Journal of
Psychopharmacology

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Journal:	*Journal of Psychopharmacology*
Manuscript ID	JOP-2018-3596
Manuscript Type:	Editorial
Date Submitted by the Author:	08-Aug-2018
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Please list at least 3 keywords which relate to your manuscript::	Schedule 1, Cannabis, MDMA, Psilocybin, British Association for Psychopharmacology
Abstract:	N/A

Restrictions on drugs with medical value: moving beyond stalemate

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A key task for psychopharmacology is to establish which medicines can provide optimal clinical benefit with minimal levels of harm. Drugs that are considered to have no medical value and a high risk of misuse or harm are listed in Schedule 1 of the UK Misuse of Drugs Regulations 2001; these currently include cannabis, 3,4-methylenedioxymethamphetamine (MDMA) and psilocybin. Schedule 1 drugs cannot be possessed or prescribed by clinicians, and research is only permitted under a Home Office license that is costly and time intensive to obtain.

By contrast, drugs that are deemed to have medical value despite a high liability for misuse or harm are placed in Schedule 2, including diamorphine, cocaine, amphetamines and ketamine. Research on these drugs is less restricted. They can be legally possessed by people with a prescription and possessed and supplied by pharmacists, doctors and dentists. Restrictions are lower still for drugs with widespread medical use listed in Schedules 3 to 5 such as buprenorphine and diazepam. In light of accumulating evidence supporting the medical value of Schedule 1 drugs including cannabis (Whiting et al., 2015), MDMA (Mithoefer et al., 2018) and psilocybin (Ross et al., 2016), this legislation creates a barrier to research and the advancement of medical science.

As part of a three-year commission from the Home Secretary, the Advisory Council for the Misuse of Drugs (ACMD) has been engaged in consultations on how research using Schedule 1 drugs might be facilitated. Based on their initial consultations, several suggestions were raised by the research community. These included a blanket exemption from Schedule 1 for research (like the Psychoactive Substances Act 2016) or the provision of a single organisational licence to bring exemption from Schedule 1 requirements for academic institutions.

To capture the views of the British Association for Psychopharmacology (BAP) in these consultations, we conducted a survey in May 2018 on our members' experiences of conducting research using controlled drugs. We received 23 detailed responses from members with a range of backgrounds, including those in a clinical, preclinical and industrial setting. Only two of these 23 respondents had no suggestions for improvement. Overwhelmingly, our members consider that the current legislative framework requires improvement to facilitate research. Specifically, Home Office licenses were reported to be prohibitively costly (requiring both an initial and renewal fee, and highly specific and costly requirements for storage). Furthermore, they were reported to create an unnecessary administrative burden and significant delays that could not be scientifically justified, given the low levels of risk compared to Schedule 2 drugs such as diamorphine (heroin).

To give specific examples, in some cases the Home Office had requested ethical approval before granting an initial license; however, the relevant ethics committee had in turn requested Home Office approval before accepting an application - a classic Catch 22 situation - causing significant frustration, excess paperwork and long delays. From an industry perspective, our members reported that opportunities to work internationally had to be declined due to the excessive costs associated with the multiple import and export licenses required under the current framework. The limited duration of import and export licences raised further challenges. Our members suggested that research councils should be made aware of these issues, as it may be necessary to request additional resources and time to complete research studies. As one respondent put it: *"As it stands, it is so difficult to even contemplate research in this area as you almost have to think 'Right, we might, if all goes well, be able to start in 2 years."*

Several respondents pointed out that the current system is unnecessarily burdensome for researchers working with small quantities of Schedule 1 drugs. The Misuse of Drugs Regulations 2001 lists an exemption for small quantities. However, apart from lysergide or any other *N*-alkyl derivative of lysergamide (1 microgram) there is no drug-specific level of exemption, and 1 milligram applies to all drugs. Problems were reported with obtaining a small quantity of a cannabinoid (total 10mg delta-9-tetrahydrocannabinol), leading to significant delay of a PhD student's submission and their supervisor, an Associate Professor of psychiatry, deciding to abandon this line of research altogether: *"In short, I can tell you without hesitation that the current legislation surrounding controlled drugs is stifling research in this area: it has essentially dissuaded me from continuing my work. I no longer work on controlled drugs."*

In contrast, experiences of working with Schedule 2 drugs were reported more favourably, providing a potential framework for legislation moving forwards: *"We routinely use schedule II drugs for experiments in animals. Process for ordering and management work well. Schedule I drugs are much more difficult due to additional licensing which effectively precludes use using these compounds despite potential value for preclinical research."*

Notably, the additional restrictions for Schedule 1 drugs was not considered scientific or appropriate given the level of risk: "*The difference in regulations for using Schedule 2 drugs e.g. PCP and Schedule 1 drugs e.g. cannabinoids, and difficulty in using Schedule 1 drugs is not evidence based or scientific. The current UK drug laws are clearly hindering research at all levels."* Although the ACMD initially considered that a blanket exemption of Schedule 1 restrictions for the research community would not be workable, feedback from our survey

highlighted that a similar exemption already exists, as University research departments are not required to hold a Home Office license to possess and supply drugs in Schedules 2 to 5. It was argued that extending this exemption to Schedule 1 should not be problematic or lead to "unintended consequences".

Shortly after our survey was completed, a high-profile case emerged in which a 12-year old boy named Billy Caldwell and his mother travelled to Canada to obtain cannabis oil to control his epileptic seizures. When they returned to the UK on June 11th 2018, the cannabis oil was confiscated by the Home Office. The situation escalated when Billy was admitted to hospital with severe and potentially life-threatening seizures, resulting in an unprecedented decision from the Home Office to return the cannabis oil on June 16th. The Home Secretary, Sajid Javid, commissioned a two-stage review on medicinal uses of cannabis products, and a coalition of academics and clinicians led by several members of the BAP called on the government remove them from Schedule 1.

The first stage of the review conducted by Chief Medical Officer Sally Davis stated: *"There is now however, conclusive evidence of the therapeutic benefit of cannabis based medicinal products for certain medical conditions and reasonable evidence of therapeutic benefit in several other medical conditions… As Schedule 1 drugs by definition have little or no therapeutic potential, it is therefore now clear that from a scientific point of view keeping cannabis based medicinal products in Schedule 1 is very difficult to defend."* The second stage of the review conducted by the ACMD agreed with this conclusion, recommending that cannabis-derived medicinal products (once clearly defined) should be moved from Schedule 1 to Schedule 2.

Home Secretary announced on 26th July 2018 that cannabis-derived medical products would be moved Schedule 2. He should be commended for rapidly commissioning these two reviews, and for informing his decision using scientific evidence. This historical move broke the longstanding and illogical stalemate of holding drugs with medical value in Schedule 1. In their commissioned review, the ACMD also concluded that: *"it is important that cannabis is not seen in isolation but as an example of a wider issue of potential 'barriers to research' associated with other drugs in Schedule 1.'"* In light of the efficiency with which cannabis products were reviewed - and the clear conclusions reached - we now hope that scientific evidence and review can challenge the Schedule 1 status of other potential medicines, including MDMA and psilocybin.

In conclusion, the results of our survey clearly demonstrate that current UK legislation hampers research into the consequences, and potential therapeutic benefits of Schedule 1 drugs. We praise the government's rapid response to cannabis based-medicinal products, and hope this will encourage further debate about the Misuse of Drugs Regulations and its impact on the field of psychopharmacology.

Acknowledgements: TF was funded by a senior academic fellowship from the Society for the Study of Addiction (SSA). AY was funded by the National Institute for Health Research (NIHR) Biomedical Research Centre at South London and Maudsley NHS Foundation Trust and King's College London. The views expressed are those of the authors and not necessarily those of the SSA, NHS, the NIHR, or the Department of Health.

Conflicts of interest: All authors are officers or council members of the British Association for Psychopharmacology (BAP). For a regularly updated list of their declarations of interest, please refer to the BAP website: https://www.bap.org.uk/council.php

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