



Home Office

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ADVISORY COUNCIL
ON THE MISUSE
OF DRUGS

The classification of cannabis under the Misuse of Drugs Act 1971

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The Home Secretary
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March 2002

Dear Home Secretary

Last October you asked the Advisory Council on the Misuse of Drugs to review the classification of cannabis preparations in the light of current scientific evidence. I have pleasure in enclosing the Council's Report.

The Council recommends the reclassification of all cannabis preparations to Class C. The Council believes that the current classification of cannabis is disproportionate in relation both to its inherent toxicity, and to that of other substances (such as amphetamines) that are currently within Class B.

In making this recommendation, however, the Council wishes it to be clearly understood that cannabis is unquestionably harmful. Furthermore, the Council is anxious that the dangers associated with the use of cannabis preparations are widely known. For this reason this Report has been written in a style that, we hope, is accessible to the public at large. A selected bibliography, from which the full bibliography and the underpinning scientific evidence has been adduced, can be found at the end of the Report.

I beg to remain etc



Professor Sir Michael Rawlins
Chairman

1. Background

- 1.1** In October 2001 the Home Secretary asked the Advisory Council on the Misuse of Drugs (the 'Council') to review the classification of cannabis preparations in the light of current scientific evidence.
- 1.2** The Council is established under the Misuse of Drugs Act 1971 to keep under review the drug situation in the United Kingdom and to advise government ministers on the measures to be taken for preventing the misuse of drugs or for dealing with the social problems connected with their misuse. In particular, the Council is required to advise on the appropriate classification of substances being specified under Part I, Part II, and Part III of Schedule 2 to the Act.
- 1.3** The classification of drugs, in Schedule 2 to the Misuse of Drugs Act 1971, is based on the harm they may cause:
- Class A** (the most harmful) includes morphine and diamorphine (heroin).
- Class B** (an intermediate category) includes amphetamines, barbiturates, cannabis and cannabis resin.
- Class C** (the least harmful) includes anabolic steroids, benzodiazepines and growth hormones.
- 1.4** When advising on the harmfulness of drugs, the Council takes account of the physical harm that they may cause, their pleasurable effects, associated withdrawal reactions after chronic use, and the harm that misuse may bring to families and society at large.
- 1.5** The Misuse of Drugs Regulations 2001 (Statutory Instrument 2001/3998) defines the categories of people authorised to supply and possess drugs controlled under the Act. In these Regulations, drugs are categorised under five schedules:
- Schedule 1** includes drugs such as cannabis that are not, conventionally, used for medical purposes. Possession and supply are prohibited without specific Home Office approval.
- Schedule 2** includes morphine and diamorphine and are subject to special requirements relating to their prescription, safe custody and the need to maintain registers.
- Schedule 3** includes barbiturates and are subject to special prescription, though not safe custody requirements.
- Schedule 4** includes benzodiazepines and are neither subject to special prescription or safe custody requirements.
- Schedule 5** includes preparations that, because of their strength, are exempt from most of the controlled drug requirements.

2. Introduction

- 2.1** The plant *Cannabis sativa* is also known as hemp. As a drug of abuse it usually takes the form of either herbal cannabis (marijuana) consisting of the dried leaves and female flower heads, or cannabis resin (hashish) which is secreted by the leaves and flowers and often compressed into blocks. Cannabis oil (hashish or hemp oil) is a concentrate of cannabinoids obtained by solvent extraction of the crude plant material or of the resin.
- 2.2** The term cannabinoid was originally used to describe the family of naturally occurring chemicals found in cannabis. Of these, the most significant is Δ^9 -tetrahydrocannabinol (THC) but there are others (eg cannabidiol and cannabinol) which, though not psychoactive, may modify the effects of THC itself. The term cannabinoid also encompasses any substance that activates cannabis receptors including synthetic (eg nabilone) and endogenous (eg anandamide) compounds.
- 2.3** This Report considers the most appropriate Class (see paragraph 1.3) into which cannabis preparations should be categorised based on its harmfulness. There is, at the present time, no authorised medicinal preparation of cannabis and, therefore, this Report is not concerned with its potential medicinal uses. The Council is aware, however, that clinical trials of cannabis derivatives are in progress. If, at some future date, one or more cannabis preparations become available as medicinal substances then the Council would advise about which Schedule, under the Misuse of Drugs Regulations 2001, they should be categorised (see paragraph 1.5). This matter, however, is entirely separate from the classification of cannabis under the Misuse of Drugs Act 1971.
- 2.4** The Report itself is based on a detailed scrutiny of the relevant scientific literature including four reviews commissioned by the Department of Health in 1998¹ as well as an update commissioned by the Home Office and completed in November 2001.²

¹ Ashton (1998), Johns (1998), and Plant (1998a, 1998b) – see bibliography.

² Nutt and Nash (2001) – see bibliography.

3. Epidemiology

3.1 Information about the use of cannabis in the UK comes from a variety of sources. None are ideal but, collectively, they provide a reasonable indication of the present scale of use and of the changes that have occurred over the past 20 years. The available sources of information come from:

- surveys of self-reported use;
- seizures (by police and customs officers);
- cautions and court appearances data; and
- National Drug Misuse databases.

3.2 Cannabis use appears to have increased dramatically over the past two decades. British Crime Survey (BCS) data show that, in England and Wales, lifetime use between 1981 and 2000 amongst those aged 20 to 24 years rose from 12 per cent to 52 per cent. In the same age group, the 2000 BCS suggested that use in the previous year was 27 per cent, and in the previous month was 18 per cent. By comparison, use of amphetamine or heroin in the past month was 3 per cent and less than 0.5 per cent respectively. The 'best' estimate (based on the 2000 BCS data) of the number of 16–24-year-olds using cannabis in the previous year is 1,503,000 (range 1,308,000–1,698,000).

3.3 In Scotland, lifetime use of those aged under 25 years in 2000 was 34 per cent (compared to 40 per cent 1996) and use in the last year was 15 per cent (compared to 25 per cent in 1996). Between 1995 and 1998 lifetime use amongst the same group in Northern Ireland rose from 12 per cent to 18 per cent. In 1998 the Northern Ireland rates for use in the last year and last month were 7 per cent and 4 per cent.

3.4 Local and national surveys indicate that cannabis use is highest amongst adolescents (aged 16 to 19 years) and young adults (aged 20 to 29 years), and more prevalent in males than females (see Table 1). Although there may be some geographical differences, there is substantial consumption in both rural and urban parts of England and Wales, and amongst adolescents and young adults from wide social and educational backgrounds. Use in Scotland and Northern Ireland is considerably lower.

Table 1: Use (%) of cannabis in the last 12 months, by age and gender, 2000 British Crime Survey³ (England and Wales)

Age (years)	Male	Female	All
16–19	28	21	25
20–24	30	24	27
25–29	23	12	17
30–34	15	6	10
35–39	9	4	6
40–44	6	3	4
45–59	3	1	2
All 16–59	12	7	9
All 16–29	27	18	22

³ Ramsay et al (2001) – see bibliography.

- 3.5** The number of seizures, by police and customs officers, increased in line with the rise in self-reported use from 17,227 in 1981 to 114,667 in 1998. The number of seizures fell, in 1999, to 97,356. In that year, police and customs officers seized a total of 71 tonnes of cannabis preparations, of which 53 tonnes were accounted for by cannabis resin. In the same year there were 15,108 seizures of heroin and 13,194 seizures of amphetamines.
- 3.6** The number of cannabis offences (as persons found guilty, cautioned, given a fiscal offence, or dealt with by compounding) rose from 15,388 in 1981 to 99,140 in 1998 before falling to 88,548 in 1999. Over 90 per cent of such recorded cannabis offences in 1999 were for 'unlawful possession'. Offences related to heroin and amphetamines in 1999 were 12,760 and 12,102 (respectively).
- 3.7** It should be noted that these figures for drug seizures and offences reflect law enforcement activities and were not designed as epidemiological tools. They are useful, however, when considered in conjunction with other data, in contributing to knowledge about long-term trends in cannabis misuse. Nevertheless, the nature and origins of these statistics should be borne in mind in their interpretation. For example, the fall between 1998 and 1999 in both the numbers of cannabis seizures, and persons dealt with for cannabis offences, should not be taken as indicating a reduction in use. The reductions in seizures were probably due to two factors. First, the law enforcement agencies have been concentrating their efforts, in recent years, on Class A substances in line with the availability targets in the Government's Drugs Strategy. The second possible factor may reflect a reduction in the number of stops and searches, especially in London, following the publication (February 1999) of the report by Sir William MacPherson, *The Stephen Lawrence Inquiry*. Although only a minority of all stops and searches result in an arrest, they are relatively important in leading to arrests for drug use.⁴
- 3.8** During the period October 1992 to March 1993, of the 20,343 people starting attendances at treatment agencies in Great Britain, 1,414 (7.0 per cent) had cannabis reported as their main problem drug. By April to September 2000, this number had risen to 3,537 out of 39,658 (8.9 per cent) attendances. This contrasts with 24,759 starting attendances for heroin misuse and 1,413 for amphetamine misuse during the same period. No individuals are reported to the Northern Ireland Addicts Index as having problematic cannabis use.

⁴ Corkery (2001) – see bibliography.

4. Risks to human health

- 4.1** Drugs affect health in a number of different ways. They can produce immediate adverse medical effects (such as death from respiratory depression with heroin) or can damage health over a period of time (such as lung and heart disease from smoking tobacco). Some drugs injure health as a secondary consequence of the way in which they are used: the sharing of needles to inject heroin, leading to infections such as human immunodeficiency virus (HIV) and hepatitis, is an obvious example. Furthermore, some drugs cause physical or mental dependence which can distort the life of the user so that they endanger themselves or others in their attempts to obtain supplies of their drug.
- 4.2** In some instances long-term damage can result from just single use (eg infection with HIV from a single injection); whereas other problems may emerge only after extended use of large amounts of drug (eg cannabis dependence).
- 4.3 Acute health risks of cannabis**
- 4.3.1 Acute health risks are those due to the direct effects of cannabis, on the body, after its immediate use. They include actions on the brain, the heart and lungs, as well as other organs.
- 4.3.2 Cannabis produces dilatation of some blood vessels and leads to constriction of others. The characteristic redness of the eye, shortly after exposure, is due to dilatation of the conjunctival blood vessels. More problematically it constricts other blood vessels leading to an increase in blood pressure. Cannabis can also disrupt the control of blood pressure leading to lower standing blood pressure and an increased risk of fainting. Cannabis also produces an increase in heart rate. Maximum increases in heart rate occur within 15 to 30 minutes of inhalation, and remain raised for two hours or more. Tolerance to the cardiovascular effects of cannabis occurs with repeated use.
- 4.3.3 The cardiovascular actions of cannabis are similar to the effects of exercise, and probably do not constitute a significant risk in healthy adolescents and young adults. They can, though, be dangerous in people with diseases of the cardiovascular system, especially those with coronary artery disease, irregularities of heart rhythm, high blood pressure, or in individuals at risk of stroke.
- 4.3.4 Cannabis has been reported to produce modest bronchodilator effects (opening of the airways) but can worsen asthma. Chronic use of cannabis has also been alleged to decrease sperm counts and sperm motility in men, and suppression of ovulation in women. The effects of cannabis on fertility, however, are unclear.
- 4.3.5 Unlike sedative intoxicants such as alcohol, cannabis does not cause respiratory depression or suppress the gag reflex even when extremely intoxicated. Moreover, the fact that cannabis is usually smoked means that the effects are almost immediate and once inhalation stops they begin to

subside. More severe intoxication may occur after the ingestion of products because of the variable speed and extent of its absorption into the body.

- 4.3.6 Nevertheless, cannabis impairs the performance of complex tasks that require sustained attention and motor control. When these involve risks to self or others (such as drivers, aircraft pilots or operators of heavy machinery), cannabis can be dangerous, and even more so when used with alcohol. Cannabis differs from alcohol, however, in one major respect: it seems not to increase risk-taking behaviour. This may explain why it appears to play a smaller role than alcohol in road traffic accidents. Cannabis intoxication tends to produce relaxation and social withdrawal rather than the aggressive and disinhibited behaviour commonly found under the influence of alcohol. This means that cannabis rarely contributes to violence either to others or to oneself, whereas alcohol use is a major factor in deliberate self-harm, domestic accidents and violence.
- 4.3.7 Acute cannabis intoxication can also lead to panic attacks, paranoia and confused feelings that drive users to seek medical help. These effects are generally short lived and usually respond to reassurance or a minor tranquilliser. In some cases acute cannabis intoxication can produce a psychotic state that may continue for some time and require treatment with antipsychotic drugs. This is similar to the psychotic states following intoxication with cocaine or amphetamines. In a few cases such an episode may be the start of a long-lasting psychotic illness, usually schizophrenia (see below). In people with pre-existent mental illness, especially schizophrenia, acute cannabis use can aggravate the condition.

4.4 Long-term health risks of cannabis

- 4.4.1 Most cannabis is smoked. Smoking, in any form, is dangerous and tobacco smoking is the largest single cause of ill health and premature death in the UK. Smoking cannabis therefore presents a real health risk, potentially similar to that of tobacco, with an increased incidence of bronchitis, asthma and lung cancer as well as disorders of the heart and circulation. Indeed, smoking cannabis may be more dangerous than tobacco since it has a higher concentration of certain carcinogens. However, there are factors with smoked cannabis that may mitigate this risk. In general cannabis users smoke fewer cigarettes per day than tobacco smokers and most give up in their 30s, so limiting the long-term exposure that we now know is the critical factor in cigarette-induced lung cancer.
- 4.4.2 Preliminary studies of lung function in regular cannabis smokers have not found a major cause for concern in the majority, but some severe cases of lung damage have been reported in young very heavy users. Since cannabis use has only become commonplace in the past 30 years there may be worse news to come. Further research, coupled with a public health education programme, is required.
- 4.4.3 Drug dependence is the process whereby repeated use of a drug leads to increasing difficulty in stopping. Dependence is a complex phenomenon whose nature differs from drug to drug and is determined by the duration and amount of the drug used as well as the characteristics of the user.

Dependence is reflected by an increasing reliance on the drug and by symptoms of withdrawal when users reduce their consumption or try to stop altogether. Cannabis dependence was once contested but has now been established as a real phenomenon and one for which people may seek help. The extent of cannabis dependence in the UK is not known but (as discussed in paragraph 3.8) for between 5 per cent and 10 per cent of drug users accessing treatment services, cannabis has been reported to be their main problem drug.

- 4.4.4 Studies amongst cannabis dependent users have revealed that when they stop they experience a real physical withdrawal syndrome characterised by decreased appetite, weight loss, lethargy, irritability, mood changes and insomnia. Reinstating the drug can terminate these symptoms. There is also a psychological craving for cannabis. Recently it has been shown that cannabis dependence reflects an altered function of cannabinoid receptors in the brain, and that withdrawal can be precipitated by administration of a cannabis receptor blocker.
- 4.4.5 Dependence is also related to the pleasure that a drug gives: the more immediate pleasure a user experiences, the more likely it is to cause dependence. It is possible to rank the risks of dependence of abused drugs with heroin and crack cocaine the worst and cannabis generally at, or near, the bottom (and well below nicotine and alcohol). Nevertheless, repeated cannabis use does lead to a significant proportion of regular users becoming dependent although the severity of their dependence is generally not such as to lead to criminal behaviour.
- 4.4.6 The other main concern about the chronic use of cannabis is whether it can lead to mental illness (especially schizophrenia). Although debated for well over a century, no clear causal link has been demonstrated. The onset of schizophrenia often occurs in the late teens, when cannabis use is most common, so that an association is inevitable. This does not, though, necessarily mean that the relationship to cannabis is causal. To make the interpretation of such findings more difficult, many of these individuals have used other drugs such as amphetamines that may also precipitate schizophrenia. Moreover, as discussed in paragraph 4.3.7, cannabis intoxication can itself lead to psychotic symptoms that may be mistaken for schizophrenia.
- 4.4.7 On the other hand cannabis use can unquestionably worsen schizophrenia (and other mental illnesses) and lead to relapse in some patients. Its use should therefore be particularly discouraged in all people with mental health problems. We do not know why those with schizophrenia use cannabis when it can make their condition worse. It may be cultural or related to peer pressure; but it is also possible that cannabis helps deal with some aspects of the illness, or possibly ameliorates some of the adverse consequences of their medication.
- 4.4.8 There is no evidence that cannabis causes structural brain damage in man. Neither radiological studies nor post mortem examinations have revealed atrophy or other causes for concern.

4.5 Cannabis and pregnancy

- 4.5.1 Tobacco smoking and alcohol use are significant causes of harm to the unborn child. A small proportion of women use cannabis during pregnancy and the birth weights of their babies are lower than expected. This is probably due to the effects of carbon monoxide in the smoke of cannabis cigarettes as similar findings are well established for tobacco smoking in pregnancy. Cannabis may also increase the risk of minor birth defects and abortion but the effect is small. Like tobacco smoking, cannabis smoking seems to increase the risk of sudden infant death syndrome.
- 4.5.2 There is some evidence that smoking cannabis during pregnancy may produce subtle alterations in neuropsychological performance of the child that persists into later life. This effect is similar to that of tobacco smoking and may be due to the actions of tobacco smoke rather than to cannabis per se. There have also been un-replicated reports that cannabis use is associated with certain forms of childhood cancers.
- 4.5.3 Taken together this data suggest that cannabis use in pregnancy is not safe but that it is probably no more dangerous to the foetus than either alcohol or tobacco. Pregnant women should continue to be warned to avoid all these substances.

4.6 Does cannabis use lead on to other drug use?

- 4.6.1 The 'gateway theory' is a term that is used in a number of ways and is probably the most controversial aspect of cannabis use. It stems from the observation made in many retrospective studies that users of the most harmful (Class A) drugs such as heroin and cocaine have also generally used cannabis first. It is therefore plausible to suggest that earlier use of cannabis had predisposed the individuals to later Class A drug use by, in some way, opening a 'gateway'.
- 4.6.2 Proving, however, that this pattern of association is causal (and that cannabis use is responsible for increasing the likelihood of other drug misuse) is very difficult due to the many confounding factors that might also act as gateways. These include the use of other substances such as alcohol, tobacco, solvents, stimulants and psychedelic agents whose consumption generally also precedes that of Class A drugs. Other important factors are the personality and environment (the peer group, social deprivation, etc) of the user. Even if the gateway theory is correct, it cannot be a particularly wide gate as the majority of cannabis users never move on to Class A drugs.
- 4.6.3 There are a few studies that have attempted to test the gateway theory by correcting for some of the more obvious confounding variables, and these have found a significant positive association (ie that early cannabis use is associated with an increased likelihood of later heroin use). Interestingly, other studies have found that the use of alcohol and tobacco in early teens (and especially in pre-adolescents) appears to be associated with the later use of many drugs including cannabis. In all these studies there is a distinct possibility that the driving factor in the misuse of drugs is the personality and/or peer group of the subject rather than the drug itself.

4.6.4 Despite all these caveats, it is likely that cannabis use (and that of alcohol or tobacco) has an effect on later Class A drug use; and that, in a small proportion of the population, progression to Class A drugs results from previous exposure to cannabis. There are several theoretical pharmacological reasons why this might occur.

4.6.5 There may also be commercial explanations. Some Class A drug dealers also deal in cannabis. A shared market increases the opportunities for acquiring and maintaining dependency on Class A drugs. The lower level of heroin use in the Netherlands, as compared with the UK, is claimed to be due to the separation of markets.

4.7 Cannabis and the health of society

4.7.1 Drug use can affect the health of others, as well as the health of the users. For example, driving a car under the influence of a drug can lead to the injury of passengers and bystanders. Cannabis appears not to make as major a contribution to road traffic or other accidents as alcohol. As discussed in paragraph 4.3.6, cannabis use does not commonly produce the mental states leading to violence to others; but the illegal market does contribute to violence in some parts of our cities.

4.7.2 Injecting a drug is one of the most important causes of the spread of blood borne infections such as HIV or hepatitis. Unlike many drugs (opiates, stimulants, benzodiazepines and barbiturates) cannabis is not used by injection and so is free of these risks.

5. Discussion

- 5.1** The epidemiological evidence demonstrates that cannabis use, especially amongst adolescents and young adults, is substantial. The apparent and ready availability of cannabis is, however, disproportionate to the relatively small numbers of people seeking help from drug treatment agencies for cannabis misuse. The high use of cannabis is not associated with major health problems for the individual or society.
- 5.2** The occasional use of cannabis is only rarely associated with significant problems in otherwise healthy individuals. Impaired psychomotor performance and, uncommonly, acute psychotic states are the most important. They are, however, self-limiting and (usually) readily managed. These harmful effects of cannabis, however, are very substantially less than those associated with similar use of other drugs, such as amphetamines, which (like cannabis) are currently classified as Class B.
- 5.3** Even the occasional use of cannabis, however, poses significant dangers for people with disorders of the heart and circulation, and for those with mental health problems such as schizophrenia. Particular efforts should be made to encourage abstinence in such individuals. Again, however, both groups are at much more significant risk from amphetamines.
- 5.4** Regular heavy use of cannabis can result in dependence, but its dependence potential is substantially less than that of other Class B drugs such as amphetamines or, indeed, that of tobacco or alcohol.
- 5.5** It is not possible to state, with certainty, whether or not cannabis use predisposes to dependence on Class A drugs such as heroin or crack cocaine. Nevertheless the risks (if any) are small and less than those associated with the use of tobacco or alcohol.
- 5.6** Cannabis impairs mental functions such as attention, memory and motor performance and should be avoided by all individuals in whom such impairment might put themselves or others at risk. These included drivers, aircraft pilots, those operating heavy machinery as well military, health and emergency personnel. Efforts to ensure abstinence in such individuals should be sustained.

6. Conclusions

- 6.1** Cannabis is not a harmless substance and its use unquestionably poses risks both to individual health and to society.
- 6.2** Cannabis, however, is less harmful than other substances (amphetamines, barbiturates, codeine-like compounds) within Class B of Schedule 2 to the Misuse of Drugs Act 1971. The continuing juxtaposition of cannabis with these more harmful Class B drugs erroneously (and dangerously) suggests that their harmful effects are equivalent. This may lead to the belief, amongst cannabis users, that if they have had no harmful effects from cannabis then other Class B substances will be equally safe.
- 6.3** The Council therefore recommends the reclassification of all cannabis preparations to Class C under the Misuse of Drugs Act 1971.
- 6.4** If this recommendation is accepted, the Council has identified a number of issues that it believes, while not directly related to the scientific consideration, to be relevant and/or merit consideration. These are outlined in Annex A of this Report.

Selected bibliography

There is a very large scientific literature on the effects of cannabis on human health and human society available. The selected bibliography and source materials listed below can be used to access the fuller literature.

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Annex A

Levels of use (prevalence)

In the debate that followed the Home Secretary's announcement that he was seeking the Council's advice on the classification of cannabis, a commonly expressed concern has been that a downward reclassification would lead to an increase in use. In part this concern appears to stem from a misunderstanding of what reclassification means. It is important to note that reclassification is not the same as decriminalisation, or legalisation. If cannabis were reclassified, criminal sanctions, including imprisonment, would remain, but the maximum sentence for offences under the Misuse of Drugs Act 1971 would be reduced.

In attempting to analyse the likely impact on prevalence of reclassification, there is very little relevant domestic learning to draw on. But it is possible to look at the experience of other countries, albeit in circumstances where civil penalties have replaced criminal sanctions. In particular, the experiences in Australia, the Netherlands and the United States are illustrative. In each of these countries a reduction in the penalties for using cannabis has not led to a significant increase in use.⁵

Monitoring patterns and trends of drug misuse is a key function of the Advisory Council, and if the Home Secretary decides to reclassify cannabis, the Council would continue to monitor prevalence rates.

Policing and enforcement issues

The Council includes members with law enforcement experience. This experience has enabled the Council to identify a number of enforcement related issues which will doubtless be in the Home Secretary's mind as he considers our Report.

Reclassifying cannabis to Class C under the Misuse of Drugs Act will mean that possession of the drug will no longer be an 'arrestable' offence in England and Wales under Section 24 of the Police and Criminal Evidence Act 1984 (PACE). Section 25 of PACE provides separate powers of arrest in strictly limited circumstances. There are already a number of criminal offences that are not 'arrestable', but clearly, if cannabis is reclassified, Ministers and the police will need to consider a revised enforcement model and guidance to officers.

Reduced penalties for cannabis offences will apply across the spectrum of offences, including for the more serious trafficking offences. The maximum penalty for trafficking cannabis would be reduced from 14 years imprisonment to 5 years. This could have an impact on the activities of organised criminals. It will be important to ensure that reclassification does not have the unintended consequence of encouraging international trafficking and that the principle of proportionality in sentencing is retained across the spectrum of cannabis offences.

⁵ United States Single (1989); Australia Donnelly, Hall and Christie (1995; 1998); Netherlands MacCoun and Reuter (1997; 2001)

Treatment

We have referred in this Report to the available data on people presenting to treatment services who have cannabis reported as their main drug of abuse. What these figures don't show, is the ratio within this group who have a genuine dependence problem. The picture is further complicated because there is anecdotal evidence that cannabis users do not go to services because they don't think their problem will be treated seriously. It is extremely important that people can source reliably good advice from services for all drug misuse problems, including cannabis. We need to increase our efforts to provide good public health information about cannabis and its potential for dependence, and our treatment services need to be able to help those with a cannabis dependency problem.

Education

In announcing any change to the classification of cannabis, it will be important to ensure that the decision and the reasons for it are properly understood. We have tried to express as clearly as we can in this Report the message that cannabis is a harmful drug. But much of the debate about cannabis and about the appropriate response of society to its use tends to overlook this fundamental truth.

More generally, the provision of accurate and objective advice on the health effects of all drugs, and where to access treatment, must be a key part of our drug strategy. In respect of cannabis, the Council hopes that this Report represents a modest contribution to that important goal.

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