug – is the drug a low-concentration or low-dose formulation of a Controlled Drug? Can the Controlled Drug element of the compounded formulation product be easily separated from other ingredients?

    Consider that low-concentration or low dose formulations may be placed in Schedule 5 when risks of dependence, toxicity and diversion are considered to be so low as to require minimal control over supply, storage and record keeping.

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