Fifty years of the UK Misuse of Drugs Act 1971: the legislative contexts

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Abstract

Purpose – *The purpose of this paper is to illustrate the history of relevant legislation before and after the 1971 Misuse of Drugs Act (MDA).*

Design/methodology/approach – *A chronological narrative of laws and reports with concluding discussion.*

Findings – *That UK legislators have not made use of the evidence base available to them and have favoured enforcement rather than treatment approaches. That current UK practice has exacerbated not contain the use of and harms caused by illegal drugs.*

Research limitations/implications – *The paper does not cover all relevant documents, especially those from non-governmental sources.*

Practical implications – *The practical implications centre on the failure of consecutive governments to reflect on and review the impact of current legislation, especially on people who use drugs.*

Social implications – *That the situations of people who use drugs are currently ignored by the government and those proven responses which save lives and reduce harm are rejected.*

Originality/value – *The paper attempts to show the historical contexts of control and dangerousness of which the MDA is one instrument.*

Keywords *Review, Legislation, Regulation, Control, Controlled substances, Evidence-based*

Paper type *Case study*

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Introduction

The Misuse of Drugs Act (1971) received Royal Assent on 25 May 1971. In total, 50 years on, the occasion is marked by continued criticism and calls for reform, not celebration or ceremony. Its place at the core of UK drugs legislation and policy has been consistently challenged as the negative outcomes rather than the hoped-for intentions of what is essentially a prohibition approach to illegal drugs are increasingly evident and evidenced. Earlier legislation had been constantly updated and amended in response to changing situations and concerns, a characteristic the Misuse of Drugs Act (MDA) attempted to end. The preceding Bill provided for powers to amend the final Act through the use of Regulations and Orders in Council [1]; their extensive use has enabled the MDA to remain, albeit amended and clarified, on the statute book. This has enabled successive governments to avoid parliamentary scrutiny and consideration of the outcomes of the Act; the growing evidence and examples of the Act's failings; and the growing examples of alternative approaches to drugs.

Before: legislation

The MDA was one more instrument in an over 100-year history of legislation covering what is now referred to as illegal drugs. The Pharmacy Act of 1852 established a register of pharmacists; the Pharmacy Act 1868 listed poisons and introduced controls on opiates,

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cocaine and barbiturates. It was intended to regulate the commercial and professional interests of pharmacists and doctors, defining who could prescribe and dispense what and established the principle of state intervention to control access to drugs, including medicines. It introduced the power of search. These and later Acts contained themes, which have remained constant in UK legislation and policy: regulation of the medical professions; labelling and definitions of medicines, poisons and drugs; an emphasis on "control".

Further Pharmacy Acts, Poisons Acts, Medicines Acts and similar followed. The Pharmacy Act 1908 amended the 1868 Act; the Pharmacy and Poisons Act 1933 required a listing "of poisons, classified into 16 schedules with matching controls imposed by the Poisons Rules" (Cahal, 1970, p. 36); the Pharmacy and Medicines Act 1941 regulated the sale of poisons and established the Poisons Board; the Pharmacy Act 1952, consolidated and up-dated by the Pharmacy Act 1954, strengthened requirements for the registration and regulation of the pharmacy profession. These provisions were consolidated in the 1968 Medicines Act, which amended or repealed 14 previous Acts [2]. The significance of the regulation of the professions is illustrated by the provisions of the Pharmacy (and Poisons) Acts but also the inclusion of regulation of the medical profession in some Dangerous Drugs Acts, "regulation" being a proxy for "control".

The first Dangerous Drugs Acts was passed in 1920. It replaced the World War One Defence of the Realm Act 1914, re-establishing powers to control morphine, heroin and cocaine, which could still be prescribed by medical practitioners in the treatment of addicts. "[…] no outright ban on prescribing to addicts was advocated […] It [the 1920 Act] ensured that […] addiction was viewed in this country primarily as a medical problem, 'as a manifestation of disease and not as a mere form of vicious indulgence'" (Teff, 1972, p. 227, quoting Rolleston Report paragraph 27). It incorporated into domestic legislation the UK's obligations under the 1912 International Opium Convention (the Hague Convention), as required by Article 295 of the Versailles Peace Treaty. It listed but did not define "dangerous drugs". The 1920 Act has been described as the "first substantial attempt in English [sic] law to establish controls" over illegal drugs (Teff, 1972, p. 226). Negotiators including Malcom Delevingne [3] wanted domestic oversight to be with the Home Office, challenging the claim of the 1919-established Ministry of Health to include "narcotics" in its remit. This established the situation where "the central authority was the Home Office, not the Ministry of Health, thus affirming the medico-penal concordat contained within policy since the 1920s" (Berridge, 2013, p. 193). The Act provided for amendment by Orders in Council, setting the precedent of the extension of powers without parliamentary debate. The Dangerous Drugs and Poisons (Amendment) Act 1923 amended the 1920 Act, adding powers to prohibit the importation of drugs.

The Dangerous Drugs Act 1928 imposed controls on cannabis, rejecting the findings of the 1893–1894 Indian Hemp Commission Report (3,000 pages in 8 volumes), which had found little evidence of harms from the use, other than "excessive", of cannabis, an argument which continues to be contested and disputed. The legislative focus shifted to poisons and medicines until the Dangerous Drugs Acts 1951 and 1964.

The Drugs (Prevention of Misuse Act) 1964 made it an offence to import or possess any substances listed in a Schedule to the Act without a Home Office licence; and ratified the 1961 UN Single Convention. The importation (though not possession) prohibition applied to medical professionals inhibited research into medical and therapeutic potentials of controlled substances. A Dangerous Drugs Act 1965 (Modification Order) 1966 amended it to include LSD, mescaline and psilocybin.

The Dangerous Drugs Act 1965 consolidated the Dangerous Drugs Acts 1951 and 1964, including Schedules of substances to be controlled. Section 5 of the Act prohibited occupiers or managers of premises to allow them to be used for smoking or dealing in

cannabis. By doing so it "unintentionally prevented research into the effects of smoking cannabis" (Cahal, 1970, p. 33). The Act re-empowered the Home Secretary to introduce amending Regulations. The Dangerous Drugs Act 1967, which implemented many of the recommendations of the second Brain Report and subsequent 1968 Regulations (Dangerous Drugs (Supply to Addicts) Regulations and Dangerous Drugs (Notifications of Addicts Regulations) strengthened regulation of the medical profession, prohibiting GPs [4] from prescribing heroin and cocaine other than for pain relief. Prescription for the treatment of addiction was now restricted to Drug Dependency Units, an attempt to prevent "irresponsible" prescription of heroin. Dangerous Drugs Acts embodied international obligations into UK law, following the precedent of the Dangerous Drugs Act 1920 and re-establishing the principle of UK drugs legislation incorporating international treaties and conventions.

Before: Commissions, committees and reports

The Rolleston Report of the 1924 Departmental Committee on Morphine and Heroin Addiction introduced what became known as the British system. It legitimated support for the treatment of addicts and GP prescribing of controlled drugs on a maintenance basis to certain categories of patients. Contemporary debate included a scapegoating of GPs, depicted as the source of illegal supplies of heroin through over-prescribing. The principles of the Rolleston Report were upheld by the 1961 Brain Report of the Inter-Departmental Committee on Drug Addiction, whose remit was to review addiction treatment since Rolleston. Confirming the conclusions of the Indian Hemp Commission, the Brain Report found no evidence of medical problems arising from the use of cannabis or that cannabis was an addictive drug.

Reconvened in 1964, the Brain Committee recognised addiction as having "a clear social dimension" (Berridge, 2013, p. 193). The Reports' recommendations led to the establishment in 1968 of Drug Dependency Units (DDUs) under psychiatric leadership, removing the power to prescribe heroin for heroin dependence from GPs. GPs continued to retain the power to prescribe for pain relief. This focus on the source of heroin to non-registered users was a theme of the 1970 parliamentary debates on the Misuse of Drugs Bill: individual GPs were seen as typifying the whole profession. This narrow regulatory focus prevented wider consideration of the origins of drug use and dependence and the identification of realistic policies in response. DDUs came under the remit of the Home Office, not the Ministry of Health. Berridge summarised government thinking at the time: "[. . .] addiction is a socially infectious condition and its notification may offer a means for epidemiological assessment and control [. . .] Brain's formulation significantly encapsulated older traditions of public-health – infection control and notification of disease – with newer ones: risk, epidemiology and the potential infection of the whole population with drug addiction" (Berridge, 2013, p. 193).

The Wootton Report was commissioned by the government's Advisory Committee on Drug Dependence. Handed to Home Secretary Callaghan in November 1968, it was published on 8 January 1969 (ACDD, 1968). Originally intended to consider both cannabis and LSD, the sub-committee confined its work to cannabis alone. Its findings included: "the long-term consumption of cannabis in moderate doses has no harmful effect" (Paragraph 29) and: "It can be clearly argued that on the world picture, cannabis use does not lead to heroin" (Paragraph 51). The Report also recommended clearer distinctions between criminal penalties on the basis of evidence-based harm, recommendations embodied in the MDB. In a statement to Parliament on 23 January 1969, Callaghan rejected the recommendation to reconsider the legal status and classification of cannabis: "It would be entirely contrary to government policy to allow this impression [that the government takes a less than serious view of the effects of drug-taking] to spread [. . .] .Accordingly, it is not the government's intention to legislate to reduce existing penalties". This has become a mantra repeated in

future responses to recommendations and conclusions of such committees, often appointed by the government and their expertise and a constant – stubborn? – reliance on punitive sanctions as the solution or response to illegal drug use. It also reflects governments' nervousness about public opinion and "messages", suggesting government policy influenced by media prejudice and pressure rather than evidence.

The misuse of drugs bill a second reading, 25 March 1970

The Bill, a document setting out proposed legislation which when debated, amended and given Royal Assent becomes an Act of Parliament, and thus law, was introduced by Home Secretary [5] James Callaghan in Harold Wilson's 1964–1970 Labour government. His introduction of the Bill was delayed whilst the Speaker of the House considered an amendment seeking to include alcohol and tobacco in Bill's provisions. The sponsors of the amendment pointed to the high death rate attributable to the use of tobacco and sought to defer debate on the Bill until it was amended to include controls of tobacco and alcohol alongside illegal drugs. During the debate, reference was made to a 23 October 1967, Ministerial statement regarding the prospects of the tobacco industry introducing voluntary agreements to restrict advertising and promotional activities: "After more than a year of negotiations, it is now clear that no further progress is possible by voluntary agreement". On that occasion, the government declined to introduce legislation to regulate tobacco smoking and the activities of the tobacco industry. The amendment was dismissed by the Speaker, reasoning that the core points could be made during the debate on the Bill [6]. Subsequent attempts to extend the provisions of the MDA to include tobacco and alcohol have not been successful, illustrating the failure of UK legislation to consider other, currently legal drugs and the harms they cause in a wider public health context.

Callaghan introduced Bill's main themes: over-prescribing by doctors; the lack of powers to control manufacture; the distinction between possession and "intent to unlawfully supply" and the penalties applying to each; the increased number of substances included in the Bill by comparison with previous legislation; the creation of a body to advise the government on drug laws and drug issues as a statutory body, in contrast to the existing Advisory Committee [7]; the strengthening of penalties, both fines and custodial sentences; concern about the growth in the use of amphetamines and barbiturates; the A, B, C classification of drugs. The classification of illegal drugs, those the Bill sought to "control", was based on an arbitrary assessment of relative harms attributed to the drugs in each category. The classes determined the severity of sanctions applied to breaches of the drug laws. More severe penalties applied to offences involving Class A drugs than to Class B, in turn, more severe than those applied to Class C. The legislation distinguished between possession and possession with intent to supply – use and trafficking.

Callaghan cited the numbers of heroin and methadone [8] "addicts" registered with the Home Office as one indication of the need to introduce additional legislation. He referred to "close co-operation between the Metropolitan Police and the US Federal Bureau of Narcotics" (Hansard 25 March 1970, Col. 1449), indicating a generally uncritical view of practice in the US rather than Europe, despite the dissimilarities between US and UK societies. In an indication of widely shared opinion at the time, inside and outside Parliament, Callaghan said: "the addicts of the hard drugs [. . .] are very sick people, unable to face the problems of life, unable to come to terms with life or their fellows. These people need help and understanding and treatment" (Col. 1448), an attitude echoed by Joint Under Secretary of State for the Home Department Elystan Morgan: "Not only have drugs an escapist and, perhaps, masochistic attractiveness in themselves, but they have a tendency to compound in a disastrous way current diseases in society and its culture" (Col. 1551). These statements illustrate the view identified by Bean which saw drug use as an individual circumstance with no associations with medical or socio-economic factors: "[. . .]

the addict came to be seen originally as a sick person and later as a sick and deviant person" (Bean, 1974, p. 6).

Summing up the debate for the government, Morgan stated: "Society cannot be squeamish in dealing with those who traffic in and profit from, human misery, degradation and death [. . .] the people of this country and especially the young, are entitled to live their lives as free from the shadow of this threat as the efforts of Parliament can safeguard" (Col. 1559). Referring to references in the debate to the role and status of cannabis and Bill's drafting without apparent reference to reports commissioned into the effects of cannabis use, Morgan claimed that the research into the effects of cannabis recommended by the Wootton Committee report would not have been available in time for the Second Reading; he did not say whether this research had in fact been commissioned [9]. He added that Section 5 of the 1965 Dangerous Drugs Act "absolutely prevents the use of premises for the smoking of cannabis, whether for research or for any other purpose" (Col. 1557).

Ministerial characterisations of people who use drugs were echoed by some speakers in the ensuing debate, along with expressions of concern that the use of illegal drugs was a threat to social stability and cultural norms: "The people who take drugs are, almost without exception, all highly disturbed people. They are not normal people, otherwise they would not take drugs" (Short, Col. 1530), moralising rather than moral view. Widely but not universally held, such views indicated both a lack of wider understanding of the use and users of illegal drugs and dismissal and demeaning of "addicts", in effect legitimising stigmatisation and marginalisation. They also conflate drug use with drug addiction. Those who expressed contrary views and drug users themselves were likely to be seen as "anti-capitalist, anti-police and anti-authority" (Bean, 1974, p. 2). Nearly 30 years later, a major report noted that: "Current legislation is driven more by morality than by the practical desire to reduce harm" and: "The law as it stands [. . .] is based more on prejudice and folk myth than on reason" (RSA, 2007, p. 294, 310–11). Such attitudes and assumptions continue to shape UK drugs legislation and policy, along with a disregard of the needs of people who use drugs.

The debate referred to previous reports; existing legislation to be replaced and repealed by the MDA; and some of the contexts which in the government's view warranted new legislation. Callaghan referred to Clause 32, giving Home Secretaries powers to "conduct or assist in conducting research into any matter relating to the misuse of dangerous drugs" citing "the need for continuing research and [it] authorises it" (Col. 1459), specifying biochemical and pharmaceutical studies; clinical and treatment studies; social and psychological descriptive studies [10]. Several speakers referred to the need for research and the general lack of knowledge and information, challenging more widespread and inaccurate views. "[. . .] arguments [. . .] have been based on very scanty information, some of which is probably highly unreliable" (Bean, 1974, p. 2). The creation of the Advisory Council on the Misuse of Drugs notwithstanding, the restrictions imposed on research into the effects and legal status of cannabis remain features of the UK drugs situation: whether or not intentionally, the MDA reinforced 1965 legislation which inhibited research into the use of drugs classified as illegal to determine their potential medical use [11]. Callaghan announced additional powers to counter over-prescribing by doctors and the reluctance of the professional bodies (the General Medical Council and the British Medical Association) to act in such cases (Col. 1448). He also misleadingly but, perhaps, unwittingly referred to drugs "controlled" by the 1964 Act (Col. 1453): the government's own statistics showed that the drugs referred to were anything but "controlled": it was becoming clear that it was not drugs which were being controlled but their users.

The misuse of drugs bill a second reading, 16 July 1970

Following Labour's defeat at the June 1970 general election, a conservative government was formed under prime minister Edward Heath. It re-introduced the Misuse of Drugs Bill,

reflecting the broad support the Bill had enjoyed in Parliament. The second Second Reading took place on 16 July 1970, now introduced by Home Secretary Reginald Maudling. Maudling emphasised that apart from some amendments to the Schedule listing specific drugs "[…] the Bill is identical to the previous one" (Hansard, 16 July 1970, Col. 1749). He reiterated the distinction the Bill made between possession and trafficking. Supporting the rationale for the Bill put forward in March by Labour's Home Secretary Callaghan, Maudling repeated that "The present law is unsatisfactory. It is fragmentary" (Column 1750), presaging the rationale for the Misuse of Drugs Bill in 1970. Maudling continued: "Its [the Bill's] purposes are clear – they are to deal with known abusers, particularly trafficking and over-prescription" (Col. 1753).

Former Home Secretary Callaghan made a statement, which can be seen as indicating the extent to which government thinking had already been established and that "research" would be unlikely to shift some basic approaches to drug laws. He attempted to distinguish between "the two types of drugs – those which are needed for medical purposes […] and those which are not so needed" (Col. 1758), a misleading binary distinction, which continues to inhibit research and governments readiness to accept research findings. The continued failure of governments to recognise this fallacy has contributed to the increasing irrelevance of UK drugs legislation. It subscribes to a view that "illegal" drugs are distinct from and separate from medical drugs, further hindering research.

This determination and presumption were illustrated by Maudling's comment that "[…] the use of hard drugs is an appalling phenomenon in our society and we must set our faces completely against it". Maudling reiterated the continued – and continuing – UK position of excluding tobacco and alcohol from equivalent provisions and controls: "It is deplorable to see people drinking themselves into cirrhosis or smoking themselves into lung cancer, but nobody proposes that either activity should be prohibited by law" [12] (Col. 1753). The contrast between the "control" of illegal drugs and of tobacco and alcohol was raised in the debate: "[…] the Bill's […] rather hypocritical. It attacks socially unacceptable drugs but does nothing about socially acceptable drugs. It attacks the drugs of young people, but does nothing about the drugs of middle-aged and elderly people […] If there is to be a distinction to be made between drugs, it should be between drugs, which are a danger to health and those which are not, but the Bill does not make that distinction" (Deakin Col. 1766) [13]. One speaker pointed to historical examples of attempts to prohibit the use of alcohol and tobacco and their failure, questioning the expectation that prohibition of the UK's controlled substances would succeed.

The ensuing debate was shorter than that in March, partly because of the time restrictions of that day's parliamentary business, partly because the March debate had covered most of what there was to be said. The increased use of amphetamines and barbiturates and the reported spate of pharmacy break-ins again featured in the debate, as did further references to the need for research, perhaps, an acknowledgement by some MPs. that their own knowledge was incomplete. Others expressed concern at the increase in powers available to the Home Secretary: Maudling had emphasised that the Bill would again give Home Secretaries powers to amend an Act as they saw fit, by Regulations and Orders in Council.

Peter Hardy referred to the shortcomings of making decisions based on superficial and misleading media coverage; the failure of the Bill and other social policy interventions to take account of social influences, implicitly referring to what would now be referred to as socio-economic inequalities; and the stereotyping of young people (Col. 1767). Comments regarding the misuse of power and role [14] by the police were dismissed, denying reports of the planting of drugs on suspects and assault; accepting such reports would undermine "the public confidence in the police […] a shortcut to discrediting established order" (Deedes Col. 1779). The widely-held misconception that "[…] those who smoked cannabis were in pretty close peril of turning over to heroin, that one would follow the other" was

repeated (Deedes Col. 1780). The debate again included ill-informed thinking and views, much of it anecdotal; and prescient opinion and predictions.

The MDA received Royal Assent on 25 May 1971, coming into effect in 1973. It re-established the UK's obligations under the 1961 UN Single Convention [15]. The preamble to the Single Convention refers to it as being "concerned with the health and welfare of mankind" (UNODC, 2013, p. 3), a reference which does not appear to have influenced the MDA and its omission of any provision for treatment. No reference was made to the Convention in the 1970 parliamentary debates. MDA provisions apply to England, Wales, Scotland and Northern Ireland.

The content of the misuse of drugs act

The MDA repealed existing UK legislation concerning dangerous and harmful drugs: The Drugs (Prevention of Misuse) Act 1964; The Dangerous Drugs Act 1965; The Dangerous Drugs Act 1967, repeals extending to "The whole Act" in each case and parts of The Medicines Act (1968), consolidating previous laws into one Act. This legislative convenience rather than reflective consideration of social policy and illegal drugs was one characteristic and purpose of the MDA. The Sections are grouped under eight headings: ACMD; Controlled drugs and their classification; Restrictions; Miscellaneous offences; Powers of the Secretary of State; Miscellaneous offences and powers; Law enforcement and punishment of offences; Miscellaneous and supplementary offences. There are six accompanying Schedules: ACMD Constitution; Controlled drugs [16]; Tribunals and advisory and professional bodies; Prosecution and punishment of offence; Savings and transitional provisions – powers for the Home Secretary; Repeals, reflecting bureaucratic convenience and regulatory powers.

Objections expressed during the debates remain unaddressed, indicating a lack of evolution and understanding of drugs, public health issues and socio-economic contexts by policymakers. UK drug laws continue to fall under the remit of the Home Office, not the Ministry or Department of Health, sustaining the UK view of drugs as a criminal justice rather than a health or social issue and responsibility. Accordingly, there is no content on treatment in the MDA.

The intent of the misuse of drugs act

Expressing his expectations at the close of his March 1970 introduction of the Misuse of Drugs Bill, Home Secretary Callaghan said: "The Bill will prove to be an important new weapon in the fight against the spread of drugs [. . .] let us not be responsible for any weakening in our attempts to stamp out what is a present and dreadful scourge" (Hansard, 25 March 1970, col. 1460). Elystan Morgan added that "the Bill contains the basic restrictions against the import, export, production, supply and possession" (Col. 1553), indicating the government's expectation that the Bill would stop the trade-in and use of illegal drugs. In the July 1970 debate, Home Secretary Maudling said "Its [the Bill's] purposes are clear – they are to deal with known abusers, particularly trafficking and over-prescription" (Hansard, 16 July 1970, Col. 1753). The opening sentence of the MDA reads that it is "An act to make new provision with respect to dangerous or otherwise harmful drugs and related matters and for purposes connected therewith". The first page of the Act, establishing the ACMD, refers to measures to be taken "for restricting the availability of such drugs or supervising the arrangements for their supply" (Section 1 (2) (a)), indications that the Act was intended to reduce the availability, and hence use, of what the Act defined as controlled drugs. These statements provide the basis on which the Act could be assessed. Many reports, including parliamentary and extra-parliamentary, have called for reform, but there has been no explicit review of the MDA and its impacts by the Home Office. The emphasis on consolidating legislation rather than identifying the origins of drug use was

made by Cahal in a contemporary observation by: "[. . .] legislation on the subject [misuse of drugs] has been constructed piecemeal. The fragmentary, inadequate and inflexible nature of such legislation [. . .] " (1970, 36).

After: Legislation

The content of the MDA has remained largely unchanged in its 50 years. A shift in complementary legislation has become apparent, from a "dangerous drugs" approach, which might be seen as having some public health relevance, to a prohibition and enforcement approach, illustrated by the titles of Acts which have effectively amended the MDA by introducing changes through other legislation. This later legislation was solely concerned with policing, enforcement, offences and sanctions. Amendments have been made using Regulations and Orders in Council "to add and vary" (Psychoactive Substances Act, 2016, 3 (2) (b)). MDA Schedule 2 has been expanded as new substances have been identified: some 30 substances have been added to Class A, 40 to Class B, 120 to Class C. Khat was added as a Class C substance in 2013, a move which was not preceded by any assessment or research into the extent of its use or of any associated harms.

The Drug Trafficking Offences Act 1986 covered organised crime and recovery of the proceeds of drug trafficking. Significantly, it clarified the provision of drug use paraphernalia in Section 34 (1) (2): "It is not an offence under subsection (1) above to supply or offer to supply a hypodermic syringe or any part of one", amending Section 9(c) of the MDA. Although referring to the smoking of opium, Section 9(c) had been interpreted by some as making the provision of needles and syringes an offence. The clarification was an implicit acknowledgement of harm reduction at the time of HIV/AIDS and the first officially recognised needle exchanges. The Criminal Justice (International Cooperation) Act 1990 incorporated the UK obligations arising from the 1988 UN Convention against illicit traffic in narcotic drugs and psychotropic substances. The Drug Trafficking Act 1994, a substantial piece of legislation with 69 Sections and 3 Schedules, included powers for the confiscation and seizure of assets of drug trafficking and associated money laundering. It repealed most of the 1986 Act, although retaining Section 34, a rare example of legislation, which could be seen as directly relevant to people who use drugs.

The Drugs Act 2005 increased police powers of search and established powers to assess arrestees for drug use and to impose treatment orders, refusal of which became criminal offences. The RSA commented that this Act is "open to the charge of violating medical ethics on the grounds that patients acquiescing to treatment under legal pressure were not consenting to their treatment in a free and informed way" (RSA, 2007, p. 298).

In a return to the "dangerous drugs" approach, the Psychoactive Substances Act (2016), "An Act to make provision about psychoactive substances and for connected purposes" (Introduction), responded to novel psychoactive substances (NPS), media campaigns and associated moral panic through banning and enforcement approaches (the Minister for Policing and Criminal Justice introduced the Bill) and introduced a new principle into UK law: that everything is illegal unless it is legal, which was not significantly commented on in the debate. Of 63 Sections and 5 Schedules, it banned "any substance which is capable of producing a psychoactive effect in a person who consumes it" (Section 2 (1) (1a)), terms fraught with ambiguity. The Second Reading debate challenged Bill's core assumptions: that it would work, despite contrary evidence from Ireland; that bans and prohibitions could be successful. It was predicted that the trade-in NPS would not be ended but would transfer to organised criminal control. Lyn Brown pointed out that "The Bill [. . .] legally decouples controlled substances from an independent and objective assessment of the harms they cause" (House of Commons Hansard, 2015, October 19, Col. 743). Norman Lamb emphasised that the ACMD had been excluded from any involvement in the Bill (Col. 749).

After: Commissions, committees and reports

In spite of the failure of the Home Office to conduct reviews of the MDA and drugs policy, a range of bodies, commissions and committees, including Parliamentary, has done so and reports on the impact and effectiveness of UK drug laws and policy continue to appear. Amongst others, an ACMD report concluded that classification "exists solely to determine which scale of penalties shall be applicable to individual drugs" (ACMD, 1979). This and later unwelcome ACMD reports – Drug Misuse and the Environment 1998, Hidden Harm 2011, International comparators 2014, Reducing opioid-related deaths in the UK 2016 – may have contributed to the increased by-passing of the ACMD by the Home Office, indicating a move to policy-based evidence, not evidence-based policy. "Evidence" in this context can be best understood as an awareness of drug policies adopted in other nations which have resulted in reduced use, reduced harmful use, fewer deaths, improved treatment provision and outcomes and reintegration.

The remit of the Police Foundation's report *Drugs and the law* included "To carry out an independent enquiry into the effectiveness of the relevant laws to assess options for legislative change" and to "describe the purpose and intention behind the existing relevant legislation" (Police Foundation, 2000, p. 138). The report was presented to Home Secretary Jack Straw by the chair, Ruth Runciman, three days before its 21 March 2000 publication. The report's recommendations (there were 82 in all) included*:* "The information and research base should be given renewed attention" and: "The main classification criteria should continue to be that of dangerousness" (ibid, 128). Straw dismissed the report and recommendations in their entirety, possibly using the content on cannabis use and classification to divert debate from more substantive content.

A 2002 Home Affairs Select Committee report recommended re-classifying MDMA to Class B, cannabis to Class C, a new offence of not-for-profit social supply, heroin prescribing, legalising drug consumption rooms and a review of the UN Conventions.

In 2003 the National Addiction Centre and the Department of Health published *Dangerousness of Drugs*, an attempt to establish a taxonomy of dangers and harms associated with the use of a range of substances, including alcohol and tobacco. A subsequent Lancet paper established a 20-substance ranking. Its authors observed that "the process by which harms are determined is often undisclosed and when the made public can be ill-defined, opaque and seemingly arbitrary [. . .] The current classification system has evolved in an unsystematic way from the somewhat arbitrary foundation with seemingly little scientific basis" (Nutt et al, 2007, p. 1047). They found little correlation between the substances examined and their MDA classification, concluding: "Our results also emphasise that the exclusion of alcohol and tobacco from the MDA is, from a scientific perspective, arbitrary. We saw no clear distinction between socially acceptable and illicit substances. The fact that the two most widely used legal drugs lie in the upper half of the ranking of harm is surely important information that should be taken into account in public debate on illegal drug use. Discussions based on a formal assessment of harm rather than on prejudice and assumptions might help society to engage in a more rational debate about the relative risks and harms of drugs" (Nutt et al., 2007, p. 1047).

The 2006 Report of the House of Commons Science and Technology Committee *Making a hash of it* called for a review of the basis on which harms were assessed and the development of a standard framework for doing so; a review of the classification system; and more consistent use of the evidence base. It specified: "The classification system purports to rank drugs on the basis of harm associated with their misuse but we have found glaring anomalies in the classification system as it stands and a wide consensus that the current system is not fit for purpose [. . .] We have proposed that the government should develop a more scientifically based scale of harm [. . .] the government has largely failed to

meet its commitment to evidence-based policymaking" (House of Commons Science and Technology Committee, 2006, p. 48).

The Royal Society of Arts established a commission "To examine, as an independent body, all aspects of the relationship between public policy and abuse of illegal drugs" (RSA, 2007, p. 4). The members of this commission represented a wide spectrum of disciplines and agencies. The concluding pages of its 2007 report *Drugs–facing facts* are highly critical of both the intent and the practice of UK drug laws and associated policy. "A policy that sets drugs in context and seeks above all to reduce drug-related harm needs a new legal framework to reflect these objectives. In our view, the Misuse of Drugs Act (1971) and the classification system it embodies achieve neither of these aims. The Act and all the later legislation following on from it should be repealed and superseded by a new Misuse of Substances Act that: * sets drugs in a wider context of substance misuse alongside alcohol and tobacco * is linked directly to a scientifically based index that makes clear the relative risks of harm from individual substances" (RSA, 2007, p. 275). Inclusion of alcohol and tobacco would add integrity and credibility; basing legislation and regulation on proven harms would provide authority and flexibility. "The current law is out of date, unwieldy and peppered with anomalies, an agglomeration of miscellaneous provisions adopted to address situations that in many cases no longer apply [...] It acknowledges no parallels and no relationships between the use of illegal drugs and the use of alcohol and tobacco [...] the best drugs policy may not be a 'drugs' policy at all but [...] a range of policies designed to address the use of drugs in their wider social setting" (RSA, 2007, p. 284, 326), a sentiment which would be shared by social epidemiologists.

Discussion

The MDA can be seen as the last of the "dangerous drugs" Acts, with additional legislation since 1973 being disguised or camouflaged through amendments to or introduction of other Acts. It could be inferred that the legislation has been awarded protected status by governments since its inception: there has been no official review of the Act's impact and a consistent refusal to heed the evidence base, with increasing disregard of reports and recommendations of the ACMD. From the outset, there have been reservations about the reliance on punishment, criminalisation, the classification system and the exclusion of alcohol and tobacco from similar consideration. The focus on criminalisation has consistently taken precedence over treatment, the supposed welfare and security of the nation over-ruling the well-being of people who use drugs: legislatively, there has been much law-making about drug use, little about drug users. The emphasis on prohibition was predicted to result in an increase in criminal involvement in the supply of drugs and so it has proved, nationally and internationally. Several speakers in the 1970s parliamentary debates referred to the over-reliance on punitive measures. After a visit to the USA to look at the prison system, Tome Iremonger reported that "The prisons there were full of drug offenders" (House of Commons Hansard, 1970a, 25 March Col 1537) [17]. Home Secretary Maudling conceded "We entirely accept that legislation, in itself, is not enough to deal with this problem [...]. We must see that action is taken in the related fields – the social and educational fields and in further research" (House of Commons Hansard, 1970b, 16 July Col 1752). More broadly: "Those whose business it is to pass our laws are deluding themselves if they believe that a law can achieve things that people themselves cannot [...] where there is a demand for drugs, prohibition does not work [...] drug prohibition laws encourage and maintain a black-market economy and a criminal subculture" (Gossop, 2000, p. 170, 172, 173).

The MDA represents an approach to social issues which favours the introduction of laws, sanctions and strategies on the basis that they might or should work, a self-deceit, which continues to bedevil UK drug policy. "*Laws and regulations* determine which substances are legal and illegal, for whom and under what conditions. Examples include the complete

prohibition of drugs, allowing distribution of a drug only in particular systems [. . .] and giving only particular individuals the right to use or prescribe drugs" (Babor *et al.*, 2010, 101). In its overview, the Police Foundation, Report concluded "In the course of our Inquiry it has become inescapably clear to us that the eradication of drug use is not achievable and is not, therefore, either a realistic or a sensible goal of public policy. The main aim of the law must be to control and limit the demand for and the supply of illicit drugs to minimise the serious individual and social harms caused by their use" (Police Foundation, 2000, p. 1).

Nevertheless, UK Governments continue to insist on law enforcement and punitive responses to the existence and use of illegal drugs, despite detailed and substantial evidence and example, from research and from practice in other jurisdictions, of alternatives. Ministerial references to "research" have not been matched by the commissioning, acceptance or use of research. Reports consistently highlight the lack of use of evidence: "The UK invests remarkably little in an independent evaluation of the impact of drug policy [. . .] " (Reuter and Stevens, 2007, p. 11); "UK investment in addiction research is woefully inadequate. The government's failure to ensure that sufficient resources are devoted to building the evidence base to underpin drugs policy is at odds with its commitment to adopt an evidence-based approach" (House of Commons Science and Technology Committee, 2006, Recommendation 37).

Legislation is paralleled by policy, which has also fallen short of needs and evidence. The reports into UK drug policy by Dame Carol Black (2020, 2021) emphasise amongst other factors the inadequacy of treatment provision and the continuing reduction of funding for such services. The first and most recent national strategies (Tackling Drugs Together, 1995, (Drugs Strategy, 2017) were comprehensive in their coverage but were not accompanied by funding. As with the MDA itself, little publicly available evaluation of these and intervening strategies seems to have been carried out. Given the effectiveness of harm reduction in the 1980s at the time of HIV/AIDS and supporting changes in legislation, it is noteworthy that governments have since retreated from the approach, which is not mentioned in the 2017 Drugs Strategy; the policy emphasis is now on "recovery", a pseudonym for "abstinence" – another delusionary approach. These are political, not evidence-based, decisions. "Harm reduction was initially a controversial concept in British drug policy, widely supported in the drug voluntary sector and amongst health interests but with no purchase at the policy level. Conservative politicians remained wedded officially to the 'war on drugs' approach in the early 1980s. The advent of HIV/AIDS enabled such ideas to move into the realm of practical policy [. . .]. Harm reduction was initially a policy strategy aimed at the reduction of HIV/AIDS and the prevention of its spread into the general population" (Berridge, 2013, p. 205). Denial of the value and benefits of harm reduction currently centres on drug consumption rooms, with government rejection of DCRs justified on the basis that legalisation would send a message that government condones the use of illegal drugs: the message which many receive is that government does not value the lives of people who use drugs. Whether or not intentionally, this represents stigmatisation, marginalisation and othering of the highest order. In their pursuance of existing drug policies and legislation, governments can be said to have absolved themselves from a social policy equivalent of the Hippocratic oath: first, do no harm.

Recent parliamentary debates have been better informed than those of the 1970s, with calls for review and repeal of the MDA, now customarily described as "not fit for purpose" and a more humane and considered attitude to people who use drugs. Parliamentarians initiated these debates, whose outcomes were not binding on the government. An early day motion has called for re-thinking UK drug laws, pointing to their failure to reduce drug supply, use and harms, including deaths (there were fewer than 100 drug-related deaths in 1971, 2996 in England and Wales in 2020, the highest figure and rate in Europe) and calling "upon the government, as a matter of urgency, to repeal and replace the Act with legislation to ensure that future drug policy protects human rights, promote public health and ensures social

justice" (House of Commons Early Day Motion 56, 17 May 2021). A debate on the MDA at 50 commented "our drugs regime remains the same, focussing on prohibition, criminalisation and punishment, rather than looking at the evidence on what reduces harm to individuals and society" (Smith, House of Commons Hansard, 2021, 17 June, Col., 496). In short, UK drug laws have worsened the problem they were intended to solve.

The MDA, preceding legislation and the nature of the 1970 parliamentary debates illustrated a lack of understanding of the contexts and implications of the use of and trade in illegal drugs; and a lack of vision and reality in the creation of drug policy. The Modern Law Review commented in 1972*:* "There is surely much to be said for squarely facing the fact that dug-taking in one form or another is bound to continue – in all probability to increase – and to formulate a realistic assessment of how a society, itself alarmingly 'pill-oriented', can come to terms with drug abuse" (Teff, 1972, p. 240), a conclusion more recently echoed by Mike Gossop: "[. . .] the quest to eliminate drug-taking has proved to be a search for a chimera. Drug taking is here to stay and one way or another we must all learn to live with drugs" (Gossop, 2000, p. 218). There has been a consistent and stubborn failure to distinguish between "is" (research) and "ought" (the desire to moralise). More fundamentally, there remains no broad agreement on the definition of a drug and, hence, a rational understanding of the purpose of drug laws (Teff, 1972). As Bean commented: "[. . .] the law on drug-taking can be linked-to value systems and political power" and "[. . .] certain social groups have had an influence on the moral passage of legal norms" (1974, 173 and 149).

Notes

1. An Act of Parliament is the principal (primary) UK legislation. Acts of Parliament may include provision for additional and clarifying (secondary) legislation to be introduced through Orders in Council, authored by the Privy Council, a body of senior politicians, not all of whom are currently elected members of either House of Parliament, appointed as advisers to the monarch. Acts may also provide for additional clarification in the form of Regulations, drafted by civil servants for ministerial approval. Acts originate in the legislative branch of government, parliament; Orders and Regulations by the executive, the sitting government. The latter are criticised by parliamentarians as diluting parliamentary sovereignty.
2. The Medicines Act 1968 has 165 pages, 136 Sections and 8 Schedules; The Misuse of Drugs Act 1971 has 42 pages, 40 Sections and 6 Schedules.
3. Delevingne has been described as "the architect of UK drug prohibition" (Shapiro, 2021, 48). From 1922 to 1932 he was the Home Office Permanent Under Secretary of State, a ministry's most senior civil servant.
4. General Practitioners or family doctors.
5. Hansard, the verbatim record of parliamentary proceedings, records state "Secretary of State for the Home Department", more usually referred to as Home Secretary.
6. This contradiction was described as inconsistent and hypocritical in the debate (Deedes, Col. 1464); Blenkinsop reminded the House "We live in a society in which there are about 300,000 alcoholics of whom 70,000 are seriously affected. Others are endangering their health with tobacco". (Col. 1471).
7. The Advisory Council on the Misuse of Drugs (ACMD) replaced the 1966 Advisory Committee on Drug Dependence on the passing of the MDA.
8. Used in opioid substitution therapy, methadone also entered the illegal drug market. Like heroin, it attracted concerns about over-prescribing, now in the control of DDUs. Before 1971, the Home Office maintained a register of heroin users, compiled using GP data. Cahal (1970, 33) cited 454 registered addicts in 1959, 753 in 1964; The Police Foundation (2000) cites 3,022 in 1973, 43,372 in 1996. After 1971 numbers were calculated using the Home Office UK Crime Survey. The Addicts Index was discontinued in 1996.
9. Paragraph 74 of the Wootton Report stated simply: "The present legal situation is unhelpful to research".

10. Page 5 of The Explanatory and Financial Memorandum to the Bill stated that research costs were "not expected to be more than £10,000 in the first year or two" (Teff, 1972, p. 237). ACMD research programmes have in the main been set by government, not independently determined.
11. The establishing of the ACMD as a statutory body is set out in the opening Section of the MDA. Whilst it might have been interpreted as providing a basis for commissioning research, its core functions were to advise government on trends and developments in drugs and dug use to add to prohibitive and proscriptive Regulations. It was established as an instrument of prohibition rather than information.
12. It was not until the 1990s that illegal drugs, tobacco and alcohol were seen by the medical and psychiatric professions as similarly potentially addictive. This did not extend to a reconsideration of their legal status or "control". – Cf. Berridge, 2013, p. 198.
13. This prejudice played a major part in the 2009 sacking of ACMD Chair David Nutt for making exactly this point: that UK drugs legislation is not based on scientific assessment of the dangerousness of substances.
14. The police power of "stop and search" was introduced in the Metropolitan Police Act 1839 and the Manchester Police Act 1844. Stop and search powers were strengthened in Section 6 (1) of the Dangerous Drugs Act 1967; and Section 23 of the Misuse of Drugs Act 1971. The police use, rather than parliamentary intention, of "stop and search" powers could be seen as a colonial legacy targeting what we now refer to as Black and Ethnic Minority populations. The Modern Law Review commented that "[. . .] the right of search prior to arrest has been condemned as an undue encroachment on privacy and civil liberty, responsible for much resentment of the police" (Teff, 1972, p. 237). From the 1920s, the "dangers" and "threats" ascribed to the use of cannabis became a proxy for police attention to African and Caribbean populations, a demonstration of systemic racism which continues to be practise – and denied. (See too Bean, 1974, p. 111 and passim).
15. The Convention came into force in 1964. It required "parties" to introduce domestic legislation in response to "serious" drug offences, including "imprisonment or other penalties of deprivation of liberty".
16. Schedule 2 lists the drugs and substances to be "controlled" by the MDA and allocates them to Classes. It has been much expanded since 1971. Teff presciently commented "[. . .] initial classifications tend to become entrenched" (Teff, 1972, p. 234).
17. The American jazz musician Dexter Gordon said in a contemporary interview: "They're building bigger and better prisons in the States and they're getting fuller and fuller. However, I don't really see how that's helping the drug problem". Melody Maker 23 July 1966.

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