RESEARCH PAPER 00/74
3 AUGUST 2000

Cannabis

Cannabis is the most widely cultivated, trafficked and used illicit drug in the United Kingdom, and there is an ongoing debate about its legal status. It is currently illegal to use cannabis either for recreational or for medicinal purposes.

In 1998 the Science and Technology Committee of the House of Lords took evidence on the medicinal effects of cannabis, and recommended that it should be made legally available for therapeutic purposes. The Government rejected any immediate changes to legislation, and has indicated that, before this could be considered, safety and efficacy of a medicinal form of cannabis should be demonstrated. Clinical trials are about to start.

An independent inquiry into the *Misuse of Drugs Act 1971* has recommended that penalties for minor cannabis offences should be reduced, but the Government is opposed to any relaxation of controls.

This paper provides statistical information on the use of cannabis. It discusses the health effects of cannabis and provides background to both these issues.

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ISSN 1368-8456

Summary of main points

- Cannabis is the most widely cultivated, trafficked and used illicit drug in the UK. It is used most commonly by the young, particularly the 16-19 year age group, with usage declining with advancing age. In 1998 64% of all drug offences involved cannabis.

- Cannabis provides relief for some patients with intractable medical problems including multiple sclerosis and there are increasing calls for its therapeutic potential to be legally recognised. The authors of the House of Lords Science and Technology Committee report on cannabis and the Independent Inquiry into the Misuse of Drugs Act 1971 are amongst those advocating that cannabis or cannabinoids should be legally available for medicinal purposes. The Government maintains that, before this could be considered, safety and efficacy of a medicinal form of cannabis must first be demonstrated and clinical trials are underway.

- Maximum penalties for cannabis offences vary throughout the EU, and are relatively severe in the UK. However, possession for personal consumption is usually dealt with by a police caution.

- Many consider that current legislative control of cannabis is ineffective and counterproductive, and that legalisation would allow a more credible preventive education message against more harmful drugs.

- Others advocate depenalisation following the Dutch approach where modest consumption in licensed premises is tolerated, whilst maintaining the illegality of the drug. This, it is claimed, separates cannabis users from the market for hard drugs which carry a greater health risk, and from contact with criminal society.

- Opponents of relaxation of the legislation argue that such moves would send a confusing message to society, that cannabis use would increase and that criminal activity would continue to circumvent and undercut legal supply. Acute toxicity of cannabis preparations is very low, but its long-term effects when taken in high doses are uncertain. There are concerns that it could be as hazardous a tobacco smoking.

- The Independent Inquiry into the Misuse of Drugs Act 1971 proposes that cannabis should be reclassified and penalties for cannabis possession for personal use should be decreased, but that trafficking should be more heavily penalised.

- The Government opposes any lessening of controls on currently illicit drugs, preferring policies that involve supply, demand and harm reduction.

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I Introduction

Two separate issues about cannabis are currently receiving attention: the use of cannabis for medicinal purposes, and the recurring debate about possible decriminalisation or legalisation of cannabis taken for recreational purposes.

Herbal cannabis has traditionally been used for its medicinal qualities, and it was possible to prescribe it as a medicine in the UK until 1973. Growing concerns about drug misuse together with a perception that it has no therapeutic value in an age of modern pharmaceutical development led to its listing as a controlled drug which cannot legally be used as a medicine.

It is now widely acknowledged that some constituents of the herb, cannabinoids, have a therapeutic potential, for the relief of the symptoms of multiple sclerosis, and in a number of other areas. Clinical trials are underway. There are calls for a rapid change to the law to enable patients to receive cannabis legally. The Government maintains that a medicinal form of the relevant cannabinoids should first be available and that safety and efficacy must be demonstrated.

The long-standing issue of decriminalisation or legalisation of cannabis continues to be raised. Some commentators argue that the current system based on detection and punishment has failed, that soft drugs are in any case tolerated by society, and that the law is out of touch. The legality of alcohol and tobacco, whose adverse health effects are well documented, is contrasted with the illegality of “recreational” drugs such as cannabis and ecstasy. In the face of widespread use of cannabis, it is argued that criminalisation of cannabis users serves little purpose, and that the fight against drug-related crime would be more effective if a greater distinction were made between “hard” and “soft” drugs.

At one end of the spectrum of opinion, pressure groups such as the Legalise Cannabis Alliance argue that the commonly employed expression “drug misuse” is inappropriate in the context of cannabis use, and legalisation would form part of the solution to the problem of opiate addiction.

Others criticise a growing “normalisation” of soft drugs, and an inconsistency in approach, including a perception of tolerance of soft drugs by politicians and police as a factor giving credence to the acceptability of drug use by the young.

In 1998 the Government published a ten year strategy for combating the problem of illegal drug misuse in the UK, with an emphasis on treatment, education and prevention.[1] The Government recognised growing public unease about the levels of illegal drug use, ready availability of drugs on the streets and a threat to communities because of drug-related crime, in addition to the threat to health posed by the use of illegal drugs. Drug problems are often associated with other social problems and the issue of drug misuse is now a factor to be

1 *Tackling Drugs to Build a Better Britain*, Cm 3945, April 1998

considered by the Social Exclusion Unit. The Government has also introduced measures in the Criminal Justice and Court Services Bill for mandatory drugs testing of offenders and arrestees.[2] The Government stresses the long-term nature of the drug strategy and sees signs of a down turn in drug use in the young.

Under the *Misuse of Drugs Act 1971* (MDA) drugs are classified A, B or C depending on the degree of harm they are considered to cause when misused. Penalties laid down in the criminal justice system are related to the class of the drug. Heroin, morphine, methadone and cocaine are in class A, reserved for the most harmful drugs, while cannabis is in class B. Hallucinogens such as ecstasy and LSD are currently in Class A.

The Government has maintained opposition to relaxation of legislation, but Keith Hellawell, the United Kingdom Anti-Drugs Co-ordinator (UKADC), has suggested that emphasis should be placed on the fight against the most harmful class A drugs, heroin and cocaine.

These 'hard' drugs are also implicated in acquisitive crime.[3] The UKADC has commented that national policy of targeting heroin and cocaine would not be at the cost of ignoring other drugs like cannabis:

> "It is not a matter that we focus on one and just ignore the other," he said, "Sometimes people say to me because we are focusing on heroin and cocaine that means we are decriminalising cannabis. That is not so.
>
> "I don't support the decriminalisation of cannabis, and we are finding in treatment centres throughout the UK that there are a growing number of people presenting themselves for treatment because of their problems with cannabis and their reliance upon cannabis. "I think it would be a bad move to legalise it, or to deal with it in any way differently from the way we are dealing with it at the moment." [4]

Conservative Party policy calls for a tough line on all forms of illegal drugs with particular emphasis on penalties for supplying drugs to children.[5] The White Paper *Tackling Drugs Together* [Cm 2846] issued by the previous government in May 1995 introduced the now widely accepted concept of harm reduction into drugs policy, in addition to emphasising the need for vigorous law enforcement, accessible treatment and education and prevention strategies.[6]

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[2] The *Criminal Justice and Court Services Bill*, Bill 91 of 1999-2000. See Library Paper 00/37, 27 March 2000

[3] ibid

[4] "Drugs tsar Hellawell joins Scottish agency: Special adviser says DEA can halt the flow of heroin and cocaine", *The Scotsman*, 20 March 2000

[5] Conservative Party, *Drugs in schools*, 7 February 2000

[6] Library Paper 95/72, *Controlling the Use of Illicit drugs: Enforcement through Criminal Sanctions and the Legalisation Debate*, 8 June 1995, Summary

The Liberal Democrats favour a wide debate on drugs policy, and have called for a Royal Commission. Discussion of anti-drugs legislation extends to members of the police, where some individuals call for reconsideration of the law.

The recent independent Police Foundation (Runciman) Inquiry which reviewed the Misuse of Drugs Act recommended a degree of depenalisation of cannabis: cannabis should be reclassified as a Class C drug, normal sanctions for possession and cultivation of cannabis for personal use would be out-of-court disposals, including formal warnings, statutory cautions or a fixed fine. Prosecutions would be the exception, and only then would a conviction result in a criminal record. However, it recommended increased penalties for trafficking. The Inquiry also recommended removal of the ban on therapeutic use of cannabis for specified medical purposes[7]

The Government does not support the Inquiry's recommendations on the reclassification of cannabis. However, it considers that some of the Inquiry's other recommendations are worth exploring.

This paper aims to give some background to these discussions. It sets out current legislation and statistical information on cannabis. It discusses in brief the arguments employed in the cannabis debate. The issue of the therapeutic use of cannabis is also discussed.

It follows on from library research paper 95/72 on *Controlling the Use of Illicit drugs: Enforcement through Criminal Sanctions and the Legalisation Debate*, 8 June 1995

[7] The Police Foundation, *Drugs and the law, Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000

II UK drug laws and drug classification

There are two main statutes governing availability of drugs in the UK.

- The *Medicines Act 1968* governs the manufacture and supply of medicinal products.
- The *Misuse of Drugs Act 1971* (MDA) controls the non-medicinal use of certain drugs. It controls not only medicinal drugs (which will also be in the Medicines Act), but drugs with no current medicinal uses.

Additional legislation in the field of drug misuse:

- The *Customs and Excise Management Act 1979* acts together with the MDA to prohibit unauthorised import or export of controlled drugs.
- The *Criminal Justice (International Co-operation) Act 1990*: Part II of this Act controls the supply of certain 'precursor' chemicals which can be used in the manufacture of controlled drugs. Controls include notification of export, record keeping and the supply of information.
- The *Drug Trafficking Act 1994*, largely a consolidation Act, enables the UK to meet its obligations under the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1998* (The Vienna Convention). It creates offences in connection with laundering and handling the proceeds of drug trafficking, and introduces measures to confiscate such proceeds. The Act allows the burden of proof to be placed on the defendant to prove that the assets were lawfully acquired and applies the civil standard of proof on the balance of probabilities.[8]

A. *Misuse of Drugs Act 1971* (MDA)

The MDA and its associated Regulations, the *Misuse of Drugs Regulations 1985*,[9] lay down the circumstances in the UK in which it is lawful to import, produce, supply, possess with intent to supply, and possess drugs of misuse – "controlled" drugs.

There are provisions within the Act for the Home Secretary to change the classification of drugs, through delegated legislation. Any submission by the Home Secretary for changes to the legislation by Order in Council or Regulation must be preceded by consultation with the Advisory Council on the Misuse of Drugs. This is the statutory body which keeps under review drugs which are, or are likely to be misused. It can appoint expert committees to consider specific issues and advises the Government on measures necessary for the prevention of drug misuse.

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8 The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000, Chapter 1, para 37

9 *Misuse of Drugs Regulations* SI 1985/2066

1. Classes and penalties

The penalties applicable to offences involving the different drugs are graded broadly according to the social harm attributable to a drug when it is misused and for this purpose the drugs are defined in three classes: A, B and C.

Class A Offences involving those in Class A attract the highest penalties – a maximum of seven years and/or unlimited fine for possession; life and/or unlimited fine for production or trafficking. A mandatory seven year sentence is now the penalty for a third conviction for trafficking.[10] This class includes the more potent of the opioid painkillers (heroin, morphine, methadone[11], dipipanone, pethidine), hallucinogens (eg LSD, ecstasy) and the stimulant cocaine. It also includes liquid cannabis, cannabinol and cannabinol derivatives (THC).[12] Any Class B drug prepared for injection counts as Class A.

Class B has lower penalties: a maximum of five years and/or unlimited fine for possession; fourteen years and/or unlimited fine for production or trafficking. It includes herbal cannabis, cannabis resin, less potent opioids (codeine, pentazocine), strong synthetic stimulants (eg oral amphetamines), and sedatives (eg barbiturates).

Class C has the lowest penalties: a maximum of two years and/or unlimited fine for possession; five years and/or unlimited fine for trafficking. It includes tranquillisers, some less potent stimulants, and mild opioid analgesics (eg buprenorphine which is used in the treatment of opioid dependency).

Most offences involving drugs are triable either way, that is, summarily by magistrates or on indictment with a jury at a Crown Court. Less serious offences are usually dealt with by magistrates' courts, where sentences cannot exceed six months and/or £5,000 fine, or three months and/or fine for less serious offences. Eighty five per cent of all drug offenders are convicted of unlawful possession.[13] Although maximum penalties are severe, just over 20 per cent of offenders receive a custodial sentence (even fewer actually go to prison), and nearly 3/4 of fines are £50 or less.[14]

Further details of penalties for offences under the *Misuse of Drugs Act 1971* are set out in Appendix 1.

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[10] *Criminal Sentences Act 1997* s.3

[11] Methadone is used in the treatment of opioid dependency but is also misused

[12] These include a variety of natural and synthetic cannabinoids, a family of substances based on the core chemical structure. The main psychoactive ingredient of all forms of cannabis is THC, see also section IIIA

[13] Drugscope (merged Institute for the Study of Drug Dependence and Standing Conference on Drug Abuse) http://www.drugscope.org.uk/drugsearch/index.html

[14] ibid

2. Drug schedules

The *Misuse of Drugs Regulations 1985*, made under the Act, divide the controlled drugs up in a different way to take account of the needs of medical practice. They define the classes of persons who are authorised to supply and possess controlled drugs while acting in their professional capacities and lay down the conditions under which these activities may be carried out. In the Regulations drugs are divided into 5 schedules each governing such activities as import, export, production, supply, possession, prescribing, and record keeping which apply to them. Details of the schedules are as follows:[15]

Schedule 1, the most restricted drugs, (eg, LSD and cannabis), can only be supplied or possessed for research or other special purposes by people licensed by the Home Office; these drugs are **not available for normal medical uses** and cannot be prescribed by doctors who do not have a licence.

All the other drugs are available for medicinal use. Most are Prescription Only, so they can only be obtained if prescribed by a doctor and supplied by a pharmacy (eg, strong analgesics like morphine, stimulants like amphetamines or cocaine, tranquillisers and most sedatives). Some very dilute, non-injectable preparations of controlled drugs - because they are so unlikely to be misused - can be bought over the counter without a prescription, but only from a pharmacy (eg, some cough medicines and anti-diarrhoea mixtures containing opiates). Medicines available in this way can also legally be possessed by anyone. The same also applies to benzodiazepine tranquillisers and hypnotics (except temazepam and flunitrazepam) even though these drugs can only be legally obtained on prescription.[16]

Schedule 2 includes such drugs as diamorphine (heroin), morphine, pethidine, cocaine. These are subject to the full controlled drug requirements relating to prescriptions, safe custody, the need to keep records, etc.

Schedule 3 includes the barbitrates (except secobarbital, now in schedule 2), buprenorphine, pentazocine, the tranquillisers nitrazepam and flunitrazepam. These are subject to the special prescription requirements, but not, for the most part, to the safe custody requirements, nor to the need to keep registers.

Schedule 4 includes benzodiazepines (other than flunitrazepam and tamazepam which are now in schedule 3) and anabolic steroids. Controlled drug prescription requirements do not apply and Schedule 4 Controlled Drugs are not subject to the safe custody requirements.

Schedule 5 includes those preparations which because of their strength, are exempt from virtually all Controlled Drug requirements other than retention of invoices for 2 years.

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[15] *British National Formulary*, September 1999

[16] Institute for the Study of Drug Dependence, http://www.isdd.co.uk/drugsearch/index.html

Additional regulations (the *Misuse of Drugs (Supply to Addicts) Regulations 1997)* effectively restrict the ability to prescribe heroin, dipipanone and cocaine for the treatment of addiction to a few specially licensed doctors.

Solvents are not classified under the Act. However, under the *Intoxicating Substances (Supply) Act 1985* it is an offence to sell solvents to someone under 18, and the *Cigarette Lighter Refill (Safety) Regulations 1999*, make it an offence to sell gas lighter refills containing butane to persons under 18 years of age.

3. Summary of the legislation for cannabis

Under the *Misuse of Drugs Act 1971*, it is illegal to grow, produce, possess or supply cannabis to another person. It is also an offence to allow premises to be used for growing, preparing, supplying or smoking it. Cannabis and cannabis resin are Class B drugs. Cannabis oil (liquid cannabis or hashish oil) derived from herbal cannabis is a Class A drug.

Cannabis and certain psychoactive cannabinoids and derivatives (cannabinol and its derivatives tetrahydrocannabinol (THC) and others) are classified under Schedule 1 of the *Misuse of drugs Act 1971* as having no therapeutic benefit. It cannot therefore be prescribed by doctors or dispensed by pharmacists and can only be possessed for research purposes with a Home Office license. A synthetic cannabinoid nabilone is licensed for prescription to patients with nausea or vomiting resulting from cancer chemotherapy, which has proved unresponsive to other drugs. Following recognition by the World Health Organisation of the therapeutic benefits of another cannabinoid, dronabinol, for the same purpose, this has been rescheduled from Schedule 1 to Schedule 2 and can be prescribed by doctors. It is however, unlicensed in the UK and has to be prescribed on a 'named patient basis'. Prescribing an unlicensed medicine places greater responsibility on the doctor.

Under the 1971 Act, maximum penalty on indictment for possession of Class B drugs is 5 years imprisonment with an unlimited fine. The maximum penalty for trafficking of Class B drugs is 14 years imprisonment and an unlimited fine with a liability to confiscation of assets in addition.[17] Growers may be sentenced to 14 years and treated as traffickers because they are normally prosecuted under section 4 of the MDA, not for cultivation under section 6. (Production, but not the cultivation of cannabis is designated a trafficking offence for the purposes of the Drug Trafficking Act 1994; confiscation of assets may result from a conviction). The owners of premises who knowingly permit or suffer the smoking of cannabis are also exposed to a maximum prison term on indictment of 14 years.

[17] *Drug Trafficking Act 1994*

a. Application of the legislation

As with other criminal offences, there is considerable discretion in how the law is applied. Although the current maximum fine for summary possession of cannabis is £2500, many police forces only caution those found in possession of small amounts of cannabis.[18] The percentage of persons dealt with by cautioning has risen from 25% in 1988 to 39% in 1998 (see statistical section VII E). A caution is part of an offender's criminal record.

The response to a parliamentary question in April 2000 discussed guidance on prosecution with regard to medicinal use of cannabis:

> **Mr Charles Clarke**: Possession of cannabis is a criminal offence and it is for the police and Crown Prosecution Service to decide whether to prosecute in a particular case, taking account of the individual merits. If there is sufficient evidence to prosecute, then both the police and the Crown Prosecution Service will weigh public interest considerations. The police have a range of guidance, the most recent was issued by the Association of Chief Police Officers in February last year; there are no plans to review this guidance. The Crown Prosecution Service assess all cases in accordance with the Code for Crown Prosecutors; this Code is currently under review.[19]

The Police Foundation report describes the use of cautioning:

> Many cases are kept away form the courts by cautioning and compounding and, in Scotland, warning letters and fiscal fines. By far the largest increase in police cautioning in England and Wales has been for cannabis offenders, from 41 % in 1990 to 55% in 1997. This has meant in practice a tripling in the number of cannabis offenders for which a caution was given, from 16,500 to 47,000. Cautions are part of an offender's criminal record. There is no provision at present for these records to expire under the Rehabilitation of Offenders Act 1974. The Government has recently issued a consultation paper proposing that this anomaly should be corrected and that cautions should immediately be spent. This would also apply to reprimands and warnings, which are to replace cautions for young people under 18 under the Crime and Disorder Act 1998.
>
> Cautioning is not used by HM Customs and Excise or in Scotland. For importation and exportation offences, compounding - a monetary penalty in lieu of prosecution – may be used in cases involving cannabis not exceeding 10 grams in weight. While compounding does not necessarily become part of an offender's criminal record, it may be mentioned in subsequent court proceedings. Its use for cannabis importation offenders fell between 1990 and 1997 from 58% to 45%.
>
> In Scotland, the procurator fiscal service which brings prosecutions in criminal cases may, if the offender agrees, offer a fine instead of prosecution. Such fines have only recently been used in drugs cases and in 1997, the first year for which figures are available, fines were accepted by 432 of 499 persons dealt with for possession of cannabis.[20]

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[18] British Medical Association, *The Misuse of Drugs,* Appendix 1, 1997

[19] HC Deb 12 April 2000 c 234W

[20] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000, chapter 7, paras 28-30

The Police Foundation report finds the use of discretion in implementing the legislation desirable, but inconsistent:

> Discretion needs a clear framework in which to operate. That is why we recommend that cautioning be put on a statutory footing, with guidelines and regulations. This has already been done for people under 18 in the provisions of the Crime and Disorder Act 1998. We do not favour less use of discretion. Better the present, somewhat informal, arrangements than a tightening up that leads to more people being brought needlessly into the criminal justice system.[21]

B. Devolution

Matters relating to both medicines and the misuse of drugs are reserved to the UK Parliament. This includes:

- The subject matter of the *Misuse of Drugs Act 1971*[22]
- The subject matter of the *Medicines Act 1968*, medical supplies and poisons[23]
- Legislation relating to international co-operation and control of substances used in the manufacture of controlled drugs[24]
- Legislation controlling drug trafficking and the proceeds of crime.[25]

As noted in the previous section, implementation of the legislation is slightly different under the Scottish courts.

C. International context

The current international legal framework mainly derives from three major United Nations drug control treaties:

- the Single Convention on Narcotic Drugs of 1961 (amended in 1972);
- the Convention on Psychotropic Substances of 1971; and
- the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

The core objective of the first two of these treaties was to confine the use of listed drugs to approved medical and scientific purposes. The third sought to strengthen international co-operation to combat illicit trafficking.

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21 ibid para 31

22 Schedule 5, Part II, section B1, *Misuse of Drugs, Scotland Act 1998*

23 Schedule 5, Part II, section J4, *Medicines, medical supplies and poisons, Scotland Act 1998*

24 Schedule 5, Part II, section B1, sections 12 to 14 of The *Criminal Justice (International Co-operation Act 1990* (substances useful for manufacture of controlled drugs)

25 Schedule 5, Part II, section B1, Part V of The *Criminal Law (Consolidation) (Scotland) Act 1995* (drug trafficking) and, so far as relating to drug trafficking, The *Proceeds of Crime (Scotland) Act 1995*

The UK, together with all the major industrialised nations of the West, is among the signatories of the 1961 UN Single Convention on Narcotic Drugs. This obliges signatories to make possession and other drugs-related activities involving a range of drugs (including heroin, cocaine and cannabis) "punishable offences".

Commentaries have been published by the United Nations interpreting various provisions of the conventions. These reveal that the references to possession, purchase and cultivation may not have been intended to cover these activities in relation to personal use. This seems to have been regarded as a loophole which on most interpretations was closed by the 1988 convention. The Police Foundation report elaborates:

> The 1988 convention also requires that each party establishes as a criminal offence the possession, purchase, or cultivation of illicit drugs for personal consumption… there is, however, a distinction between penalties for trafficking and those for personal consumption offences. Trafficking offences must be liable to sanctions which take into account the grave nature of such offences. The sanctions should include imprisonment or other forms of deprivation of liberty, pecuniary sanctions and confiscation. There is no similar requirement to have imprisonment, pecuniary sanctions and confiscation for personal consumption offences.
>
> The conventions leave precise implementation of any matters to individual states…[but] where the possession, purchase or cultivation is for trafficking, and with relation to trafficking offences generally, the requirement to establish criminal offences is absolute and may not be evaded on the grounds of being contrary to a country's constitutional principles or the basic concepts of legal system. The effect is to allow far more room for manoeuvre for personal consumption offences than for trafficking offences.[26]

This flexibility is reflected in the variety of levels of control within national legislation. Current legal controls of cannabis in the UK are comparatively restrictive. Countries with a more liberal regime include the Netherlands,[27] Italy, Spain, Canada, and some states within Germany, Australia and the USA.[28]

Room for Manoeuvre, a report prepared by the Institute of the Study of Drug Dependence (ISDD)[29] to inform the Police Foundation Inquiry, compares a number of national drug laws. It sets out how, depending where in Europe one commits an act such as possession of drugs for personal use, the act might be disregarded, or proceeded against administratively, or

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[26] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000 chapter 1, para 11

[27] Dutch cannabis policy is described in greater detail in Section VI E of this paper

[28] Science and Technology Select Committee (HL), *Cannabis: the scientific and medical evidence*, 4 November 1998, HL 151, 1997-98, box 3: current legal controls.

[29] ISDD now amalgamated with the Standing Conference on Drug Abuse (SCODA) under the name DrugScope

prosecuted under criminal law.[30] Examples of variation in national approaches to cannabis legislation thus include:[31]

Use: Italy, Germany and the Netherlands do not prohibit personal consumption. Spain applies administrative sanctions when use is in public. In Sweden and France use is a criminal offence. In the UK it is an offence to use opium but otherwise the relevant offence is possession, as in other countries which do not specifically make use an offence.

Possession: In Spain possession for personal use is not a criminal offence but a serious administrative offence, although unlikely to be punished unless committed in public. Italy also treats it as an administrative offence. Portugal has now voted to decriminalise consumption and possession of small amounts of illegal drugs (this includes cannabis and heroin) for personal use. Users will instead be reported to a special commission responsible for ensuring that they seek treatment. The trafficking of illegal drugs will remain a criminal offence.[32]

Cultivation of cannabis: this is an administrative offence in Spain if intended for personal use.

Minor supply: In Italy it is not a criminal offence to share drugs without payment among a group of users. In Spain the setting up of a common fund by a number of addicts in order to obtain drugs for their own consumption has been declared not a matter for prosecution. Administrative sanctions may apply if sharing takes place in public. By contrast, in the UK and other countries passing drugs within a group constitutes supply.

The ISDD report comments:

> *What the International Conventions require*
> The requirements of the international conventions on use and on supply are clear and generally uncontested. Supply has to be prohibited and criminalised, use does not (even though it has to be limited and, in the case of psychotropic substances such as ecstasy, prohibited). But the middle ground is murky. There are many questions as far as possession and related acts are concerned...
>
> *National laws vary*
> It might be thought that all modern states have approximated their drugs legislation. This turns out to be generally true of legislation in relation to trafficking. However,

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[30] Nicholas Dorn and Alison Jamieson, *Room for Manoeuvre. An overview of comparative legal research into the national drug laws of France, Germany, Italy, Spain the Netherlands and Sweden and their relation to the three international drugs conventions*, Institute for the Study of Drug Dependence, 1999, [overview report, DrugScope http://drugscope.org.uk/, 2000]

[31] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000 chapter 1

[32] BBC news, *Portugal decriminalises personal drug use*. 7 July 2000 http://news.bbc.co.uk/hi/english/world/europe/newsid%5F822000/822891.stm

> European states vary quite considerably in their legislation on drug possession and related issues, including self-supply (eg through self-cultivation) and 'social supply' or sharing of drugs amongst users. In some states, this middle ground is towed 'upwards' (towards supply) and becomes criminalised, whilst in other cases it is towed 'downwards' by its association with drug use, and middle ground acts are not criminalised.
>
> *Where the room for manoeuvre comes from*
> The international conventions do not impact 'directly'. They have to be adopted at national level, a process which inevitably involves interpretation. At national level, both the political climate of the day and constitutional/legal considerations set the context within which proposals for drug policy are considered. The result is that, depending on where in Europe one commits an act such as possession of drugs for personal use, the act might be disregarded, or proceeded against administratively/civilly, or prosecuted under criminal law.

The Police Foundation report considers the implications of the UN Conventions with regard to cannabis:

- The main MDA offences have to apply to cannabis as to other drugs;
- but there is no requirement to place cannabis in one Class rather than another, not the least because the imposition of penalties is largely a matter of domestic law. It is already dissociated from the other Single Convention Schedule 1 drugs, most of which are Class A;
- imprisonment is not required by the conventions as a sanction either for possession or for cultivation for personal consumption. Alternatives to conviction and punishment may be considered, including treatment, education, aftercare, rehabilitation, or social reintegration;
- some trafficking offences where cannabis is involved may also be 'appropriate cases of a minor nature' where the same alternatives to conviction and punishment could be considered;
- it would be possible …without renegotiating the conventions to permit the therapeutic use of cannabis, cannabis resin or extracts and tincture of cannabis. The conventions do, however, prevent the prescription of cannabinols (except nabilone and dronabinol) for medical treatment.[33]

The Government, however, has commented about international obligations:

> …it is incumbent on us all to appreciate that there are significant contradictions between the coffee shop policy in the Netherlands and international agreements. The single convention on narcotic drugs 1961 states that effective measures against abuse of narcotic drugs require co-ordinated and universal action; the convention calls for international co-operation aimed at common objectives. That is our policy…[34]

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[33] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000 chapter 7, para 23

[34] HC Deb 22 May 2000 c 672

III Historical context

Cannabis is derived from the Indian hemp plant, *Cannabis sativa*, which is both found wild and cultivated in many countries as a source of rope fibre. It is easily cultivated in Britain.

Cannabis has been used as a herbal medicine since ancient times. Assyrian tablets dating from the 7th century BC make reference to cannabis,[35] and it was documented as a herbal remedy in a Chinese pharmacy text of the first century AD. In India, the Middle East and North Africa the products of the hemp plant have long played a similar role to that played by alcohol in Europe. It featured in Culpeper's Herbal in 1653. It was widely used in Western medicine in the 1840s and was used for a variety of complaints such as muscle spasm, menstrual cramps and rheumatic complaints. As with many other herbal remedies, it fell into disuse as a larger repertoire of medicinal drugs became available.

Cannabis did not attain popularity as a recreational drug in the UK until the 1950s. Since the early 1970s cannabis has been one of the most widely misused illegal drugs. The *Dangerous Drugs Act 1964*, passed to enable the UK to ratify the Single Convention on Narcotic Drugs 1961, made it an offence to cultivate cannabis or to permit premises to be used for smoking or dealing in cannabis or cannabis resin. However, it was prescribable as a medicine until 1973. The House of Lords report on Cannabis elaborates:

> 2.8 Drug abuse has been the subject of international conventions since 1912. In 1961 these were consolidated and brought up to date by the UN Single Convention on Narcotic Drugs. Cannabis and cannabis resin were listed in Schedule IV, which entitled (but did not oblige) parties to adopt "special measures of control", and to ban them altogether "except for amounts which may be necessary for medical and scientific research only, including clinical trials..." (Article 2.5). According to the Home Office (p 150), this reflected "WHO's view that the drug was widely abused, had no therapeutic value and was obsolete in medical practice". Under the Dangerous Drugs Act 1964 (shortly consolidated by the Dangerous Drugs Act 1965), which implemented the Convention in the United Kingdom, cannabis was still able to be prescribed, though subject to certain controls. The tincture received a "licence of right" under the Medicines Act 1968; doctors were therefore still able to prescribe it.
>
> 2.9 The scale of drug abuse increased dramatically during the 1960s. In 1971 the UN adopted a further Convention on Psychotropic Substances; and the United Kingdom enacted the Misuse of Drugs Act 1971, which repealed the Act of 1965 and other enactments, replacing them with a more comprehensive and flexible regime. Cannabinol and its derivatives including THC (the chemical which gives cannabis its psychoactive properties…) appeared in Schedule I to the Convention, and parties were therefore obliged to ban them "except for scientific and very limited medical purposes by duly authorised persons" (Article 7(a)). In 1973 the licences of right granted in 1968 were reviewed, and the original Misuse of Drugs Regulations (SI

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[35] Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence,* 9th Report, HL paper 151 1997-98, para 2.1

> 1973 No. 797) were made under the 1971 Act. Cannabis's licence of right was not renewed, and the Regulations listed cannabis, cannabis resin and cannabinol and its derivatives in Schedule 4 - which is now Schedule 1 to the Misuse of Drugs Regulations 1985 (No. 2066) - thereby prohibiting medical use altogether.
>
> 2.10 According to the MCA [Medicines Control Agency], by 1973 there was "insufficient evidence" to support medical use of the tincture (Q 174), and it was rarely prescribed except to patients who were already drug misusers. The Parliamentary Under-Secretary of State for Health told the Commons on 14 January 1998 (col. 320), "It was rarely used and, when it was, it was used mainly for its sedative qualities. Advice at the time from the World Health Organisation was that cannabis was no more effective than any other available drug in treating the conditions for which it was used, so its use was stopped". According to the Department of Health, there was also a problem of diversion to recreational use through bogus prescriptions (Q 174).[36]

A number of independent Commissions have investigated the effects of cannabis. The impact of cannabis consumption on the people of India was investigated by the Indian Hemp Commission in 1894. The Commission concluded that "the moderate use of hemp drugs is practically attended by no evil results at all."[37]

Between 1968 and 1972 government appointed committees in Britain,[38] Canada[39] and the United States[40] cast doubt on the medical justification for the legal status of cannabis. The Wootton report of 1968 reported that:

> Once the myths were cleared, it became obvious that the case for and against was not evenly balanced. By any ordinary standards of objectivity, it is clear that cannabis is not a very harmful drug.[41]

The US Schafer report of 1972 reported:

> There is little proven danger of physical or psychological harm from the experimental or intermittent use of natural preparations of cannabis…Existing social and legal policy is out of proportion to the individual and social harm engendered by the drug.[42]

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36 Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, paras 2.8-2.10

37 Lynn Zimmer and John P Morgan, *Marijuana Myths, Marijuana Facts*, published by Lindesmith Center, 1997, p 1

38 Home Office Advisory Committee on Drug Dependence, *Cannabis:report* (Wootton Report), 1968

39 Canadian Government Commission of Inquiry, *Cannabis; a report of the Commission of Enquiry into the Non-medical use of Drugs (*Le Dain Report), Ottawa, Information Canada, 1972

40 United States. Commission on Marihuana and Drug Abuse, *Marihuana, A signal of misunderstanding; first report* (Shafer Report), 1972

41 Lynn Zimmer and John P Morgan, *Marijuana Myths, Marijuana Facts*, published by Lindesmith Center, 1997, p 1

42 ibid

A. Cannabis preparations

The sticky resin produced by the flowers and top leaves contains a number of psychoactive substances, collectively known as cannabinoids: these collectively make up the drug called cannabis. The potency of the cannabis obtained from a plant is dependent on the content of delta-9-tetrahydrocannabinol (THC), the most important of the cannabinoids. THC content is dependent on the part of the plant used, the method of cultivation, and the preparation of the extract:

- 'Bhang', obtained from cut tops of uncultivated plants with a low resin content is the least potent.
- 'Ghanga' or marijuana from flowering tops and leaves from specially cultivated plants has a higher resin content and is more potent. Both of these herbal preparations (also known as 'grass' or 'weed') are usually smoked in hand-rolled cigarettes ('joints' or 'reefers'). Potency is variable, with a THC content of 1-10 per cent.
- Cannabis resin (hashish) is the resin itself, in the form of a sticky brown cake which can be smoked or eaten.
- Liquid cannabis or hashish oil is extracted from cannabis resin, and is more potent. Tobacco is dipped in this before smoking. It may contain up to 60 per cent THC, and is a Class A drug.[43]

Smoking is the usual method of consuming cannabis, but it can also be eaten, requiring a larger dose to produce the same effect, slower onset of action, but which then lasts longer.

There is a perception that cannabis users are exposed to products of greater potency than users in the 1960s and 1970s. Sophisticated plant breeding has produced highly potent varieties such as 'skunkweed'. This was raised by witnesses in the House of Lords inquiry into cannabis. The report comments that:

> However, the Home Office Forensic Science Service, who have data on the THC content of seized cannabis samples, do not support the view that most users in the United Kingdom are exposed to material containing ten times as much THC as in the 1960s and 1970s. They say, "Cannabis resin…has a mean content of 4-5 per cent, although the range is from less than 1 per cent to around 10 per cent. This pattern has remained unchanged for many years...
>
> On the other hand, there appears to have been an increase in the THC content of herbal cannabis…The Forensic Science Service report that herbal cannabis in the United Kingdom currently also contains an average of 4-5 per cent THC. They also report cannabis grown in the home, using improved growing techniques and improved plant varieties, now produces herbal cannabis with a considerably higher THC content, with an average close to 10 per cent and a range extending to over 20 per cent. The use of "hydroponic" cannabis (grown in a nutrient solution rather than in soil) appears to be increasing rapidly…[44]

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[43] Bucknell & Ghodse, *Misuse of Drugs*, 3rd Edition, 1996, 3-047

[44] Select Committee on Science and Technology, *Cannabis: the Scientific and Medical Evidence,* 9th Report, HL paper 151 1997-1998, paras 6.12-6.13

IV Health effects of cannabis

There are more than sixty different cannabinoids found in the cannabis plant. The most abundant of these is THC and accounts for its intoxicating properties. Some of the cannabinoids are not psychoactive, but may modify the effects of THC. The precise action of the various cannabinoids is not yet understood, and much work is going on in this field. Cannabinoids appear to interact with the body's own pain relief systems.

THC and other cannabinoids are absorbed very rapidly through the lungs and into the blood stream and because they are fat soluble are rapidly taken up by the body tissues and may remain stored in body fats for long periods. The slow release of THC from these tissues produces low levels of drug in the blood for several days after a single dose, but there is little evidence that any significant pharmacological effects persist for more than 4-6 hours after smoking or 6-8 hours after oral ingestion.[45] However cannabis may remain traceable in the urine for perhaps a week in an occasional user and a month in a heavy user.[46]

The action of cannabis appears to be related to specific receptors[47] which are present in nerve cells of the brain and spinal cord, and in some peripheral tissues. It is now known that attachment of cannabinoids to these CB1 receptors is related to its effects on pain relief, control of movements, on memory impairment and control of body temperature. It is thought also that its intoxicant properties are related to CB1 receptors. A second type of receptor (CB2) exists about which little is known. These are found in cells of the immune system and are thought to have a role in the physiology of the immune system.[48]

A. Short term effects

In Western countries cannabis is generally used as an aid to relaxation and a way of becoming mildly intoxicated or 'high'. It causes a number of noticeable but usually mild physical effects including increased pulse rate and decreased blood pressure, bloodshot eyes, dry mouth and occasional dizziness. The psychological effects of cannabis can be subtle and hard to classify. The Health Education Authority states:

> The drug has a mildly sedative effect and seems to increase the extent to which a person is (or allows themselves to be) open to external influences. The subtlety of these effects mean that they can be interpreted by the user in a wide variety of ways, depending on what the user expects or wants to happen and on the reactions of those around them. All these influences, together with the 'loosening' effect of the drug, mean that cannabis is used to produce relaxation, sociability, talkativeness, hilarity or episodes of introspective reflection.[49]

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[45] Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 3.5

[46] Home Affairs Committee, *Drugs and Prisons*, Fifth Report, 9 November 1999, HC 363-II 1998-99 Memorandum by HM Prison Service, para 5.15

[47] Receptors are specific proteins on the surface of the cell to which the drug molecule binds

[48] Select Committee on Science and Technology, *Cannabis: the Scientific and Medical Evidence,* 9th Report, HL paper 151 1997-1998, para 3.6

[49] Health Education Authority webpage; http://www.trashed.co.uk/

Acute toxicity of cannabis and the cannabinoids is very low. There are no records of fatal overdose.[50] Official statistics record two deaths involving cannabis (and no other drug) in 1993, two in 1994 and one in 1995; [51] but these were due to inhalation of vomit. Animal studies have shown a very large separation (by a factor of more than 10,000) between pharmacologically effective and lethal doses.[52]

The short term effect of cannabis on the cardiovascular system - an increase in heart rate and decrease in blood pressure – could pose a risk to an individual with angina or other cardiovascular disease. In addition, while under the influence of cannabis:

- There may be impairment of short-term memory.
- Cannabis affects body co-ordination, so manual skills (e.g. driving a vehicle, or operating machinery) are impaired.
- Inexperienced users may undergo temporary, and in a small percentage of cases, severe psychological distress and confusion.
- Less extreme feelings of anxiety, panic and suspicion are not uncommon.
- With higher doses, there may be perceptual distortions, forgetfulness and confusion, and varying degrees of temporary psychological distress, particularly if the user is anxious or depressed.
- Heavy use amongst those with latent or existing mental disorders may aggravate their condition.
- A heavy user constantly intoxicated by cannabis may appear apathetic, lack energy and perform poorly at work or in education. This state may persist for weeks after stopping using the drug.[53]

The relationship between cannabis and schizophrenia is a cause for concern. A report by the Royal College of Psychiatrists and Royal College of Physicians comments:

> In individuals already affected by the condition, it can exacerbate the symptoms, but whether cannabis can cause schizophrenia is uncertain…It is not clear whether cannabis causes schizophrenia or whether the personality characteristics which predispose adolescents to use cannabis are also linked to schizophrenia…[54]

B. Tolerance and dependence

It is now accepted that tolerance (the need to take more of the drug to produce the same effect) to the effects of cannabis can develop, although this effect is not evident for most users in Western countries who may smoke only one or two cigarettes two or three times a week. Where high daily doses are consumed, as in some Eastern countries, it is evident that

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50 ibid

51 Select Committee on Science and Technology, *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 4.3

52 ibid

53 ibid

54 Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, p 9

tolerance does develop, and this is confirmed in laboratory studies where regular cannabis users showed less impairment of performance than occasional users.[55]

Physical dependence (where withdrawal of the drug produces physical symptoms) has been disputed in the past as it is not evident at the levels smoked by most users in the UK. It appears to occur rarely. However, psychological dependence, an inability to stop taking the drug, does occur in heavy long term users. The House of Lords report states:

> Professor Griffith Edwards, a member of the Advisory Council on the Misuse of Drugs (Q 27), said that, using internationally agreed criteria (DSM-IV—see Box 2), there seemed no doubt that some regular cannabis users become dependent, and that they suffer withdrawal symptoms on terminating drug use. According to the WHO report, cannabis dependence is characterised by a loss of control over drug use, cognitive and motivational impairments that interfere with work performance, lowered self-esteem and often depression. Professor Hall wrote, "By popular repute, cannabis is not a drug of dependence because it does not have a clearly defined withdrawal syndrome. There is, however, little doubt that some users who want to stop or cut down their cannabis use find it very difficult to do so, and continue to use cannabis despite the adverse effects that it has on their lives." In oral evidence he added that users who sought treatment for cannabis dependence had typically taken large amounts of cannabis every day for perhaps 15 years or more.
>
> … The Institute for the Study of Drug Dependence likewise conclude that, while physical dependence is rare, "Regular users can come to feel a psychological need for the drug or may rely on it as a "social lubricant": it is not unknown for people to use cannabis so frequently that they are almost constantly under the influence"
>
> …It is therefore clear that cannabis causes psychological dependence in some users, and may cause physical dependence in a few. The Department of Health sum up the position thus (p 45, cp Edwards Q 28): "Cannabis is a weakly addictive drug but does induce dependence in a significant minority of regular cannabis users."[56]

However, there is no evidence for a specific “amotivational syndrome” that has been suggested may occur in long-term heavy users, with loss of ambition, apathy and social deterioration.[57] This is thought to represent ongoing intoxication in frequent users of the drug.[58]

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55 Bucknell & Ghodse, *Misuse of Drugs*, 3rd Edition, 1996, 3-049

56 Select Committee on Science and Technology report *Cannabis: the scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, paras 4.25, 4.26, 4.33

57 Bucknell & Ghodse, *Misuse of Drugs,* 3rd edition, 1996, 3-051

58 Select Committee on Science and Technology report, *Cannabis: the scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 4.14

C. Driving impairment

Driving impairment was discussed in the House of Lords report on cannabis: the Department of Health rates driving impairment as "the major concern from a public health perspective" raised by recreational use. It is not clear how long subtle cognitive impairments persist. Most assume only a few hours; DETR suggests 4 hours at the most; Professor Heather Ashton of the University of Newcastle-upon-Tyne suggested that subtle cognitive impairments could persist for 24 or even 48 hours or more.[59] The House of Lords report adds:

> On the other hand the impairment in driving skills does not appear to be severe, even immediately after taking cannabis, when subjects are tested in a driving simulator. This may be because people intoxicated by cannabis appear to compensate for their impairment by taking fewer risks and driving more slowly, whereas alcohol tends to encourage people to take greater risks and drive more aggressively (POST note 113; cp DH p 240).
>
> 4.8 Analysis of blood samples from road traffic fatalities in 1996-97 (the results of the first 15 months of a three year DETR study - *Press Notice 94/Transport*, 11 February 1998) showed that 8 per cent of the victims were positive for cannabis, including 10 per cent of the victims who were driving. However, it is not clear what figures would have been obtained from a random sample of road users not involved in accidents (DH Q 211); and some of those who tested positive may have taken the cannabis as much as 30 days before, so that the effects would have worn off long since (DH p 240). The interpretation of traffic accident data is further confounded by the fact that 22 per cent of the drivers found to be cannabis-positive also had evidence of alcohol intake; proportions of alcohol-positives among cannabis-positive drivers as high as 75 per cent have been reported in other countries in similar studies. Professor Hall considers cannabis's contribution to danger on the roads to be very small; in his view the major effect of cannabis use on driving may be in amplifying the impairments caused by alcohol (cp Keen Q 42). According to a survey of 1,333 regular cannabis users by the Independent Drug Monitoring Unit (IDMU) in 1994, users who drove reported a level of accidents no higher than the general population; those with the highest accident rates were more likely to be heavier poly-drug users.[60]

Road traffic legislation gives the police powers to require motorists to provide specimens for laboratory analysis where they suspect that they are unfit to drive through drugs. The deployment of roadside screening technology for drugs would require a change to primary legislation.[61]

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[59] Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 4.7

[60] ibid para 4.7- 4.8

[61] HL Deb 16 February 1999 c 546W

The DETR has been conducting trials on devices which sample drugs in sweat and saliva.[62] The House of Lords report comments on the technical difficulties of monitoring cannabis intoxication:

> It is difficult to see how cannabis intoxication could be monitored, if its use were permitted. There could be no equivalent of the breathalyser for alcohol, since small amounts of cannabis continue to be released from fat into the blood long after any short-term impairment has worn off...[63]

The Department of Transport plans action against drug-driving as part of its Road Safety Strategy. The strategy document states:

> **4.21** Driving whilst impaired by drugs is a serious criminal offence with penalties similar to those for drink-driving. The law does not make a distinction between illegal or misused drugs and over-the-counter or prescription drugs taken as directed by a medical practitioner. Drivers can be convicted if there is evidence that: their driving was impaired; and the impairment was due to drugs.
> **4.22** The causal relationships between drugs and driving accidents have not yet been established, and we do not know how much drug-driving is taking place. We will be finding out more through the research described below.
> **4.23** Studies have shown that compared with ten years ago, five times as many people killed in road accidents had a trace of an illegal drug in their body. Cannabis was by far the most common illegal substance found. However, whilst it is likely that shortly after use the active ingredient of cannabis impairs driving, traces of the drug can remain in the body for up to four weeks, long after it has ceased to have any effect. This can present difficulties for enforcement until we have further research findings.
> **4.24** Class A drugs are most likely to have an adverse effect on driving. According to interim survey results, they were found in 6% of cases (compared with 12% for cannabis). This was a small increase compared with 10 years ago.
> **4.25** In the studies of road accident fatalities referred to above, it was found that there had been no change in the incidence of medicinal drugs over the period. There is scope, nevertheless, to improve enforcement and to make people more aware of the risks of driving while their ability is affected by drugs.
>
> **ACTION PLAN: TACKLING DRUG-DRIVING**
> **4.26** We need to improve the way drug-driving is identified so that existing laws can be enforced more effectively.
> **4.27** At present there is no equipment for screening drivers for drugs at the roadside. **Devices are being developed for roadside use. These devices will need to be able to detect the presence of Class A drugs and also the ingredient in cannabis that could impair driving.**
> **4.28 Improved training will be introduced for police officers, in techniques for recognising and testing drivers who may have taken drugs, and in tests of co-**

[62] HC Deb 16 February 1999 c 564W
[63] Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 4.9

ordination to help assess whether a driver's behaviour is impaired by drugs. These techniques have been successfully trialled by a number of police forces.
4.29 The police will be given the power to undertake tests of co-ordination and, when suitable equipment is available, to require suspected drivers to give samples for screening. This will need primary legislation but will create an effective regime to control drug-driving to operate alongside the drink-driving one.
4.30 Research is essentially in three strands: first, to identify the prevalence of drugs among drivers; second, to examine the nature of the effects which different drugs have on driving behaviour; and third, to devise techniques to address the problem by enforcing the law.[64]

D. Long term effects

There is little research on the long-term effects of heavy cannabis usage, and many uncertainties. Medical opinions tend to take a cautious approach.

The consequences of *smoking* cannabis appear to pose a potential long term health hazard. Regular cannabis smokers suffer from an increased incidence of respiratory disorders including cough, bronchitis and asthma. There is as yet no epidemiological evidence for an increased risk of lung cancer, but, by analogy with tobacco smoking, it is likely that any link might take decades to become evident.[65] The tar yield from marijuana is similar to that of tobacco. A working party of the Royal College of Psychiatrists and Royal College of Physicians states:

> …it is also important to appreciate that the smoke from a cannabis joint contains most of the same constituents as tobacco smoke, including the carcinogens. It is not surprising therefore, that regular cannabis smokers develop chronic bronchitis and squamous metaplasia (a pre-cancerous change) of the respiratory tract, and it is likely that in time it will become apparent that they are also at increased risk of cancer.[66]

Press reports have indicated that research at the University of California has produced evidence to show that THC, the major psychoactive ingredient in cannabis, is likely to impair the body's ability to resist cancer.[67]

There is uncertainty about the adverse effect of long term use on cognitive performance, particularly in heavy users. There can be significant impairment in complex manipulation of learned material, and evidence given to the House of Lords Inquiry suggested that some such impairment may persist after cannabis use is discontinued, but such residual deficits, if present, are small, and their presence controversial. The Lindesmith publication "Marijuana

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[64] Department of the Environment, Transport and the Regions, *Tomorrow's roads: safer for everyone, The Government's road safety strategy and casualty reduction targets for 2010*, 1 March 2000, Dep 00/430

[65] Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 4.19

[66] Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, p 247

[67] "Cannabis 'Cancer risk' puts therapy in doubt", *Press Association*, 21 June 2000

Myths, Marijuana Facts" states "there is no convincing evidence that heavy long-term marijuana use permanently impairs memory or other cognitive function."[68]

While the House of Lords report quotes the World Health Organisation suggesting that there is no evidence that cannabis adversely affects human fertility, or that it causes chromosomal or genetic damage, the Royal Colleges report states that cannabis has been shown to reduce sperm production in men and "probably reduces fertility in men."[69]

The World Health Organisation reports that pregnant women smoking heavily may have low birth weight infants and a short gestation. This may be due to inhalation of carbon monoxide in cannabis smoke which reduces oxygen carrying capacity of the blood, rather than to any direct effects of the cannabis. The NHS National Teratology Information Service advises that, although there is no conclusive evidence to suggest an increase in fetal abnormalities "We would not recommend the legalisation of cannabis because of the potential fetotoxicity that may occur if it is used in pregnancy."[70]

1. Literature reviews for Department of Health

In addition, three literature reviews were commissioned by the Department of Health.[71] The views are the authors' own, and are not necessarily those of the Department of Health.[72]

- Cannabis: Clinical and Pharmacological Aspects[73]

  Effects discussed include health risks such as psychiatric effects, cardiovascular health risks, adverse effects on the respiratory system, damage to the immune system, reproductive effects, and risks to society in the form of increased traffic accidents and antisocial behaviour. The author concludes (inter alia) that the long term effects of present day cannabis use have yet to be evaluated. "One cannot expect the human pathology of this drug to be written before one or two decades"

- Psychiatric aspects of cannabis use[74]

  The epidemiology[75] of untoward effects are discussed; also effects in vulnerable and non-vulnerable individuals, longer-term psychiatric effects and implications for psychiatric

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[68] Lynne Zimmer and John P Morgan, *Marijuana Myths, Marijuana Facts*, The Lindesmith Center, 1997, p 70
[69] Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, p 9
[70] Select Committee on Science and Technology *Cannabis: the Scientific and Medical Evidence* 9th Report, HL paper 151 1997-1998, para 4.15-4.16
[71] Dep 98/508
[72] HC Deb 8 June 1998 c 464W
[73] Professor CH Ashton, *Cannabis: Clinical and pharmacological aspects,* May 1998
[74] Dr Andrew Johns, *Psychiatric aspects of cannabis use*, May 1998
[75] Study of health effects within a population

services and research. The author, Dr Andrew Johns, of the Department of Forensic Psychiatry, Institute of Psychiatry comments on implications for clinical practice:

> Assuming that health-care staff share the characteristics of the general population, then about 20% will have tried cannabis (Ramsay and Parcy 1996). Perhaps in consequence of this and in ignorance of recent research, it is probable that most health-care workers regard cannabis as a drug which has rather benign effects on the general population and the capacity to induce short-lived states of disturbance in a minority. Such views are out of date. There is now an urgent need for those who provide mental health-care and primary health-care to update themselves with regard to the appreciable prevalence of adverse effects of cannabis, ranging from short-lived affective [mood] change, to induced psychoses and interactions with underlying mental illness and other drugs of misuse.[76]

- Therapeutic Aspects of Cannabis and Cannabinoids[77]

  This discusses therapeutic possibilities and concludes (inter alia):

> The role of cannabinoids in modern therapeutics has yet to be determined but the evidence in this report shows that it would be irrational not to explore it. The active components of a drug which mankind has prized as a medicine for eight thousand years should not be discarded lightly, and certainly not simply because of concern about its recreational use. Logic dictates that the Government should take steps to relax the regulations which currently inhibit controlled and co-ordinated human research, and modify the Misuse of Drugs Act in such a way as to permit doctors to prescribe cannabinoids in a wider range of medical conditions.

The Department of Health is including the effects of long term heavy cannabis use in a four year £2.4 million Drug Misuse Research Initiative announced in May 2000. A total of 14 research studies on a range of drug-related issues are being commissioned. Issues to be tackled are:

- the effectiveness and cost-effectiveness of methods of treatment and care
- the impact of waiting lists for drug treatments
- using time on a waiting list positively to increase treatment success
- links between drug use and mental health problems
- the effect of drug use on the psychosocial development of young people
- prevention and treatment interventions aimed at young people
- effects of long term heavy cannabis use. [78]

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[76] Dr Andrew Johns, *Psychiatric aspects of cannabis use*, May 1998, 5.1

[77] Dr Philip Robson, *Therapeutic aspects of cannabis and cannabinoids,* May 1998

[78] Department of Health press notice 2000/0275, *Gisela Stuart launches research programme on drug misuse*, 12 May 2000

V Cannabis for therapeutic purposes

It appears that some people with intractable medical conditions use cannabis to obtain symptomatic relief despite its illegality, and there is growing pressure to allow doctors to prescribe it for medicinal purposes.

A number of reports have recently reflected research and a growing public interest in the medicinal benefits of cannabis.

A. British Medical Association report

The British Medical Association issued a report on "Therapeutic uses of cannabis" in November 1997. This reviewed the potential therapeutic benefits of cannabis and cannabinoids, and supported the policy statement issued in 1997 at the BMA's Annual Representative Meeting that certain additional cannabinoids should be legalised for wider medicinal use.[79] The report reviewed the evidence for therapeutic benefits in a variety of areas including (among others):

- Nausea and vomiting associated with cancer chemotherapy
- Muscle spasticity (as in multiple sclerosis, spinal cord injury)
- Pain
- Loss of appetite (as in AIDS)
- Epilepsy
- Glaucoma
- Asthma

As an example, muscle spasticity, with recurrent painful cramps and combinations of weakness, tremor, abnormal movements and problems with bladder and bowel control occurs in conditions such as multiple sclerosis, cerebral palsy and spinal cord injuries. The BMA report found that a number of clinical studies lend weight to anecdotal reports of alleviation of spastic symptoms in multiple sclerosis patients, but few patients have been studied, and the results were not always favourable. Results for spinal cord injury patients were also mixed. The authors concluded that cannabinoids may have a potential use for patients with spastic neurological disorders, but that carefully controlled trials are needed:

> Depending on the results of such trials there may be a case for considering extension of the indications for nabilone (and allowing THC) for use on a named patient basis, in chronic spastic disorders unresponsive to standard drugs.[80]

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[79] British Medical Association, *Therapeutic uses of cannabis*, 1997, p 2
[80] ibid

The report concludes that:

> The information is meagre but nevertheless it can be concluded that although cannabis itself is unsuitable for medical use, individual cannabinoids have a therapeutic potential in a number of medical conditions in which present drugs or other treatments are not fully adequate. Long-term effects of chronically administered cannabinoids have not been studied, but present evidence indicates that they are remarkably safe drugs with a side effects profile similar to many drugs used for the same indications…
>
> .. The acute toxicity of cannabinoids is extremely low: they are very safe drugs and no deaths have been directly attributed to their recreational or therapeutic use. However, cannabinoids have actions on many body systems and, like all drugs, cause unwanted effects. Although some of these are frequent in medicinal use, they are not usually severe."

One of the authors of the report, Heather Ashton,[81] said:

> "We are not recommending smoking cannabis, because of the risks of carcinogenicity, the complex mix of constituents, and the inability to control dosage. What we are calling for is properly controlled research with pure cannabinoids and further development of synthetic agents without psychotropic activity" [82]

The authors consider that properly controlled trials with pure cannabinoids are now required, and call for changes in the licensing of cannabinoids under the *Misuse of Drugs Act 1971* to allow for this. The report recommends that:[83]

> The World Health Organisation should advise the United Nations Commission on Narcotic Drugs to reschedule certain cannabinoids under the United Nations Convention on Psychotropic Substances, as in the case of dronabinol. In response the Home Office should alter the Misuse of Drugs Act accordingly.
>
> In the absence of such action from the WHO, the Government should consider changing the Misuse of Drugs Act to allow the prescription of cannabinoids to patients with particular medical conditions that are not adequately controlled by existing treatments.

The report also suggests the development of a central registry of patients prescribed cannabinoids so that long term effects can be followed.

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81 Emeritus Professor of clinical psychopharmacology, University of Newcastle

82 "BMA wants licensing of cannabis to be changed" *British Medical Journal,* 22 November 1997

83 Full details of the recommendations and details of use of cannabis in individual illnesses will be found in the BMA report

B. House of Lords Science and Technology Committee Report[84]

The House of Lords Science and Technology Committee carried out an enquiry into the medical effects of cannabis, taking evidence on ‘the scientific case for and against continuing to prohibit the medicinal and recreational uses of cannabis’ (its remit did not include consideration of evidence on the social and legal aspects of cannabis use).

Key questions to be addressed were:

- What are the physiological effects (immediate, long-term, and cumulative) of taking cannabis on its various forms?
- What are the psychological effects?
- How do these effects vary with particular methods of preparation and administration?
- To what extent is cannabis addictive?
- To what extent do users develop tolerance to cannabis?
- What is the evidence that cannabis in its various forms has valuable medicinal actions, and in the treatment of which diseases? How rigorous is the evidence? Is there a case for a prolonged clinical trial, even if the current level of control is maintained?
- On the basis of the answers to these questions, how strong is the evidence in favour of permitting medical use? How strong is the scientific evidence in favour of maintaining prohibition of recreational use?

The Committee’s report recommended that cannabis should be made available for medicinal purposes: while remaining a controlled drug it should be moved to "Schedule 2".[85] However, the report finds enough evidence of toxic effects of cannabis to justify maintaining the present ban on recreational use.[86]

The following press release elaborates:

> … Lord Perry of Walton, chairman of the inquiry said: "We have seen enough evidence to convince us that a doctor might legitimately want to prescribe cannabis to relieve pain, or the symptoms of multiple sclerosis (MS), and that the criminal law ought not to stand in the way. Far from being a step towards general legalisation, our recommendation would make the ban on recreational use easier to enforce. Above all, it would show compassion to patients who currently risk prosecution to get help."
>
> [..] Cannabis is a "Schedule 1" drug, and cannot be used at all in medicine, except for research under special Home Office licence. The Lords recommend that it should be moved to "Schedule 2". This would allow doctors to prescribe it, subject to certain special regulations, and it would allow doctors and pharmacists to supply it in accordance with a prescription.

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84 Science and Technology Select Committee, *Cannabis: the scientific and medical evidence*, 4 November 1998, HL 151 1997-98

85 Select Committee on Science and Technology report *Cannabis: the scientific and Medical Evidence,* 9th Report, HL paper 151 1997-1998

86 See Section VI D of this paper

> The report sets out evidence that cannabis can be effective in some patients to relieve the symptoms of MS, and against certain forms of pain. The Lords say, this evidence is enough to justify a change in the law. They are less convinced about its effectiveness in other conditions, including epilepsy, glaucoma and asthma. The Lords welcome the fact that clinical trials of cannabis are currently being launched, by the Royal Pharmaceutical Society, and by Dr Geoffrey Guy of GW Pharmaceuticals, with a view to the eventual licensing of cannabis as a medicine. The Lords say, however, that cannabis should be rescheduled now, rather than waiting several years for the results of these trials. If cannabis ever becomes a licensed medicine, the Lords do not envisage it being licensed for smoking; they call for research into alternative delivery systems.
>
> At present, people who use cannabis for medical reasons risk prosecution; and juries sometimes refuse to convict such people, which brings the law into disrepute. If prescription were legalised, then someone using cannabis for medical reasons who was accused of recreational use could clear himself at once by producing the prescription.[87]

The following aspect was considered important: "smoking cannabis carries similar risks of respiratory disorders to smoking tobacco. It is also possible, though not proved, that exposure to cannabis smoke increases the risk of cancers of the mouth, throat and lung."[88]

The report had a mixed response, being welcomed by patients using the drug for symptomatic relief and by campaigners for legalisation. The need for safety prompted a more cautious approach by some official bodies.

The Royal Pharmaceutical Society welcomed the House of Lords call to move cannabis from Schedule 1 to Schedule 2 under the *Misuse of Drugs Regulations 1985*, so that it could be prescribed subject to certain conditions. Professor Tony Moffat , the Society's chief scientist is reported as saying that until scientists could establish which cannabinoids were the most therapeutically beneficial, initial trials should be allowed to use standardised preparations of cannabis.[89]

The British Medical Association opposed the recommendation to transfer cannabis and cannabis resin from Schedule 1 to Schedule 2. Instead the BMA recommended that certain cannabinoids should be rescheduled and the regulations made sufficiently flexible to allow clinical trials to proceed urgently. The BMA believes that this route will allow the development of targeted medicines whereas simply prescribing cannabis will not resolve the uncertainty and lack of evidence on its pharmacological effects.[90]

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87 HL press notice, 11 Nov 1998

88 Science and Technology Select Committee, *Cannabis: the scientific and medical evidence*, 4 November 1998, HL 151 1997-98, para 8.21

89 *The Pharmaceutical Journal*, 14 November 1998

90 BMA Press release, *BMA calls for active research effort to produce new cannabis-based drugs but says crude cannabis is unsuitable for medical use,* 11 November 1998

The Multiple Sclerosis Society welcomed the House of Lords report and called for rescheduling of cannabis so that it can be prescribed by hospital specialists. In the meantime it hopes that prosecuting authorities and the courts will deal compassionately with MS patients who use cannabis.[91] However, the MS Society has said the government needed to ensure that the same safety and quality standards should be set up for testing cannabis as are used for other drugs.[92]

The Police Foundation report endorsed the view of the House of Lords report that cannabis and cannabis resin should be moved from Schedule 1 to Schedule 2 of the Regulations. It recommends also that if there is any delay in adopting this recommendation pending the development of a plant with consistent dosage, a defence of duress of circumstance on medical grounds should be available for those accused of the possession, cultivation or supply of cannabis.

C. Government position

A petition supporting legalisation of cannabis for medical use was presented to Parliament on 27 April 1998. Observations by the Secretary of State for Health on this petition are recorded:

> The issues which surround the prescribing of cannabis are complex and not capable of easy or quick resolution. This does not mean, however, that a lesser standard of scientific evidence should be accepted compared with other drugs in the case of cannabis. We are sympathetic to the plight of people who obtain no relief from existing medication but the decision on the prescribing of cannabis must be right. The existing evidence does not support its licensing for therapeutic use and until the evidence is forthcoming, the Government cannot sanction its use.[93]

The Government's initial response to the House of Lords report on cannabis, given in answer to Parliamentary Questions, was that cannabis should not be available on prescription unless or until the safety, quality and efficacy of a medicinal form have been scientifically established and a marketing authorisation issued by the Medicines Control Agency.[94]
The official response elaborates:[95]

> 17. Dronabinol, one of the cannabinoids, is, as the report mentions, already subject to less stringent controls under the 1971 UN Convention on Psychotropic Substances than the other cannabinoids because of its now recognised therapeutic value. Accordingly it is in Schedule 2 rather than Schedule 1 of the Misuse of Drugs Regulations 1985.

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91 *The Pharmaceutical Journal*, 14 November 1998
92 http://www.news.bbc.co.uk/hi/english/health/newsid_211000/211863.stm
93 UP 1823 1997/98 19 April 1998
94 HC Deb 18 November 1998 c 607W
95 Science and Technology Select Committee 2nd report, *Cannabis Government Response*, 4 March 1999, HL paper 39 1998-99, Appendix 2

> If it becomes clear that any of the remaining cannabinoids have therapeutic potential the Government will seek amendment of the 1971 Convention which would make it possible to place these substances in Schedule 2 of the 1985 Regulations without breach of the Convention…
>
> …the Government is unwilling to allow cannabis to be prescribed on an unlicensed basis. But it may be worth describing some of the implications of the recommendation were it to be implemented.
>
> …If cannabis could be prescribed on a named patient basis the doctor would, as the report acknowledges, take on him or herself full responsibility not only for the welfare of their patient but also for a person being allowed to possess cannabis. In the case of cannabis we do not believe that it would be reasonable to burden doctors with that responsibility.
>
> …Allowing raw cannabis (which would usually be smoked) as a medicine would seriously blur the distinction between misuse and therapeutic use. It would send confusing messages to the public about the risks of misusing the drug. People caught in possession of unprescribed cannabis by the police would frequently argue that it was for therapeutic purposes and claim that the prescription had been lost.
>
> On the other hand, if a medicinal form of the drug were available it would be possible to retain a clear difference between the two forms. The risk of diversion of the medicinal form to the illicit market would be no greater than it is for current medicines which contain controlled drugs, on which there are controls on production, supply and possession. [96]

The House of Lords issued a response to this regretting that the "mind of the Government appears to be closed on this issue" and hoping that, in the light of the results of the new research underway it would revisit the recommendations of the Committee at an early date.

D. Clinical trials

Home Office permission has been granted to GW Pharmaceuticals Ltd to grow cannabis with the aim of developing a cannabis-based medicine.[97] Research is being carried out to isolate the various chemicals in the cannabis plant and to demonstrate which have medicinal qualities but without the psychoactive side-effects. Clinical trials are about to start. GW Pharmaceuticals hopes to be able to bring cannabis-based prescription medicines to market by 2003.[98]

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[96] Government reply to the Report if the House of Lords Select Committee on Science and Technology, *Cannabis, the Scientific and Medical Evidence*, 9th Report, 4 March 1999, HL Paper 151 1997-98

[97] UK medicinal cannabis project, http://www.pharmj.com/SearchFrame.html

[98] "Clinical trials to start", *The Pharmaceutical Journal*, Vol 264 No 7092, 15 April 2000, p 568

Ministers have commented on the progress of clinical trials:

> **Ms Hewitt**: The Medical Research Council is supporting a clinical trial to look at the efficacy of cannabis extracts in the treatment of spasticity in multiple sclerosis patients. The trial was announced in December 1999 and is being run by Dr John Zajicek (Derriford Hospital, Plymouth) and the MRC Clinical Trials Unit.
>
> The trial is making good progress; local ethical committee approval has been obtained in principle and an application has been made to the Medicines Control Agency for the appropriate licence. The cannabinoids will be given exclusively in capsule form. Recruitment of patients is planned to start later in the summer. The results will be available in abut 2.5 years, after formal scientific assessment of the results has taken place.[99]

And:

> **Ms Stuart**: […]Evidence from clinical trials of safety, quality and efficacy of a medicine is part of the information that is assessed by the MCA in coming to a decision about whether a product should be licensed for marketing in the United Kingdom. If a marketing authorisation were to be issued by the MCA, we would seek to modify the current Misuse of Drugs Act controls on the use of cannabis.[100]

The Observer comments that the United Kingdom Anti-Drugs Co-ordinator, Keith Hellawell, has indicated that cannabis could be legally available in as little as two years.[101]

A study reported in *Nature* in March 2000 provides further evidence of the efficacy of cannabinoids in the treatment of multiple sclerosis. The study which used a model of MS in mice was carried out at the Institute of Neurology at University College London. This demonstrated that the cannabis derivative tetrahydrocannabinol (THC) and some synthetic cannabinoids were effective in controlling neuromuscular symptoms of MS such as tremor and spacticity (muscle rigidity).[102] The Multiple Sclerosis Society comments that "The study provides a firm basis for the human trials of cannabis in MS that will commence shortly."[103]

E. Private Member's Bill

The *Misuse of Drugs (Amendment) Bill* (Bill 50 of 1998-99) was introduced as a 10 Minute Rule Bill on 24 February 1999 by Paul Flynn. Its purpose was to make provision for the production, supply and possession and use of cannabis resin for medicinal purposes. It was scheduled for second reading on 5 November 1999, but was 9th in order of business and did not proceed.

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[99] HC Deb 4 July 2000 c 137W

[100] HC Deb 14 April 2000 c 296W

[101] "Medicinal cannabis 'legal in two years'", *Observer,* 2 July 2000, p15

[102] David Baker et al, "Cannabinoids control spasticity and tremor in a multiple sclerosis model" *Nature,* Vol 404, 2 March 2000, pp 84–87

[103] http://www.mssociety.org.uk/asp/news/487.htm

The bill was reintroduced on 9 March 2000 (Bill 85 of 1999/2000) to be read for the second time on 21 July 2000. It was low in the order of business and was not moved.

F. EU situation[104]

The use of cannabis for medical purposes has been debated in Europe, principally in Denmark, Germany, Spain, the Netherlands and Austria, as well as in the UK.

Germany made changes to the narcotic drug law in 1998 to allow cannabis derivative THC for medicinal purposes. Import of the US artificially produced product Marinol is permitted, to be used as a pain relief for cancer patients receiving chemotherapy, an appetite stimulant for AIDS patients, for asthma patients, and to combat insomnia[105]

In Austria the Viennese drug plan was presented in 1999, proposing that the medical use of cannabis should be researched after clarification of the legal and organisational framework.

Spain is considering future research. The Netherlands carried out a review on 1997 on the potential medical use of cannabis and concluded that the evidence was insufficient to justify cannabis for medical use. However, more research has been called for and clinical trials are planned.

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[104] European Monitoring Centre for Drugs and Drug Addiction, *1999 Extended Annual Report on the state of the drugs problem in the European Union*, p 79

[105] ibid

VI The cannabis debate

Decriminalisation or depenalisation is generally taken to mean either the non-enforcement or the abolition of criminal sanctions for the possession of small amounts of illicit drugs for personal use. Although the use of drugs would be tolerated, trafficking (including supply, production, import and export) would remain illegal.

Legalisation in its fullest extent, where all the points of supply and consumption process are legal, is rarely proposed without some restrictions. The proposed degrees of regulation of distribution and consumption of drugs vary and alternatives range from licensing of the drug in various ways, such as licensing commercial premises for sale and consumption of cannabis, as in Amsterdam's 'coffee shops', to restrictions similar to those of alcohol, including a minimum age.

Paul Flynn, Member for Newport West, and a long-time campaigner for relaxation of cannabis legislation, introduced a bill on 13 April 2000 to "allow the supply and consumption of cannabis and cannabis resin on licensed premises".[106] At second reading on 9 June 2000 an objection was taken. It was rescheduled for 21 July 2000, but was low in the order of business and was not moved. Mr Flynn also laid an Early Day Motion on similar lines:

> That this House believes that the use of recreational cannabis should be allowed under strictly controlled conditions for an experimental period on the lines of the licensed cannabis cafes in the Netherlands.[107]

This had received 21 signatures by 21 July 2000.

Pros and cons of decriminalisation and legalisation are argued forcefully by both sides of the debate. Campaigners for legalisation maintain that prohibition acts as a smokescreen to avoid addressing social and economic factors that lead to people using drugs. The case for legalisation contends that prohibition is both wrong, and does not work in practice. Arguments put forward for legalisation include:

- The health effects of cannabis are minor in comparison with other legal substances such as tobacco; the decision to use or not should be one of informed personal choice.
- Legalisation would allow a more credible prevention and education message against more harmful hard drugs.
- It would separate those involved in cannabis use from contact with criminal society.
- Legalisation would reduce tension between citizens and the police.
- It would allow regulation of quality control of drugs supplies thus reducing health risks.
- Through regulation it would be easier to prevent supplies reaching the young and vulnerable.

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[106] *Licensing (Cannabis).* Bill 113 of 1998-99
[107] EDM 798, 6 June 1999-2000

- Legalisation would reduce costs of law enforcement, the criminal justice system and imprisonment.
- Savings in manpower and financial savings could be directed towards enforcement of hard drugs and for prevention and treatment.
- Legalisation would remove the drugs market from criminal hands, and revenues would be transferred to Government.

The campaign group Transform argues in favour of legalisation (of all drugs) combined with regulation:

> As soon as the question is raised of reform to end prohibition, opponents of reform point to the dangers of illicit drug use. We are all agreed that drugs can be misused, but it is because of this that legalisers call for increased control and regulation of the market. This can only be achieved by bringing the trade back in to the legal framework (i.e. we should legalise drugs because they are dangerous, not because they are safe.) What supporters of legalisation are calling for is a debate of drug policy in the light of the fact that there is an increasing prevalence of the use of drugs and increasing misuse.
>
> The question we must ask is, are the policies and legislation effective in dealing with level and type of drug use that is taking place? On the basis of all the available evidence, prohibition would seem to be singularly ineffective.
>
> In the high emotion of the debate, it is often difficult to make a distinction between the consequences of drug use and the consequences of using an illegal drug. The major producers and suppliers of illegal drugs operate in the clandestine world of organised crime which is violent and unregulated. Users have to pay very high prices for drugs (of extremely variable quality) and users who have no other source of income often resort to crime in order to fund their habit. (An average dependent heroin user involved in property crime will need to steal about £30 000 worth of property each year to pay for their drugs.)
>
> Due to the fact that alcohol, tobacco, sleeping pills and methadone are readily available through legal outlets, there is almost no involvement from organised crime in the sale of these products. The price is relatively low and consequently there is no property crime associated with their use, even amongst dependent addicts. There are no violent turf wars fought over their distribution. The producers and suppliers of these substances are controlled and regulated…[108]

The campaign group "Legalise Cannabis Alliance" sees decriminalisation as "a particularly undesirable version of prohibition". Commenting in its document *Legalise and Utilise* it states:

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[108] Danny Kushlick, Director, Transform, *Drug Policy discussion document*, (The campaign for effective drug policy), April 2000

> On closer examination however, a huge flaw in this policy becomes apparent: the crucial supply is merely side stepped. There would be no legal supply. Undoubtedly this would give a boost to just those illegal suppliers who are at work today. Such a programme, clearly is heading for disaster. What is being suggested in effect is that illegal profiteers should supply a legalised and sanitised commodity.[109]

Arguments against legalisation include:

- Legalisation would send a message to the young that drug taking is acceptable.
- Legalisation would send a message that cannabis is harmless, whereas it can have both acute and chronic adverse health effects.
- Cannabis consumption would rise. Its illegal status currently deters many. Increases would occur in the young and vulnerable – preventing tobacco reaching these groups has proved difficult.
- Legalisation would not prevent criminal involvement; criminal activity would continue to circumvent and undercut legal supply.
- Criminal activity could be transferred to more lucrative drugs – increasing concentration on sales of hard drugs.
- The regulation of drug usage would be problematic – who should be allowed to buy drugs, what strengths should be available, where should they be sold?

Enlarging on several themes:

A. The freedom of the individual versus the duty of the state

The argument for legalisation would state that the principle of informed personal choice (such as operates in a wide range of personal activities eg tobacco smoking) should also apply to drugs use. If harm is caused to others (eg to family, committing crimes), the state can act against the harm, but not against the drug use per se.

In the case of cannabis, it is argued that harmful effects are minimal, that it is used in youth and use diminishes naturally with age. 22% of 16-19 year olds (the age group most likely to use cannabis) surveyed had tried it in the last month.[110] Such is the widespread use in the population that many regard it as normal.

Despite this level of use, there is no evidence that cannabis use leads to acquisitive crime in the same way as heroin and crack-cocaine.[111] Criminal statistics associated with cannabis appear to be largely related to flouting of the current drugs legislation.

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[109] Legalise Cannabis Alliance *Cannabis: Legalise and Utilise Manifesto and Information Document* 1999

[110] Home Office, *1998 British Crime Survey (BCS)*

[111] The Police Foundation, *Drugs and the law, Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000 chapter 7, para 19

The argument against legalisation maintains that cannabis is not a safe drug: if it were legalised public perception would be that the Government believes it to be safe. Both this and removal of its illegal status would lead to increased consumption. The United Nations *World Drug Report* comments:

> That physical availability can and does impact on use has been demonstrated on numerous occasions…examples include the higher rate of opiate abuse among physicians, nurses and pharmacists compared with the general population; the effect of cigarette vending machines on smoking by minors; the high rate of opiate dependence among American troops in Vietnam compared to the Pacific phase of World War II.[112]

The comparison with tobacco is rejected by those who argue against legalisation. Many consider that if attempts were made to introduce it to society as a new drug, it would be considered too hazardous to health to be allowed onto the market. The Government's duty is to reduce harmful effects of drug taking in the population – to legalise cannabis would send a confusing message to the young.

B. Perceived harms caused by enforcing the current laws

Advocates of decriminalisation argue that public health factors are not the only criteria to be taken into account in determining the degree of regulation of cannabis. The wider scope of public and individual welfare should be taken into account. Many drug users are given criminal records or are sent to prison. This creates tensions between the police and otherwise law-abiding citizens. Current legislation exposes users to criminal contacts in order to obtain supplies, creating opportunities to introduce individuals to more harmful drugs. Massive profits are made by organised crime.

Correspondence in the *British Medical Journal* submitted by senior pubic health physicians calls for social context to be considered:

> Social opportunity costs arise as a result of criminalising cannabis users. These include exclusion from school, university and employment; incarceration; and blighting of their lives and careers as consequences of becoming involved with criminal subcultures. Furthermore, cannabis should be considered against the health consequences of alternative drugs, such as alcohol, which compete within a similar social niche. Current ethics do not provide an even-handed assessment of alcohol - the drug of choice of older people - and cannabis - the drug of choice of many younger people.[113]

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[112] United Nations International Drug Control Programme, *World Drug Report*, 1997, p 195

[113] John R Ashton, regional director of public health, NHS Executive North West, Mark A Bellis, head of public health, Public Health Sector, Liverpool John Moores University, "Social context should be added to domains being considered", *British Medical Journal*, vol 320, 17 June 2000, p 1671

Others argue that following legalisation organised crime would still be involved in supply as it would aim to provide drugs more cheaply than the legal (probably taxed) sources of supply.

1. The gateway theory

It has been argued that the use of cannabis leads to the use of more dangerous drugs such as heroin and cocaine. As long ago as 1968 the Advisory Committee on Drug Dependence concluded that there was no convincing evidence that cannabis use led to heroin use,[114] and this has been confirmed in more recent studies. However, there are social, cultural and market conditions associated with cannabis use that might influence the taking of other drugs by cannabis users. Polydrug use is increasingly common. The World Health Organisation concluded that a likely explanation for some cannabis users also using other drugs was

> …a combination of selective recruitment into cannabis use of non-conforming adolescents who have a propensity to use illicit drugs, and the socialisation of cannabis users within an illicit subculture…[115]

Those in favour of legalisation argue that at present cannabis use takes place within an illegal drugs social scene which increases the opportunity and encouragement to use other drugs. In addition pressure may be exerted by cannabis dealers to try harder drugs.

C. Is the status quo working?

Levels of cannabis use and seizures are given in detail in the statistical section of this paper. The decriminalisation lobby argues that as illegal drug use is going up in spite of massive expenditure on enforcement the current system does not work.

Since the 1970s there have been increasing numbers of prosecutions under the Misuse of Drugs Act, accelerating in the 1980s and 1990s. In 1998 64% of all drug offences involved cannabis. Cannabis possession dominates all offences under the Misuse of Drugs Act. Cannabis type seizures accounted for over 75% of the quantity of all illegal drugs seized in 1998 (see section VII D).

Many cases are dealt with outside the courts by cautioning or compounding.[116] It could be argued that a tendency towards decriminalisation is already in operation. A *Panorama* programme discussed the case for the decriminalisation of cannabis and featured the results of a three-year study tracking the changes in police attitudes towards illicit drugs. It

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[114] *Cannabis. Report by the Advisory Committee on Drug Dependence* (the Wootton report), Home Office, 1968, para 51

[115] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000 chapter 7, para 18

[116] No prosecution but a monetary penalty is paid – limited in drugs cases to offences involving herbal cannabis or cannabis resin not exceeding 10 grams in weight. Maximum payable is £100

commented on the increasing tendency for police to issue a caution for possession of cannabis:

> The study, which looked at the reactions of 95 officers in three different forces to various hypothetical cases involving cannabis, heroin and Ecstasy, reveals police are more tolerant of drugs than they were ten years ago.
>
> More than two-thirds of those surveyed said they would probably not prosecute a man for having four cannabis plants, because it was a 'run of the mill' case and the suspect was likely to be released with a caution.
>
> However, more than two-thirds said possession of a small amount of heroin was a 'serious' drugs case and they would prosecute. A tough line was also taken with ecstasy, with nine out of 10 police saying possession of 20 pills was a 'serious' offence.
>
> Police officers rated cannabis below coffee on an addiction scale and only slightly higher on a potential harm scale. Cannabis was far below alcohol or tobacco on both measures.[117]

Others argue that even more people would become involved in drug taking if it were further decriminalised or legalised.

Home Office Minister Charles Clarke, speaking in a debate on controlled drugs and law enforcement, stated:

> Most of those who favour legalisation recognise that the balance of the argument would be tipped against them if consumption significantly increased as a consequence of the legalisation of drugs. Common sense and the lessons of history suggest that that would be the case, and it might help if I outline the current levels of drugs use. According to surveys, 1.25 million people in this country used cannabis in the past month. In contrast, between 10 million and 11 million people have smoked tobacco, and 42 million people have consumed alcohol in the past month. However, the illegality of some of the drugs that I have described limits use and deters many other people from using them. Furthermore, the main effect of decriminalisation or legalisation would be an increase in the consumption of drugs, which would be a bad thing for various reasons. The Government's policy on all legal and illegal drugs should be motivated by a desire to reduce use, whether we are talking about tobacco, alcohol or other drugs. [118]

Research on attitudes to illegal drugs was carried out by MORI on behalf of the Police Foundation. The research, in which 1,645 people aged 16-59 were interviewed at home in April 1999, found:

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[117] "Police: Ex-Top Cop Joins Drug Legalisation Campaign", *Press Association*, 15 November 1999
[118] HC Deb 12 April 2000 c 94WH

> Two-thirds of Britons believe that drug laws are not tough enough…Almost the same proportion (69%) disagree with the statement "taking drugs is a matter of personal choice and should not be against the law", with 21% taking the libertarian position. Despite this, it is commonly accepted that the police are powerless to stop people taking drugs; 69% agree with this statement, and 22% disagree. This is a perception shared by drug users themselves. About a quarter of users said fear of a criminal record (23%), loss of employment (25%) and fear of prison (24%) would be a factor in influencing them to stop using drugs.
>
> Public attitudes towards cannabis users are fairly liberal. Almost half (48%) say cannabis should be legalised (36% are against this), 61% consider it not very or not at all harmful (compared to 15% for tobacco), and 54% think cannabis users should be the lowest priority for the police.[119]

D. Health aspects

Advocates of decriminalisation and legalisation argue that by treating cannabis the same as heroin and cocaine, the drugs education message is undermined. It is argued also that what constitutes a dangerous drug is a value judgement and that it is inequitable to criminalise cannabis smokers while allowing the use of tobacco and alcohol – which are responsible for large scale ill health. The Police Foundation report, while acknowledging that cannabis is not a harmless drug, argues that the main issue for any consideration of the current law on cannabis is how harmful it is compared with other major illicit drugs The ‘degree of risk’, brought to bear in many health arenas, does not justify the current legislation. Many commentators argue that cannabis is less harmful than alcohol or tobacco. Although it is estimated that 120,000 people die in the UK every year from smoking related diseases and around 30,000 from alcohol misuse there are very few recorded deaths attributable to cannabis.[120]

> If our drugs legislation is to be credible, effective and able to support a realistic programme of prevention and education, it has to strike the right balance between cannabis and other drugs.[121]

In a paper on “The Dynamics of Deciding to Use Illicit Drugs” prepared to inform the work of the Police Foundation Inquiry, Professor Howard Parker of Manchester University raises concerns that we are beginning to see evidence that the once clear distinction between the ‘recreational’ and ‘hard’ drugs of heroin and cocaine is breaking down:

> …Partly this is because of the more extended range of street drugs and their designer properties whereby the move from speed to E to coke is now far more likely – with more rungs on the ladder. The relatively benign experiences contemporary youth

[119] MORI poll, Attitudes to illegal drugs, March 2000, http://www.mori.com/

[120] *Drugs Dilemmas and Choices*, Royal College Psychiatrists and Royal College of Physicians, 2000, p 246

[121] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000, chapter 7, para 1

> have had with their 'recreational ' drugs during the 1990s perhaps also facilitates some graduation to more dependency seeking drugs. Finally the war on discourse, in which all drugs are collectively defined as bad and dangerous, has also played an unfortunate part in this. The occasional attempts by the Drugs Prevention Industry to demonise a particular drug (such as cannabis or ecstasy) have also misfired: the end results among young people having been switching and/or a belief that those drugs not highlighted must be less dangerous. This is one reason why heroin, marketed as cheap, smokeable brown is penetrating the youth drugs market.[122]

The safety of cannabis is questioned by those who argue that to encourage the use of cannabis smoking, thought to be possibly as damaging to the lungs as tobacco smoking (which is responsible for one in five deaths in Britain[123]), and with significant other health risks, would be irresponsible and that legalising cannabis would be sending a confusing message to society.

The Home Office Minister, Charles Clarke voiced government concerns about adverse health effects:

> It is important to set out the current assessment of the medical and social effects. A 1997 World Health Organisation report confirmed that cannabis has both acute and chronic health effects. The acute effects include damage to people's ability to learn and to carry out many tasks, including operating machinery and driving vehicles. The chronic effects include damage to mental functioning, especially learning abilities, which may not be reversible for prolonged and heavy users. A cannabis dependence syndrome has been identified in heavy users, and the drug can exacerbate schizophrenia in people who are already affected by that illness. There are also the obvious health risks associated with smoking the drug. That is why the British Medical Association has concluded that cannabis in its plant form is unsuitable for medical use.[124]

The House of Lords Science and Technology Committee, which recommended that cannabis should be made available for medical use, found "enough evidence of toxic effects of cannabis to justify maintaining the present ban on recreational use". Besides being intoxicating, they report that:

- regular heavy use can lead to psychological dependence, and even in some cases to physical dependence, involving withdrawal symptoms;
- cannabis can pose a risk to people with a heart condition;
- cannabis can exacerbate pre-existing mental illness;
- smoking cannabis is as bad for the lungs as smoking tobacco, and may cause cancer.[125]

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[122] Professor Howard Parker, *Despite the Law. The Dynamics of Deciding to Use Illicit Drugs,* Manchester University, November 1998, p *82*

[123] Royal College of Physicians, *Nicotine Addiction in Britain A Report of the Tobacco Advisory Group of the Royal College of Physicians* 2000, p 15

[124] HC Deb 12 April 2000 c 92WH

[125] HL press notice, 11 Nov 1998

It considered smoking of cannabis of particular importance:

> smoking cannabis carries similar risks of respiratory disorders to smoking tobacco. It is also possible, though not proved, that exposure to cannabis smoke increases the risk of cancers of the mouth, throat and lung[126]

The recent report issued by a working party of the Royal College of Psychiatrists and Royal College of Physicians (supported by the Joseph Rowntree Foundation) aims to inform the drugs debate. It comments with regard to safety:

> Cannabis is certainly not a safe drug even though its dangers may be less obvious than those of tobacco and alcohol. The evidence that it produces dependence is now beyond dispute. Long term, regular use leads to tolerance and increasing difficulty stopping despite wishing or attempting to do so, and North American population surveys consistently suggest that 5-10% of those who have used cannabis more than once become dependent. Experimental studies have established that sudden cessation of use is followed by withdrawal symptoms, and drug dependence clinics in the UK, USA, Australia, Sweden and the Netherlands report increasing numbers of patients whose main complaint is their inability to give up cannabis. Although the risk of dependence is substantially less than for nicotine and opiates, it is comparable with that of alcohol, and there is no doubting the magnitude of the burden alcohol dependence places on British society.[127]

It adds:

> …legalising the production and sale of cannabis would have important adverse effects as well as benefits. Police and criminal justice costs would be reduced and important new sources of revenue would be available to government - but consumption, accident rates and long-term damage to health, with associated NHS and social services costs, would all rise. More research is needed into both the medicinal benefits and the long-term ill effects of cannabis, and legislative experiments, as in Holland, should be encouraged rather than discouraged. In the meantime, the medicinal use of cannabis on a named-patient basis should be allowed for specific conditions if supported by well-designed clinical trials. People requiring cannabis to relieve disabling conditions should not be prosecuted.[128]

The report comments that on the basis of our present knowledge, only four conclusions seem justified:

- There needs to be a well-informed public debate about the policy options open to us…although it is possible that the UK Government's present stance with regard to cannabis is the least unsatisfactory policy available, this is not self-evident…

[126] Science and Technology Select Committee (HL) Ninth report, *Cannabis: the scientific and medical evidence*, HL 151 1997-98, 4 November 1998, para 8.21

[127] Royal College of Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000

[128] ibid chapter 10 p 217

- More research is needed on the long-term effects of cannabis use and about the contribution of cannabis intoxication to motor vehicle and other accidents.
- Social experiments such as that conducted by the Dutch government should be encouraged, not discouraged.
- It is difficult to justify ever imprisoning someone simply for possession or personal use of cannabis. Its international treaty obligations do not oblige the UK Government to do so and in the USA, where several states reduced the maximum penalty for possession in the 1970s from imprisonment to a fine, there was no evidence that this led to any significant increase in consumption.[129]

Michael Glossop, researcher at the National Addiction Centre at the London University Institute of Psychiatry and head of research at the Addictions Directorate of the Maudsley Hospital, London, has a different perception of the health risks:

> Cannabis does not produce any significant changes in hormonal or in blood biochemistry. Nor does it have any effect on the liver or kidneys. Its effects on the electrical activity of the brain are equally unremarkable… The changes that do occur seem to be predominantly in brain chemistry, but the significance of these has yet to be established.
>
> In terms of lethal dose, cannabis is an exceptionally safe drug…With cannabis it would be virtually impossible to ingest enough of the drug for it to have a lethal effect…Cannabis is one of the least toxic drugs known to man, and there is no evidence that anyone has ever died as a direct result of taking an overdose of it.
>
> …As with every other illegal drug there have been several sensational reports linking cannabis with brain damage, genetic damage and deformed babies. There is no convincing evidence associating cannabis with any of these effects, though, on the last point, pregnant women might well be advised to avoid any unnecessary drugs during their term of pregnancy…[130]

Financial burden of drugs problem

Costs of tackling the drugs problem are spread over a range of aspects. By far the largest expenditure goes on costs of enforcement. Out of a total annual expenditure of £1.4 billion spent on drug misuse in the UK in 1997-98, law enforcement and international supply activities account for 75% (Enforcement includes probation, court and prison services 62%, international supply encompasses customs and excise, Foreign and Commonwealth Office, police 13%), treatment and rehabilitation 13%, and education and prevention only 12%.[131]

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[129] ibid

[130] Michael Glossop, *Living with Drugs*, 5th edition, 2000, pp 108-9

[131] *ONS Social Trends 29*, 1999 edition

Those in favour of legalisation argue that a reduction in the need for law enforcement, court and prison costs would release funds which could be employed more beneficially in drugs education and prevention and in treatment and harm reduction strategies.

It can be argued that laws restricting legal access to drugs drive up their price and so aid prevention – however, a high drug price generates more crime among the group of *hard* drug users who resort to crime to finance their habit.

It is also recognised that laws themselves have an impact on demand – most individuals comply with the legislation. Removal of legal constraints could have an impact particularly on individuals who are currently non-users. This could be particularly relevant in the case of cannabis which is seen as relatively harmless.

Perceived advantages of legalisation include the transfer of huge revenues to Government by means of taxation on drugs, while eradicating an illegal market with all its attendant costs of law enforcement, criminal justice and imprisonment. Proper quality control would ensure that drug taking would carry fewer health risks. A legal supply and a regulated market could more easily prevent the young or vulnerable gaining access to the market.

E. International perspective

Current legal controls of cannabis in the UK are comparatively restrictive. Countries with a more liberal regime include the Netherlands, Italy, Spain, Canada, and some states of Germany, Australia and the USA.[132] See section IIC for a discussion of international comparisons. Holland in particular has a liberal regime which excites both approval and disapprobation.

1. Dutch drug policy

Dutch drug policy is aimed at maintaining a separation between the market for soft drugs (cannabis products such as hashish and marijuana) and the market for hard drugs which carry a greater health risk (eg heroin and cocaine). The policy aims to prevent soft drug users from obtaining supplies and socialising in an illegal environment.

The Dutch Opium Act of 1919 (as amended in 1928 and 1976) regulates the production, distribution and consumption of “psychoactive substances”. Possession, commercial distribution, production, import and export and advertising are all punishable by law. Since 1985 this has also covered activities preparatory to trafficking in hard drugs. The *use* of drugs is not punishable by law.

[132] Science and Technology Select Committee (HL), Ninth report, *Cannabis: the scientific and medical evidence*, HL 151 1997-98, 4 November 1998, box 3: current legal controls

The Opium Act now separates some drugs on the basis of risk. Penalties for heroin, cocaine, amphetamines and LSD, which are classified as presenting "unacceptable risk" have been raised in line with other European countries, while use, possession and trading in small amounts of cannabis is tolerated in designated premises. Possession of up to 30g of cannabis is a minor offence. Possession of hard drugs is a criminal offence.[133]

A "Principle of Expediency" exists under the Dutch Penal Code, which empowers the Public Prosecutor to refrain from prosecuting in criminal offences if this is in the public interest. Guidelines lay down that punishable offences involving hard drugs other than for individual use take the highest priority, followed by punishable offences involving soft drugs other than for individual use. Investigation and prosecution for possession of hard drugs for individual consumption (generally 0.5g) and soft drugs to a maximum of 5g carry the lowest priority.

Dutch policy has, in effect, created a regulated market for the small-scale supply of cannabis to adults through so-called "coffee shops". Sale of soft drugs at coffee shops is not prosecuted provided that certain conditions are met. Sale of hard drugs is forbidden. If coffee shops comply with the guidelines the sale of a maximum of 5g of hashish or marijuana per transaction is generally not investigated.

These are the 1,500 or so cafés - usually small, independent and unlicensed - which sell cannabis, under strict conditions (the sale technically remains an offence):

- Alcohol and drugs are not sold in the same premises
- no more than five grams cannabis per person are sold in any one transaction;
- no hard drugs are sold;
- drugs are not advertised;
- the coffee shop does not cause any nuisance;
- no drugs are sold to minors (under 18);
- no minors are admitted to the premises.

Policy on coffee shops is largely decided at local level, between local authorities, the police and public prosecutors.
The use of the expediency principle is commonly referred to as decriminalisation. The ISDD report, *Room for Manoeuvre*, disputes this: it states that commentaries that refer to a decriminalisation of possession or legalisation of supply of cannabis or of other controlled drugs in the Netherlands are incorrect:

> In the Netherlands, possession and supply are prohibited and criminalised as envisaged in the international drug conventions. However, the expediency principle is applied in most cases of possession in relation to supply of small quantities of cannabis through coffee shops. The coffee shops are tolerated as long as they stick to

[133] National Strategies, *Annual Report on the State of the Drugs Problem in the European Union 1998,* Chapter 4

> cannabis and do not cause community nuisance problems, although their activities even in relation to cannabis are strictly speaking illegal. A similar policy applies to cultivation of cannabis in the home on a small scale, which is tolerated – as long as the neighbours do not complain of the pungent smell, in which case the plants are removed by police (as prohibited objects).[134]

A recent development in Holland has been the acceptance by a narrow majority of a motion asking the government to create a legal framework for supply of marijuana to coffee shops. Many local authorities, which regulate the coffee shops, are reported to be in favour of the change, but the Minister of Justice, Benk Korthals opposes the motion. He is quoted in the *Financial Times*: "This sends the wrong signal, and is contrary to international treaties."[135]

There are both enthusiasts and detractors of the current Dutch system. The coffee shops have been criticised for creating nuisance in the surrounding area, and for attracting "drug tourists", and the Dutch have come under pressure to revise these policies. Unlicensed points of sale, such as private houses and delivery services, have spread rapidly in cities, according to the Justice Ministry.[136] France, concerned about the import of drugs from the Netherlands and Belgium, re-imposed controls on its border with Belgium and Luxembourg, the main routes from Holland. Holland has responded by reducing the number of coffee shops. Administrative measures are instituted at local level to combat nuisance problems.[137]

However, many see a positive outcome from the Dutch policy; this is reflected in the Police Foundation report:

> …we have been impressed by its results. These indicate: a similar level of cannabis use to other countries; a lower prevalence than in the United Kingdom, especially among young people, aged 16-19; a stable population of problem drug users, with a rising average age, and a high proportion of them in touch with treatment services; virtually no volatile substance misuse, and a ratio of drug-related deaths which is the lowest in Europe. We think there are two important lessons for the United Kingdom. The first is the potential benefit of treating demand problems as primarily health problems, with the result that social exclusion of young people through drug offending is kept to a minimum. The second is the potential benefit of separating the market for cannabis from that for heroin in particular.[138]

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[134] Nicholas Dorn and Alison Jamieson, *Room for Manoeuvre. An overview of comparative legal research into the national drug laws of France, Germany, Italy, Spain the Netherlands and Sweden and their relation to the three international drugs conventions*, Institute for the Study of Drug Dependence, London 1999

[135] "Dutch cannabis vote irks cabinet", *Financial Times*, 28 June 2000

[136] ibid

[137] ISDD, *Netherlands alcohol and drug report*, 1997

[138] The Police Foundation, *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000, overview, para 32

However, the Police Foundation report recognises that

> in the present political and cultural climate, it is difficult to see the introduction of Dutch-style coffee shops in the United Kingdom. The contradictions between domestic and international law and these practices are too great…[139]

The Government's position was reflected in answer to a Parliamentary Question in May 2000:

> **Mr. Flynn:** How does the Minister respond to the conclusions of the Police Foundation that, after 20 years of decriminalisation in the Netherlands, cannabis use is far less than it is in Britain, and that that country has the lowest ratio of drug deaths in Europe? After 30 years of prohibition in this country, heroin use has increased by 2,000 per cent., and cannabis use is the highest in Europe. Has not the Police Foundation demolished the main plank of the Government's policy by also concluding that young people in Holland are far less likely to experiment with heroin than those elsewhere in Europe?…
>
> **The Minister of State, Home Office (Mr. Charles Clarke):** …It is not clear that the Dutch policy has been a success. The Dutch Government have reduced both the overall numbers of coffee shops and the amount of cannabis that can be bought with impunity in any one transaction. I understand that they will be reviewing the policy again this year. The semi-legal trade in cannabis in the Netherlands has also helped to make that country a safer place for big-time crooks. That is why there are substantial problems in that regard. In addition, it is incumbent on us all to appreciate that there are significant contradictions between the coffee shop policy in the Netherlands and international agreements. The single convention on narcotic drugs 1961 states that effective measures against abuse of narcotic drugs require co-ordinated and universal action; the convention calls for international co-operation aimed at common objectives. That is our policy…[140]

The Royal Colleges' report comments that the Dutch experiment is quoted both as evidence that removing the penalties for use and possession of cannabis is safe and harmless, and as proof that any relaxation of the law inevitably leads to rising consumption and social disorder:

> The truth lies somewhere in between. Depenalisation in 1976 did eventually lead to a substantial increase in consumption, but there was little evidence that this was accompanied by any increase in ill effects, medical or social, and Dutch consumption never rose beyond the levels already reached in the USA and other parts of Europe. Substantial numbers of drug takers were, however, attracted from other neighbouring countries, and the governments of those countries became increasingly hostile to the experiment.[141]

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[139] ibid para 53

[140] HC Deb 22 May 2000 c 672

[141] Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, Chapter 10, p 251

2. Experience in the US

It is argued that more availability does not equate to more demand – cannabis use did not escalate in the US, which decriminalised the possession of the drug in several states in the 1970s.[142] This is refuted by those who believe that simple economics dictate that increased availability and decreasing price would increase demand.

Prohibition of alcohol is seen as an example of the inability of legislation to prevent any form of drug use when there is widespread pubic opposition to it. The Working Party of the Royal Colleges of Psychiatrists and Royal College of Physicians discusses alcohol during Prohibition in the USA (1920-1933):

> … alcohol consumption had begun to fall before Prohibition in 1915, but most Americans continued to drink less during Prohibition, and after its repeal alcohol-related diseases rose once more. Furthermore, in areas where there was public support for the laws, such as in the rural South and West, they were effectively enforced. On the negative side, organised crime and political corruption flourished and deaths from illicit alcohol increased…

Many sources of illicit alcohol appeared in the first few months of Prohibition. Even so, in the early 1920s consumption dropped greatly to about 30% of the pre-Prohibition levels - an historic low point. When illegal sources became well established, drinking and prices increased, but by 1927 it was still only two-thirds of that of 1911 and 1914 levels.[143]

Compliance with the legislation in different elements of American society varied according to political, cultural and ethnic associations.[144]

Unravelling the changing patterns of drug and alcohol use and relating these to interventions in the criminal justice system is far from straightforward. Other social and economic factors will have an influence and it can be difficult to apportion credit or blame. The effect of drugs legislation seems even more complex.
Cannabis, which was relatively freely available in the US in the 1970s, replaced heroin use for many of the opiate-using soldiers returning from Vietnam, and may partly explain why they did not continue to use heroin.[145]

In the 1980s President Reagan called for a "National crusade against drugs", involving drug testing at schools and workplaces, improved treatment and rehabilitation, and greater public intolerance of drug use. However, drug use had peaked in the late 1970s and early 1980s

[142] Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, Chapter 10, p 252
[143] ibid chapter 9, pp 194-197
[144] ibid
[145] Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, Chapter 9, p 212

before these measures were introduced.[146] The Royal Colleges' report comments that the difference in Regan's approach compared to his predecessors was the move away from treatment in favour of criminal sanctions, law enforcement, border policing and international control efforts. The Anti-Drug Abuse Act in the mid-1980s released large funds for law enforcement, and a second bill included severe penalties for dealing, personal use and possession:

> The effect [of harsh criminal sanctions] was to greatly increase the number of people imprisoned, so that by the late 1990s the USA had a higher percentage of its population in prison than any other nation and was spending $24billion annually on the 1.2 million prisoners serving sentences for non-violent drug-related crimes…
>
> President George Bush continued this policy in 1989, officially declaring the "War on Drugs"…
>
> Although the total number of Americans using drugs continued to decline during the 1980s and 1990s, the harm experienced by both users and the rest of society intensified. From 1988, casual cocaine users became fewer, but addicts and heavy users…retained their habits….by segregating the problem among those with the least resources to help themselves, failing to address the harsh social conditions in inner city ghettos, and emphasising enforcement above treatment, the problems of impoverished, heavy drug users living in areas with few prospects worsened.[147]

The report comments that unless the drug using population is willing to change its lifestyle and attitudes a simple ban is rarely effective, and may produce greater harm, either to individual or public health, social relationships, or through the development of a criminal black market. However, restrictions that limit use with a degree of public support may reduce overall harm. The balance will be determined by how widespread is the drug's use in the first place.

F. Independent Inquiry into the Misuse of Drugs Act 1971

The Police Foundation Inquiry into the MDA reported on 28 March 2000. *Drugs and the Law*[148] proposes that the classification of individual drugs and associated penalties "should be adjusted to reflect current scientific understanding of the relative risks they pose." While heroin and cocaine would continue to be in Class A, the most dangerous category, ecstasy and LSD would transfer to class B and cannabis would become a class C drug. Dame Ruth Runciman DBE, who chaired the inquiry, said:

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[146] Royal College Psychiatrists and Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000, Chapter 9, 206

[147] ibid, pp 207-208

[148] The Police Foundation, *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, Chairman Vicountess Runciman DBE, 2000

> We have concluded that the most dangerous message of all is that all drugs are equally dangerous. When young people know that the advice they are being given is either exaggerated or untrue in relation to less harmful drugs, there is a real risk they will discount everything else they are told about the most hazardous drugs, including heroin and cocaine.[149]

While recognising that cannabis is not a harmless drug, the Inquiry argues that the existing law and maximum penalties against possession of cannabis produce more harm than they prevent. In addition to the demands placed on police time and resources, it bears most heavily on young people in inner cities – especially from those minority ethnic communities. The report comments:

> Even with the use of discretion…the law's implementation damages individuals in terms of criminal records and risks to jobs and relationships to a degree that far outweighs any harm that cannabis may be doing to society. Moreover young people, particularly young black and Asian people and particularly where stop and search is concerned, perceive the law as unfair.[150]

It also inhibits accurate education and the relative risks of drugs including those of cannabis itself. It recommends:

- Cannabis and cannabinoids should be class C drugs
- Possession should be punishable by a caution or fine (maximum £500 for persistent offending)
- Growing cannabis for personal use should be punishable by fixed penalty fine
- Increased penalties for trafficking
- Removal of the ban on therapeutic use of cannabis for specified medical purposes

The report recommends that:

> - Heroin, cocaine and its derivative 'crack' should remain as class A drugs - reflecting their exceptionally powerful, addictive potential
> - Ecstasy and LSD should move from Class A to Class B. This would place them in the same category as amphetamines -a change recommended to the enquiry by the Association of Chief Police Officers
> - Cannabis should be transferred from Class B to Class C
> - Buprenorphine, a synthetic opiate that is currently a Class C drug, should move up to Class B

[149] "Inquiry urges law reform to reduce the harm caused by dangerous drugs and to target traffickers", Press release, *Independent Inquiry into the Misuse of Drugs Act 1971,* 28 March 2000

[150] The Police Foundation, *Drugs and the law, Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000, Chapter 7, para 32

Penalties for possession:

- Prison should no longer be a penalty for possession of drugs in Classes B and C
- The maximum prison sentence for possession of Class A drugs should be reduced and imposed only where community sentences and treatment have failed or been rejected.
- Cautioning - the current police response to half of all possession offences – should become a statutory sanction, with guidelines so that treatment and other conditions can be imposed on offenders. A caution would not go on a criminal record.
- Police powers of arrest following 'stop and search' should remain when class A and B drugs are found, but not in the case of class C drugs. One member of the Inquiry, Assistant Commissioner Denis O'Connor, expressed reservations about implications of this recommendation for operational policing, although he agreed the problems are not insurmountable
- Fines on the Scottish model which carry no criminal record should be introduced

Drug dealing and trafficking

The Inquiry finds that despite large increases in the number and quantity of seizures, there is no evidence that drugs have become harder to obtain or more expensive. Although one of the most effective sanctions against convicted drug dealers is seizure of assets, it also notes that the average confiscation order made by the courts in 1997 was less than £4000. To strengthen the law against dealers and traffickers it calls for:

- A new offence, to allow courts to sentence for persistent dealing in drugs rather than only for single acts of supply
- A National Confiscation Agency (also recently proposed by the Home Office) to improve the efficiency of procedures for removing drug-related assets from convicted traffickers. Responsibility for enforcing confiscation orders would be transferred from magistrates to the Crown Court.
- Statutory sentencing guidelines to ensure the courts take account of aggravating factors in drug cases, such as involvement in organised criminal groups, use of violence or firearms, supplying drugs to minors or involvement of children in dealing.

Drug treatment services

The Inquiry highlights evidence that specialist treatment is cost-effective in reducing problem drug use and associated criminal activity. It points to a serious shortage of drug treatment facilities, which receive just 13 per cent of the total national budget compared to 62 per cent allocated to law enforcement. The Inquiry proposes:

- A rapid and substantial shift of resources towards treatment services
- Closer monitoring of private prescribing of controlled drugs to problem users
- Amended regulations enabling all controlled drugs to be prescribed in instalments, limiting the scope for prescriptions to be abused
- Removal of the ban on the therapeutic use of cannabis for specified medical purposes.[151]

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[151] ibid

1. Government response

The Government does not support the Inquiry's recommendations on the reclassification of cannabis, cannabinols, ecstasy or LSD, but considers other recommendations worth exploring in detail. With regard to ecstasy the Home Office states that the Advisory Council on the Misuse of Drugs looked at the classification of ecstasy in 1996 and considered that the possible adverse effects are sufficiently serious to warrant it remaining a class A drug. The UKADC is chairing an inter-departmental working group set up to consider the recommendations of the Police Foundation Inquiry's report. A Home Office press release states:

> almost no one is given an immediate custodial sentence solely for the possession of cannabis unless there is evidence of persistent flouting of the law (p.106 para 34).
>
> Custody acts as an important backstop to ensure that defendants appear in court for this range of offences and as a way of helping to enforce other penalties such as fines or community sentences. Police powers of arrest for drugs possession, which neither we nor they wish to see abolished, are also dependent on these offences being imprisonable. Where imprisonment is imposed, the courts in each case has thought it justified. In these circumstances it would be wrong for the court to be denied use of that which they - and the appeal courts - regard as proportionate punishment...

However, it considers:

> There are other recommendations which we consider are worth exploring in more detail. These include the suggestion of a new offence of dealing, greater controls on private prescription of class A drugs and the idea of attaching conditions to cautions…
>
> … It is important that police cautioning is consistently applied and this should be reflected in the guidance which organisations like ACPO[152] produce. The government has also created an independent Sentencing Advisory Panel to advise the Court of Appeal on the production of sentencing guidelines across the whole range of offences.
>
> The Government along with ACPO and the Sentencing Advisory Panel will look at the recommendations of this report. For juveniles, the law has already been changed as the Report recommends, to place cautioning into a statutory framework (as reprimands and final warnings under the Crime and Disorder Act 1998).[153]

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[152] Association of Chief Police Officers

[153] Home Office Press Notice 014/2000, Home Office statement on Police Foundation Report, *Drugs and the Law*, 28 March 2000

The Government has commented on the obligations imposed by international agreements:

> Mr. Flynn: To ask the Secretary of State for the Home Department what assessment he has made of claims in the Police Foundation's report on the results of cannabis decriminalisation in the Netherlands.
>
> Mr. Charles Clarke: The committee of inquiry set up by the Police Foundation has produced a thorough report with a large number of recommendations and the Government will give it careful attention. However, the Government have made it clear that they do not support the Inquiry's recommendations on the re-classification or depenalisation of cannabis.
>
> The Government have a clear and consistent view about the damage which drugs can cause to individuals, their families and the wider community, the link between drugs and crime, and the corresponding need to maintain firm controls. The Government are opposed to any lessening of controls on currently illicit drugs but favour a wide-ranging approach--we see a need for a balance of policies involving supply reduction, demand reduction and harm reduction.
>
> The Police Foundation's report acknowledges that there are significant contradictions between Dutch drugs policy, under which small-scale possession and supply of cannabis remains illegal but the laws are not enforced and international agreements. The Preamble to the Single Convention on Narcotic Drugs 1961, states that effective measures against abuse of narcotic drugs require co-ordinated and universal action and that such action calls for international co-operation guided by the same principles and aimed at common objectives. The Government support these principles and have no intention of breaching their obligations under the 1961 United Nations drugs convention which commit the international community to working together against the illicit drug trade. It naturally follows from this that the Government also have no intention of allowing for the systematic non-enforcement of the law.[154]

The UKADC is chairing an inter-departmental working group set up to consider in full the recommendations of the Police Foundation Inquiry's report.

The House of Commons Home Affairs Committee held a single evidence session on the Report of the Inquiry in June 2000. Oral evidence was given by Lady Runciman and other members of the Inquiry.[155]

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[154] HC Deb 10 May 2000 c 406W

[155] Home Affairs Committee, 1999-2000 *Report of the independent Inquiry into the Misuse of Drugs Act 1971 Drugs and the Law,* Minutes of evidence, HC 561-i 8, June 2000

VII Statistics information on cannabis

The statistical section of this paper looks at the latest data that is available on cannabis, with particular reference to other illegal drugs, both in the UK and internationally.

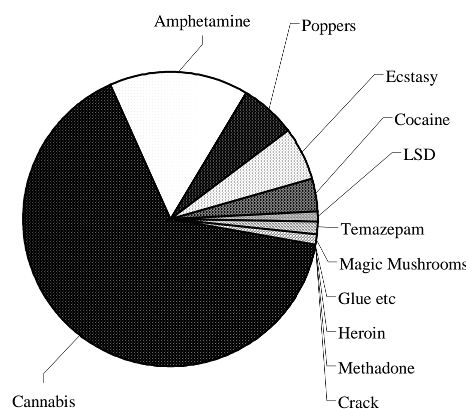
Actual data on the use of illegal drugs is very difficult to collect as receipts for black market goods are rarely, if ever, issued. Because of this, the published data analysis produced is normally based on survey data, where respondents are asked about their particular drug habits in confidence. Surveys of self reported drug use cannot provide a precise estimate of the number of people in the population who have taken controlled drugs. Some respondents may be reluctant to admit to illegal behaviour even when assured of anonymity and the confidentiality of their replies. They might refuse to answer questions, exaggerate, conceal their drug use or be less willing to admit to taking drugs that carry the most social disapproval. The main source of self reported drug figures is the 1998 British Crime Survey (BCS)[156] and the first section of this part of this paper relies heavily on the results from this survey. Later sections employ data gathered by the United Nations, central government departments and regional authorities.

A. Users

Table 1 in appendix 2 shows the percentage of all age groups who said they had taken particular types of drugs in the preceding month, as recorded by the 1998 BCS.[157] The table suggests that the major users of drugs are the young with between 10% and 19% of all 16-29 year olds having taken drugs in the preceding month. A summary of the results for all 16-59 year olds from table 1 is presented below in table 1a.

Table 1a: Percentage of 16-59 year old people who said they had taken particular drugs in the last month

	16-59		
	M	F	All
Cannabis	7	4	5
Amphetamine	2	1	1
Poppers	1	*	1
Ecstasy	1	*	*
Cocaine	1	*	*
Temazepam	*	*	*
Methadone	*	*	*
LSD	*	*	*
Glue etc	*	*	*
Heroin	*	0	*
Crack	*	*	*
Magic Mushrooms	*	0	*
Any drug	8	4	6



Notes: * less than 0.5%

Source: 1998 British Crime Survey (BCS), weighted data, Table B4, Home Office.

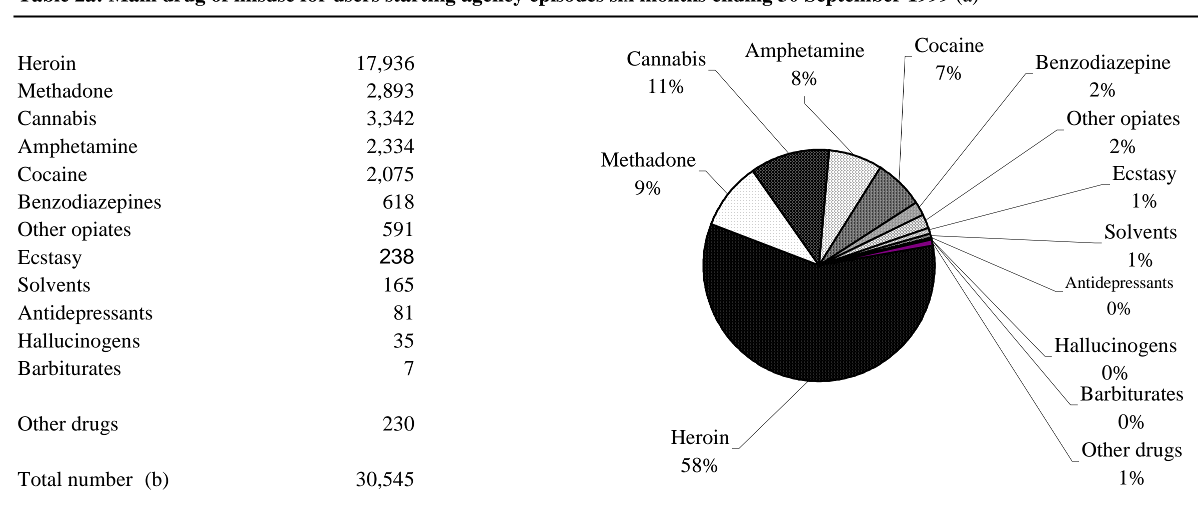
156 Home Office, *1998 British Crime Survey (BCS)*, 1998
157 ibid

The tables show that 6% of 16-59 year olds said they had taken at least one form of illegal drug over the preceding month, with males twice as likely then females to be users. Illegal drug use appears to be a youth problem as the percentage of users diminishes the older the age group observed. Cannabis is the most popular of the prohibited drugs, for all age groups, with 5% of 16-59 year olds having taken cannabis in the preceding month. The next most popular illegal drugs are amphetamines, poppers and ecstasy. 16-19 year olds are the most likely age group to use cannabis with 19% having tried it in the last month. Again there is a sex differential with 20% of males saying they had used cannabis in the last month compared to 17% of females.

B. Misuse

Table 2 in appendix 2, summarised for the six months ending 30 September 1999 in table 2a below, gives the main drug of misuse for users starting agency episodes in England. The information is collected from Regional Health Authority returns on people who have presented themselves to services with problem drug misuse for the first time, or for the first time for six months or more. Doctors are required to notify patients who they consider to be addicted to one or other of fourteen listed drugs to which restrictions apply. The number of addicts who are notified is probably only a small proportion of the number of regular drug misusers. Some will have not sought medical treatment or will be waiting for treatment and will therefore not have been notified. In addition, it may also be that, for a variety of reasons, doctors will not notify all the addicts they see. Despite the limitations on these figures as a guide to the true number of addicts, the statistics do give an indication of the trend in the numbers dependant on notifiable drugs. Users may be recorded as misusing up to five types of drugs but only one is recorded as the main drug of misuse, as shown in table 2a below.

Table 2a: Main drug of misuse for users starting agency episodes six months ending 30 September 1999 (a)



Drug	Number
Heroin	17,936
Methadone	2,893
Cannabis	3,342
Amphetamine	2,334
Cocaine	2,075
Benzodiazepines	618
Other opiates	591
Ecstasy	238
Solvents	165
Antidepressants	81
Hallucinogens	35
Barbiturates	7
Other drugs	230
Total number (b)	30,545

Notes: (a) A user may report misusing (and perhaps injecting) several drugs. One drug is recorded as the main drug of misuse.
(b) Includes drug free

Source: DOH Statistical Bulletin 2000/13 Statistics from the region, July 2000

In the six month period ending 30 September 1999 there were 31,000 users who were reported as starting agency episodes. This was an increase of 5,600 or 23% on the number who reported in the six month period ending 30 September 1996. The most frequently reported main drug of misuse was heroin, the main drug of 58% of all misusers. Cannabis has regularly been reported as the third largest drug of misuse, after heroin and methadone, accounting for 11% of all reported episodes in the six months ending 30 September 1999.

C. Mortality

The main measure of drug related death is published in the records of deaths assigned to accidental and other poisoning by solid or liquid substances, where the underlying cause of death is reported on the death certificate.[158]

Table 3 below gives the number of drug related deaths from 1993 to 1996. There are often a number of drugs listed on the death certificate, if two drugs are mentioned such as cannabis and heroin then the death will appear twice in table 3. In each of the four years alcohol was recorded as the largest cause of death, accounting for over 80% of the drug related deaths shown in table 3. Of the number of deaths attributed to illegal drugs, methadone and heroin were the largest causes of death in each year. Cannabis was mentioned 35 times on death certificates in the four years given in table 3, about one tenth of the number of times paracetamol appeared on death certificates in 1996.

Table 3: Drug related deaths
England & Wales

	1993	1994	1995	1996
Alcohol	3,240	3,457	4,018	4,372
Paracetamol	324	278	331	288
Methadone	221	259	299	357
Temazepam	179	165	140	95
Heroin	55	90	129	187
Solvents	57	49	57	n.a.
Tobacco	58	47	48	29
Amphetamine	22	20	40	29
Cocaine/crack	12	21	19	15
Ecstasy	13	23	10	12
Cannabis	9	12	10	4
LSD	-	1	-	-

Note: As mentioned in the records of deaths assigned to accidental and other poisoning by solid or liquid substances

Sources: HC Deb 7 July 1998 c434W
ONS *Social Trends 29*, 1999 edition

[158] HC Deb 7 July 1998 c 434W

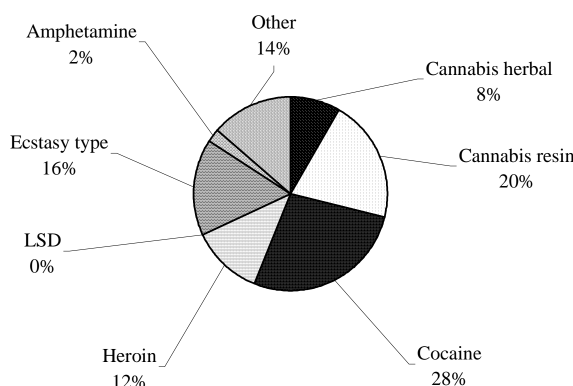
D. Seizures

There is no reliable statistical information on the actual amount of drugs that are supplied to 'markets' in the UK each year. What information is available, is on the amount of illegal drugs seized by drug enforcement agencies such as police forces and customs services. Table 4 in appendix 2 shows the quantity of controlled drugs seized by the UK authorities from 1991 to 1998. It must be remembered that changes in the amount of seizures do not just vary from year to year because more drugs are being supplied. Conservative estimates suggest that seizures account for only 10% of all drugs destined for UK markets.[159] The amount of drug enforcement agency funding, the quality of information supplied to them and changes in the recording procedures have also occurred.[160]

Table 4 suggests that the quantity of all drugs seized, with the exception of LSD, has increased over the period with the quantity of cannabis plants seized increasing the most. In 1998 cannabis type seizures accounted for over 75% of the quantity of all illegal drugs seized. The quantity of cannabis; herbal, plants, resin and liquid seized increased by 130%, 710%, 280% and 200% respectively between 1991 and 1998. Table 5 below gives a breakdown, by drug type, of the estimated value of illegal drug seizures in 1998.[161] Of the illegal drugs whose value has been estimated, cocaine had the highest single drug value and accounted for 28% of the value of all drugs seized, although the estimated value of *all* cannabis type products seized suggests that the combined total would be greater than 28%.

Table 5: Estimated value of drug seizures 1998
United Kingdom

	£000
Cannabis, of which:	
Herbal	69,527
Plants (numbers)	n.a.
Resin (HOC estimate)	170,000
Liquid	n.a.
Cocaine	227,917
Crack	2,516
Heroin	99,504
LSD	140
Ecstasy type	132,605
Methadone	n.a.
Morphine	n.a.
Amphetamine	18,046
All main drug types	831,775



Note: n.a. not available

Source: Home Office Statistical Bulletin 3/00 *Drug Seizures and Offender Statistics, 1998, 16 February 2000*

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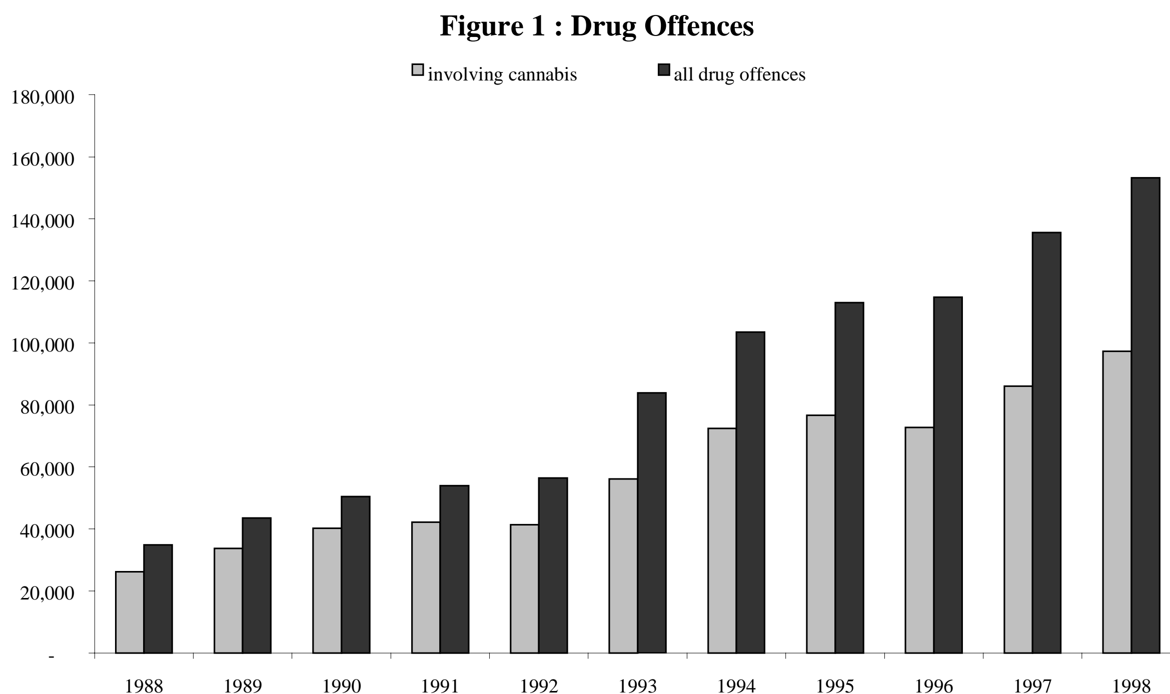
[159] EMCDDA, *Extended annual report on the state of the drugs problem in the EU,* 1999
[160] Home Office Statistical Bulletin 3/00, *Drug Seizures and Offender Statistics*, 1998, 16 February 2000
[161] ibid

E. Offenders

Data on arrests, as opposed to offences recorded and people cautioned by the police or found guilty at court, are not routinely collected centrally for any crime. Tables 6 and 6a in appendix 2 show the number and percentage of people found guilty, cautioned, or settled with by compounding[162] for *all* drug offences 1988 to 1998. The total number of persons dealt with for *all* drug offences has increased by 23% over the ten-year period from 35,000 persons in 1988 to 153,000 persons in 1998. The percentage of persons dealt with by sentencing has fallen, from 60% of the total number of persons dealt with in 1988, down to 44% in 1998 while the percentage of persons dealt with by cautioning has risen from 25% in 1988 to 39% in 1998. Figure 1 below shows the number of *all* drug offences compared to the number of drug offences involving cannabis. Of the 153,000 known offenders in 1998, the majority, some 97,000 or 64% of all drug offences, involved cannabis.

Figure 1 : Drug Offences

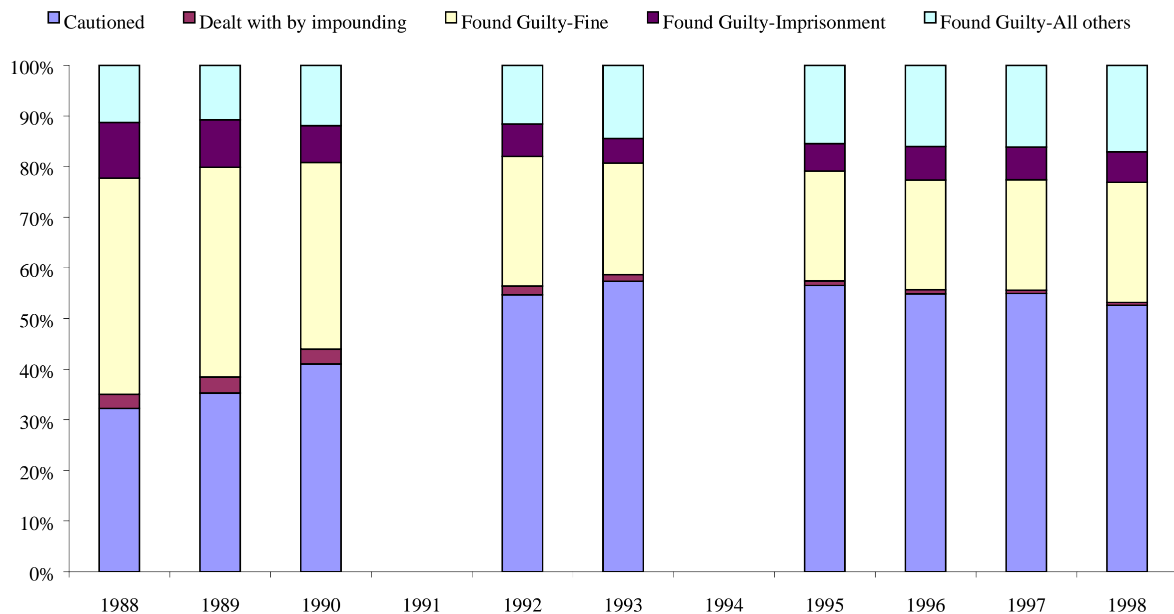


Tables 7 and 7a in appendix 2 also shows the number and percentage of persons found guilty, cautioned or dealt with by compounding for drug offences involving cannabis for 1988 to 1998. The total number of persons has increased by 71,000, or 272%, between 1988 and 1998. The number of persons dealt with by cautioning has increased from 8,000 in 1988 to 50,000 in 1998 a rise of almost 500%. The number of persons being found guilty has also risen from 17,000 in 1988 to 46,000 in 1998, a rise of 172%.

[162] The payment of a penalty *in lieu* of prosecution in cases involving the importation of small amounts of cannabis for personal use

The trend in how an offender is dealt with for *all* drug offences is also apparent in the figures for the number of persons dealt with for drug offences involving cannabis, as shown in tables 7 and 7a in appendix 2 and figure 2 below.

Figure 2: Persons Cautioned, Fined, Imprisoned or otherwise dealt with for Drug Offences involving Cannabis



In 1988, 32% of the persons dealt with for drug offences involving cannabis were cautioned compared to 43% who were found guilty and fined, 11% who were found guilty and imprisoned and 11% who were found guilty and dealt with otherwise. By 1998 of the 97,000 persons dealt with for drug offences involving cannabis: 51% were cautioned 23% found guilty and fined, 17% who were found guilty and dealt with otherwise and 6% found guilty and imprisoned.

F. The economics of legalising cannabis

There is no definitive way to examine the total monetary gain/loss from legalising cannabis. Standard economic cost and benefit analysis is not possible, as there is a lack of the basic data required to complete such an analysis with any degree of accuracy. When trying to answer a question such as 'What would be the gains from legalising cannabis?' the analysis is complicated due to several major difficulties, not least of which is quantifying some of the variables. Therefore, the section below suggests just some of the gains and losses that could arise, if cannabis were to become a licit drug.

The 1998 Comprehensive Spending Review estimated that drug related spending across the UK in 1997/98 was approximately £1.4 billion.[163] From this total, the cost of enforcement including probation, court and prison services accounts for 62% or £870 million and the cost of international supply activities, such as customs and the police, 13% or £180 million. Holding all other variables constant and assuming that cannabis accounts for 75% of all illegal activity[164] there would be a reduction in the estimated total of drug related spending of around about £790 million a year from here. Further assuming that cannabis products would be subject to the same levels of taxation and duty as currently paid on a packet of cigarettes, Government revenue would increase by approximately £1 billion a year[165] suggesting a gain to the public purse of around about £1.6 billion a year. There would also be costs to legalising cannabis. It has been estimated that the loss in revenue from court fines would amount to some £2 million and the increase in treatment and rehabilitation, from the increased misuse of cannabis, £137 million.[166]

G. International comparisons

Usage

As given in table 1 in appendix 2, cannabis use is most prevalent amongst the young in Britain with 16% of all 16-24 having used cannabis in the last month and just under 40% ever having used cannabis in their lifetime.[167] Table 8 in appendix 2 shows the results from four surveys that looked at the prevalence of cannabis use amongst the young, in four different parts of the world. The results for Britain from the BCS for annual cannabis usage[168] suggest that in the US and Australia the annual use of cannabis amongst the young is similar but higher than in Canada and the EU average, as shown in table 8. Further, the results from EU school surveys of 15-16 year olds, reproduced in figure 3 below, which asked about lifetime use of cannabis, show the prevalence of cannabis use among this age group in the UK (England and Wales) is higher than in all other EU countries, including the Netherlands.

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163 *ONS Social Trends 29*, 1999 edition

164 Based on seizure by quantity figures from section D of the statistics information on cannabis section of this paper.

165 ODCCP *Cannabis as an illicit narcotic crop: a review of the global situation of cannabis consumption, trafficking and production* ODCCP, website www.odccp.org

166 House of Commons Library research, Our ref: 2000/5/176SG

167 Home Office Research Study 197 *Drug Misuse Declared in 1998: results from the British Crime Survey*, Table B2, 1999

168 Home Office Research Study 197 *Drug Misuse Declared in 1998: results from the British Crime Survey*, Table B3, 1999

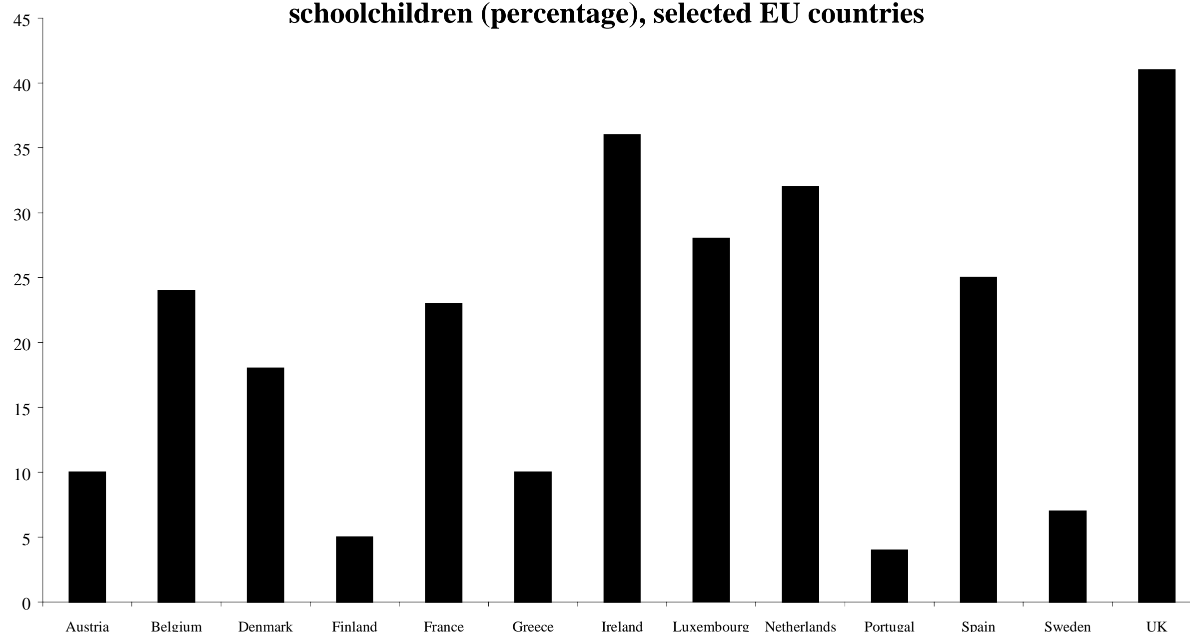

Figure 3: Lifetime experience of cannabis use among 15-16 year old schoolchildren (percentage), selected EU countries

The general population

Results from other international surveys into cannabis use in the population, though not directly comparable with the surveys reported in table 8 due to methodological differences, do suggest that annual cannabis use is more prevalent in developed countries, than in developing countries, amongst the general population. In Australia, US, Canada and the EU the percentage of the general population who admitted to using cannabis at least once in the last twelve months were 13%, 8%, 7% and 5% respectively. By comparison in developing countries an annual prevalence of cannabis use greater than 3% of the general population has been rarely reported.[169] There is also some evidence to suggest that the percentage of annual cannabis usage in the general population varies between the individual EU countries surveyed. In the UK and Spain reported annual cannabis usage of 8% and 7% respectively were well above the EU average of 5% while the Netherlands, France & Germany and Sweden reported annual cannabis usage rates of 5%, 4% and 1% of the general population respectively.[170]

Seizures

In the previous sections we have seen that cannabis is the most widely cultivated, trafficked and abused illicit drug in Britain. The associated problems of the illicit use of cannabis are not restricted to this country. World wide, over half of the seizures of restricted drugs by

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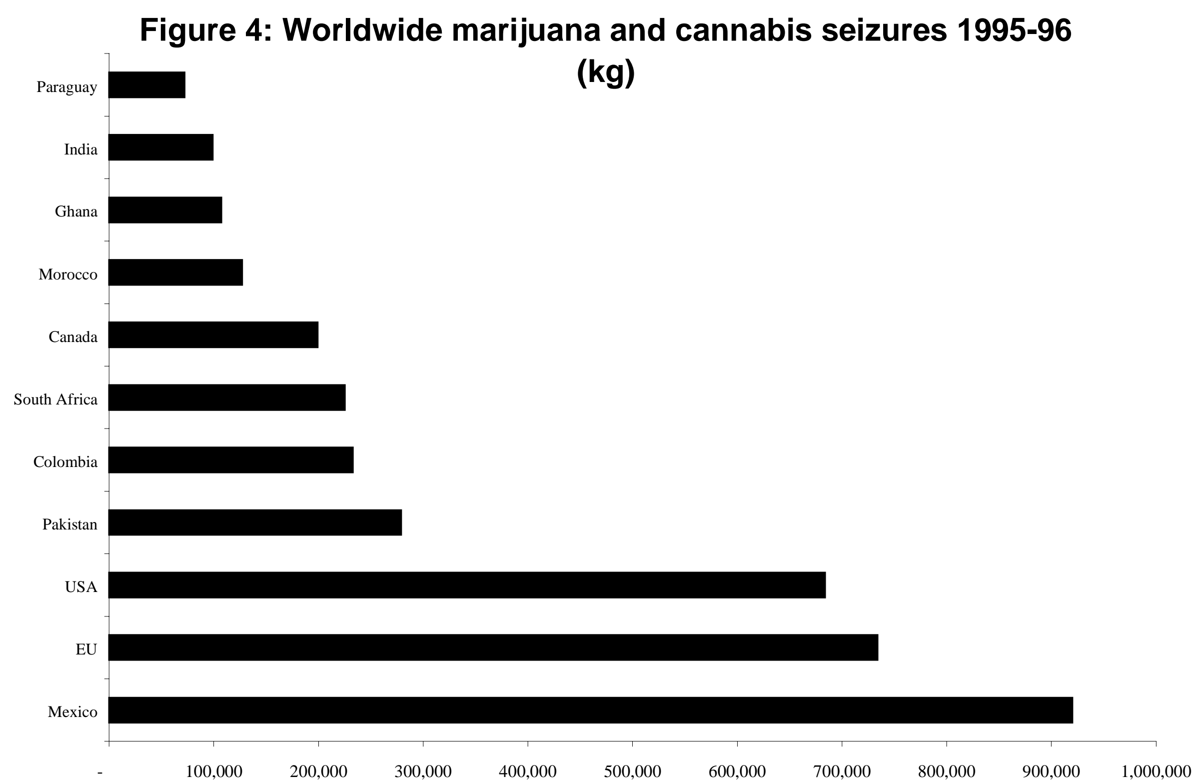
[169] ODCCP, *Cannabis as an illicit narcotic crop: a review of the global situation of cannabis consumption, trafficking and production,* ODCCP website www.odccp.org

[170] EMCDDA, *Extended annual report on the state of the drugs problem in the EU,* 1999

police forces have been marijuana (herbal cannabis) and hashish (cannabis resin) seizures.[171] Table 9 in appendix 2, summarised in figure 4 below, shows the world wide seizures of marijuana and hashish by police authorities in 1995/96.



In 1995-96, 40% of all the marijuana and hashish seized world wide was seized by the Mexican and US authorities, and 17% by authorities in the EU. Of the total quantity of marijuana seized world wide: 50% was accounted for by the Mexican and US authorities. This is in contrast to the amount of hashish seized, which was predominantly seized by the authorities in the EU and Pakistan who seized 46% and 29% respectively.

Figure 5 below shows the breakdown of the percentage of all cannabis seizures, by quantity, as presented in the extended annual report of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)[172], made by individual member states' authorities in the EU in 1997. According to the EMCDDA the total quantity of cannabis seized in the EU increased rapidly in the early 1990s from 236,000 kg in 1989 to their peak of 734,000kg in 1995-96, as shown in table 9 in appendix 2. Since then the total quantity of cannabis seized has remained relatively stable and in 1997, 705,000 kilograms were seized. Figure 5 shows that authorities in Spain and the UK seized the largest amount of cannabis in the EU in 1997 accounting for 44% and 22% of the total quantity seized respectively.

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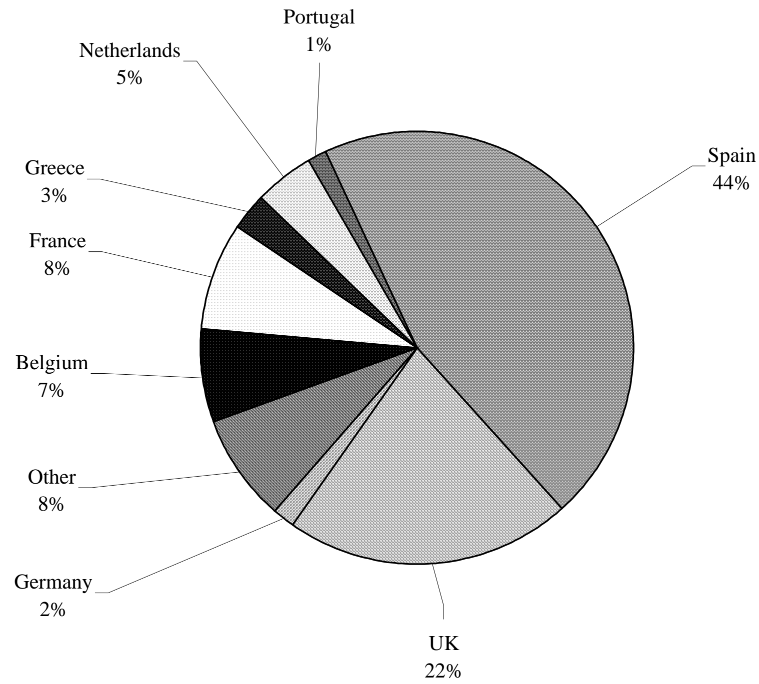
[171] ODCCP, *Cannabis as an illicit narcotic crop: a review of the global situation of cannabis consumption, trafficking and production,* ODCCP website www.odccp.org
[172] EMCDDA, *Extended annual report on the state of the drugs problem in the EU,* 1999

Figure 5: Estimated percentage of cannabis seizures in the EU



Appendix 1 - Penalties under *Misuse of Drugs Act 1971*

Prosecution and Punishment of Offences under the *Misuse of Drugs Act 1971*[173]

Section Creating Offence	General Nature of Offence	Mode of Prosecution	Maximum penalty		
			Class A Drug Involved	Class B Drug Involved	Class C Drug Involved
s.4(2)	Production, or being concerned in the production, of a controlled drug	(a) Summary	6 months or £5,000 fine, or both	6 months or £5,000 fine, or both	3 months or £2,500 fine, or both
		(b) On indictment	Life or a fine, or both	14 years or a fine, or both	5 years or a fine, or both
s.4(3)	Supplying or offering to supply a controlled drug or being concerned in the doing of either activity by another	(a) Summary	6 months or £5,000 fine, or both	6 months or £5,000 fine, or both	3 months or £2,500 fine, or both
		(b) On indictment	Life or a fine, or both	14 years or a fine, or both	5 years or a fine or both
s.5(2)	Having possession of a controlled drug	(a) Summary	6 months or £5,000 fine, or both	3 months or £2,500 fine, or both	3 months or £1,000 fine, or both
		(b) On indictment	7 years or a fine, or both	5 years or a fine, or both	2 years or a fine or both
s.5(3)	Having possession of a controlled drugs with intent to supply it to another	(a) Summary	6 months or £5,000 fine or both	6 months or £5,000 fine, or both	3 months or £2,500 fine, or both
		(b) On indictment	Life or a fine, or both	14 years or a fine, or both	5 years or a fine, or both
s.6(2)	Cultivation of cannabis plant	(a) Summary	6 months or £5,000 fine, or both		
		(b) On indictment	14 years or a fine, or both		

[173] Source: taken from *Misuse of Drugs Act 1971* Schedule 4

Section Creating Offence	General Nature of Offence	Mode of Prosecution	Punishment		
			Class A Drug Involved	Class B Drug Involved	Class C Drug Involved
s.8	Being the occupier, or concerned in the management, of premises and permitting or suffering certain activities to take place there	(a) Summary	6 months or £5,000 fine, or both	6 months or £5,000 fine, or both	3 months or £2,500, or both
		(b) On indictment	14 years or a fine, or both	14 years or a fine, or both	5 years or a fine, or both
s.9	Offences relating to opium	(a) Summary	6 months or £5,000 fine, or both		
		(b) On indictment	14 years or a fine, or both		
s.11(2)	Contravention of directions relating to safe custody of controlled drugs	(a) Summary	6 months or £5,000 fine, or both		
		(b) On indictment	2 years or a fine, or both		
s.12(6)	Contravention of direction prohibition practitioner, etc from possessing, supply, etc., controlled drugs	(a) Summary	6 months or £5,000 fine, or both	6 months or £5,000 fine, or both	3 months or £2,500, or both
		(b) On indictment	14 years or a fine, or both	14 years or a fine, or both	5 years or a fine, or both

Appendix 2 - Statistical Appendix

Statistical Information

Table 1: Percentage of age groups who said they had taken particular drugs in the last month

	16-19			20-24			25-29			30-34			35-39			40-44			45-59			16-59			16-29		
	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All	M	F	All
Cannabis	20	17	19	21	12	16	15	5	10	6	2	4	4	2	3	3	1	2	2	*	1	7	4	5	18	11	14
Amphetamine	7	6	6	5	4	4	3	1	2	1	1	1	*	*	*	*	0	*	*	*	*	2	1	1	5	3	4
Poppers	3	*	2	4	2	3	1	*	*	1	*	*	*	*	*	*	0	*	*	*	*	1	*	1	2	1	1
Ecstasy	3	*	2	4	2	2	1	*	1	*	*	*	*	*	*	0	0	0	0	0	0	1	*	*	2	1	1
Cocaine	*	0	*	2	1	1	1	1	1	1	0	*	*	*	*	1	*	1	*	0	*	1	*	*	1	*	1
Temazepam	0	2	1	*	0	*	1	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	1	*
Methadone	*	1	1	*	0	*	0	0	0	*	0	*	0	0	0	0	0	0	*	0	*	*	*	*	*	*	*
LSD	2	0	1	0	0	0	*	*	*	*	0	*	0	0	0	0	0	0	0	0	0	*	*	*	*	*	*
Glue etc	2	*	1	0	0	0	0	0	0	*	0	*	0	0	0	0	0	0	0	0	0	*	*	*	1	*	*
Heroin	1	0	*	1	0	*	*	0	*	*	0	*	*	0	*	0	0	0	*	0	*	*	0	*	*	0	*
Crack	0	0	0	*	0	*	*	*	*	*	0	*	0	0	0	0	0	0	*	0	*	*	*	*	*	*	*
Magic Mushrooms	1	0	*	*	0	*	0	0	0	*	0	*	0	0	0	0	0	0	0	0	0	*	0	*	*	0	*
Any drug	25	19	22	24	12	17	17	6	11	7	3	5	5	3	4	3	2	2	2	1	1	8	4	6	21	11	16

Notes: * less than 0.5%

Source: 1998 British Crime Survey (BCS), weighted data, Table B4, Home Office.

Table 2: Main drug of misuse for users starting agency episodes (a)
England

Six months ending	30-Sep 1993	30-Sep 1996	31-Mar 1997	30-Sep 1997	31-Mar 1998	30-Sep 1998	31-Mar 1999	30-Sep 1999
Heroin	7,720	14,334	15,597	12,392	13,635	16,081	16,772	17,936
Methadone	3,025	3,574	3,704	2,852	2,925	3,088	3,029	2,893
Amphetamine	1,841	2,248	2,009	1,999	2,141	2,490	2,367	2,334
Cannabis	1,078	1,533	1,660	1,934	2,201	2,775	2,894	3,342
Cocaine	497	870	1,020	925	1,143	1,668	1,627	2,075
Benzodiazepines	844	659	558	598	616	693	564	618
Other opiates	547	493	454	436	461	633	544	591
Ecstasy	186	268	246	223	141	196	173	238
Solvents	172	166	158	148	167	157	139	165
Antidepressants	37	92	66	55	111	107	96	81
Hallucinogens	195	74	67	49	42	43	39	35
Barbiturates	14	8	5	5	-	4	6	7
Other drugs	269	402	260	303	264	317	249	230
Total number (b)	16,810	24,879	25,925	21,996	23,916	28,599	28,499	30,545

Notes: (a) A user may report misusing (and perhaps injecting) several drugs. One drug is recorded as the main drug of misuse.

(b) Includes drug free

Sources: DOH Statistical Bulletin 1999/33 Statistics from the region, December 1999
DOH Statistical Bulletin 2000/13 Statistics from the region, July 2000

Table 4: Quantity of seizures of controlled drugs: by type of drug (kg)
United Kingdom

	1991	1992	1993	1994	1995	1996	1997	1998
Cannabis, of which:								
Herbal	9,525	11,391	11,976	11,579	13,872	34,374	31,120	21,660
Plants (numbers)	8,896	11,839	40,589	57,846	94,202	116,218	114,988	71,970
Resin	22,676	39,705	41,585	51,430	44,607	66,937	118,849	85,823
Liquid	3	7	13	12	6	18	27	7
Cocaine, of which:	1,984	2,365	2,954	2,992	3,654	4,097	5,432	7,395
Crack	583	878	1,155	1,320	1,444	1,332	1,745	2,436
Heroin	493	546	656	744	1,395	1,070	2,235	1,345
LSD (thousands of doses)	170	544	454	214	382	216	164	40
Ecstasy type (a) (thousand of doses)	365	554	302	1,564	555	5,798	1,926	2,095
Methadone	427	441	613	729	941	1,357	1,570	1,552
Morphine	119	106	137	135	94	118	134	155
Amphetamine	6,821	10,570	11,719	12,970	15,443	18,261	18,575	18,290

Note: (a) MDMA until 1995

Sources: Home Office Statistical Bulletin 3/00 *Drug Seizures and Offender Statistics, 1998*, 16 February 2000

Table 6: Persons dealt with for drug offences by action taken and year
United Kingdom

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Dealt with at court	23,168	27,715	29,911	29,481	27,622	40,284	48,588	53,216	55,625	66,027	78,052
Sentenced	20,962	24,972	26,713	25,808	23,466	32,226	40,099	44,139	46,480	55,351	66,909
Found not guilty	2,206	2,743	3,198	3,673	4,156	8,058	8,489	9,077	9,145	10,676	11,143
Cautioned	8,820	12,380	17,025	20,742	24,746	35,522	44,822	48,824	48,080	56,756	59,675
Settled by compounding	733	1,063	1,184	1,066	716	733	778	668	634	547	514
Fiscal Fine	-	-	-	-	-	-	-	-	-	500	611
Other	2,094	2,423	2,313	2,701	3,340	7,333	9,276	10,259	10,434	11,788	14,304
Total persons	34,815	43,581	50,433	53,990	56,424	83,872	103,464	112,967	114,773	135,618	153,156

Source: Home Office Statistical Bulletin 3/00 *Drug Seizures and Offender Statistics, 1998,* 16 February 2000

Table 6a: Percentage of persons dealt with for drug offences by action taken and year
United Kingdom

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Dealt with at court	67%	64%	59%	55%	49%	48%	47%	47%	48%	49%	51%
Sentenced	*60%*	*57%*	*53%*	*48%*	*42%*	*38%*	*39%*	*39%*	*40%*	*41%*	*44%*
Found not guilty	*6%*	*6%*	*6%*	*7%*	*7%*	*10%*	*8%*	*8%*	*8%*	*8%*	*7%*
Cautioned	25%	28%	34%	38%	44%	42%	43%	43%	42%	42%	39%
Settled by compounding	2%	2%	2%	2%	1%	1%	1%	1%	1%	0%	0%
Fiscal Fine	-	-	-	-	-	-	-	-	-	0%	0%
Other	6%	6%	5%	5%	6%	9%	9%	9%	9%	9%	9%
Total persons	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 7: Persons dealt with for drug offences involving cannabis by action taken and year
United Kingdom

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Total Persons	26,111	33,669	40,194	42,209	41,352	56,054	72,392	76,694	72,745	86,034	97,249
Cautioned	8,412	11,892	16,487	N	22,606	32,153	N	43,357	40,177	47,055	49,978
Dealt with by impounding	732	1,062	1,179	O	716	727	O	662	634	539	555
Fiscal fine	na	na	na	T	na	na	T	na	na	438	438
				A			A				
Found Guilty	16,967	20,715	22,528	V	18,030	23,174	V	32,675	31,934	38,002	46,183
Absolute or conditional discharge	1,356	1,638	2,099	A	2,154	3,457	A	4,734	4,467	5,372	6,334
Probation or supervision	764	968	1,209	I	970	1,529	I	2,392	2,515	2,883	3,311
Community Service Order	510	665	906	L	978	1,530	L	2,154	1,957	2,287	2,513
Combination Order	na	na	na	A	na	278	A	655	779	887	1,098
Fine	11,154	13,933	14,806	B	10,608	12,329	B	16,653	15,816	18,676	22,538
Imprisonment	2,865	3,147	2,930	L	2,620	2,737	L	4,198	4,866	5,488	5,692
Other	318	364	578	E	700	1,314	E	1,893	2,003	2,430	3,007

Table 7a: Percentage of persons dealt with for drug offences involving cannabis by action taken and year
United Kingdom

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Total Persons	*100%*	*100%*	*100%*		*100%*	*100%*		*100%*	*100%*	*100%*	*100%*
Cautioned	*32%*	*35%*	*41%*	N	*55%*	*57%*	N	*57%*	*55%*	*55%*	*51%*
Dealt with by impounding	*3%*	*3%*	*3%*	O	*2%*	*1%*	O	*1%*	*1%*	*1%*	*1%*
Fiscal fine	*na*	*na*	*na*	T	*na*	*na*	T	*na*	*na*	*1%*	*0%*
				A			A				
Found Guilty	*65%*	*62%*	*56%*	V	*44%*	*41%*	V	*43%*	*44%*	*44%*	*47%*
Absolute or conditional discharge	*5%*	*5%*	*5%*	A	*5%*	*6%*	A	*6%*	*6%*	*6%*	*7%*
Probation or supervision	*3%*	*3%*	*3%*	I	*2%*	*3%*	I	*3%*	*3%*	*3%*	*3%*
Community Service Order	*2%*	*2%*	*2%*	L	*2%*	*3%*	L	*3%*	*3%*	*3%*	*3%*
Combination Order	*na*	*na*	*na*	A	*na*	*0%*	A	*1%*	*1%*	*1%*	*1%*
Fine	*43%*	*41%*	*37%*	B	*26%*	*22%*	B	*22%*	*22%*	*22%*	*23%*
Imprisonment	*11%*	*9%*	*7%*	L	*6%*	*5%*	L	*5%*	*7%*	*6%*	*6%*
Other	*1%*	*1%*	*1%*	E	*2%*	*2%*	E	*2%*	*3%*	*3%*	*3%*

Source: House of Commons research, Our ref: 2000/4/67SG

Table 8 : Importance of cannabis amongst the young, selected countries or areas
Percentage

Country or area, year of survey	Prevalence	Age range	Percentage	Source
Australia, 1996	ever used	13-14 year olds	28	Center for Behavioural Research
		15-16 year olds	47	
		17-18 year olds	55	
US, 1996	ever used	13-14 year olds	20	National Institute on Drug Abuse
		15-16 year olds	34	
		16 year olds	40	
		17-18 year olds	42	
Canada, 1995	ever used	13-14 year olds	-	Canadian Centre on Substance Abuse
		15-16 year olds	29	
		17-18 year olds	33	
EU countries, 1994/95	ever used	13-14 year olds	6	European Monitoring Centre for Drugs and Drug Addiction
		15-16 year olds	16	
		17-18 year olds	26	
Selected EU Countries, various years	ever used	15-16 year olds		European Monitoring Centre for Drugs and Drug Addiction
Austria			10	
Belgium			24	
Denmark			18	
Finland			5	
France			23	
Greece			10	
Ireland			36	
Luxembourg			28	
Netherlands			32	
Portugal			4	
Spain			25	
Sweden			7	
UK (England & Wales) (Not BCS data)			41	

Source: ODCCP *Cannabis as an illicit narcotic crop: a review of the global situation of cannabis consumption, trafficking and production* ODCCP website www.odccp.org

Table 9: Worldwide cannabis seizures 1995-96

Kilograms

Country or area	Marijuana	Hashish	Total
Mexico	912,000	7,000	920,000
EU	293,000	441,000	734,000
USA	657,000	26,000	684,000
Pakistan		279,000	279,000
Colombia	227,000	6,000	233,000
South Africa	225,000		225,000
Canada	166,000	34,000	199,000
Morocco	38,000	89,000	127,000
Ghana	107,000		107,000
India	93,000	5,000	99,000
Paraguay	72,000		72,000
Jamaica	49,000		49,000
Thailand	44,000		44,000
Senegal	41,000		41,000
Malawi	24,000		24,000
Russian Federation	20,000		20,000
Brazil	17,000		17,000
Nigeria	17,000		17,000
Turkey		15,000	15,000
Iran		15,000	15,000
Kenya		13,000	13,000
Sri Lanka		6,000	6,000
Poland		5,000	5,000
Bulgaria		5,000	5,000
Lebanon		4,000	4,000
Romania		3,000	3,000
Nepal		2,000	2,000
Other	179,000	14,000	193,000
Total	3,078,000	969,000	4,047,000

Notes: Totals may not add due to rounding

Source: UN *Bulletin on Narcotics 1997* Issue 1 -004, ODCCP

VIII Further reading

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- Working Party of the Royal College Psychiatrists and the Royal College of Physicians, *Drugs Dilemmas and Choices*, 2000

- Richard Stevenson, *Winning the War on Drugs: To Legalise or Not?,* Institute for Economic Affairs, 1994

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- Lynn Zimmer and John P Morgan, *Marijuana Myths Marijuana Facts,* Published by Lindesmith Center, 1997

- Michael Gossop, *Living with Drugs*, 5th edition, 2000

- Nicholas Dorn, *Regulating European Drug Problems Administrative Measures and Civil Law in the Control of Drug Trafficking, Nuisance and Use*, 1999 ISDD

- The Police Foundation *Drugs and the law. Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, 2000

Several documents were produced specifically to inform the work of the Inquiry. These include:

- Professor Robert Baldwin, *Regulatory Drug Use.*, London School of Economics and Social Science, January 1999

- Professor Howard Parker *Despite the Law. The Dynamics of Deciding to Use Illicit Drugs,* , Manchester University , November 1998

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