

Chapter 9

Drug classification system

SUMMARY

This chapter examines the ABC drug classification system and considers criticisms and issues that have arisen over the classification criteria and process. It then examines the options for reform in this area.

INTRODUCTION 9.1 The ABC classification scheme for drugs has been controversial during recent years in the United Kingdom. Although there has been much less discussion about the classification system within New Zealand, there has been some criticism of the process by which drugs are classified. In this chapter we consider the evolution of New Zealand's three-tiered system of classification, and consider in some detail the criticisms that have been levelled at the similar system in the United Kingdom and their applicability to New Zealand. We then examine the options for reform.

ADOPTION AND DEVELOPMENT OF THE CLASSIFICATION SYSTEM 9.2 The ABC classification system has its origins in the 1973 report of the Blake-Palmer Committee.⁶⁶⁷ The report noted that “there are significant differences in the potential for harm of the drugs used illegally and for the non-medical purposes in their typical forms of illegal use”.⁶⁶⁸ The report recommended making a formal distinction between controlled drugs with different potential for harm, especially between cannabis plant and the opiates, seeing this as having “important symbolic significance.”⁶⁶⁹ It suggested the failure of the law to draw such a distinction could be wrongly interpreted as indicating either that the “establishment” was outdated in its knowledge and attitude towards drugs or that the drugs involved were interchangeable.⁶⁷⁰ The report also noted the different harms associated with the ways in which particular drugs are administered. Except where there are legitimate medical purposes, injecting a drug is generally more harmful than administering that same drug orally.⁶⁷¹

667 A committee set up by the Board of Health in 1970 to inquire into drug abuse and drug dependency in New Zealand chaired by the Deputy Director of Health, Geoffrey Blake-Palmer.

668 Board of Health Committee on Drug Dependency and Drug Abuse in New Zealand *Second Report* (NZ Board of Health Report Series, No 18, Wellington, 1973) 42.

669 *Ibid.*, 48.

670 *Ibid.*

671 *Ibid.*

9.3 Accordingly the report recommended, among other things, that:⁶⁷²

- controlled drugs should be placed in several separate schedules (or parts of schedules) which broadly indicate their relative potential for harm and degrees of control deemed necessary;
- consideration should be given to the suggestion that the illegal use or administration by injection of a drug prepared for oral use should be deemed to place it in a category of higher harmfulness carrying a higher maximum penalty; and
- provision should be made for periodic review, in light of the developing understanding of drugs and drug misuse, of both the classification of drugs and the penalties attaching to their illegal production, distribution, possession and use.

The Misuse of Drugs Act 1975

9.4 The Misuse of Drugs Act 1975 implemented many (but not all) of the report's recommendations. For example, the suggestion of different penalties for different forms of administration of a drug was not pursued. However, its recommendation for different classifications depending on the harmfulness of a drug was accepted, with the Act establishing a three-tier classification system. Drugs are classified as Class A, B or C for the purpose of fixing the penalty that applies to their illegal production, distribution, possession and use. The system is modelled on the Misuse of Drugs Act 1971 (UK).

9.5 The Hansard debate on the Drugs (Prevention of Misuse) Bill (which later became the Misuse of Drugs Bill) contains no discussion of the different types of drug harm or how these are to be weighed in assigning individual drug classifications. Nor is it clear what process was used to put the different drugs into different schedules. There is nothing to suggest any rigorous scientific analysis was undertaken, although there is reference in the Hansard debate to experts and departmental officials giving evidence that satisfied members that substances were listed in the appropriate schedules based on knowledge of their effects at the time.⁶⁷³

Subsequent amendments to New Zealand's classification system

9.6 Since 1975 there have been a number of significant amendments to the classification system.

9.7 An amendment in 1998 added a fourth schedule to the Misuse of Drugs Act listing precursor substances. We discuss the issues relating to precursor substances in chapter 12.

⁶⁷² For a full list of recommendations see *ibid*, 100.

⁶⁷³ See the transcript of the second reading debate (18 July 1975) 399 NZPD 3142-3157; the role of officials and experts is discussed on page 3146.

- 9.8 An amendment in 2000 clarified that the classification of a drug is based on the risk of harm a drug poses to individuals or to society by its misuse and accordingly:⁶⁷⁴
- (a) drugs that pose a very high risk of harm are classified as Class A drugs; and
 - (b) drugs that pose a high risk of harm are classified as Class B drugs; and
 - (c) drugs that pose a moderate risk of harm are classified as Class C drugs.
- 9.9 In 2000 an amendment also altered the process for classifying drugs. In 1977, when the Act first came into force, the Executive had an unfettered power to classify substances as controlled drugs by Order in Council. New drugs could be readily added to the three schedules, and substances could be reclassified or removed. This power was curbed in 1992 so that an Order in Council could only change the name or description of any substance already listed in the first and second Schedules,⁶⁷⁵ but could add, omit or rename any substance listed in the third Schedule. Other amendments to drug classifications had to be made by Act of Parliament.
- 9.10 Fuller powers to classify drugs by Order in Council were restored in 2000, subject to a new affirmative resolution procedure provided for in the standing orders. An Order in Council cannot be brought into force until a resolution is made by Parliament approving it through that procedure.⁶⁷⁶
- 9.11 Another feature of the 2000 amendments was the establishment of the Expert Advisory Committee on Drugs (the EACD) to advise the Minister of Health on drug classifications. The Minister of Health cannot recommend to the Governor-General that an Order in Council be made under the process described above without consulting with and considering advice given by the EACD.⁶⁷⁷ The amendment sets out a range of matters on which the EACD must advise and which the Minister must consider before making an Order in Council.
- 9.12 As outlined earlier in chapter 4, the classification system was amended again in 2005 with the introduction of the new restricted substances category. Substances included in that category are regulated rather than prohibited. Restricted substances can be added or removed by Order in Council subject to the affirmative resolution procedure.⁶⁷⁸
- 9.13 The 2005 amendment also introduced some new restrictions on the use of the Order in Council procedure. These preclude the use of the procedure to decrease or remove the classification of a controlled drug. This means a controlled drug cannot be moved to a lower level of classification or changed to a restricted substance without recourse to the full legislative process.⁶⁷⁹
- 9.14 We return to the issues around the Order in Council process later in the chapter.

674 See Misuse of Drugs Act 1975, s 3A.

675 Such an amendment could also only be made if it was necessary to render the name consistent with international scientific usage.

676 See Misuse of Drugs Act 1975, s 4A.

677 See Misuse of Drugs Act 1975, s 4B.

678 See Misuse of Drugs Amendment Act 2005, s 34.

679 See Misuse of Drugs Act 1975, s 4.

United Kingdom

- 9.15 Like New Zealand, the United Kingdom has a three-tier classification system designed to control particular drugs according to their comparative harmfulness either to individuals or to society at large. There is no statutory definition of harm but the Misuse of Drugs Act 1971 (UK) establishes an Advisory Council on the Misuse of Drugs (ACMD) to keep the drug situation in the United Kingdom under review and to advise ministers on measures for preventing or dealing with drug misuse.

Canada

- 9.16 In Canada, the Controlled Drugs and Substances Act 1996 classifies drugs for penalty purposes in four schedules. The maximum penalty for drug offences depends upon which schedule the drug appears in. There are also two schedules of precursor substances. The Canadian Act does not specify the basis on which particular substances have been included in particular schedules. Canada does not have a statutory committee equivalent to the EACD in New Zealand or the ACMD in the United Kingdom.

Australia

- 9.17 In Australia, the National Drugs and Poisons Scheduling Committee established under the Therapeutic Goods Act 1989 (Cth) makes decisions at a federal level on the Standard for Uniform Scheduling of Drugs and Poisons (SUSDP). Decisions on the SUSDP do not in themselves have the force of law but are recommendations for incorporation into state and territory legislation. The SUSDP covers all medicines and controlled drugs. Neither New South Wales nor Victoria classify drugs according to drug type. In each case, the maximum penalty depends on the conduct at issue (importing, manufacture, supply or possession etc), with drug type being a matter for sentencing discretion.

Europe

- 9.18 According to the Police Foundation Inquiry report (discussed more fully below), in most European jurisdictions drugs are not classified for penalty purposes. It is left to the courts to decide the impact of drug type on penalty. While many European countries do have a classification system, this is generally for purposes connected with medical prescription. The exceptions are Italy and Portugal where a six-tier classification system is used, and the Netherlands which has a two-tier system. Under the two-tier system in the Netherlands, a distinction is drawn between drugs that have an unacceptable risk of harm (drugs like heroin, cocaine, LSD, amphetamine and cannabis oil) and hemp products (drugs like hashish and cannabis leaf).

- 9.19 There has been very little discussion or debate about the ABC classification system in New Zealand, although there has been some criticism of the classification process. However, possible reform of the similar ABC classification system in the United Kingdom has been considered on a number of occasions over the last decade. We review the relevant reports below.

The Independent Inquiry into the Misuse of Drugs Act 1971 (the “Police Foundation Inquiry”)⁶⁸⁰

- 9.20 In 1997, a Committee chaired by Viscountess Runciman was established to inquire into the effectiveness of drug laws in the United Kingdom. Amongst other matters, the Committee considered whether it remained appropriate to classify drugs using the three-tier ABC classification system based on comparative harm.
- 9.21 The Committee noted that the United Kingdom was alone among European countries in using such a system. It considered whether to do away with classes of drug altogether. The main advantage of the “no class” approach would be that attention would focus on the different forms of conduct at issue (for example, manufacture, supply, sale for profit, possession and use) irrespective of the drug involved.
- 9.22 As an alternative, the Committee considered whether the number of classes should be reduced to two. The Committee noted that this would enable a clear division to be opened up between seriously harmful and less harmful drugs. But, while commending the two-tier system in the Netherlands for its attempt to draw a clear and meaningful distinction between harmful and less harmful drugs, it doubted whether this accurately reflects the complexity of the situation. In the Committee’s view, there are drugs that occupy an intermediate position between less harmful drugs like cannabis and seriously harmful drugs like heroin, and it believed the classification system should reflect this. Ultimately the Committee recommended no change to the three-tier system. However, it suggested there should be a much more systematic approach to the assessment of harm.
- 9.23 In reaching this conclusion, the Committee argued that the major justification for controlling drugs lies in the harm that the use of drugs causes to users, people affected by users and the community at large. Accordingly, it thought that it was appropriate to consider the relative harms of different drugs on these groups. The Committee noted that the relative harmfulness of drugs is determined by a number of factors, some applying to the individual and some to society. Having regard to the various harms involved, the Committee suggested the following criteria for assessing the harmfulness of drugs for classification purposes:⁶⁸¹
- their potential for dependency and addiction
 - toxicity
 - risk of overdose
 - risk to life and health
 - injectability
 - association with crime
 - association with problems for communities
 - public health costs.
- 9.24 Applying those criteria, the Committee suggested a number of changes to the existing classifications. These recommendations were not accepted by the Government.

680 *The Police Foundation Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (Police Foundation, London, 1999).

681 *Ibid*, chapter 3, paragraph 38.

The report of the Science and Technology Committee⁶⁸²

- 9.25 In 2006, the United Kingdom House of Commons Science and Technology Committee presented a detailed critique of the scientific anomalies within the classification system. It concluded that the three-tier classification system in the United Kingdom was not “fit for purpose”⁶⁸³ and should be abandoned. The Committee suggested the ranking of drugs based on harm needed to be “decoupled”⁶⁸⁴ from penalties for drug offences.
- 9.26 The Committee considered that this “decoupling” is necessary because knowledge of drug harms is constantly evolving, thus requiring constant revision of the classification system. The law cannot keep up. Also, there is very little scientific knowledge of the harms associated with some drugs. The Committee suggested a more sophisticated and scientific scale of harm should be developed and continually revised in light of evolving scientific knowledge. The purpose of the scale would be to inform policy-making and education. The scale would also apply to alcohol and tobacco.
- 9.27 The Committee declined to say how penalties for drug offences should be set, other than noting that “a greater emphasis on the link between misuse of a drug and criminal activity” and “a cleaner distinction between possession and supply are possibilities”.⁶⁸⁵
- 9.28 A number of the criticisms of the classification system in the report relate specifically to the performance of the ACMD and are therefore of limited relevance in the New Zealand context. However, the following criticisms are relevant:
- there is no evidence that giving a drug a higher classification acts as a deterrent;
 - there has been little evaluation of the impact of changes to drug classifications;
 - there is uncertainty about the definition of harm which creates confusion about classification decisions;
 - there is an insufficient evidence base for many classification decisions;
 - the boundaries between the classes are arbitrary;
 - the rigid nature of the system makes it difficult to move substances between classes as new evidence emerges;
 - the difficulties surrounding classification suggest that the time and effort involved in making classification decisions are unwarranted;
 - there is no systematic approach to determining when reviews of classification are necessary.
- 9.29 The United Kingdom Government rejected the Committee’s finding that the classification system is not “fit for purpose”, arguing that the three-tier system discharges its functions fully and has withstood the test of time. In the

682 Science and Technology Committee “Drug Classification: Making a Hash of it?” HC (2005–2006) 1031.

683 Ibid, 3.

684 Ibid.

685 Ibid, 46.

Government's view, the three-tier system allows meaningful distinctions to be made between drugs and "its familiarity and brand recognition amongst stakeholders and the public is not to be dismissed".⁶⁸⁶

Matrix of harm: Nutt/Blackmore hierarchy of harms

- 9.30 In the wake of the Police Foundation Inquiry, the ABC classification system was considered against a matrix of drug-related harm developed by Professors David Nutt, William Blakemore, William Salisbury and Leslie King.⁶⁸⁷ The matrix uses nine criteria for determining harmfulness grouped under three headings:
- (a) *physical harms* which include (i) a substance's acute toxicity (ii) its chronic toxicity and (iii) its ability to be ingested by the more dangerous means of injection rather than swallowing;
 - (b) *likelihood of dependence* which includes (iv) the intensity of pleasure derived (v) psychological withdrawal symptoms and (vi) physical withdrawal symptoms;
 - (c) *social harms* which include (vii) the damage done to others by drug users' intoxication (viii) the likely health care costs of drug misuse and (ix) other social harms such as child neglect, acquisitive crime and the erosion of family relationships.
- 9.31 Two groups of experts were asked to score each substance for each of the nine parameters. The first group was a group of consultant psychiatrists who were on the register of the Royal College of Psychiatrists as specialists in addiction. The second group comprised other scientists and experts in psychoactive drugs.⁶⁸⁸ A four-point scale (0–3) was used with 0 being "no risk" and 3 "extreme risk". For each substance, the scores were combined as a "mean harm score" to provide an overall index of harm.
- 9.32 The scores do not take into account the effect of prevalence. This reflects a deliberate decision on the part of the authors to focus on the intrinsic harm of a particular drug, independent of its rate of use.⁶⁸⁹ Social harm here refers to the effects at the individual level rather than the aggregated social costs for a drug, so that the assessment of social harm is different from those assessments under most other harm indices.

686 Secretary of State for the Home Department "Government Reply to the Fifth Report From the House of Commons Science and Technology Committee Session 2005–06 HC 1031: Drug Classification Making a Hash of it?" (Cm 6941, 2006) 3.

687 David Nutt and others "Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse" (2007) 369 *Lancet* 1047.

688 The first group completed the questionnaires independently. The second group used the Delphi method.

689 In a letter to the editor of the *Lancet* the authors explained: "Our method focused on the intrinsic harm of substances, independent of prevalence, because, to guide investment in policing and education, we need to be able to assess substances when their use is low, but with the potential to become widespread." David Nutt and others "Letter to the Editor" (2007) 369 *Lancet* 1857.

- 9.33 A table setting out the results of the assessment is provided below. It indicates that there was a significant correlation between the scores of the two groups of experts. Another point of particular interest is the high harm scores of alcohol and tobacco relative to a number of illegal drugs.

TABLE ONE
Matrix of harm: Nutt/Blackmore hierarchy of harms

	Physical Harm				Dependence				Social Harm			
	Mean	Acute	Chronic	Intravenous	Mean	Pleasure	Psychological dependence	Physical dependence	Mean	Intoxication	Social Harm	Health-care costs
Heroin	2.78	2.8	2.5	3.0	3.00	3.0	3.0	3.0	2.54	1.6	3.0	3.0
Cocaine	2.33	2.0	2.0	3.0	2.39	3.0	2.8	1.3	2.17	1.8	2.5	2.3
Barbiturates	2.23	2.3	1.9	2.5	2.01	2.0	2.2	1.8	2.00	2.4	1.9	1.7
Street methadone	1.86	2.5	1.7	1.4	2.08	1.8	2.3	2.3	1.87	1.6	1.9	2.0
Alcohol	1.40	1.9	2.4	NA	1.93	2.3	1.9	1.6	2.21	2.2	2.4	2.1
Ketamine	2.00	2.1	1.7	2.1	1.54	1.9	1.7	1.0	1.69	2.0	1.5	1.5
Benzodiazepines	1.63	1.5	1.7	1.8	1.83	1.7	2.1	1.8	1.65	2.0	1.5	1.5
Amphetamine	1.81	1.3	1.8	2.4	1.67	2.0	1.9	1.1	1.50	1.4	1.5	1.6
Tobacco	1.24	0.9	2.9	0	2.21	2.3	2.6	1.8	1.42	0.8	1.1	2.4
Buprenorphine	1.60	1.2	1.3	2.3	1.64	2.0	1.5	1.5	1.49	1.6	1.5	1.4
Cannabis	0.99	0.9	2.1	0	1.51	1.9	1.7	0.8	1.50	1.7	1.3	1.5
Solvents	1.28	2.1	1.7	0	1.01	1.7	1.2	0.1	1.52	1.9	1.5	1.2
4-MTA	1.44	2.2	2.1	0	1.30	1.0	1.7	0.8	1.06	1.2	1.0	1.0
LSD	1.13	1.7	1.4	0.3	1.23	2.2	1.1	0.3	1.32	1.6	1.3	1.1
Methylphenidate	1.32	1.2	1.3	1.6	1.25	1.4	1.3	1.0	0.97	1.1	0.8	1.1
Anabolic steroids	1.45	0.8	2.0	1.7	0.88	1.1	0.8	0.8	1.13	1.3	0.8	1.3
GHB	0.86	1.4	1.2	0	1.19	1.4	1.1	1.1	1.30	1.4	1.3	1.2
Ecstasy	1.05	1.6	1.6	0	1.13	1.5	1.2	0.7	1.09	1.2	1.0	1.1
Alkyl nitrites	0.93	1.6	0.9	0.3	0.87	1.6	0.7	0.3	0.97	0.8	0.7	1.4
Khat	0.50	0.3	1.2	0	1.04	1.6	1.2	0.3	0.85	0.7	1.1	0.8

Table: Mean independent group scores in each of the three categories of harm, for 20 substances, ranked by their overall score, and mean scores for each of the three subscales.⁶⁹⁰

690 Nutt and others, above n 687, 1051.

- 9.34 The authors of the study concluded that the results of the study do not provide justification for the sharp A, B or C classifications in the Misuse of Drugs Act (UK).⁶⁹¹ They found a fairly poor correlation between a drug's class under that Act and its harm score. While recognising the convenience of the system for determining penalties, they considered that the sharply defined categories are essentially arbitrary unless there are obvious discontinuities in the full set of scores. However, if a three-tier system was to remain, they suggested that drugs with harm scores equal to that of alcohol and above might be Class A, cannabis and below might be Class C and drugs in between might be Class B.
- 9.35 Some criticisms have been made of the matrix of harm. The matrix treats all harms as being of equal weight; the harm score for each drug is simply the mean of the total scores for the drug across all nine criteria. As a consequence, for example, acute physical harm including death has an equal weight to the harm of psychological dependence, or the social harm caused by intoxication. There is room for debate as to whether some types of harm should have greater weight than others when assessing the overall harmfulness of a drug.⁶⁹²
- 9.36 The matrix has also been criticised for being too subjective. The United Kingdom's Academy of Medical Sciences, for example, considered that the reliance of the matrix on the subjective assessment of experts means it made only indirect use of advances in knowledge of brain science, measurements of the clinical and social impact of drugs on individuals and populations, and the economic and social costs of drug misuse.⁶⁹³

The report of the Royal Society for the Encouragement of Arts, Manufacture and Commerce (RSA) Commission⁶⁹⁴

- 9.37 The 2007 report of the RSA Commission on Illegal Drugs, Communities and Public Policy (an independent Commission established by the RSA) also recommended the abandonment of United Kingdom's ABC classification system.
- 9.38 The report made similar criticisms of the three-tier system to those made in the Science and Technology Committee's report. The Commission was particularly concerned about the way the system was used by the Government to convey messages about drug use. It suggested that where the classification system is used in this way, it either fails to transmit the desired message at all or else sends signals that are garbled. The Commission also considered that the "opacity" of the classification system and the "oversimplifications built into its workings"

691 Ibid.

692 See letter to the editor from John Britten and others, who argue that the harm score for tobacco should be higher – "For tobacco, the score for chronic harm resulting from killing more than 100,000 people each year in the UK is more than offset by low scores for acute harm and intravenous use." John Britten and others "Letter to the Editor" (2007) 369 *Lancet* 1857.

693 The Academy of Medical Sciences *Brain Science, Addiction and Drugs – An Academy of Medical Sciences Working Group Report Chaired by Professor Sir Gabriel Horn FRS FRCP* (The Academy of Medical Sciences, London, 2008).

694 The RSA Commission on Illegal Drugs, Communities and Public Policy *Drugs – Facing Facts* (RSA, London, 2007).

reduce its value as a sentencing tool and undermine it as a prevention strategy, since prevention depends on the accuracy and plausibility of official information about drugs.⁶⁹⁵

- 9.39 The Commission proposed an entirely new legal framework for the control of harmful substances. This would be in four parts:
- (a) A new Misuse of Substances Act that would be drafted in broad and general terms, expressing the State's intention of controlling substances and defining in general terms the activities that would constitute offences such as cultivation, manufacture and supply of controlled substances. It would also make clear the circumstances in which the supply and use of controlled drugs would not constitute offences.
 - (b) A schedule setting out a graduated list or gradient of all specific offences in descending order of seriousness and the range of penalties to be attached to each offence.
 - (c) An index comprising a list of substances set out in descending order of harmfulness, which could be generated by a matrix mapping of the various types and degrees of harm associated with the substances in question.
 - (d) A table or regulatory map setting out the method and degree of regulation of each substance.
- 9.40 A key feature of the proposal is that neither the statute, nor the schedule to it, would name any individual substance, determine its criminality or allocate penalties to its supply or possession. The schedule would rank offences but not substances. Individual substances would be listed in an index and be ranked in order of their harmfulness on the basis of scientific and sociological evidence. The gravity of any offence and therefore the penalties attached would be determined by reference to the index.
- 9.41 However, the index would not form an integral part of the new Act itself. Instead the index, which would need to be well publicised, would have a "quasi legal" status and would be taken into account by courts when dealing with offences under the Act.⁶⁹⁶ Both the index and the table would be regularly updated to include new substances and to reflect changes in the evidence relating to the relative harmfulness of substances that are already included. This would effect consequential changes in the penalties attached to offences involving the substances in the index. The Commission noted that there may not currently be sufficient research capacity to achieve this. However, if necessary, it suggested a research capacity should be created to allow for regular (perhaps five yearly)⁶⁹⁷ reviews.

695 Ibid, 287.

696 Ibid, 319.

697 Ibid, 320. The report records that Professor Nutt suggested five yearly reviews in an evidence session with the Science and Technology Committee as part of its follow up on its report.

The report of the Academy of Medical Sciences⁶⁹⁸

- 9.42 The Academy of Medical Sciences (AMS) was invited by the United Kingdom Government to consider, in consultation with experts, the societal, health, safety and environmental issues raised by the Government's Foresight Report⁶⁹⁹ and to make recommendations for public policy and research needs. It convened a working group chaired by Sir Gabriel Horn to undertake the task. Chapter 5 of the working group's report considered the issue of harm and regulation, including the drugs classification system.
- 9.43 The AMS commissioned a national programme of public engagement to ensure that its final recommendations were informed by both scientific evidence and public concerns and aspirations. In this respect, the AMS report noted that drug laws are controversial and public consultation is essential if changes to legislation are to be implemented effectively.
- 9.44 Most participants in the public engagement activities considered the United Kingdom's drug classification to be "confused, inconsistent and arbitrary".⁷⁰⁰ The AMS suggested, therefore, that the classification system needed to be revised to reflect more accurately the harms associated with each drug.
- 9.45 The report also called for the development of new quantitative indices of all harms attributable to legal and illegal drugs. These could be used by the ACMD, along with other evidence, to inform its advice on the harmfulness of individual substances and decisions on whether and how drugs should be classified. The new indices would also inform decisions as to whether the three-tier classification system itself is too fine or too coarse to "capture" the different levels of harm.⁷⁰¹
- 9.46 For completeness, we note that although the report stopped short of calling for the legalisation of the possession and use of drugs, it recommended that in striking a balance between individual freedom and the harms of substance misuse, account needed to be taken of the long-term harm of criminalising the possession of drugs for personal consumption.

SHOULD THE CLASSIFICATION SYSTEM BE REFORMED?

- 9.47 The New Zealand classification system is more developed than its counterpart in the United Kingdom. The 2000 amendments set out the basis for making drug classifications, with Class A being drugs posing a very high risk of harm, Class B posing a high risk of harm and Class C posing a moderate risk of harm. In addition, the Act is more explicit about the classification process and the factors that are to be taken into account in drug classification decisions. However, there has been no systematic review of the individual drug classification decisions made before the 2000 amendments, and it is generally accepted that some of the current classifications are anomalous in light of the available scientific evidence.
- 9.48 Despite these differences, many of the criticisms of the classification system in the reports reviewed above are relevant in the New Zealand context. We examine those criticisms below.

⁶⁹⁸ The Academy of Medical Sciences, above n 693.

⁶⁹⁹ Foresight *Drugs Futures 2025?* (Office of Science and Technology, London, 2005).

⁷⁰⁰ The Academy of Medical Sciences, above n 693, 74.

⁷⁰¹ *Ibid*, 73.

Criticisms of the present classification system

- 9.49 The first criticism is that there is no evidence that the classification system itself or changes in individual drug classifications have a deterrent effect. However, deterrence is only one of the purposes of sentencing. It is not the only or even the predominant purpose. Sentencing should reflect the culpability of the offender. If the reason for controlling drugs is that they cause harm, there is a coherent argument that the more harmful the drug, the more culpable it is to deal with it, and the greater the penalty should be. It is undoubtedly desirable that the effects of drug classifications, and changes to them, are evaluated, but the absence of information about their deterrent effect does not necessarily provide a reason for abandoning the current system.
- 9.50 The second criticism is that there is uncertainty about the definition of harm which creates confusion for classification decisions. Related to this are concerns that there is an insufficient evidence base for many classification decisions and that the boundaries between drug classes are arbitrary. In part, this argument rests on confusion about the purpose of the definition. In chapter 2, we discussed the difficulties surrounding the measurement of drug harm and expressed some scepticism about the value of attempts to describe and quantify the costs of all drug use. But these difficulties do not necessarily make it wrong to group drugs into broad harm categories for the purpose of fixing maximum penalties for drug offences.
- 9.51 Inevitably with any classification system there will be issues about where the boundaries for each category should be drawn. But the same is true in drawing the boundaries for any criminal offence. We acknowledge that the evidence base for drug harm is less developed for some drugs than for others. Nevertheless, there does appear to be broad consensus amongst scientists on the relative harms of most controlled drugs. For example, as we noted above, there was a significant correlation between the scores of the two groups of experts that independently assessed drug harms for the Nutt/Blakemore matrix.
- 9.52 The third criticism is that the classification system is vulnerable to political and media pressure, resulting in classification decisions that are not based upon scientific evidence. This has undoubtedly been the experience in the United Kingdom, where recommendations of the ACMD about the classification of cannabis and ecstasy have been ignored by the United Kingdom Government. More recently, the Chair of the ACMD has been sacked because of his public comments about anomalous drug classifications. In New Zealand, the recommendations of the EACD have never been ignored,⁷⁰² although there have been occasions, such as the recent recommendation relating to the classification of BZP, when the EACD itself has not been unanimous in its recommendations. However, the Government has on occasion made its views of a particular drug known before the EACD has examined the evidence, which has made it difficult for the EACD (which includes government officials in its membership) to take an alternative position.
- 9.53 We acknowledge the potential for drug classification decisions to be vulnerable to political and media pressure. However, even the most scientific scale of harms necessarily involves some element of value judgement. On that basis, arguably,

702 Although it should perhaps be noted that the EACD has never recommended a downward reclassification of any drug.

it is appropriate for classification decisions to depend to some extent on political judgements. What is important is that those judgements are informed as far as possible by the evidence. In any event, public and media concern about particular drugs will almost inevitably feature in decisions about the penalties for drug offences no matter how they are set. The involvement of an expert committee in the classification process at least ensures that evidence relating to drug harms is considered when penalty levels are set.

- 9.54 The fourth criticism of the current classification system is the lack of any systematic approach to reviewing drug classifications to take account of developments in scientific knowledge. However, if a three-tier classification system were to be retained, this issue could be addressed by a statutory provision that put in place a system for regular review of classification decisions.
- 9.55 The final criticism is that the system acknowledges none of the nuances in drug-taking behaviour in terms of risk and harmfulness. The Blake-Palmer Committee was concerned about this issue even before the current Act was passed. The practical reality is that the harmfulness of a drug to an individual user depends on a range of factors, including the frequency of use, the mode of administration and individual personal factors. However, in our view, this does not mean an assessment cannot be made of the relative harmfulness of different drugs. It is the average harm arising from the use of a drug that is important, not its variability in the individual case.

OPTIONS
FOR REFORM
OF THE
CLASSIFICATION
SYSTEM

Reform of the current classification system

- 9.56 There is a range of options for reforming the current classification system.

Option 1: A single maximum penalty for all drugs

- 9.57 Under this option, the ABC classification would be dispensed with. Substances would be classified as controlled drugs but not broken into classes in legislation. The same maximum penalty would apply to a drug offence irrespective of the particular drug involved. (There are alternative ways of dividing offences involving different forms of conduct (that is, manufacturing, importing or exporting, or large-scale supply). Some of these are discussed in chapter 10.)
- 9.58 The actual sentence to be imposed in any individual case would be left to the discretion of the sentencing judge. There could, however, be some statutory guidance about the factors that were to be taken into account, including matters such as the harmfulness of the particular drug involved. The higher courts might also issue some sentencing guidance. But a major difficulty would be that there would be no systematic way of informing the judiciary about the different harms associated with different drugs.
- 9.59 The main advantage of this option is that it would avoid most of the difficulties with classifying drugs, including some of the problems of assessing their relative harms, gaps in scientific knowledge and the need for review of classifications from time to time to take account of developing knowledge. However, it would leave a very broad range of conduct to the discretion of the sentencing judge. For example, if the current life sentence was to be retained as the maximum penalty for dealing in methamphetamine (currently a Class A drug), it would mean that

this penalty would be available for dealing in drugs such as BZP and cannabis (currently Class C drugs). It seems desirable that Parliament give greater guidance than this as to the maximum penalties that should apply to drug offences that involve widely varying degrees of harm.

- 9.60 A variant on this option would be a system such as that proposed in the RSA report under which the substances would not be named in the statute but incorporated by reference to their scale on a “quasi-legal” scientifically based index of drug harms. However, we consider there is a real difficulty with this approach because it would provide none of the certainty that is required when defining serious criminal offences. It is essential that the public know, and understand, the boundaries of criminal offences and the penalties that apply. This means that, if dealing with particular substances is to attract substantial criminal penalties, both the nature of the substances and the nature of the dealings that are prohibited should be specified in primary legislation.

Option 2: A two-tier classification system

- 9.61 Under this option, there would be one tier of the classification system for seriously harmful drugs and one tier for less harmful drugs.
- 9.62 The main advantage of a two-tier system is that it might provide clearer and more easily understood categories than a three-tier system and the lines may also be more easily drawn. However, arguably it is too simple a system to deal with the wide range of harms posed by different drugs. That was certainly the views of both the Blake-Palmer Committee and the Police Foundation Inquiry. It may also create misconceptions that there are “hard drugs” and “soft drugs” and that the latter are not harmful, although to some extent this occurs anyway under a three-tier classification with Class C drugs being perceived as “soft drugs”.

Option 3: Retain the current three-tier classification system

- 9.63 The advantage of this option is that it may discriminate more accurately than a two-tier system between the different levels of harm posed by different drugs. It gives a clearer signal about the level of penalty Parliament intends for certain types of offending involving particular drug types. Against that, the current difficulties with classifying drugs would remain, although at least some of these could be avoided by a provision for regular review of classification decisions. Provision for regular review would ensure that such decisions were kept up-to-date with developing scientific knowledge and relevant changes in the drug landscape.
- 9.64 If this system is retained, it will be important that there is a full scale review to assess the appropriate drug classification of current drugs before any new legislation is passed. It is clear that some of the current classifications are inconsistent with what is now known about drug harms. For example, if we generally accept the Nutt/Blakemore scheme for assessing harm, it would seem to follow that the current classifications of LSD, GHB (fantasy) and ecstasy, which are all assessed as less harmful than alcohol, tobacco and cannabis, do not reflect the relative harm associated with these substances. Following a full scale review of classifications, it would also be desirable that there is continual and regular monitoring and evaluation of the effects of classification decisions and of any changes that are made to them.

Option 4: A more nuanced classification system based on a scientifically based drug harm matrix

- 9.65 Under this option, further tiers could be added to the classification system with maximum penalties being based on the score a drug type receives on a scientifically based drug harm matrix. This multi-tiered classification system would, like the current three-tiered scheme, be included in legislation.
- 9.66 The main argument for this option is its focus on evidence-based classification. In this respect, it could assist in promoting a better public understanding of drug harms. However, this option also has real difficulties. The problems surrounding the accurate measurement of drug harms discussed earlier would be exacerbated under this option. The more tiers in the system, the harder it would become to categorise drugs into the appropriate harm category. In addition, a multi-tier system has the potential to distort the sentencing process because it would create a large number of offences with little between them in terms of culpability.

Q13 Do you favour:

- (a) no classes and a single maximum penalty for all drugs;
- (b) a two-tier classification system;
- (c) retention of the current three-tier system based on an improved assessment of risk and regular reviews;
- (d) a more nuanced classification system (four-tier plus) based on a scientifically based drug harm matrix;
- (e) some other approach? (please specify)

Defining harm

- 9.67 If a classification system is retained, as it would be under options 2 to 4, there needs to be criteria to determine the classification to be applied to each substance.
- 9.68 Section 4B of the Misuse of Drugs Act requires the EACD to advise the Minister on, and the Minister to take into account, a number of matters when making drug classification decisions. These factors are intended to provide the basis for the assessment of drug harm:
- (a) the likelihood or evidence of drug abuse, including such matters as the prevalence of the drug, levels of consumption, drug seizure trends, and the potential appeal to vulnerable populations; and
 - (b) the specific effects of the drug, including pharmacological, psychoactive, and toxicological effects; and
 - (c) the risks, if any, to public health; and
 - (d) the therapeutic value of the drug, if any; and
 - (e) the potential for use of the drug to cause death; and
 - (f) the ability of the drug to create physical or psychological dependence; and
 - (g) the international classification and experience of the drug in other jurisdictions; and
 - (h) any other matters the Minister considers relevant.

- 9.69 In our view, there are problems with the approach to these criteria. The current classification system is used to decide whether or not particular substances should be prohibited and, if so, the class into which each substance falls. This in turn determines the maximum penalty that applies to a substance's misuse. The same factors are therefore taken into account in deciding whether or not a drug should be prohibited as are taken into account in deciding maximum penalties for drug offences. But these are very different decisions which depend upon quite different considerations.
- 9.70 As we outlined in chapter 8, except where there are international obligations, decisions about whether and how to regulate drugs should be based on which regulatory approach will most effectively minimise drug-related harm. Decisions about maximum penalties for drug offences depend on an assessment of how culpable it is to deal with the substance. The level of culpability depends in turn on how much harm is caused to others by the particular conduct involving the drug.
- 9.71 The effect of having a single list of factors for both decisions is that it contains a number of factors that have no relevance to penalties for drug offences. For example, the therapeutic value of a substance is relevant to the way it is regulated, including the possibility of making it available on prescription. However, once it has been decided to prohibit a substance (whether it is available on prescription or not), it is difficult to see the relevance of a substance's therapeutic value to penalty levels for its misuse. In our view, the list of factors that determine a drug's classification for penalty purposes needs to be different from the list of factors that determine the way it is regulated.
- 9.72 The most important consideration for determining maximum penalties for drug offences is how much harm is caused to others by any particular substance. The more harmful a substance is, the more culpable it is to deal with it and the higher the maximum penalty should be. It is therefore necessary to consider how to assess the nature and severity of drug harm. This kind of assessment is also necessary to inform decisions about drug regulation.
- 9.73 We have already outlined the proposals for defining drug harm that are made in the various United Kingdom reports that consider drug classification. Although there are some differences between the proposals, most agree that the factors described under the headings used in the Nutt/Blakemore scheme (set out in paragraph 9.30 above) should be taken into account.⁷⁰³
- 9.74 More controversial is the relevance of prevalence. Section 4B(2)(a) of the Misuse of Drugs Act treats prevalence as a relevant factor. It requires consideration of "the likelihood or evidence of drug abuse... levels of consumption, drug seizure trends, and the potential appeal to vulnerable populations". It is sometimes argued that prevalence should be taken into account in fixing maximum penalties because of the importance of deterring harmful conduct where it is prevalent. However, in our view, prevalence is not a relevant factor for fixing maximum penalties, because it does not bear on an individual offender's culpability. In other words, an offender should be responsible only for the harm he or she

⁷⁰³ Dr Doug Sellman and others in New Zealand have begun some work on developing a scale for assessing the risks different drugs pose to public health.

causes, not for harm that is done by others. In any event, there is no evidence that giving drug offences higher maximum penalties does act as a deterrent, as the United Kingdom reports make clear.

- 9.75 Another factor seen as relevant to the assessment of harm, under section 4B(2)(g), is “the international classification and experience of the drug in other jurisdictions”. The experience of the drug in other jurisdictions is clearly relevant. However, we are not convinced that considering overseas drug classifications is useful, since different classification systems are used in different countries and not all systems are evidence-based. Instead, there should be a requirement to consider assessments of drug harms undertaken both in New Zealand and in other jurisdictions. There is increasing interest internationally in the development of scientifically based indices of drug harms. The AMS report also suggests ways in which drug harms can be measured in a more objective way. It is appropriate that developments in this area are taken into account when making assessments of drug harms.
- 9.76 Section 4B(2)(h) identifies as a factor “any other matters the Minister considers relevant”. In our view, a broad open-ended factor of this kind is undesirable, because it leaves uncertainty about the matters that should be considered when assessing harm. It also detracts from the principle that decisions about drug classifications should as far as possible be evidence-based.
- 9.77 The next issue is how harm is to be assessed. The Nutt/Blakemore scheme suggests that this should be done through the scoring of harm by experts from different disciplines. The AMS report, while acknowledging this process as a step forward, suggests that its reliance on the subjective assessment of experts means it makes only indirect use of advances in knowledge of brain science, measurements of the clinical and social impact of drugs on individuals and populations and the economic and social costs of drug misuse. Implicit in this is the suggestion that objective criteria should replace subjective assessment.
- 9.78 However, in our view, a purely objective assessment of drug harms is simply not possible. How different types of drug harm are to be weighed against each other depends to an extent on values. We are not convinced, for example, that equal weight can be given to the different types of drug harms (that is, physical harms, likelihood of dependence and social harms) as the Nutt/Blakemore scheme contemplates. The judgements are more nuanced than that. There are also significant gaps in the evidence. Notwithstanding these difficulties, we suggest, expert advice on drug harms can and should inform decisions about drug regulation and the penalties for drug offences. Without this, it is doubtful whether good policy outcomes can ever be achieved because of the controversial and emotive nature of drug issues. We discuss the possible composition of an expert advisory committee next.

Q14 Do you agree that there should be separate criteria for the decision to regulate a drug and the decision to classify a drug in order to determine penalty? Is it appropriate to classify drugs on the basis of their risk of harm? If so, should harm include physical harms, dependence potential and social harms? Is prevalence a relevant factor in defining drug harm? Are any other factors relevant?

The role of an expert advisory committee

9.79 Section 5 of the Misuse of Drugs Act 1975 authorises the Minister of Health to establish advisory and technical committees. As we have noted, legislative amendments in 2000 required the Minister to establish an Expert Advisory Committee on Drugs (EACD) to advise the Minister on drug classification matters. Section 5AA(2) provides:

- (2) The functions of the Committee are –
- (a) to carry out medical and scientific evaluations of controlled drugs, and any other narcotic or psychotropic substances, preparations, mixtures, or articles; and
 - (b) to make recommendations to the Minister about –
 - (i) whether and how controlled drugs or other substances, preparations, mixtures, or articles should be classified; and
 - (ii) the amount, level, or quantity at and over which any substance, preparation, mixture, or article that is a controlled drug (or is proposed to be classified as a controlled drug), and that is to be specified or described in clause 1 of Schedule 5, is to be presumed to be for supply; and
 - (iii) the level at and over which controlled drugs to which clause 2 of Schedule 5 applies are presumed to be for supply; and
 - (c) to increase public awareness of the Committee's work, by (for instance) the timely release of papers, reports, and recommendations.

9.80 We note that the ACMD in the United Kingdom has a much broader role than the EACD in New Zealand. This includes, for example, a role in advising on matters such as drug education and treatment.

9.81 In our view there is a need for a statutory committee (or sub-committee) of experts to advise the Government on the nature and severity of drug harms to inform decisions about how drugs should be regulated and the penalties for drug offences. The existence of a statutory committee will ensure that expert evidence about the nature and severity of drug harms is at least considered when making these decisions.

- 9.82 Section 5AA of the Misuse of Drugs Act prescribes the membership of the EACD. It requires:
- (a) up to five people who between them have appropriate expertise in pharmacology, toxicology, drug and alcohol treatment, psychology, and community medicine;
 - (b) up to three people employed by the public service who between them have appropriate expertise in public health, the appropriateness and safety of pharmaceuticals and their availability to the public, and border control; and
 - (c) one police employee, one employee of the Ministry of Justice with expertise in the justice system, and one person representing the views of consumers of drug treatment services.
- 9.83 Four issues with an expert committee arise:
- whether the committee should be independent;
 - whether the expert committee should retain consumer representation;
 - whether the current composition of the committee has the necessary expertise to advise Government on drug regulation and classification; and
 - the size of the committee.

Independence of the committee

- 9.84 There are arguments both for and against government representation on the committee. The arguments for including government representation is that this will ensure that the interests of government are factored into the committee's recommendations. Arguably, this is important for two reasons. First, the recommendations may have an impact on government expenditure. For example, recommendations about any given regulatory approach will inevitably involve costs, and recommendations about penalty levels may affect the prison population. The involvement of government officials might help to ensure that the recommendations are affordable and achievable. Secondly, as we have already indicated, to an extent the assessment of harms involves value judgements. Arguably, these judgements are more appropriately made by government than by experts.
- 9.85 However, there are also strong arguments against government representation. Most importantly, the committee's recommendations may be perceived as lacking independence and may therefore lack credibility. The involvement of government officials, or indeed anyone in a representative capacity, may also be seen as detracting from the principle that drug policy should be evidence-based.
- 9.86 On balance, we consider that an independent committee is the better option. At the very least the chair should not be a government official and the committee should have statutory independence. In any event, it is important that the evidence on which the committee recommendations are based, in particular the evidence relating to drug harms, should be made available both to Ministers and to the public so that there is transparency about the basis on which recommendations are made.

Consumer representation

- 9.87 The reason for having an expert committee is to ensure that decisions on drug policy are evidence-based. There may therefore be an argument that consumers lack the necessary expertise to advise on the nature and severity of drug harm. Against that, consumers may be able to provide some insight into the likely impact of alternative regulatory approaches, this being an area where the evidence is currently lacking. At least until some experience has been gained with alternative regulatory approaches, this may be some of the best evidence available.

Committee expertise

- 9.88 We consider that expertise in pharmacology, toxicology, drug and alcohol and drug treatment and community medicine is important and should remain. We would, however, add to that list neuroscience, emergency medicine, psychiatry and expertise in drug policy, research and evaluation. What we have in mind for the latter is a person who is able to contribute up-to-date information on developments in other jurisdictions, including information about alternative regulatory approaches and the evidence of their effectiveness.

Committee size

- 9.89 The optimal size for a committee of this type would be about eight people. This should be sufficient to cover the needed areas of expertise without becoming unduly large and cumbersome. We propose a committee of eight people who between them have appropriate expertise in one or more of the following: pharmacology, toxicology, drug and alcohol treatment, psychology, community medicine, neuroscience, emergency medicine, psychiatry and expertise in drug policy, research and evaluation.

Q15 Do you agree that there is a need for an expert committee to advise on drug regulation and drug classification (if a classification system is retained)? Should the committee be independent? Should it have consumer representation? What expertise is required? What is the committee's optimal size?

Controlled drug analogues

- 9.90 The current classification system makes explicit provision for controlled drug analogues. A controlled drug analogue is a substance that has a structure substantially similar to that of a controlled drug unless that substance is itself listed as a controlled drug or is a pharmacy-only medicine, a prescription medicine or a restricted medicine regulated under the Medicines Act 1981.⁷⁰⁴ Whenever a substance is classified as a controlled drug, all of its analogues, unless they are themselves already classified as controlled drugs or medicines, are Class C drugs by default.⁷⁰⁵

704 Misuse of Drugs Act 1975, s 2(1).

705 Ibid.

- 9.91 The analogue provision has proved reasonably effective in recent years at catching emerging new substances that are structurally similar to controlled drugs, but that are not prohibited under the Act. This has meant that these substances are automatically prohibited. However, providing a default classification is something of a compromise because it involves trying to anticipate the development of new drugs that might become a problem in the future. We understand that an analogue does not necessarily have a similar risk of harm as its parent drug; it may be more or less potent or harmful, or its potency or risk of harm may be unknown.
- 9.92 Currently, an assessment of the evidence of harm associated with an analogue is not required, so that these substances are not normally assessed by the EACD. Also, even if an analogue is assessed by the EACD against the criteria in the Act and is found to have a lower than moderate risk of harm, it cannot have its classification as a Class C drug removed, because the Act does not allow for this. (Analogues that have therapeutic purposes and are classified as medicines are excluded from Class C, but analogues that do not have therapeutic purposes (even if they have a low or no risk of harm) will always remain Class C drugs simply because they are analogues.)
- 9.93 We suggest that some changes are needed here. Assuming that the current classification system largely remains intact, the default classification as Class C should be retained. However, this should be an interim measure that applies only until the drug analogue has been assessed against the criteria in the Act and classified. If it would not qualify, based on its own harm profile, for inclusion in Class C, it should be removed.

Q16 Do you agree that controlled drug analogues should by default be included as Class C drugs, but only on an interim basis so that they can be evaluated and appropriately classified?

THE CLASSIFICATION PROCESS

- 9.94 As we outlined earlier, an amendment in 2000 provided for drug classification decisions to be made by Order in Council subject to an affirmative resolution procedure. The ability to classify through primary legislation remains as occurred with BZP. Primary legislation is also required, as noted earlier, to reduce the classification of any drug.
- 9.95 The affirmative resolution procedure works in the following way. Once an Order in Council is made, the Minister must lodge a notice of motion in the House that the order be approved. The notice of motion stands referred to the Health Select Committee which must report to the House on the motion within 28 days of its being lodged. The notice of motion can only be moved if the Health Committee has reported back on the motion or 28 days has passed. The approval must be obtained within a year of the notification of the making of an Order in Council in the *Gazette*. The House can only approve or reject an Order in Council; it cannot amend or substitute it.⁷⁰⁶

⁷⁰⁶ See Misuse of Drugs Act 1975, s 4A.

- 9.96 At the time it was introduced, it was argued that the power to classify drugs by Order in Council was necessary “to provide for the expeditious classification of controlled drugs” as a response to the “expansion of the illicit drug market in New Zealand”.⁷⁰⁷ It was seen as too time consuming to amend the schedules by an amendment to the Misuse of Drugs Act, since that limited New Zealand’s ability to respond quickly to the creation of new synthetic or designer drugs.⁷⁰⁸ The affirmative resolution procedure was intended to provide a check on Executive power.
- 9.97 The Order in Council/affirmative resolution procedure has been criticised by the Regulations Review Committee and the New Zealand Law Society amongst others. A particular concern is that a drug’s classification determines whether an offence is committed and if so the maximum penalty, including life imprisonment in the case of a Class A drug. Decisions of this kind, which bear on individual liberty, should be subject to the full parliamentary process.⁷⁰⁹
- 9.98 The problem is compounded by the 2005 amendments that restrict the truncated procedure to upward but not downward classifications. It seems anomalous that a truncated Parliamentary process is available to create new offences and increase penalties but not to reduce them. George Tanner, then Chief Parliamentary Counsel, in a 2004 submission to the Regulations Review Committee described the problem as follows:⁷¹⁰
- The orthodox way of making laws is by Parliament enacting statutes and the Executive making regulations under the authority of statutes enacted by Parliament. This has served New Zealand well. The affirmative resolution procedure is an unfortunate hybrid that has none of the advantages of the traditional means of legislating. The process is part parliamentary and part executive. The clear distinction between the traditional law-making processes is blurred. The affirmative resolution procedure is muddled law-making.
- 9.99 There are a number of other difficulties with the procedure. It restricts the scope of public participation (because of truncated select committee consideration) and parliamentary scrutiny and therefore “degrades the ordinary parliamentary law-making process”.⁷¹¹ In addition, Orders in Council are delegated legislative instruments and are therefore vulnerable to challenge on the ground of *ultra vires*.⁷¹² Such a challenge might be brought if the procedural requirements imposed by the Act have not been adhered to, or if an order purports to do something that falls beyond the scope of the delegated legislative power.
- 9.100 Since the provisions came into force, the majority of Orders in Council have been to change the classification of existing drugs rather than classify new drugs. The relatively small numbers of Orders in Council dealing with new drugs suggest that the problem the procedure was established to fix may have been overstated.

707 Hon Annette King (Minister of Health) (7 November 2000) 588 NZPD 6374.

708 Hon Georgina Te Heuheu (Associate Minister of Health) (5 October 1999) 580 NZPD 19707-19708.

709 George Tanner “Submission by Chief Parliamentary Counsel to Regulations Review Committee – Inquiry into Affirmative Resolution Procedure”.

710 Ibid.

711 Ibid, 12.

712 *Ultra vires* is a Latin phrase that literally means “beyond the powers”.

Moreover, the procedure is not necessarily any more expeditious than urgent legislation. For example, the Misuse of Drugs (Classification of Ephedrine and Pseudoephedrine) Order 2003 took over 10 months to bring into force. Recently an Order in Council classifying ketamine as a controlled drug lapsed and did not come into force because it was not approved by the House within a year of its being notified in the *Gazette*. Moreover, as we outlined in chapter 5, technically the regime under the Hazardous Substances and New Organisms Act 1996 applies to any new psychoactive substance. To that extent the justification for the Order in Council process⁷¹³ rests on a misunderstanding of the current law.

- 9.101 In our view the Order in Council procedure is not justified and brings with it an unacceptable risk of challenge. Drug classification decisions require full parliamentary scrutiny.
- 9.102 However, the Order in Council procedure does have one significant strength. As we outlined earlier, the process requires the Minister to take into account advice on certain matters (essentially relating to the harmfulness of the drug that is being classified) before promoting an Order in Council. This ensures that drug classification decisions are informed by expert opinion. As we have noted earlier, we consider that drug classification decisions are informed by expert evidence if good outcomes are to be achieved, given the controversial and polarising nature of drug issues and emotional reactions to them.
- 9.103 Therefore, if the procedure is abolished, we suggest there should be a requirement that the Minister present to the House a report from the expert committee at the time legislation is introduced, or as soon as reasonably practicable thereafter in the case of a Member's Bill. The report should spell out the nature and extent of the harm associated with the substance being classified, the available evidence about what regulatory approach would best minimise that harm, and which broad harm category the substance fits into. This would ensure Parliament's decisions and public debate are fully informed by independent and expert advice. We note that the Act has in the past given the Minister a function of providing and publishing reports, information, and advice concerning the misuse of drugs.⁷¹⁴
- 9.104 If the Order in Council process is retained, it is more logical that the procedure should also be available for downward classifications and removing substances. It is anomalous that the Order in Council process can be used to create new offences (by adding substances to the schedules) and increase penalties (by reclassifying upwards), but primary legislation is required to reduce penalties (reclassifying downwards) or abolish offences (remove substances from the regime).

713 The justification being that New Zealand needs to be able to respond quickly to the creation of new synthetic or designer drugs because they are not otherwise regulated until they are classified.

714 Section 4A as inserted by section 2 of the Misuse of Drugs Amendment Act 1978 provided that "the functions of the Minister, on behalf of the Crown, shall include the provision and publication of reports, information and advice concerning the misuse of drugs and the treatment and rehabilitation of persons suffering from the misuse of drugs". This section was repealed in 2000 when the EACD was established.

Q17 Do you agree that drug classifications should be made by primary legislation rather than by Order in Council? If so, should there be a requirement for the Minister to table an expert report on drug harms when legislation is introduced?

Q18 If the Order in Council process is retained, should it be available for reducing classifications as well as increasing them?