CONSERVATIVE
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A briefing paper by the Conservative Drug Policy Reform Group

Misinterpretation of the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001 in the case of the call for the rescheduling of psilocybin.

Overview

1) **The current position of the UK Home Office (HO) recognises market authorisation as the only route to rescheduling.** This has no basis in law; it is a misinterpretation and misapplication of the MDA 71 and the MDR 2001 legislation.

2) **Psilocybin and other compounds which find themselves in Schedule 1 of the MDR 2001 have potential as psychiatric and medical interventions, but crucially this is not the extent of their utility.** Neuroimaging research undertaken by Dr Robin Carhart-Harris and Professor David Nutt at Imperial College London have already found that psilocybin affects multiple areas and networks of the brain that are implicated in depression and other prevalent mental health conditions – leading to the emergence of a multi-billion pound global industry even before the full scope of psilocybin's function and medicinal potential has been explored.

3) **Either the current system of rescheduling works – i.e., it is responsive to the evidence and the needs of society – or it does not, in which case the system needs to be revised.** The HO has been made aware of the case for the rescheduling of psilocybin; it has been **approved by the Prime Minister,** and yet the HO fails to act, perpetuating what can be considered the worst research blackout in scientific history.

4) **While the UK HO fails to act, North American neighbours Canada and the US continue to capitalise on UK science.** The flight of Dr Robin Carhart-Harris to the US is indicative of the UK's abdication of its position as world leader in the space.

The case for rescheduling psilocybin is uncontroversial

Psilocybin has potential as a treatment for a plethora of psychiatric and medical conditions. Yet, many proposed trials, which could address a huge unmet clinical need both in the UK, and globally, fall by the wayside due to the extended time frames, increased costs, and prohibitive stigma associated with researching controlled drugs in Schedule 1 of the Misuse of Drugs Regulations 2001 (MDR 2001)[1].

Recent YouGov poll data shows that across all demographics a majority (55%) of the UK public supports a change in the law to facilitate research into psilocybin for treatment development, with the don't knows excluded, this is a 4-1 view.[2] This is shared by the Prime Minister who told Crispin Blunt MP in an office

call to discuss drugs policy on 26 May 2021 that he had approved rescheduling the previous day. This is understood to follow a formal Policy Unit submission.

Yet in practice the Home Office (HO) fails to action the simple, repeated request to commission the Advisory Council on the Misuse of Drugs (ACMD) to review its designation as a Schedule 1 substance and act on its recommendations, even though psilocybin has been recognised by the HO as a promising medical and psychiatric intervention. The reason given for not actioning the review of psilocybin's scheduling is that it has not yet achieved market authorisation. But market authorisation is not a prerequisite for rescheduling, and as such the decision not to call for an urgent ACMD review of psilocybin on this grounds is unfounded. Such a lack of action which does not recognise the substance's non-medical scientific research utility and is equivalent to complicity in the abdication of the UK's position as a world leader in life sciences research and an active hindrance in the development of new treatments for mental health conditions.

The position the HO maintains is holding up a change to the Schedule 1 status of psilocybin, with dire consequences for the UK's life science sector and population groups who stand to benefit from related treatment development

Despite the overwhelming evidence that it has medical and experimental potential, psilocybin remains in Schedule 1 of the Misuse of Drugs Regulations 2001 (MDR 2001). The HO is failing to act on calls for the urgent rescheduling of psilocybin which would remove barriers to its application in life sciences research. Thereby, abdicating the UK's position as a leader within the space. Indeed it was only through persistence in the face of these overwhelming barriers to research that UK scientists were able to make discoveries which led to the emergence of the medical psychedelic sector, which is set to grow to over £10 billion by 2027[3]. Some of these very same researchers are now leaving the UK to better pursue further research in this area, due to this unnecessary legislative stifling that is being proactively redressed in jurisdictions abroad[4].

It has been brought to the attention of the HO that psilocybin's Schedule 1 designation is incommensurate with the evidence of its harm profile and medical and scientific utility, and they have responded inadequately. This was indicated by minister Kit Malthouse in a response during the business debate in the House of Commons on the 50th anniversary of the Misuse of Drugs Act 1971 (MDA 1971), in which he intimated that *only* the identification of a "proven medical use" of psilocybin could precipitate its rescheduling (the full comment can be found in Annex 1 below). This is in line with one of the governing perceptions of ministers in this debate; that a medicinal product achieving market authorisation is a prerequisite for consideration of rescheduling. Evidence available to the Prime Minister, HO, ACMD and the public is being dismissed as insufficient for initiating a review, highlighting that a misinterpretation of the legislation is governing these matters. In sum, psilocybin's other indicated and further uses outside of its applications as a medicine are going unconsidered.

This issue does not apply to psilocybin alone: LSD, DMT, MDMA, Bufotenin, Mescaline, the 2Cs and others all fall within the psychedelic class of chemicals which may shed light on the nature of numerous medical and psychiatric conditions, and thus the possibilities of treating them. But studying them may also contribute to the understanding of the brain and the human condition more generally, with potential to extend human knowledge incalculably. This additional utility of these substances in scientific and

medical research is entirely ignored in regulatory discourse with a myopic focus on their possible application as medicines.

Is it a legislative possibility to reschedule a substance prior to it achieving market authorisation at all?

The ACMD is technically able to commission its own work but it is underfunded and understaffed - meaning that it lacks the capacity to do so, as such a review of the scheduling of a substance such as psilocybin must come in practice from the HO. However, as mentioned, the HO bizarrely singles out market authorisation as the only route to rescheduling it recognises, and as such will not request the ACMD to review and make recommendations on the status of psilocybin, prior to market authorisation from the MHRA. On the recommendation of the ACMD, if they came to the conclusion that it was right to do so, the Secretary of State could subsequently amend the 2001 Regulations via a Statutory Instrument on the negative procedure.

The only block to this review being commissioned is the miscorrelation of issues mentioned above and a misrecognition of the nature of the MDA 71 and MDR 2001, by which it is assumed that market authorisation must be first achieved — this has no basis in law and represents either whimsical choice, obstinacy or ignorance.

The route to market authorisation

Market authorisation of a Schedule 1 substance is achieved via an application made to the MHRA on the completion of phase 3 trials with a single formulation of a substance, often triggering the HO to call for a review of the scheduling of said controlled substance by the ACMD. The ACMD then, ideally, makes recommendations consistent with the evidence obtained through the multi-million pound clinical trial process, often taking over a decade. While Schedule 2 does make it easier to prescribe a so-designated controlled drug, Schedule 2 substances are still heavily controlled. There is evidence to counter fully any misapprehension that such a move would make psilocybin any more easily accessible or readily available outside of the contexts specifically stipulated for its scientific use, such as via diversion from experimental contexts or unregulated prescribing, until market authorisation is duly achieved.

What is the appropriate use of the existing legislation in the case of the scheduling of psilocybin?

Psilocin and its esters (including psilocybin) are listed in Class A of the MDA 1971, Schedule 1 of the MDR 2001 and Part 1 of the Misuse of Drugs Designation Order 2015. Accordingly, psilocybin cannot be produced, supplied or prescribed without specific HO approval. Psilocybin was placed into these categories to meet obligations of article 2.5 of the UN Single Convention on Narcotic Drugs 1961, which (we submit) was intended to be operated in a flexible way as the needs of society change - giving an implicitly high level of state autonomy.

The MDA 1971 is designed to implement restrictions on the production, supply, possession and prescription of controlled drugs; yet, crucially, it contains a provision by which the Secretary of State is required to make provisions to permit certain medical practitioners and pharmacists (when acting in their respective capacities) to prescribe, administer, manufacture, compound, possess, or to supply a controlled drug (s.7(3)). There is an exception to this (under s.7(4)) in the case of any controlled drug which, in the opinion of the Secretary of State, it would be “in the public interest” for the production, supply and

possession of particular controlled drugs to be "wholly unlawful or unlawful except for purposes of research or other special purposes", or for it to be unlawful "for practitioners, pharmacists and persons lawfully conducting retail pharmacy businesses to do any of the things mentioned in [s.7(3)] except under a licence or other authority issued by the Secretary of State". Thus, even here, flexibility is woven into the fabric of the MDA 1971 and its associated Regulations to allow for the movement of substances between the schedules of the legislation as the needs of society require and to permit research using, and into, substances controlled under the MDA 1971. Market authorisation as a prerequisite to any such permission is nowhere mentioned. Therefore, it is manifestly possible for the Home Secretary to request an ACMD review of the scheduling of psilocybin, if minded that it was right to do so, prior to it achieving market authorisation. (As discussed below, a precedent has been set for doing so in the case of cannabis in 2018.)

The ACMD, who have recently been called upon to investigate barriers to researching controlled drugs including psilocybin, have updated their standards of procedure to include an appendix detailing the 'Factors to consider in scheduling decisions'. This refers to things such as the substance's safety, toxicity and behavioural effects, as well as the substance's dependence and diversion potential amongst other less relevant factors. Most pertinent to the point at hand is number 2:

> *2. Status as a medicine in humans or animals – does the drug have a UK Marketing Authorisation, or is it permitted to be manufactured as a pharmaceutical Special? Consider that drugs without UK Marketing Authorisation will usually be placed in Schedule 1.*[5]

It is clear that the ACMD actively anticipates there to be instances where the substance they are commissioned to review may *not* have achieved market authorisation, and that without it a substance would usually, but not *necessarily*, be placed in Schedule 1. That said, the ACMD's own definition of Schedule 1 stipulates that substances in this category "do not have UK marketing authorisation". From this it can be concluded that the decision of the HO not to pursue the rescheduling of psilocybin prior to market authorisation, even when it has been approved by the Prime Minister, is unreasoned as well as unreasonable.

The effect of Schedule 1 designation on substances with experimental utility

The route to rescheduling via market authorisation, i.e., the route popularly misunderstood to be the only one available, does not consider the utility of certain substances in scientific research. A hypothetical substance in Schedule 1 could have no apparent medical utility, yet if it were not prohibitively expensive to research due to this designation, studies could be undertaken by a small research institute into its effects on the brain. Leading researchers to insights into Alzheimer's disease (for example) and its cure - the substance itself never reaching market authorisation, its value being solely in its capacity to facilitate experimental scientific research. This situation is analogous to that of psilocybin and other Schedule 1 psychedelics. It also carries an irony in that early research into psychedelic mechanisms of action indicates their propensity for neurogenesis and thereby their potential as a breakthrough treatment for traditionally irreversible neurodegenerative conditions — including Alzheimer's disease itself.

While it is now known that psilocybin has potential as a psychiatric and medical intervention, this is not the extent of its utility, and these plural benefits were in fact discovered as a result of investigation into its mechanism of action. Neuroimaging research undertaken by Dr Robin Carhart-Harris and Professor David Nutt at Imperial College London in 2012, found that psilocybin affects areas of the brain that are

implicated in depression, making the chance discovery that it could be used as a treatment for the condition[6]. This groundbreaking study inspired funding from the MRC to conduct a clinical trial in treatment-resistant depression. This proved positive, opening up the most promising new form of treatment for depression since the invention of SSRI antidepressants 30 years ago, sparking the birth of a sector set to grow to over £10 billion by 2027. But in order to undertake this initial neuroimaging research multiple Schedule 1 licenses had to be obtained from the UK HO, taking several years and costing upwards of £5000 per license. The study was the first to research the brain on psilocybin and was conducted with 30 healthy volunteers with the cost per dose estimated at £1500, a ten fold greater cost than standard trials, due mainly to difficulties in obtaining licenses for production, importation, supply and storage of psilocybin - which at the time had been issued only 4 times previously. Lead investigator Dr Robin Carhart-Harris is now leaving the UK on account of the opportunities for a researcher of his calibre and interests overseas in the absence of his trailblazing discoveries being cultivated by legislative change which would facilitate it. This can be directly attributed to the unchanging scheduling of psilocybin and other compounds which hold similar potential as research tools, as well as medicines, like LSD, DMT and many others, which still find themselves in Schedule 1 of the MDR 2001 — 20 years since they were first placed there on the basis of evidence which does not stack up and 50 years since they were first proscribed from research entirely.

There is precedent to reschedule prior to market authorisation

Disproving beyond further discussion that market authorisation is not a necessary precursor to rescheduling, is the case of cannabis-based products for medicinal use in humans (CBPM) which were rescheduled by statutory instrument in 2018, almost 20 years after a House of Lords committee recommended moving cannabis to Schedule 2. (It is worth noting that there is already substantially more evidence for the safety and efficacy of psilocybin than there was, and still is, for medical cannabis). Following the precedent that this has set for the rescheduling of controlled drugs from Schedule 1 to Schedule 2 prior to market authorisation as a medicinal product, we propose a similar wording for the case of psilocybin — with an additional provision precluding the prescription of unlicensed medicinal products outside of clinical and experimental research (details of which can be found in the report *Medicinal Use of Psilocybin*).

In conclusion

It is the false connection being made by the HO between market authorisation and rescheduling — which is not written in law, not sensible, and is stifling neuropsychopharmacological research, and other related fields — that has lead to the loss of top researchers, and possibly the UK's position as a world leader in the life sciences sector. While research into Schedule 1 drugs is in theory possible, in practice a tiny, woefully insufficient fraction of the possible research into psilocybin can actually take place. Psilocybin's unjustifiable Schedule 1 status has led to many academics being deterred from these lines of research entirely; time wasted enacting this rescheduling equates to nothing more than loss for the UK on multiple levels.

The market authorisation and the scheduling of a particular substance are related, but not interdependent upon one another. This misinterpretation of the law appears to be the defining issue in the case of the extended hold-up on rescheduling of psilocybin. The MDA 1971 was intended to be flexible and forward

looking and its associated MDR 2001 are intended to be permissive — facilitating policy changes according to it, which in this case involve responding to the available evidence and allowing the prescription of these drugs for medical and scientific research. The idea was to set up a structure that would allow Government to act in a flexible way with regards to drugs that may constitute medical and scientific opportunities, but it is not being enacted as such.

Either the current system works or it does not and the system needs to be revised. (The CDPRG is currently producing a follow-up to *Medicinal Use of Psilocybin*, which will investigate exactly how much research is lost to the current regulations, and how much unnecessary expenditure is occasioned compared to if psilocybin were placed in Schedule 2.)

The scheduling of psilocybin (and others) should be made commensurate with the evidence of its harms and potential utility in medicine and science so that onshore research may be facilitated post haste to benefit the UK life sciences sector, patients and the UK public as whole.

Annex 1

17/6/21: Kit Malthouse addressed the rescheduling of psilocybin during his contribution to the Business Debate on the 50th Anniversary of the Misuse of Drugs Act 1971:

> "If I may crave your indulgence, Madam Deputy Speaker, I want to deal with one or two particular issues that have been raised. My hon. Friend the Member for Reigate and I have been in ongoing correspondence and conversation about the impact of the legislation on research and the business that may come from it, and he raised that during his speech. As he will know, there are clinical trials already under way into the use of the compound psilocybin, and I am hopeful that they will produce positive results. If they do—if there is a proven clinical and medical use—then obviously, as we have in the past, we will have to adapt to that as we go. I have commissioned the Advisory Council on the Misuse of Drugs to look more widely at barriers placed in the way of clinical research in all sorts of areas of narcotic and other drugs, to ensure that we are getting the balance right to enable that legitimate form of research, and the health benefits that may come from it, to be pursued."

Endnotes

1. *Medicinal Use of Psilocybin*. Rucker et al. 2020.
2. *Public Attitudes to Psilocybin Assisted Therapy*, Psilonautica and DrugScience. 2021.
3. *Psychedelic Drugs Market Size Is Projected To Reach $10.75 Billion By 2027*. Financialnewsmedia.com News Commentary. 2021.
4. *New $6.4M research program to advance psychedelics research and treatments*. EurekAlert. 2021.
5. *Standard Operating Procedure for using evidence in ACMD reports.* 2021.
6. *Neural correlates of the psychedelic state as determined by fMRI studies with psilocybin.* Carhart-Harris, et al. 2012.