Review of the UK's Drugs Classification System - a Public Consultation.

Home Office
Crime and Drug Strategy Directorate
May 2006

[Note (May 2010): This a draft of a consultation paper which was not, in fact, approved for publication in 2006. The draft, with some passages redacted, is being released under Freedom of Information Legislation.]

CONTENTS

Ministerial Foreword

<redacted>

Purpose of the Review

<redacted>

Consultation

You may wish to respond to some of the basic issues in this consultation along the lines of the following questions:

<redacted>

Historical Background

3.1 Drug legislation in the UK has been developing since the first Dangerous Drugs Act in 1920. The principles of drug laws have been broadly the same; to drive down misuse by imposing penalties on supply and possession. Regulations are also in place to permit health professionals appropriate access to drugs that have proven medical use.

3.2 Imposing penalties on the offence of possession is intended to deter use, particularly experimentation by young people. It can be argued that the deterrent effect may not be as strong as it was in the past but illegality is still an important factor when people are considering engaging in risk taking behaviour.

3.3 Drug laws have evolved so a greater emphasis and greater penalties are imposed on those supplying drugs rather than individuals misusing them. There is general agreement that the individual who supplies drugs should be dealt with more severely than the individual who misuses drugs.

3.4 Under the Dangerous Drugs Acts of 1964 and 1967, all drug offences were treated with the same degree of seriousness. For example, cannabis and heroin possession offences attracted the same levels of penalties. Increasing pressure for reform began to build because the law did not recognise the relative harms different drugs caused and it was therefore deemed disproportionate and unfair.

3.5 The Misuse of Drugs Act 1971 sought to address the perceived inequalities by establishing a scale of harm. The Act was agreed through cross party consensus, being introduced to Parliament under a Labour Government but gaining Royal Assent in 197 1 under a Conservative Government. In introducing the legislation in 1970, the Labour Home Secretary, James Callaghan, said: "The object here is to make, so far as possible, a more sensible differentiation between drugs. It will divide them according to their accepted dangers and harmfulness in the light of current knowledge and it will provide for changes to be made in the classification in the light of new scientific knowledge."

The Three Classes

3.6 The current classification system is contained in Schedule 2 to the 1971 Act and divides all the controlled drugs into 3 Classes - A, B, and C. Since the Act came into force there have been various amendments to reflect changes in the patterns of drug use, but these have largely been to incorporate new drugs as they have emerged in society or reflect the increasing harmfulness and/or misuse of existing and previously uncontrolled drugs. There have been very few instances of drugs moving between the classes following review, with Cannabis being the most obvious example. More recent changes have included the addition of GHB in 2003 and ketamine in January 2006 as Class C drugs.

The Schedules

3.7 The Misuse of Drugs Regulations 2001 also divide controlled drugs into schedules depending on the extent of their legitimate medical use. The purpose of the schedules, which are linked to but separate from the classification system, is to set out the conditions governing the storage, administration and destruction of controlled drugs to prevent them leaking onto the illicit market. The scheduling system is explained in more detail later in this document (paragraphs 4.2 - 4.4)

The Advisory Council on the Misuse of Drugs

3.8 All changes to both the classification and scheduling systems require consultation with the Advisory Council on the Misuse of Drugs (ACMD) and Parliamentary agreement. The ACMD was also established under the 1971 Act. It is an independent non-departmental body comprising, at present, 36 experts from a variety of relevant backgrounds whose role is to advise the Government on a broad range of drug related issues.

3.9 Membership of ACMD includes expertise from the fields of police, judiciary, academics, GPs and other health care professionals such as psychiatrists, drug treatment service providers and the voluntary sector. Members are appointed by the Secretary of State in accordance with the guidance issued by the Office of the Commissioner for Public Appointments.

3.10 The ACMD has a statutory duty to keep under review the situation in the United Kingdom with respect to the misuse of drugs and to advise Ministers of the measures which they consider should be taken to deal with social problems which arise from drug misuse. In addition, the ACMD has a duty to consider any matter relating to drug dependence or misuse that may be referred to them by Ministers. The Home Secretary is obliged by law to consult the ACMD before controlling a drug, changing its classification or making regulations.

The Current Classification System and Schedules

Classification System and Penalties

4.1 The following section presents the current structure of classification. The existing three-tier classification system can be summarised in tabular form as follows, showing the main drugs within each class and the maximum penalties for possession and supply:

Class	A	B	C
Main Drugs in each class	Heroin, Cocaine (includingCrack), Methadone, Ecstasy, LSD	Amphetamines, Barbiturates, Codeine	Cannabis, Benzodiazepines (Tranquilisers), GHB, Ketamine, Anabolic Steroids
Maximum Penalty for Possession	7 years plus unlimited fine	5 Years plus unlimited fine	2 years plus unlimited fine
Maximum Penalty for Supply	Life plus unlimited fine	14 years plus unlimited fine	14 years plus unlimited fine

Note that the maximum penalty for the supply of Class C drugs was increased from 5 to 14 years at the same time cannabis was reclassified in January 2004. This measure ensured there would be no change to the penalty for supplying cannabis when the drug was moved from Class B to C.

Changes in classification and New Drugs

4.2 Drug Patterns are constantly changing which can lead the Government to act by amending a drug's classification or to bring a new drug under control. The initial source that signals the need for a change in law will vary. It may be prompted by a Ministerial request; it may be as a result of increased international controls by United Nations; or emerge following reports of increased prevalence or seizures from Government officials or Advisory Council members.

4.3 The Advisory Council has more recently established dedicated groups to carry out a complete analysis of a particular drug. The groups have been able to call upon expert evidence outside of the Advisory Council to better inform their discussion. The resulting report contains a recommendation on whether there should be a change to the controls on the particular drug. The Home Secretary will consider the content of the report carefully and meet with officials and other Ministers as necessary to discuss the merits of the case presented, as well as the potential repercussions of the proposals. If the Home Secretary is content overall with the recommendation there is a consultation paper issued and placed on the Home Office website so that all stakeholders have the opportunity to comment on the proposed change.

4.4 Subject to the responses from the consultation, the Government will proceed with the necessary legislative change. Changes to the Classes are carried out by the draft affirmative resolution procedure with an

order signed in Privy Council after debates in both Houses of Parliament.

The Schedules

4.5 A great many drugs which are known to be misused also have legitimate medicinal uses. Controlled drugs are also placed in schedules, contained in the Misuse of Drug Regulations 2001, which restrict their use according to their relative scientific and/or medicinal value. The schedules set out conditions governing their storage, administration and destruction.

4.6 The table below sets out the 5 schedules in order of controls.

Schedule	Control Level	Description	Drugs
1	High	No recognised medicinal use.	Ecstasy, LSD, cannabis
2	High	The most potent and harmful drugs that can be used clinically.	Heroin, Morphine, Cocaine
3	Medium	Lighter controls on storage and administration.	Buprenorphine Temazepam
4	Medium	Lighter controls on storage and administration. Lesser controls on prescription than schedule 3	Most tranquilisers, Ketamine, Steroids
5	Low	Contains very low levels of controlled drugs that can be bought over the counter	Kaolin and Morphine

4.7 The role and purpose of the schedules is far simpler than that of the classification system; the schedules' primary aim is to regulate and guide scientific and medical (i.e. legitimate) use and storage of drugs. Similarly, the basis or the schedules is also simpler, in that it is based on harm to health and medical use. The schedules thus represent a more purely medical/scientific logic than the classification system. They are considered in the context of international controls in section 7 of this paper.

What is the classification system for?

4.8 As previously stated, the classification system provides a framework on sentence length to the courts that differentiates penalties according to drug types and according to whether the offence was for possession or supply. It provides a long term, mechanism that reflects

the UK Government position on society's relationship to drugs, as well as a mechanism that can be revisited and revised.

4.9 The intention behind the existing approach was to create a system which was sensible and equitable reflecting the consensus that different drugs and different acts deserve different severity of response; for example it is generally accepted an offence of possession of cannabis should attract a lesser penalty than an offence of heroin supply.

4.10 It is important to have an enduring and stable mechanism for drug control to allow the Criminal Justice System in respect of drug offences to function effectively. Society needs reassurance that there is a coherent system in place to categorise drugs and determine the penalties for their possession and supply.

4.11 The classification system provides an established means (through Advisory Council on the Misuse of Drugs) for revisiting and revising the system to ensure it reflect present-day drug patterns. When a new drug becomes misused the Advisory Council are able to make a quick assessment of its harms and where it should fit in the classification system. This is important because new drugs come into fashion or are discovered our understanding of medical or social harms may change, or public and political priorities may change.

4.12 Like much legislation, the drugs classification system has secondary and tertiary impacts on society, which may not be its explicit, primary aim. It can for example send a signal about the Government's vision of society and the Government's understanding and assessment of harms associated with particular drugs (related to the seriousness of the penalty). Through sentencing, and through influencing perceptions and behaviour, classification may also impact on drug use choices, by informing the decisions of dealers and users.

4.13 Such impacts will always exist and may create a tension between intended and unintended consequences. For example, the drugs classification system may be read as a reflection purely of harm ('hard' and 'soft' drugs) by young people and thus impact on their drug choices. This is an issue to be borne in mind when considering broader communication strategies in relation to drugs policy and the public.

4.14 The drugs classification system is not a simple measure of social or medical harms caused. It takes very careful analysis from a wide range of expert sources to ensure as unbiased and objective assessment as possible.

4.15 The drugs classification system is not a suitable mechanism for regulating legal substances such as alcohol and tobacco. The distinction between legal, prescription and illegal substances is not unequivocally based on pharmacology, economic or risk benefit analysis. It is also based in large part on historical and cultural precedents. A classification system that applies to legal as well as

illegal substances would conflict with deeply embedded historical tradition and tolerance of consumption of a number of substances that alter mental functioning (ranging from caffeine to alcohol and tobaccos. Legal substances are therefore regulated through other means.

What is the classification system based on?

4.16 Classification is based on:

- Scientific knowledge (medical, social scientific, economic, risk assessment)
- Political and public knowledge (social values, political vision, historical precedent, cultural preference)

4.17 Historically, the current classification system grew out of a desire to see a fairer and proportionate approach to penalties for drug offenses. Establishing such an approach involved consideration of existing knowledge on social and medical harms, as well as political vision and an understanding of the perceptions of the public.

4.18 Public consultation and international consultation with partners, as well as understanding and assessing risks, has become increasingly important to the review of classification. Classification is increasingly based on a combination of scientific knowledge as well as political and public knowledge. The following table sets out a range of inputs into classification

Table of knowledge inputs into classification system

Knowledge type	Comment
Scientific evidence on medical harms and risks is integrated into the drugs classification system; this is always under review, as the nature and content of scientific knowledge changes.	Integrated into classification via the ACMD
Social and economic knowledge: Understanding of the social context and complexity of social harms and risks is provided through consideration of social research generally as well as the pursuit of in-house research into the drugs problem (covers e.g. user groups, vulnerable groups, social impacts such as crime, interaction with CJS, economic costs of use and treatment). This is similarly under continuous review as the nature and content of social scientific knowledge changes.	Integrated into classification via the ACMD
Public consultation is an important mechanism for accessing and considering wider views of experts and non-experts alike, assessing core social values and consensus	Input into process through post ACMD recommendation consultations and current broader consultations with public/stakeholders
International partners' insight and experience is important source of learning from other contexts	Liaison with international officials provides input into process
Political knowledge: the expertise of politicians - an understanding of the political context, the potential long term consequences of decisions.	Integral to the process

4.19 All of these inputs to the decision-making process are important. No single form of knowledge, or rationality associated with that knowledge (for instance, that rationality associated with medical science) is sufficient on its own. Classification decisions must take account of scientific knowledge of medical harms, and social and economic evidence, as well as the insight provided by public consultation and risk assessment and the knowledge and understanding provided by the public bodies and Government departments.

How is a Drug's Harm Measured?

5.1 The Advisory Council on the Misuse of Drugs was set up under the Misuse of Drugs Act 1971 to provide independent expert advice to Government on a broad range of drugs issues. This includes the classification of drugs according to their relative harms. When considering the harmfulness of an individual drug the Advisory Council takes into account various factors including the physical harm of taking the drug on individual occasions and after prolonged use; the degree of pleasure and the drug's potential for physical and psychological withdrawal; the effects of intoxication as well as the harm to families and communities. The greater the impact a drug has on individuals and society the higher the Class within which it will fall.

Harm to the individual User

Physical Harm: This refers to organ damage caused by the drug in question.

- **Acute:** Immediate effects on drug use, overdoses, heart attacks, psychotic episode.
- **Chronic:** Health consequences on repeated use, organ damage, mental health problems etc.
- **IV:** Should reflect the dangers of intravenous use of these drugs (if appropriate).

Pleasure: The pleasurable and reinforcing/ "addictive" dangers of the drug and therefore the propensity to craving.

Withdrawal

- **Psychological:** The need to continue to take drugs to avoid feeling of altered mood when stopping.
- **Physical:** Physical symptoms of withdrawal that predispose to continued use.

Harm to families and the Community

- **Intoxication:** Dangers due to society from the acute disinhibiting/intoxicating effects of the drug, accidents, drug driving etc.
- **Social:** Damage to social fabric caused by alterations in behaviour (especially increased criminality) due to drugs and also drug dealing.
- **Medical:** Secondary consequences of drug use, such as HIV, hepatitis.

5.2 The immediate harms to health of the individual are highly

influential to the overall harm of the drugs and there is a strong link to the class of the drug - any drug that can cause overdose will be considered very harmful. These drugs often have other longer term harms associated with prolonged use such as damaged organs and veins.

5.3 All drugs have some degree of social harm. Any drug can impair the motor functions in the brain, psychoactive drugs cause intoxication and so put the individual at risk of self-harm. This may be domestic accidents, work related injuries or road crashes from drug-driving.

5.4 Some substances such as amphetamines and other stimulants cause aggression or mental instability and can therefore fuel violence and anti-social behaviour. Drug misuse can certainly worsen existing mental health problems, will slow recovery and often cause relapse.

5.5 A drug's pharmacology will also affect the degree to which its use is re-enforced. Heroin is a highly addictive substance and cannabis less so. individuals often resort to crime to ensure they have sufficient supplies. For example, the Arrestee Survey for 2003/4 shows that 68% of shoplifting offences and 63% of burglaries were carried out by those who had taken heroin crack and cocaine in the last 12 months. Extreme levels of dependence on drugs such as heroin and crack cocaine can lead just a few individuals having a highly negative impact on a whole community. All drugs are associated with some degree of criminal behaviour.

5.6 The social impact of drug misuse is a significant factor in establishing the overall level of harm and consequently its classification. There are other social harms which are secondary but still highly significant in assessing the overall impact of a drug. The ACMD report "Hidden Harm: the children of problem drug users" published in 2003 revealed the extent and scale to which UK drug users' misuse impacted on their children's development and welfare for example.

5.7 When considering the different harms of a new drug of misuse and its potential for becoming controlled, the Advisory Council will consider each harm separately.

5.8 The assessment of harm is normally carried out first by the Advisory Council's Technical Committee or on occasion by a dedicated group. For example, the Council established a Ketamine group to assess the harm of that drug. Such groups are made up of a few Council members whose expertise will cover, typically, pharmacology, chemistry, treatment and social science. The groups are free to co-opt members from any field or discipline to ensure they have the full range of expertise to produce a comprehensive assessment of a drug's harm. The Technical Committee have recently been applying an individual score, effectively giving a grade of harm to each drug as part of its consideration of a drug.

5.9 Points are apportioned according to the following scale:

3 = major/seriousness effects
2 = moderate effect,
1 = mild effect, and
0 = no effect

The final overall "score" is based on points from 9 criteria and will be between 0-27. The scores themselves are subjective but discussions throughout the process with other members iron out anomalies in an attempt to provide a more objective overall assessment. Each criteria carries identical weight. It may be appropriate to lend more weight to some criteria than others, e.g. social harm.

Consultation

You may wish to respond to the issues in this consultation along the lines of the following questions:

<redacted>

Legal and Socially Accepted Substances

Relationships with alcohol and tobacco

6.1 People have used substances that alter mental functioning almost since the beginning of time. Some are, or have become socially acceptable, whilst others have been made illegal. Alcohol and tobacco have a long tradition of social acceptability in the majority of countries across the world (with the obvious exception of Muslim countries in respect of alcohol, whilst tobacco is becoming less acceptable in certain countries). The production, marketing and distribution of these undoubtedly harmful substances tend to operate within a regulated regime of supply. The regulations generally aim to minimise access to children and young people determined by age (16 for tobacco, 18 for alcohol in the UK).

6.2 There are also restrictions on where it is acceptable to consume these products and there are considerable restrictions on advertising their use. Regulations are also imposed to limit strength and potency of these products recognizing that access to very high strengths would be even more damaging to public health.

6.3 To many young people the regulation of tobacco and alcohol and the prohibition of drugs presents a dichotomy in terms of harm. They question why substances of considerable harm such as cigarettes and alcohol are able to be consumed relatively easily when possessing a drug like cannabis can lead to prosecution.

Alcohol

6.4 Around a quarter of the UK adult population drink above the recommended weekly guidelines, which increases the risk of causing or experiencing alcohol-related harms. The Department of Health have calculated that the cost of alcohol-related harms in England alone is up to £20bn per annum. These harms include:

- harms to health:
- crime and anti-social behaviour;
- loss of productivity in the workplace; and
- social harms, such as family breakdown.

6.5 The Department of Health estimate there are over 30,000 hospital admissions annually for alcohol dependence and up to 22,000 premature deaths per annum.

Tobacco

6.6 Although tobacco use has decreased in the UK over the last 30 years here are still 106,000 deaths in the UK caused by smoking every year (84,900 in England). Smoking costs the NHS about £1.5bn per year. Main diseases include lung cancer, bronchitis, and heart disease.

6.7 Harms from tobacco are predominantly confined to the harms to

an individual's health and to some extent those around the user. The social harms to tobacco use are minimal compared to alcohol. Nicotine can induce strong dependence in individuals where they find extreme difficulty in maintaining abstinence even when the damage to health is clearly apparent.

Controls

6.8 There has not, in the UK, been any attempt to impose controls comparable to illicit drugs where it would be an offence to possess and supply alcohol and tobacco. The social acceptability of, for example, alcohol would make such controls unacceptable to the majority who use alcohol responsibly and therefore impractical. But alcohol and tobacco account for more health problems and deaths than illicit drugs. To many young people this presents problems in understanding the rationale behind controlling drugs such as cannabis and ecstasy when their misuse contributes less overall harm to society than widely available drugs such as alcohol and tobacco.

6.9 In terms of death, illegal drugs amounted to 1,388 in 2003 compared to about 20,000 for alcohol and 100,000 for tobacco.

6.10 <redacted>

6.11 <redacted>

International Controls

7.1 Drugs are a global issue and it is important to be mindful of this wider context. The UK is a signatory to all three UN conventions on drug matters: the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the Convention Against illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

7.2 The Conventions are mutually supportive and apply control measures in order to ensure the availability of substances for medical and scientific purposes and to prevent their diversion into illicit channels. They also include general provisions on illicit trafficking and drug misuse. The 1961 and 1971 Conventions have greater relevance for this consultation as the 1988 Convention focuses more on precursor chemicals and drug trafficking.

- **Single Convention on Narcotic Drugs 1961.** This Convention aims to combat drug abuse by co-ordinated international action, limiting the possession, use, trade in, distribution, import, export, manufacture and production of drugs exclusively to medical and scientific purposes.

- **Convention on Psychotropic Substances 1971.** The Convention establishes an international control system for psychoactive substances such as LSD and tranquilizers.

- **Convention against the illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.** This Convention provides measures against drug trafficking, including provisions against money laundering and the diversion of precursor chemicals. It also provides for international cooperation through extradition of drug traffickers, controlled deliveries and transfer of proceedings.

7.3 Narcotic drugs, such as heroin or morphine, are defined as having pain killing or stupefying qualities. Psychoactive or psychotropic substances are defined as being able to affect mental activity. Not all drugs fit neatly into one or other category, for example cannabis is listed as a narcotic but also has psychoactive effects.

7.4 Two hundred and fifty of the most misused narcotic and psychoactive substances are placed in one of five schedules according to a classification of their therapeutic value and risk of abuse and health dangers. The drugs in the schedules are listed broadly in order of their harmfulness and addictiveness. The purpose of this listing is to control and limit the use of these drugs according to a classification of their therapeutic value, risk of abuse and health dangers.

7.5 The UK schedules broadly mirror the UN scheduling arrangements. There are some difficulties in making direct comparisons as the Conventions have been arranged in different formats. The 1971 Convention is set out in 5 schedules very much resembling our own

schedules. However, the 1961 Convention contains 4 schedules. The first three contain drugs in decreasing levels of dangerousness whilst Schedule IV contains drugs upon which countries may wish to impose conditions to prevent any medical use.

7.6 There are some important similarities and differences in the way the Conventions are applied. Heroin (diamorphine) is one drug where there is international consensus on its dangerousness and potential for addiction. Countries without exception place high levels of control on it. Nearly all countries also prevent the medical use of heroin, with the exception of the UK.

7.7 All signatory countries to the United Nations Drug Conventions are expected to comply with them by imposing controls. However, individual countries can decide for themselves how to control the drugs within their own domestic legal framework. The international Community expects countries to adopt broadly comparable controls, i.e. higher controls for drugs in the higher schedules. Countries carry this out in a variety of different ways depending on their own legal system.

7.8 Drug controls and strategies in individual countries are evaluated by the international Narcotics Control Board (INCB) under the United Nations. The INCB is the independent and quasi-judicial monitoring body for the implementation of the United Nations international drug control conventions. INCB produce an annual report that sets out trends in drug use, supply and production across the world and make recommendations on what more actions should be taken to tackle drug misuse. They also monitor individual countries legal changes to ensure they do not violate the Conventions.

International Comparisons

Controls in European Union Countries

8.1 Individual countries in the EU are all signatories to the UN Conventions but take differing approaches to the classification of controlled drugs. Some EU Member States distinguish between narcotic and psychoactive substances within their domestic legislation and some combine the two in a list that is based on the drug's medicinal use or potential harm.

8.2 Some member states, including the UK, classify controlled drugs according to their relative harm in order to provide a proportionate sentencing framework for the courts. In some other countries the penalties for possessing and supplying a controlled drug will depend on the type of drug in question, while in others, the penalties relate to the activity (i.e. cultivation, possession or supply) regardless of the type of drugs involved.

8.3 Looking at these differences in a little more detail, the nature of the drug itself determines the level of penalties for drug offences in 11 EU Member States (the UK, Belgium, Spain, Ireland, Italy, Cyprus, Latvia, Luxembourg, Malta, The Netherlands and Portugal). Of these, in Latvia, Malta and Portugal the penalty is only varied in respect of drug trafficking offences, whereas in Belgium, Ireland and Luxembourg it only differs for the offence of possession of (a small amount of cannabis for personal use.

8.4 In the remaining 14 EU Member States, the law does not recognise differences between drugs and the harms they cause. Drug offenses may incur the same penalty regardless of the substance involved. Judicial authorities do, however, consider the nature of the substances, as well as the quantity and other determining factors, when sentencing through use of their discretionary powers. A more detailed breakdown of EU Member States' current arrangements is included at Annex A.

Controls in the United States

8.5 in the United States, the central drug legislation is the Controlled Substances Act 1970 which places all regulated substances into one of five schedules, based on the substances medicinal value, harmfulness and potential for abuse or addiction. The Act is described more fully at Annex B.

8.6 To summarise, Schedule I is reserved for the most dangerous drugs that have no recognized medical use, the other schedules 11 to IV contain drugs of decreasing in overall harm while Schedule V is the classification used for the least dangerous drugs. The Act also provides a mechanism for substances to be controlled, added to a schedule, decontrolled, removed from control, rescheduled, or transferred from one schedule to another. The criteria for considering the appropriate

schedule are enshrined in statute.

8.7 The criteria cover:

1) A drug's actual or relative potential for abuse;
2) The scientific evidence of a drug's pharmacological effect;
3) The state of current scientific knowledge regarding the drug or other substance;
4) The history and current pattern of abuse;
5) The scope, duration, and significance of abuse;
6) Risk to the public health;
7) A drug's psychological or physiological dependence liability;
8) Whether the substance is an immediate precursor of a substance already controlled.

Penalties

8.8 When considering appropriate penalties, the US courts take into account the type of drug and its schedule together with the amount of the drug seized and the criminal history of the offender. These factors are then applied as a formula through a grid system that determines the sentence the court is permitted to impose. In practice, it means that a court will first determine the drug type and amount. The range of penalties available to the court will depend on whether there were any previous convictions. It follows that an offence involving a small amount of a relatively less harmful drug such as diazepam will incur a lesser penalty than greater amounts of more harmful drugs such as heroin and when there are previous offenses. The grid system for trafficking penalties is included at the end of Annex B below.

Controls in New Zealand

8.9 The key piece of drug legislation in New Zealand is the Misuse of Drugs Act 1975, which is similar to the UK's legislation in placing drugs in 3 classes. The basis for classifying drugs as either Class A, B or C was reviewed in 2000 with the aim of reducing the apparent inconsistencies in relative harms. A more detailed view of the New Zealand system is at Annex C.

8.10 A new basis for classifying controlled drugs was introduced by the Misuse of Drugs Amendment Act 2000. The Act now states that the classification of controlled drugs is based on the risk of harm that the misuse of the drug poses to individuals or society. Accordingly:

- drugs that pose a very high risk of harm are classified as Class A
- drugs that pose a high risk of harm are classified as Class B
- drugs that pose a moderate risk of harm are classified as Class C.

In 2006 the New Zealand Government added a further class - Class D to cover Benzlypiperazines (BZPs) known as 'party pills'. The new class applies certain regulatory restrictions on their sale while research is carried out on the harms of the drug. After research is completed BZPs

may become classified as a controlled drug.

8.11 The legal changes in 2000 included the establishment of an Expert Advisory Committee on Drugs (EACD). The mandate of the EACD is to ensure that New Zealand's drug classification decisions are evidence-based, appropriate to their domestic situation, but also consistent with international obligations.

8.12 The factors that the EACD must advise the Minister on when it considers a particular substance are set in statute and include:

- Iikelihood or evidence of abuse, including prevalence of the drug, seizure trends and potential appeal to vulnerable populations
- specific effects of the drug, including pharmacological, psychoactive and toxicological effects of the drug
- the risk, if any, to public health
- therapeutic value of the drug, if any
- the potential for overdose
- the ability to create physical or psychological dependence
- the international classification and experience of the drug in other jurisdictions
- other matters considered relevant by the Minister
- potential presumption for supply and justification for this.

8.13 The procedure for controlling drugs is a similar process to the UK system through the Advisory Council on the Misuse of Drugs, Ministers and Parliament. When a drug is to be considered by the EACD the first step is for officials to prepare a preliminary paper which is circulated to EACD members. The EACD then considers the paper and provides its expert advice. Final papers will then be produced which will provide the basis for the advice to the Minister of Health who decides whether or not to make a recommendation to the Governor General and Cabinet. After consultation, before any law change is made regarding the classification status of a drug, it must be approved by Parliament.

Schedules/Classes

8.14 The Act contains four Schedules - the First, Second and Third Schedules identify substances classified as controlled drugs under the Act. Schedule 4 identifies substances that are classified as precursor substances. The Act's Schedules are often referred to as Classes. The first Schedule is Class A, the second Schedule, Class B and the third Schedule is Class C.

8.15 The New Zealand system has strong parallels to the current UK system. One important similarity is the potential severity of the penalties associated with offences involving controlled drugs. Offences involving First Schedule (or Class A) drugs provide for more stringent penalties than offences involving Second Schedule (Class B) drugs and so forth.

Alternatives Systems for Consideration

<redacted>

Consultation

<redacted>

Application to England, Wales, Scotland and Northern Ireland

Any changes to the Classification system would apply to in England, Wales and Scotland and Northern Ireland.

Impact on Regulation

Changes to the classification system could be far reaching on its impact on the Criminal Justice system, business etc and a partial Regulatory Impact Assessment is attached.

Comments, using the attached response form should be addressed to <redacted>, **Drugs Legislation and Enforcement Unit, Home Office, Floor 6, Peel Building, 2 Marsham St, London SW1P 4DF.**

(E-Mail: <redacted>)
by July 2006.

A copy of this letter and attachments is also available online on the Home Office website (www.homeoffice.gov.uk). If you have any queries about this letter, please contact me on <redacted>.

Consultation Response - please e-mail to

<redacted>

Alternatively, send by hard copy by June 2006 to:

<redacted>
Drug Legislation and Enforcement Unit,
CDSD,
Floor 6,
Peel Building,
Marsham St,
London
SW1P 4DF

From:_____
_____
_____
_____

CONSULTATION LETTER: PROPOSED CHANGES TO THE MISUSE OF DRUGS LEGISLATION

I have the following views on:

* My reply may be made freely available.
* My reply is confidential.
* My reply is partially confidential (indicate clearly in the text any confidential elements

Signed:_____

* Delete as appropriate

Code of Practice on Consultation

This consultation follows the Code of Practice an Consultation the criteria for which are set below.

The six consultation criteria

1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

2. Be clear about what your proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that your consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor your department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.

6. Ensure your consultation follows better regulation best practice, including carrying out a Regulatory impact Assessment if appropriate.

The full code of practice is available at:
http://www.cabinetoffice.gov.uk/regulation/Consultation/introduction.htm

Consultation Coordinator

If you have any complaints or comments about the consultation process, you should contact the Home Office consultation coordinator Redacted by email at: Redacted

Alternatively, you may wish to write to:
<redacted>
Consultation Coordinator
Performance and Delivery Unit
Home Office
3rd Floor Seacole
2 Marsham Street
London SW1 P 4DF

Email Disclaimer

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