

The 'drug policy ratchet': why do sanctions for new psychoactive drugs typically only go up?

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Citable statement

The policy response to the burgeoning of new psychoactive compounds is typically to progressively ratchet up sanctions, a process driven by politics and ideology as well as analysis of the harms of drugs and policy responses.

Introduction

The rapid emergence of a plethora of new psychoactive substances (NPS) in recent years has led to increased interest in the process of drug scheduling and control, much of it reflected in the pages of this journal (1-4). A common response to these new drugs in the UK has been to include them in the existing legislative system for control, as shown in table one below.

Whatever the benefits of this type of control, it is not without harm. It makes criminals of the substance's users and also hinders research on its potential effects; both harmful and therapeutic. In political discussions, there is a tendency both to ignore the potential benefits of new substances and to underestimate the harms related to prohibition. In academic journals, the debate has focused on whether a rational, scientifically informed control mechanism can be developed for NPS, and what form it would take.

In this contribution for debate, we argue that both historical analysis and contemporary experience suggest that drug control cannot be understood fully as a rational, scientific response to the prevalence and dangers of various substances. We note that there is, in effect, a ratcheting process which means that substances labelled as drugs are more likely to face tighter rather than looser control. In recent years, this ratcheting has been extended by the practice of banning generic classes of substances (e.g. synthetic cannabinoids and the substituted cathinones) instead of individual substances, with modern generic control first applied in the UK in 1977 to the phenethylamine family (which includes MDMA). The introduction of temporary class drug orders (TCDOs) has added a further tool to the process of ratchet-tightening. This drug policy ratchet operates even when evidence emerges that tight control is failing to reduce related harms (5), or is producing unintended harms that are disproportionate to the benefits of control (6). Less discriminate extension of control through the use of generic bans is even more likely than the banning of individual substances to have the disadvantages of preventing research on beneficial uses and of pushing the market towards unknown, potentially more harmful substitutes (7). Generic bans and TCDOs may also make it even more difficult to loosen control. It would be very difficult scientifically to demonstrate that a whole group of substances pose lower risk than suggested by their initial classification. It would be difficult politically to avoid permanently prohibiting a drug that had been subject to a TCDO

The historical work of David Courtwright, James Mills and others shows some of the past mechanisms of this ratchet. Our more recent ethnographic observations of UK policy, both in the civil service (Stevens) and on the Advisory Council on the Misuse of Drugs (ACMD, Measham), reveals some of the ways in which the policy process most often continues to exemplify MacCoun's ninth implicit rule of evidence use in drug policy (8): 'Scientific

research on drugs cannot motivate a change from tough law to lenient law, but it can motivate a change in the opposite direction’.

TABLE 1 ABOUT HERE

Historical patterns of control

If we look at the decisions that have been taken on drug control under the British Misuse of Drugs Act 1971 (MDA, see table one), then it is clear that it has been much more common for drugs to be controlled than to remain uncontrolled after risk assessment, and for them to be moved up classes and schedules than down in the legal control system. Often this has been in accordance with recommendations of the Advisory Council on the Misuse of Drugs (ACMD). It is worth noting that the only occasions on which the UK government has explicitly ignored the advice of the ACMD - on cannabis in 1978 and 2008, MDMA in 2009 and (probably) khat in 2013 - the effect has been to subject a substance to a higher level of control than was recommended by the Council. We suggest that the regulation of novel psychoactive substances should be understood in the context of the history of drug control. We argue that this reveals a pattern in which some psychoactive products have been prohibited on the basis of guilt by various kinds of association.

The classification of psychoactive substances as drugs is itself tied up with the history of prohibition. The emergence of the word ‘drugs’ to describe these substances resulted from, and did not pre-exist, the creation of legal controls (9). The early measures in this field were driven by an alliance of moral entrepreneurs and social progressives who wished to tame the emerging, globalised markets for intoxicating substances (10). These were thought to pose a

threat both to public health and the moral order. But not all intoxicating substances ended up being banned. The scale, power and social embeddedness of the tobacco and alcohol industries have protected these commodities from prohibition (except for the interlude for alcohol in the USA following the National Prohibition Act of 1919) (11). They were not, and still are not, generally classified as drugs in the policies of most developed countries. The substances that have been included in drug control are those considered to be guilty by deviant association, lunatic association, molecular association, or a combination of the three.

The substances that were first banned, both in the USA and the UK, were those that were associated with use by groups who were considered as deviant from the perspective of the white, protestant elite who focused on the perceived threat from minority ethnic migrants and their 'alien' traditions (10, 12-15). This pattern of prohibition of substances that are associated with foreign ethnicities and deviant subcultures continued throughout the 20th century. For example, the British government has repeatedly refused to loosen control of MDMA, in contradiction to ACMD recommendations. This has been the favourite drug of the rave and dance scene from the late 1980s onwards; with rave being the only musical genre ever to be criminalised in the UK (in the Criminal Justice and Public Order Act of 1994). It now seems likely that the government will ignore the ACMD's recent recommendation not to prohibit khat. This would be another example of banning a substance of which the use is associated with a marginalised, migrant group.

The prohibition of drugs is usually justified on the basis of their health harms. In the case of cannabis, this argument has focused on the harms to mental health. This was a particular issue in the inclusion of cannabis in the regimes of control that were established by both the 1925 Geneva Opium Conference and the 1961 Single Convention. As Mills (13, 15) has

shown, both decisions were informed by highly dubious data from Dr John Warnock, the British colonial administrator of the Egyptian Lunacy Department from 1895 to 1923.

Warnock spoke little Arabic but felt himself able to conclude that 41 per cent of cases of insanity in Egypt were caused by cannabis. He was no doubt helped in coming to this conclusion by his belief that inmates' denial of cannabis use was a sure indicator that they were indeed users of the substance.

The 2004 downward classification of cannabis in Britain, from class B to C, is listed in table one as one of the recent exceptions to the rule of tightening control. The link between cannabis and mental health - and in particular the link between the higher THC content of emergent hybrid skunk and cannabis psychosis - was soon recruited to the task of arguing for a re-tightening of the ratchet. This was frequently exemplified by journalists and campaigners using stories of middle class young men whose schizophrenia followed their cannabis use to argue for reversal of the declassification. In justifying its decision to implement this reversal (despite the repeated advice of the ACMD to keep cannabis in class C), the government referred again to the mental health risks of cannabis use. Once again, cannabis had been found guilty by its association with mental illness.

Some substances have been banned without evidence that they were being widely used, or that they were particularly harmful, but on the basis of their similarity to other banned substances. The 1912 International Opium Convention (Article 14) banned all new derivatives of opium, morphine and cocaine if they were 'shown by research, generally recognised, to be liable to similar abuse and productive of like ill-effects'. But current control systems do not always wait for such evidence to emerge before banning new substances and derivatives. For example, substituted pyrovalerones (e.g. naphyrone) were banned in 2010 in

the UK just weeks after the substituted cathinones (e.g. mephedrone). Methoxetamine was banned in 2013 along with similar compounds. In both cases these generic controls were not introduced on the basis of evidence of *existing* use or harm, or even of desirability amongst users (16), but because of presumed harm through a pharmacological comparison with other controlled substances, their relative potency and effects (17, 18). Thus, despite the lack of evidence of significant existing use or harm, whole groups of chemical compounds have been identified and controlled through generic bans in a process of guilt by molecular association.

Patterns in contemporary policy making

The history of drug policy making shows that decisions on drug control have not resulted solely from dispassionate analysis of relative harms. Instead, it reveals patterns of thinking about the control of psychoactive substances that continue to this day. Our experience of working with policy makers shows some continuing systematic influences on evidence use in policy making that tend to support the drug policy ratchet. Some of this experience has been published by Stevens (19). This ethnographic study was based on six months working as a policy adviser to the highest levels of the British civil service on issues of drugs and crime. It showed how, as in other jurisdictions (20), these civil servants faced an avalanche of information that they could potentially draw on in making their policy recommendations to ministers. They knew it was impossible to digest all this information, so they developed rules of thumb by which to judge which reports were worth reading. They learnt what type of evidence was likely to help them succeed in producing policies that found favour with ministers and their special advisers. In form, they learnt that persuasive evidence was most likely to be quantitative, unambiguous and suitable for presentation in simple graphs (known colloquially as ‘killer charts’). In content, the evidence that was most likely to be chosen was

that which did not disrupt existing policy narratives. The role of evidence in policy is often to support rather than to challenge the currently dominant policy discourse (21, 22). As noted by an early critic of the MDA (23), ‘political parameters delimit the possible universe of discourse for what purport to be open-ended scientific debates’.

One of the dominant tropes of current political narratives on drug policy is the desire to appear tough. During the ethnographic study of Stevens, frequent use was made of the word ‘totemic’ to describe policies that showed the government to be tough in its quest to protect the public from harmful people and substances. Tough policies were described as being especially appropriate for ‘other’ people, including unruly youths and ‘high harm causing users’. This desire to use drug policy to send a tough message has frequently informed drug classification decisions, most recently the swift passage of legislation banning substituted cathinones in April 2010. This was given cross-party support less than three weeks before a general election. Indeed, whilst many liberal commentators criticised the ‘pre-election prohibition fast-track’ (24, 25), the criticism from the Conservative Opposition (26). The ACMD review was pre-empted both by the national press, reporting that a ban was ‘likely’ (27), and by the Labour Prime Minister, who declared that once he heard the ACMD’s advice, he would take ‘take immediate action. We are determined to act to prevent this evil from hurting the young people of our country’ (28). It is this type of political rhetoric that would make it so difficult to reverse a ban made under a TCDO.

Of course, the narrative of ‘totemic toughness’ is not the only one that is told in policy discussions. There is also the narrative of evidence-based policy. It is worth reflecting here on the work of Thomas Mathiesen (29). He coined the phrase ‘silent silencing’ for the processes by which inconvenient truths are diverted from impacting on policy. One of these processes,

which Mathiesen calls ‘absorption’, occurs when an alternative vision that opens up possibilities of long-term fundamental change is accepted in name and partially in practice, but it is then set to the task of continuing the existing system of control. This can be seen in the absorption of the idea of evidence-based policy making in the field of drug policy. As demonstrated by the authors referred to above, evidence was called on throughout the 20th century to provide justifications for drug control decisions. The creation of the MDA itself followed some recommendations from the precursor of the ACMD - the Advisory Committee on Drug Dependence – and gave this committee a statutory footing (13). However, decisions in the last decade on cannabis, MDMA and (probably) khat show that politicians sometimes choose to ignore the recommendations of independent experts, despite their pledges of allegiance to evidence-based policy. In line with MacCoun’s ninth law, they have ignored ACMD advice when it has been to loosen control, but not when it has been to tighten the ratchet. Please do not read this paragraph, or indeed this article, as a plea for scientists to be left alone to make policy decisions without reference to the democratic process. Please do note the way in which political rhetoric absorbs and reproduces the demand for evidence to be respected, while political practice continues to insert other, unacknowledged interests into the process of decision making.

Conclusion

Both historical analysis and contemporary ethnographic experience suggests to us that the metaphor of the ratchet is a useful device for understanding developments in drug control and classification decisions. Legislative control tends to be tightened. Occasionally, the ratchet slips and a drug moves down a class. But the ratchet is usually re-tightened in due course.

Some might argue that increasing control is necessary under the precautionary principle; it makes sense to impose control on little-known substances that may turn out to be harmful before a sizeable market emerges. But this principle fails to explain why some relatively well-known substances have been moved to more tightly controlled classes when this is not justified by the evidence of associated harms (e.g. cannabis in 2009, psilocybin mushrooms in 2005 and khat in 2013) and others have not been moved to a less tightly controlled class when evidence suggests that harms may initially have been overestimated (e.g. MDMA). Neither does this principle explain the move towards very restrictive scheduling, nor the move towards blanket generic controls, both of which deny any potential therapeutic or recreational use of NPS which may emerge as relatively low harm (30) .

In contrast, we have suggested that the ratchet can be explained by long standing tendencies to criminalise users of psychoactive substances that become associated with stigmatised groups, with mental illness or with chemically similar substances that have been banned already. In addition, there are patterns of speech and action within the contemporary ‘thoughtworld’ (31) of civil servants and politicians that tend to extend, rather than limit, the scope of legislative control of NPS. This is evident in, among other developments, the shift to TCDOs and generic controls.

This is not a fully determined, inevitable process. It can be contested by a range of researchers, writers and activists. We suggest that recognition of the ratchet and some of the ways in which it works can help us to use evidence and public deliberation to better fit drug policies to the prospects of reducing harms.

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Table 1: Changes to drug classification under the Misuse of Drugs Act 1971 and Drugs Act 2005

Changes that have increased penalties		Changes that have reduced penalties	
<i>Selected drugs that have been placed under control by MDA or Drugs Act since 1971</i>	<i>Drugs that have been moved to a higher class in MDA</i>	<i>Drugs that have been taken out of control by MDA since 1971</i>	<i>Drugs that have been moved to a lower class in MDA</i>
Phenethylamines, including MDMA (into class A in 1977)	Methaqualone (from C to B in 1984)	Propylhexedrine (removed from class C in 1996)	Nicodicodine (from A to B in 1973)
Anabolic steroids (into class C in 1996)	Methylamphetamine (from B to A in 2006)		Cannabinol and its derivatives (from A to C in 2004)
Unprocessed fungi containing psilocin or its esters (into class A in 2005)	Cannabinol and its derivatives (from C to B in 2008)		Cannabis (from B to C in 2004)
Ketamine (into class C in 2006)	Cannabis (from C to B in 2009)		
Gamma-butyrolactone (into class C in 2009)	Pipradrol (from C to B in 2012)		
Synthetic cannabinoid agonists (into class B in 2009)			
Piperazines (into class C in 2009)			
Substituted cathinones (into class B in 2010)			
Substituted pyrovalerones (into class B in 2010)			
Generically defined pipradrol derivatives (into class B in 2012)			
Methoxetamine and generically defined analogues of ketamine and phencyclidine (into class B in 2013)			

Source: Based on appendix one of (32), with more recent additions.