ALASKA LEGISLATURE COMMITTEE FILES, 2005 2006 8672

11797 SENATE HEALTH,EDUCATION & SOCIAL SERVICES

*Controlled Drugs and Substance Act*, but with simple possession decriminalized by designation as a "contravention," much like the scheme proposed in Bill C-344.[307] However, unlike the amendments proposed in Bill C-344, we do not support a lessening of the penalties for any form of trafficking or possession for the purposes of trafficking. Thus, our preference would be to mandate proceeding against incidents of possession and/or cultivation for personal use by ticketing, except where the offence is committed in the presence of specified aggravating circumstances. For example, in recognition of the safety and policing concerns expressed by law enforcement agencies, the Committee believes that possession charges linked to impaired driving offences should continue to be prosecuted as a criminal offence under the CDSA.[308] Implementation of these proposals may require a redrafting of the possession offences in the CDSA, in order to retain present penalties for 'aggravated' possession charges.

The Committee deliberated at considerable length over the question of whether criminal sanctions should be retained for simple possession of cannabis in relation to schools and other places frequented by youth. However, most Committee members were reluctant to propose a scheme that operates more onerously against youth than it does against their adult counterparts. Furthermore, trafficking, or possession for the purposes of trafficking, in or near a school or other place frequented by those under eighteen, and trafficking to persons under eighteen, are already "aggravating factors" to be considered at the time of sentencing. Because trafficking-related offences and penalties will not be affected by the decriminalization scheme we propose, those provisions will continue to apply. Therefore, the Committee proposes that possession of a small amount of cannabis for personal use, even on school property, should also be a "ticketable" offence under the new scheme. The Committee expects that school boards will continue to impose their own administrative controls, as necessary, to further deter students from bringing cannabis onto school property in much the same way as they do now with other substances.

By designating as contraventions, those offences relating to the possession or cultivation of small amounts of cannabis for personal use, the proposed decriminalization scheme would leave existing criminal sanctions in place to allow the full force of the law to continue to be brought to bear against anyone who traffics in or cultivates cannabis products for profit. Retaining a criminal offence for possession of cannabis in association with an impaired driving offence would do the same for those individuals whose substance use risks grave and substantial harm to others. Finally, decriminalization would have the added benefit of maintaining Canada's compliance with the International Conventions discussed in Chapter 7.

## 3. COMMITTEE OBSERVATIONS — CANNABIS

*The Committee observed the following:*

- *Smoking any amount of marijuana is unhealthy, because of its high concentration of tar and benzopyrene.*
- *The consequences of conviction for possession of a small amount of cannabis for personal use are disproportionate to the potential harm associated with that behaviour.*
- *DECRIMINALIZING the possession of small amounts of cannabis for personal use would not affect the penalties or consequences for trafficking, or for the possession of any other controlled substance.*
- *All orders of government must undertake to inform Canadians about the potential harms associated with cannabis use and, in particular, the heightened risk to young persons.*

### RECOMMENDATION 40

**The Committee recommends that the possession of cannabis continue to be illegal and that trafficking in any amount of cannabis remain a crime.**

**RECOMMENDATION 41**

**The Committee recommends that the Minister of Justice and the Minister of Health establish a comprehensive strategy for decriminalizing the possession and cultivation of not more than thirty grams of cannabis for personal use. This strategy should include:**

- **Prevention and education programs outlining the risks of cannabis use and, in particular, the heightened risk it poses to young persons; and**
- **The development of more effective tools to facilitate the enforcement of existing *Criminal Code* prohibitions against driving while impaired by a drug.**

---

299 Introduced on 4 May 2001 by Dr. Keith Martin, M.P. (Esquimalt—Juan de Fuca). An earlier version of the bill was given first reading on 26 October 1999; see Bill C-266, 2nd Session, 36th Parliament.

300 Because this is a study of the non-medical use of drugs, the adequacy and operation of the *Medical Marijuana Access Regulations* will not be included in the discussion

301 Trafficking or possession for the purposes of trafficking, in amounts in excess of 3 kg, is a purely indictable offence, punishable by a maximum of life imprisonment; see sections 5(1), (2) and (3) of the *Controlled Drugs and Substances Act*.

302 Eugene Oscapella, Canadian Foundation for Drug Policy and Harm Reduction Network, Testimony before the Committee, February 28, 2001.

303 Josée Savoie, "Crime Statistics in Canada, 2001," *Juristat*, Statistics Canada, Canadian Centre for Justice Statistics, Catalogue no. 85-002-XIE Vol. 22 no.6, p. 11.

304 This theory rests on the argument that, given legal access to a substance like cannabis, would-be purchasers are no longer forced to consort with criminals, many of whom may also be involved in the sale of much more harmful substances.

305 Ernie Howe, Addictions Services-Outpatient, Testimony before the Committee, May 23, 2002.

306 Corporal Ken Murray, RCMP, Testimony before the Committee, April 15, 2002.

307 To be logically consistent, it may also be advisable to deal with cultivation for personal use in the same manner if that is practically and administratively possible.

308 Chief Superintendent Bob Lesser, Drug Enforcement Branch, Federal Services Directorate, RCMP, Testimony before the Committee, October 3, 2001.

---

ORIGINAL ARTICLE

# Risk Factors Predicting Changes in Marijuana Involvement in Teenagers

*Marianne B. M. van den Bree, PhD; Wallace B. Pickworth, PhD*

**Background:** Marijuana use during adolescence has various adverse psychological and health outcomes. It is poorly understood whether the same risk factors influence different stages in the development of marijuana involvement.

**Objective:** To establish which risk factors best explain different stages of marijuana involvement.

**Design:** Data were collected at 2 points using computer-assisted personal interview (wave 1 and wave 2 were separated by 1 year). Twenty-one well-established risk factors of adolescent substance use/abuse were used to predict 5 stages of marijuana involvement: (1) initiation of experimental use, (2) initiation of regular use, (3) progression to regular use, (4) failure to discontinue experimental use, and (5) failure to discontinue regular use. Data were analyzed using logistic regression analysis.

**Participants:** Middle school and high school students (N=13718, aged 11-21 years) participating in the National Longitudinal Study of Adolescent Health (Add Health).

**Results:** Three risk factors (own and peer involvement with substances, delinquency, and school problems) were the strongest predictors of all stages. Their combined presence greatly increased risk of initiation of experimental (odds ratio, 20) and regular (odds ratio, 87) marijuana use over the next year. Personality, family, religious, and pastime factors exerted stage-specific, sex-specific, and age-specific influences.

**Conclusions:** Assessment of substance, school, and delinquency factors is important in identifying individuals at high risk for continued involvement with marijuana. Prevention and/or intervention efforts should focus on these areas of risk.

*Arch Gen Psychiatry. 2005;62:311-319*

MARIJUANA IS THE MOST commonly used illicit drug. Approximately 50% of secondary-school students in the United States indicate having used marijuana.[1] It is one of the leading substances reported in arrests, emergency department and treatment admissions, and autopsies.[2] Short-term risks of marijuana use include traffic accidents[3] and unprotected sex.[4] In addition, marijuana use is associated with lack of motivation; greater involvement with and inability to quit other substances; psychiatric problems, including depression, schizophrenia, anxiety, suicide, conduct problems, antisocial behavior, and criminal behavior; and reduced chances of participation and stability in adult roles (eg, not graduating from high school, abortion, unemployment, and divorce).[5-13]

Experimentation with substances usually takes place during adolescence when tolerance is lower and risk of dependence is greater than in adulthood.[14] Although most adolescents use marijuana infrequently, without adverse health consequences, a minority progress to harmful use.[15] A better understanding of the risk factors that put adolescents at increased risk for experimentation with marijuana, progression to regular use, and failure to discontinue use can make important contributions to the evidence-based development of prevention and intervention programs.

Previously published studies have indicated that marijuana involvement is associated with a multitude of risk factors, including psychological, family, peer, and school variables.[16] However, most risk factor studies conducted to date have focused on a single aspect of the development of marijuana involvement, usually lifetime use or initiation of experimentation.[16] It is poorly understood to what extent well-established risk factors are associated with different stages of marijuana involvement.[17] The primary aim of our study was to establish and compare the contributions of risk factors to the stages

Author Affiliations: Division of Psychological Medicine, College of Medicine, Cardiff University, Cardiff, Wales (Dr van den Bree); National Institute on Drug Abuse, Intramural Research Program, National Institutes of Health, Baltimore, Md (Dr Pickworth). Dr Pickworth is now with the Battelle Center for Public Health Research Evaluation, Baltimore.

**Table 1. Marijuana Use Development From Wave 1 to Wave 2[a]**

| | | Wave 2 | | | |
|---|---|---|---|---|---|
| | | Experimental Use | | Regular Use | |
| Wave 1 | | No | Yes | No | Yes |
| Experimental use | | | | | |
| No | 10 331 (83) | 9090 (88), group A | 981 (10), group B | | 260 (3), group C |
| Yes | 2123 (17) | 955 (45), group D | 786 (37), group E | | 382 (18), group F |
| Regular use | | | | | |
| No | 12 454 (91) | | | 11 812 (95) | 642 (5) |
| Yes | 1264 (9) | | | 640 (47), group G | 664 (53), group H |

[a] Values are expressed as number (percentage) of subjects. Experimental user, 1-10 times; regular user, >10 times. Five stages were assessed based on comparisons of groups who changed their marijuana use since wave 1 vs those who did not. Stages were initiation of experimental marijuana use (compared groups A and B), initiation of regular marijuana use (compared groups A and C), progression to regular use (compared groups E and F), failure to discontinue experimental use (compared groups E and D), and failure to discontinue regular use (compared groups H and G).

of initiation, progression, and failure to discontinue experimental and regular marijuana use. Most previous studies have focused on 1 or a few risk factors. Our second aim was to evaluate a wide range of relevant risk factors to provide well-funded evidence for their relative importance in predicting development of marijuana involvement. Third, most previous studies have been cross-sectional in nature. Our study uses a longitudinal design, enabling us to predict developments in marijuana involvement based on risk factors assessed in the previous year.

## METHODS

The National Longitudinal Study of Adolescent Health (Add Health) was established to determine the causes of health-related behaviors of adolescents and their outcomes in young adulthood. The primary sampling frame included all high schools in the United States with an 11th grade and at least 30 enrollees. From this, a systematic random sample of high schools was selected. Overall, 79% of schools contacted agreed to participate (final sample of 134 schools). Among students, a random sample was selected to take part in in-home interviews. Sixteen thousand seven hundred six subjects were selected to be interviewed at 2 points, wave 1 in 1995 (response rate, 78.9%) and wave 2 in 1996 (response rate, 88.2%). Estimates in this sample were not significantly biased by missing data from dropouts and graduates.[18] The Add Health study and sampling procedures are described in detail elsewhere.[19] For the present study (N = 13 718), we excluded any nonrandomly selected subsamples, duplicates, and students with missing data on marijuana use. Subjects were aged 11 to 21 years, with a mean (SD) age of 15.4 (1.6) years.

Data were gathered by computer-assisted interview, which yields higher reported prevalences of high-risk behaviors than regular interviews.[20] Interviews took 1 to 2 hours and were administered in the presence of trained assistants. Subjects responded to questions by typing in answers on a laptop computer. Sensitive questions, including those on marijuana involvement, were given on headphones. This avoided the problem of underreporting, which may occur in situations where subjects are face to face with the interviewer.[20] At wave 1, adolescents indicated how many times they had used marijuana during their lives; 1 year later, during wave 2, they reported on their use since wave 1. For both waves, we established the following groups: nonusers, experimental users (used 1-10 times), and regular users (used >10 times). We subsequently assessed changes in marijuana involvement between the 2 waves according to 5 stages: (1) initiation of experimental use (we selected nonusers at wave 1 and compared those who started experimental use at wave 2 with those who had remained nonusers), (2) initiation of regular use (we selected nonusers at wave 1 and compared those who started regular use at wave 2 with those who had remained nonusers), (3) progression to regular use (we selected experimental users at wave 1 and compared those who progressed to regular use at wave 2 with those who had remained experimental users), (4) failure to discontinue experimental use (we selected experimental users at wave 1 and compared those who had discontinued experimental use at wave 2 with those who had remained experimental users), and (5) failure to discontinue regular use (we selected regular users at wave 1 and compared those who had discontinued regular use at wave 2 with those who had remained regular users) (**Table 1**).

Risk factors were established at wave 1 and were used to predict these 5 stages of marijuana involvement. To establish these risk factors, 8 major risk factor domains were first established a priori from the literature, and variables (total of 238) were selected from the Add Health data set to best represent these domains. Next, factor analysis was used to identify within each domain the presence of subdomains (21 identified altogether). Factor solutions were rotated orthogonally (Varimax rotation) to make individual risk factors within each domain independent from each other. For each subject, for each risk factor, summed risk factor scores were obtained by adding those items with relatively high loadings on a factor (≥0.30) and discarding items with lower factor scores. The great majority of the sample had no missing responses for all items making up each risk factor (ie, ≥95% of the sample had 0 missing values for each of the 21 risk factors). Individuals with 10% or more of the responses to a summed score missing were excluded from further analyses. For those with fewer than 10% missing values, an imputation formula was used, based on replacing the missing items by the mean of the nonmissing responses. Prior to further analysis, the scored risk factors were normalized using the Blom transformation.[21] The correlation coefficients between the factors as obtained by factor analysis and normalized summed risk factors were equal to or exceeded 0.90 for 18 of 21 subdomains, illustrating the legitimacy of the procedures used to obtain summed risk factors (ie, excluding items with factor scores >0.30, imputation of missing values, and normalization of the summed scores). We conducted 2 sets of logistic regression analyses. First, in analyses including 1 risk factor at a time, we evaluated their association with each of the stages

of marijuana involvement. Subsequently, we performed stepwise logistic regression analyses to select the subset of risk factors best predicting the 5 stages of marijuana involvement. Included as independent variables were all risk factors that were significant in the first set of analyses. For all regression analyses, a conservative significance level of $P \leq .03$ for factors to enter and remain in the model was specified a priori. The influences of age,[7] race,[22] urbanicity,[23] and socioeconomic status[24] (parental educational and occupational status) on the relations between the risk factors and marijuana involvement were taken into account in all analyses. These variables were force-entered into each model before the introduction of the risk factors. Therefore, the associations between the stages of marijuana involvement and the risk factors were corrected for the influences of these 5 variables. Socioeconomic status was assessed by 2 variables: parental level of education and occupation. In the case of a single residential parent, these were the only 2 indicators of socioeconomic status used. In the case of 2 residential parents, the mean level of education and of occupational level was used in regression analyses. Since sex differences have been established in substance use,[25,26] we performed regression analyses including sex as a covariate and, if significant, the analysis was repeated for males and females separately. Data were missing for 29% of the subjects on the items assessing the relationship and activities undertaken with the father. Therefore, regression analyses were run twice, first, including these 2 factors and establishing their significance on the marijuana variables, and next, on having established that these influences were not significant, the regression analyses were repeated excluding these 2 variables, allowing us to include more subjects in the analysis. The results of the latter analyses are presented. The significance of mean differences between groups was assessed by *t* test (level of $P \leq .05$ used). All analyses were performed using SAS (SAS Institute Inc, Cary, NC).[27]

## RESULTS

The majority of adolescents had not tried marijuana, and among those who had, experimental use was more common than regular use. However, most adolescents who had used marijuana at wave 1 continued to do so 1 year later (Table 1).

All risk factor information was gathered at wave 1, allowing us to establish the influences on the development of marijuana involvement over the next year. Boys had significantly higher mean scores on most risk factors, except somatic symptoms, depressive symptoms, self-doubt, irrational decision making, activities with mother, and religious involvement, for which girls scored higher (**Table 2**). There were no significant sex differences for activities with father and extent to which the parents allow the adolescent to make independent decisions.

Most risk factors contributed significantly to at least some of the stages of marijuana involvement (**Table 3**). However, 3 risk factors were stronger predictors than others and influenced all stages of marijuana development: own and peer involvement with substances; delinquency; and school-related problems. Other risk factors had smaller effects and tended to be stage and/or sex specific. Considerably more risk factors significantly influenced initiation of experimental and regular marijuana use than progression to regular use or failure to discontinue experimental and regular use.

Stepwise regression analyses were performed to establish the set of variables best predicting each stage of marijuana involvement. The results (**Table 4**) further confirmed the importance and global influence of these 3 risk factors. "Own and peer involvement with substances" predicted initiation of experimental marijuana use (odds ratio [OR], 1.79 for boys and 2.94 for girls), initiation of regular use (OR, 2.72 for boys and girls combined), failure to discontinue experimental use (OR, 0.65 for girls), and failure to discontinue regular marijuana use (OR, 0.62 for boys and girls combined). Delinquency predicted initiation of experimental marijuana use (OR, 1.30 for boys and 1.34 for girls), initiation of regular use (OR, 1.36 for boys and girls combined), progression to regular use (OR, 1.35 for boys), failure to discontinue experimental use (OR, 0.71 for boys), and failure to discontinue regular use (OR, 0.77 for boys and girls combined). School variables predicted initiation of experimental marijuana use (OR, 1.17 for boys and 1.21 for girls), initiation of regular use (OR, 1.57 for boys and girls combined), and progression to regular use for girls (OR, 1.60). Other risk factors exerted stage-specific and sex-specific influences: low religiosity predicted initiation of experimental marijuana use in girls (OR, 0.78) and initiation of regular use in boys and girls combined (OR, 0.83); independent decision making predicted progression to regular use in boys (OR, 1.30); and activities with the mother predicted failure to discontinue regular marijuana use for boys and girls combined (OR, 1.17).

We divided the sample into age groups 11 to 15 years (n = 7334) and 16 to 21 years (n = 6999) and conducted age-specific analyses for the 3 stages of marijuana involvement in Table 3 for which significant age differences were found. For initiation of experimental use in girls, 4 risk factors were significant for the younger age group (own and peer involvement with substances, OR, 3.12 [95% confidence interval (CI), 2.50-3.90]; delinquency, OR, 1.39 [95% CI, 1.15-1.67]; unhappy in school, OR, 1.25 [95% CI, 1.08-1.44]; and religion, OR, 0.76 [95% CI, 0.66-0.87]), while only own and peer involvement with substances (OR, 3.12 [95% CI, 2.42-4.02]) and religion (OR, 0.81 [95% CI, 0.68-0.97]) were significant in the older group. For initiation of regular use for boys and girls combined, own and peer involvement with substances and trouble in school were significant in both the younger (OR, 2.94 [95% CI, 2.11-4.09] and OR, 1.61 [95% CI, 1.20-2.16], respectively) and older age groups (OR, 2.87 [95% CI, 2.10-3.94] and OR, 1.63 [95% CI, 1.20-2.23], respectively). In addition, delinquency (OR, 1.42 [95% CI, 1.06-1.89]) and irrational decision making (OR, 1.36 [95% CI, 1.08-1.71]) were significant in the younger age group, while inactive pastimes was significant for the older age group (OR, 1.35 [95% CI, 1.05-1.75]). Finally, failure to discontinue experimental use for girls was explained by religion only in the younger age group (OR, 1.34 [95% CI, 1.05-1.72]) and own and peer involvement with substances only in the older age group (OR, 0.54 [95% CI, 0.36-0.82]).

To further establish the influences of the 3 strongest risk factors on marijuana involvement (combining the factors "trouble in school" and "happy in school"), we divided the sample in a high-risk group who scored in the upper 33% for each of the 3 risk factors (n = 1386) and a low-risk group who scored in the lower 33%

**Table 2. Means, Standard Deviations, and *P* Values Associated With *t* Tests for Sex Differences for the Risk Factors***

| Domain | Boys, Mean (SD) | Girls, Mean (SD) | *P* Value |
|---|---|---|---|
| Daily activities† | | | |
| Active pastime | 7.72 (2.90) | 6.91 (2.77) | <.001 |
| Passive pastime | 6.31 (2.78) | 5.34 (2.69) | <.001 |
| Psychological health‡ | | | |
| Somatic symptoms | 14.67 (7.59) | 17.73 (8.92) | <.001 |
| Positive emotions | 8.15 (2.63) | 7.84 (2.75) | <.001 |
| Depressive symptoms | 6.41 (5.30) | 7.97 (6.40) | <.001 |
| Personality§ | | | |
| Self-doubt | 21.99 (5.80) | 24.14 (6.37) | <.001 |
| Irrational decision making | 10.85 (2.86) | 10.95 (2.91) | .047 |
| Problem avoidance | 11.44 (2.58) | 10.98 (2.46) | <.001 |
| School situation‖ | | | |
| Dissatisfaction with school | 21.38 (6.48) | 20.82 (6.32) | <.001 |
| Trouble in school | 10.91 (5.16) | 9.20 (4.62) | <.001 |
| Family functioning¶ | | | |
| Relations with mother | 31.47 (3.80) | 30.82 (4.69) | <.001 |
| Activities with mother | 3.84 (1.70) | 4.44 (1.71) | <.001 |
| Relations with father | 22.34 (3.53) | 21.59 (4.12) | <.001 |
| Activities with father | 12.19 (2.67) | 12.14 (2.62) | .28 |
| Family relations | 24.91 (4.53) | 24.47 (4.92) | <.001 |
| Independent decision making | 5.02 (1.61) | 5.04 (1.54) | .43 |
| "Rough living"# | | | |
| Substance involvement, substance involvement of peers | 8.85 (10.11) | 7.75 (8.91) | <.001 |
| Violence | 2.04 (2.92) | 0.91 (1.81) | <.001 |
| Delinquency | 3.85 (4.77) | 3.03 (3.71) | <.001 |
| Religion** | 13.60 (4.85) | 14.39 (4.74) | <.001 |
| Neighborhood†† | 13.69 (2.40) | 13.50 (2.56) | <.001 |

*Analyses are based on the full sample regardless of the status of marijuana use. To facilitate interpretation, the means are given for the nonnormalized risk factors. However, the *t* tests are based on the normalized risk factors. In the case of unequal variances for the 2 groups, *t* tests are based on the Satterthwaite method.[27]

†Active pastimes include active sports, exercise, hobbies, rollerblading, cycling, working around the house, and chores. Passive pastimes include hours watching television and videos, playing video and computer games, and listening to the radio.

‡Somatic symptoms include feeling tired, weak, moody, and/or dizzy, having trouble relaxing, frequent crying, insomnia; waking up tired; feeling very sick, feeling hot, frequent stomachaches, feeling fearful, poor appetite, chest pains, headaches, aches and/or pains, cold sweats; painful urination, too sick for social activities, sore throat and/or cough; acne; and being too sick for school. Positive emotions include feeling hopeful about the future, enjoying life, and feeling happy and just as good as others. Depressive symptoms include feeling depressed, sad, the blues, lonely, bothered by things, people dislike you, life is a failure, fearful, too tired to do things, it's hard to get going, life is not worth living, people are unfriendly to you, poor appetite, and talking less than usual.

§Self-doubt includes not feeling proud of self, not liking self, having no good qualities, feeling unloved and unwanted, not fitting in, having low energy, having poor coordination, ill sick, not recovering quickly, and often sick. Irrational decision making includes not seeing many approaches to problems, not researching solutions, irrational decision making, not evaluating outcome of decision, and not believing in accomplishment through hard work. Problem avoidance includes never arguing with anyone, never criticizing others, never feeling sad, avoiding confronting problems, and relying on gut feelings.

‖Dissatisfaction with school includes being happy at school, part of school, and close to people at school; feeling teachers treat students fairly, safe in school, students prejudiced, and teachers care about me, and having no trouble with homework. Trouble in school includes having trouble with teachers, having trouble paying attention, frequently skipping school, being suspended, repeating a grade, having trouble with homework, being expelled, not wanting to attend college, having a low grade point average, and being unlikely to attend college.

¶Relations with mother includes having a good relationship with mother, good communication with mother, mother is warm and loving, discusses ethics with mother, mother encourages independence, having few arguments about behavior, feeling mother cares, and being close to mother. Activities with mother includes talking about grades, school issues, personal problems, and life; working on school projects; going shopping; to the movies, concerts, plays, or sporting events; and doing things. Relations with father includes a good relationship with father, good communication with father, father is warm and loving, feeling father cares, and being close to father. Activities with father includes talking about grades and school issues; working on school projects; talking about life; having few arguments about behavior; discussing personal problems; father would be disappointed if didn't graduate from college; going to the movies, concerts, plays, or sporting events; father disappointed if didn't graduate from high school; and doing things. Family relations includes family paying attention to you, having fun together, understanding you, caring about you, and not wanting you to leave home. Independent decision making includes making own choices on television amount and television programs, clothing, diet, weekday bedtime, friends, and weekend curfew.

#Substance involvement, substance involvement of peers includes frequent alcohol consumption, drunkenness, 5 or more drinks on a single occasion, alcohol use outside family, being hung over, throwing up after drinking, best friends drink alcohol, alcohol use more than 2 to 3 times, regretting actions because of alcohol, best friends smoke marijuana, regular cigarette smoking, best friends smoke cigarettes, regretting sex because of alcohol, having parental trouble because of alcohol, having dating problems because of alcohol, ever smoking cigarettes, driving while drunk, having problems with friends because of alcohol, being drunk at school, getting into physical fights because of alcohol, having first sex at an early age, having school problems because of alcohol, and spending nights away from home without permission. Violence includes pulling a knife or gun on someone, having a knife or gun pulled on you, being shot, stabbing someone, using a weapon in a fight, seeing a shooting or stabbing, being jumped or stabbed, carrying a weapon to school, getting into physical fights, and being seriously injured from a fight. Delinquency includes shoplifting, stealing worth more than $50, causing property damage, painting graffiti, burglary, selling drugs, being loud or rowdy in public, lying to parents about whereabouts, joyriding, and running away from home.

**Religion includes attending religious services, religion is important to you, prayer, participating in youth groups, and believing scriptures are the word of God.

††Neighborhood includes neighbors looking out for others, being unhappy to move, knowing most neighbors, stopping and talking to neighbors, feeling safe in neighborhood, and being happy in neighborhood.

**Table 3. Associations of the Risk Factors With Marijuana Involvement***

| | Initiation of Experimental Use | | Initiation of Regular Use | | Progression to Regular Use | | Failure to Discontinue Experimental Use | | Failure to Discontinue Regular Use | |
|---|---|---|---|---|---|---|---|---|---|---|
| Risk Factor | Boys | Girls | Boys | Girls | Boys | Girls | Boys | Girls | Boys | Girls |
| Active pastimes | | | | | | | | | | |
| Inactive pastimes | 1.14 | 1.14 | | | | | | | | |
| Somatic symptoms | 1.15 | 1.28 | | 1.48 | | | | | | |
| Positive emotions | | 0.80 | | 0.73 | | | | | | |
| Depressive symptoms | 1.16 | 1.33 | | 1.44 | | | | | | |
| Self-doubt | | 1.20 | | 1.44 | | | | | | |
| Irrational decision making | | 1.14 | 1.24 | 1.46 | | 1.34 | | | 0.82 | |
| Problem avoidance | | | | | 0.79 | | | | | |
| Dissatisfaction with school | 1.34 | 1.62† | 1.58† | 2.03† | | | | | 0.78 | |
| Trouble in school | 1.51† | 1.83† | 2.16† | 2.32† | | 1.60† | | | 0.76 | |
| Relations with mother | 0.86 | 0.80 | | 0.73 | | | | | | |
| Activities with mother | | | | | | | | | | 1.40 |
| Relations with father | 0.79 | 0.74 | | 0.57† | | | | | | |
| Activities with father | | | | | | | | | | |
| Family relations | 0.78 | 0.69 | 0.68 | 0.66† | | | | | | |
| Independent decision making | | 1.20 | 1.30 | | 1.29 | | | | | |
| Substance involvement | 2.15† | 3.77† | 2.63† | 6.08† | 1.51† | 1.49 | 0.76 | 0.64† | 0.54† | 0.64† |
| Violence | 1.49 | 1.55† | 1.68† | 2.10† | | | | | | |
| Delinquency | 1.71† | 2.21† | 1.77† | 3.54† | 1.32 | | 0.72 | 0.80 | 0.68 | 0.75 |
| Religion | 0.73 | 0.70 | 0.76 | 0.73 | | | | 1.20 | | |
| Neighborhood | | | | | | | | | | |

*Values are expressed as odds ratios. Analyses are based on normalized, summed risk factor scores. Significant odds ratios were obtained from regression analyses run for each of the individual risk factors separately. Covariates age, race, urban status, and parental educational and occupational status were force-entered into each model before the introduction of the risk factors. A significance level of $P \leq .05$ for factors to enter and remain in the model was specified a priori. See Table 2 for explanation of risk factors.

†Odds ratios of highest value (≤0.67 or ≥1.50).

(n=1696), while excluding the middle 33%, and repeated the regression analyses. In the high-risk group, 28% of adolescents initiated marijuana use in the next year compared with 2% in the low-risk group (OR, 19.90 [95% CI, 12.02-32.95]). Regular marijuana use was initiated by 16% in the high-risk group compared with 0.3% in the low-risk group (OR, 78.40 [95% CI, 26.40-232.85]). In the low-risk group, no individual progressed to regular use (39% in high-risk group) or continued using marijuana experimentally or regularly (52% and 60% in high-risk group, respectively), so no ORs could be calculated for these 3 stages.

## COMMENT

In this large population-based sample, 13% of nonusers at wave 1 had become involved with marijuana 1 year later (at wave 2, 10% experimentally and 3% regularly). More than half (55%) of adolescents who had experimented with marijuana at wave 1 continued to use marijuana either experimentally (37%) or regularly (18%). The great majority of regular users at wave 1 remained involved with marijuana (53% on a regular basis and 20% experimentally). These numbers indicate that initiation tends to result in continuation.

The risk factors that have been most consistently related to marijuana use in the literature include the following: (1) Daily activities. Low levels of engagement in prosocial activities are associated with marijuana use[28,29]; (2) Psychological health. Marijuana use is associated with intrapersonal difficulty,[30] poor control of emotions,[30] and depression and anxiety[31,32]; (3) Personality. Risk of marijuana use may be increased in those with limited inner resources to cope with psychological stress[33] and poor self-concept.[34-36] Other personality traits associated with increased risk include deviance,[37] rebelliousness,[35] being unempathetic,[38] and unconventionality[30,38]; (4) School situation. School-related risk factors include poor academic performance,[39-41] low connectedness to school,[44] truancy, and school dropout[45-47]; (5) Family functioning. Risk factors within the family environment include poor, inconsistent family management practices; family conflict; low bonding[48,49]; poor parental monitoring; and lack of structure and rules[35,42,50]; (6) Rough living. Risk of marijuana use is increased in those with greater use of other substances[6,51] and substance-using friends.[49,51-53] Marijuana use has also been associated with a maladaptive conflict style,[54,55] aggression,[56] delinquency,[6,7,57] violence,[23,58] and precocious and risky sexual behavior[59,60]; (7) Religiosity and conservative beliefs may protect against adolescent substance use[61]; and (8) Risk of substance use may be greater in disadvantaged neighborhoods.[62,63]

Our analyses indicated that, when analyzed individually, most of these risk factors predicted at least some stages of marijuana involvement. However, the strongest predictors were substance use by adolescents themselves and their peers; delinquency; and school-related problems. These factors also influenced most stages of marijuana involvement, suggesting that intervention efforts aimed at these risk factors may be broadly applicable. In addition, when

**Table 4. Stepwise Logistic Regression Analysis on the Development of Marijuana Use Between Waves 1 and 2***

| Significant Factor | OR (95% CI) Boys | Girls |
|---|---|---|
| **Initiation of Experimental Marijuana Use** | | |
| Substance involvement, substance involvement of peers | 1.79 (1.53-2.10) | 2.94 (2.48-3.49) |
| Delinquency | 1.30 (1.17-1.54) | 1.34 (1.16-1.55) |
| Trouble in school | 1.17 (1.02-1.35) | |
| Unhappy in school | | 1.21 (1.08-1.36) |
| Religion | | 0.78 (0.70-0.87) |
| | R, E* | A* |
| **Initiation of Regular Marijuana Use†** | | |
| Substance involvement, substance involvement of peers | 2.72 (2.21-3.34) | 2.72 (2.21-3.34) |
| Trouble in school | 1.57 (1.31-1.88) | 1.57 (1.31-1.88) |
| Delinquency | 1.36 (1.13-1.64) | 1.36 (1.13-1.64) |
| Religion | 0.83 (0.71-0.97) | 0.83 (0.71-0.97) |
| | A, E* | A, E* |
| **Progression to Regular Marijuana Use** | | |
| Delinquency | 1.26 (1.09-1.68) | |
| Independent decision making | 1.30 (1.05-1.60) | |
| Trouble in school | | 1.60 (1.28-2.01) |
| | R* | |
| **Failure to Discontinue Experimental Marijuana Use** | | |
| Delinquency | 0.71 (0.61-0.84) | |
| Substance involvement, substance involvement of peers | | 0.65 (0.50-0.84) |
| | | A* |
| **Failure to Discontinue Regular Marijuana Use†** | | |
| Substance involvement, substance involvement of peers | 0.62 (0.50-0.77) | 0.62 (0.50-0.77) |
| Delinquency | 0.77 (0.66-0.90) | 0.77 (0.66-0.90) |
| Activities with mother | 1.17 (1.02-1.34) | 1.17 (1.02-1.34) |
| | E, O* | E, O* |

Abbreviations: A, age of the subject at wave 1; CI, confidence interval; E, parental education; O, parental occupation; OR, odds ratio; R, race; U, urban status.

*Analyses based on normalized, summed risk factor scores. In all regression analyses, the following factors were specified to be entered into the model: the age of the subject at wave 1 (A), race (R), urban status (U), parental education (E), and parental occupation (O). In case any of these factors were significant, their abbreviation is included in the table. The $\chi^2$ test for the combined effect of the independent variables is based on the −2 log likelihood method. A significance level of $P = .03$ was specified for the $\chi^2$ score for entering a factor in the model and for the factor to remain in the model.

†Sex differences were nonsignificant; therefore, boys and girls were combined in analyses on this variable.

we performed analyses on the younger (11-15 years) and older (16-21 years) age groups separately, these risk factors remained the strongest predictors.

Our results confirm previous reports of the importance of the risk factors "substance use by self and peers"[20,31,33,64] and "delinquency."[20,28,65] Use of alcohol or drugs during adolescence increases the risk of substance dependence in adulthood.[8] Marijuana use has been related to failure to quit other substances.[11] Peers may influence adolescent substance use by changing personal attitudes, serving as role models, and being a source of information and providing access, encouragement, and a social setting for experimentation with substances.[64,66,68] Deviant peer affiliations pose a risk to retention rates during substance abuse treatment and may need to be dealt with specifically during treatment.[69] The combination of the risk factors "substance abuse" and "delinquency" may lead to a career of crime.[16] High rates of substance use, involvement with delinquent activities, and being part of deviant peer groups seem to reflect low concern with the future or perceived future perspectives. Indeed, illicit drug use is associated with reduced chances of successful participation in adult roles.[12]

School-related variables presented the third strong risk factor. Poor academic achievement[13,41,62,45,47] has been previously associated with marijuana involvement. The present study used a broader assessment of the school situation. Risk factor "trouble in school" included, in addition to an indicator of test results (grade point average), information on problems with teachers, trouble paying attention, frequently skipping school, suspension, repeating a grade, expulsion, and no desire or intention to attend college. "Dissatisfaction with school" assessed being happy in school, part of school, safe in school, close to people in school, whether teachers care about students and treat them fairly, and whether other students are prejudiced. The few previous studies that have used similar broader evaluations of the school environment have also found that the broader school context is an important risk factor in marijuana involvement.[36,44] Interestingly, one of these studies found that school bonding is closely related to self-efficacy.[36] Our findings are not limited to marijuana use; we have previously found that school-related problems predict experimentation with cigarettes and progression to regular smoking.[70] It has been previously reported that remedial academic classes can improve not only school performance but also reduce smoking rates.[71]

Adolescents spend a major part of their lives in school. Certain school characteristics (eg, high turnover of staff and pupils, pupil-staff ratio, absenteeism, and indices of low socioeconomic status in pupils) have been associated with childhood disorder and deviance[72] and may also increase risk of marijuana involvement. Schools can play a role in shaping the development of socially approved conduct,[73] and active discouragement of substance use in schools can be effective.[74] Positive results achieved with classroom-based programs aimed at increasing academic and social competence as well as school-bonding[75] become particularly relevant in the light of the present results.

Other significant predictors in our study exerted stage-specific, sex-specific, and age-specific influences. Religion reduced risk of initiation of experimental marijuana use for girls (both age cohorts), initiation of regular use for boys and girls combined (but not in age-specific analyses), and continuation of experimental marijuana use in younger girls. It has previously been reported that religiosity and conservative beliefs are protective factors for adolescent substance use.[45,70] Possibly, the protective effects of religiosity may exert themselves through the family environment[76] or by enhancing ability to cope with stress.[76]

Family-related variables have been previously reported to be important in the development of adolescent substance use involvement. We found that 2 family-

related risk factors influenced marijuana involvement, independent decision making (eg, freedom in choosing what to wear, eat, when to go to bed, television time and programs) predicted progression to regular use for boys, and activities with the mother (eg, discussing school grades and personal problems) predicted discontinuation of regular marijuana use for boys and girls combined. Both parental monitoring and parent-child attachment have been previously related to adolescent substance involvement.[77,78] In our study, these influences were found to exert stage-specific and sex-specific influences. Possibly, family-related factors become less influential once the impact of other mediating factors (for example, socioeconomic status) and peer influences have been statistically accounted for, as in the analysis used in this study.

Two other factors were only significant in age-specific analyses: irrational decision making predicted initiation of regular marijuana use for boys and girls combined and inactive pastimes predicted the same variable for the older age cohort. Irrational decision making is characterized by the inability to make rational decisions, to research solutions, to evaluate outcomes of decisions, and to believe things can be accomplished through hard work. It reflects a lack of responsibility and self-efficacy, personality traits that have been previously related to marijuana involvement.[79] Inactive pastimes (hours spent watching television, playing computer and video games, listening to the radio) have also been related to risk of substance use.[28,29]

Most risk factor studies have focused on the initiation of marijuana use. The few studies that have also focused on discontinuation of use have indicated that use of other licit and illicit drugs, deviance, selection of social settings favorable for use, increased risk of victimization, and self-medicating to improve mood are important risk factors.[80-82] These findings are in agreement with our results. In addition, we found the progression and failure to discontinue (ie, of experimental and regular use) stages were influenced by considerably fewer risk factors than the initiation stages, and the 3 risk factors with the strongest associations with marijuana use were also the strongest predictors of failure to discontinue.

Adolescents with the highest scores on all 3 risk factors had considerably increased risks of initiating experimental (20 times) and regular marijuana use (87 times). When selecting the highest and lowest scoring groups for each risk factor individually, rather than combined, ORs ranged between 1.6 and 4.0, strongly indicating that the presence of multiple risk factors makes adolescents especially vulnerable for marijuana use and abuse. Therefore, directing intensive prevention and intervention efforts at those groups at greatest risk may be more successful than programs aimed at all students in a school, many of whom will never consider trying marijuana. The percentages of adolescents who were increasingly involved with marijuana were in the high-risk group more frequently than the low-risk group (28% vs 2% for experimental initiation; 16% vs 0.3% for regular initiation; 39% vs 0% for progression; 52% vs 0% for continued experimental use; and 60% vs 0% for continued regular use). This indicates that successful prevention and/or intervention efforts based on these combined risk factors may have an effect on a large proportion of adolescents at risk.

Identification of individuals at risk should take place in any setting where the 3 most important risk factors can be assessed, for example, in schools, medical practices, the judicial system, and substance treatment centers. Prevention and intervention should incorporate strategies to address other substance use and the peer group, delinquent activities, and the school situation. In addition, our finding of fewer risk factors influencing the progression and failure to discontinue use stages suggests that the greatest opportunities for intervention are during earlier stages of marijuana involvement. During later stages, genetic and other biological factors involved in habituation and dependence may become increasingly important[83] and treatment, more difficult.

Although we evaluated many carefully selected risk factors, not all relevant aspects of risk were assessed (for example, genetic factors[26,83] or attitudes toward drug use[84]). Despite the advantages of a longitudinal design, we cannot rule out the possibility that other factors at wave 1 influenced both risk factors as well as marijuana involvement. In addition, the analytical methods used cannot account for complex interactions between risk factors. Sample sizes were lower for analyses of the progression and failure to discontinue use stages. This could have influenced our finding of fewer significant risk factors and should be taken into account when evaluating our conclusions. Many comparisons between behaviors and marijuana involvement were made in this study, and it is therefore possible that significant findings have arisen owing to chance. Reassuringly, however, all associations were in the expected directions and agree with results obtained in previous studies. In addition, a conservative approach was adopted by presenting the results in terms of the strongest findings ($P$ values of $\leq .03$ for the regression analyses). Additional research, also including clinical populations, is needed to confirm the results and to further enhance their practical implications.

Our study indicates that the assessment of licit substance use, information on peers, delinquency, and how adolescents experience their school environment strongly predict risk of involvement with marijuana. Therefore, these risk factors can be used to identify adolescents who may require early and intensive prevention efforts and to address these factors in efforts to help them.

**Submitted for Publication:** March 31, 2004; final revision received July 27, 2004; accepted August 20, 2004.
**Correspondence:** Marianne B. M. van den Bree, PhD, Division of Psychological Medicine, Cardiff University, Heath Park, Cardiff CF14 4XN, Wales (vandenbreemb@cardiff.ac.uk).
**Funding/Support:** This research uses data from the National Longitudinal Study of Adolescent Health (Add Health) project, a program project designed by J. Richard Udry, PhD, principal investigator, and Peter Bearman, PhD, and funded by grant P01-HD31921 from the National Institute of Child Health and Human Development, Bethesda, Md, to the Carolina Population Center, University of North Carolina at Chapel Hill, with cooperative funding participation by the National Cancer In-

stitute; the National Institute of Alcohol Abuse and Alcoholism; the National Institute on Deafness and Other Communication Disorders; the National Institute on Drug Abuse; the National Institute of General Medical Sciences; the National Institute of Mental Health; the National Institute of Nursing Research; the National Institutes of Health Office of AIDS Research, Office of Behavioral and Social Science Research, Office of the Director, and Office of Research on Women's Health; the Department of Health and Human Services, Office of Population Affairs; the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics and Office of Minority Health; the Department of Health and Human Services, Office of Public Health and Science Office of Minority Health; the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; Bethesda, Md, and the National Science Foundation, Arlington, Va. Persons interested in obtaining data files from the Add Health project should contact Add Health Project, Carolina Population Center, 123 W Franklin St, Chapel Hill, NC 27516-2524 (http://www.cpc.unc.edu/addhealth).

Acknowledgment: We are grateful for continual information technology and library support provided by Mary Pfeiffer, Michael J. Owen, MD, Eliot Gardner, PhD, Hollie V. Thomas, PhD, Andrew McBride, MD, and Nicole Eid have provided helpful comments.

## REFERENCES

1 Johnston LD, O'Malley PM, Bachman JG. *Monitoring the Future National Survey Results on Adolescent Drug Use: Overview of Key Findings*. Bethesda, Md: National Institute on Drug Abuse, US Dept of Health and Human Services; 2003.
2 Dennis M, Babor TF, Roebuck MC, Donaldson J. Changing the focus: the case for recognizing and treating cannabis use disorders. *Addiction*. 2002;97(suppl 1):4-15.
3 Williams AF, Peat MA, Crouch DJ, Wells JK, Finkle BS. Drugs in fatally injured young male drivers. *Public Health Rep*. 1985;100:19-25.
4 Kingree JB, Braithwaite R, Woodring T. Unprotected sex as a function of alcohol and marijuana use among adolescent detainees. *J Adolesc Health*. 2000;27:179-185.
5 Tunving K. Psychiatric effects of cannabis use. *Acta Psychiatr Scand*. 1985;72:209-217.
6 Rey JM, Sawyer MG, Raphael B, Patton GC, Lynskey M. Mental health of teenagers who use cannabis: results of an Australian survey. *Br J Psychiatry*. 2002;180:216-221.
7 Fergusson DM, Horwood LJ, Swain-Campbell N. Cannabis use and psychosocial adjustment in adolescence and young adulthood. *Addiction*. 2002;97:1123-1135.
8 Brook DW, Brook JS, Zhang C, Cohen P, Whiteman M. Drug use and the risk of major depressive disorder, alcohol dependence, and substance use disorders. *Arch Gen Psychiatry*. 2002;59:1039-1044.
9 Tunving K. Psychiatric aspects of cannabis use in adolescents and young adults. *Pediatrician*. 1987;14:83-91.
10 Weiser M, Reichenberg A, Rabinowitz J, Kaplan Z, Caspi A, Yasvizky R, Mark M, Knobler HY, Nahon D, Davidson M. Self-reported drug abuse in male adolescents with behavioral disturbances, and follow-up for future schizophrenia. *Biol Psychiatry*. 2003;54:655-660.
11 Ford DE, Vu HT, Anthony JC. Marijuana use and cessation of tobacco smoking in adults from a community sample. *Drug Alcohol Depend*. 2002;67:243-248.
12 Kandel DB, Davies M, Karus D, Yamaguchi K. The consequences in young adulthood of adolescent drug involvement: an overview. *Arch Gen Psychiatry*. 1986;43:746-754.
13 Brook JS, Balka EB, Whiteman M. The risks for late adolescence of early adolescent marijuana use. *Am J Public Health*. 1999;89:1549-1554.
14 Chen K, Kandel DB, Davies M. Relationships between frequency and quantity of marijuana use and last year proxy dependence among adolescents and adults in the United States. *Drug Alcohol Depend*. 1997;46:53-67.
15 Johnston LD, O'Malley PM, Bachman JG. *Monitoring the Future National Survey Results on Drug Use, 1975-2002, Volume I, Secondary School Students*. Bethesda, Md: National Institute on Drug Abuse, National Institutes of Health, Dept of Health and Human Services; 2002.
16 Clayton RR. Transitions in drug use: risk and protective factors. In: Glantz MD, Pickens RW, eds. *Vulnerability to Drug Abuse*. Washington, DC: American Psychological Association; 1992:15-51.
17 Warner LA, Kessler RC, Hughes M, Anthony JC, Nelson CB. Prevalence and correlates of drug use and dependence in the United States: results from the National Comorbidity Survey. *Arch Gen Psychiatry*. 1995;52:219-229.
18 Udry JR, Chantala K. Missing school dropouts in surveys does not bias risk estimates. *Soc Sci Res*. 2003;32:294-311.
19 Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, Tabor J, Beuhring T, Sieving RE, Shew M, Ireland M, Bearinger LH, Udry JR. Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *JAMA*. 1997;278:823-832.
20 Turner CF, Ku L, Rogers SM, Lindberg LD, Pleck JH, Sonenstein FL. Adolescent sexual behavior, drug use, and violence: increased reporting with computer survey technology. *Science*. 1998;280:867-873.
21 Rice G. *Statistical Estimates and Transformed Beta Variables*. New York, NY: John Wiley & Sons; 1958.
22 Reardon SF, Buka SL. Differences in onset and persistence of substance abuse and dependence among whites, blacks, and Hispanics. *Public Health Rep*. 2002;117(suppl 1):S51-S59.
23 Finkle L, Williams J. Alcohol and drug use of inter-city versus rural school age children. *J Drug Educ*. 1999;29:279-291.
24 von Sydow K, Lieb R, Pfister H, Holler M, Wittchen HU. What predicts incident use of cannabis and progression to abuse and dependence? a 4-year prospective examination of risk factors in a community sample of adolescents and young adults. *Drug Alcohol Depend*. 2002;68:49-64.
25 Block J, Block JH, Keyes S. Longitudinally foretelling drug usage in adolescence: early childhood personality and environmental precursors. *Child Dev*. 1988;59:336-355.
26 Miles DR, van den Bree MB, Pickens RW. Sex differences in shared genetic and environmental influences between conduct disorder symptoms and marijuana use in adolescents. *Am J Med Genet*. 2002;114:159-168.
27 SAS Institute Inc. *SAS OnlineDoc, Version 8*. Cary, NC: SAS Institute Inc; 1999.
28 Pate RR, Heath GW, Dowda M, Trost SG. Associations between physical activity and other health behaviors in a representative sample of US adolescents. *Am J Public Health*. 1996;86:1577-1581.
29 Harrison PA, Narayan G. Differences in behavior, psychological factors, and environmental factors associated with participation in school sports and other activities in adolescence. *J Sch Health*. 2003;73:113-120.
30 Brook JS, Whiteman M, Gordon AS, Cohen P. Changes in drug involvement: a longitudinal study of childhood and adolescent determinants. *Psychol Rep*. 1989;65:707-726.
31 Christie KA, Burke JD Jr, Regier DA, Rae DS, Boyd JH, Locke BZ. Epidemiologic evidence for early onset of mental disorders and higher risk of abuse in young adults. *Am J Psychiatry*. 1988;145:971-975.
32 Robertson JR, Miller P, Anderson R. Cannabis use in the community. *Br J Gen Pract*. 1996;46:671-674.
33 Nicholi AM Jr. The nontherapeutic use of psychoactive drugs: a modern epidemic. *N Engl J Med*. 1983;308:925-933.
34 Kaplan HB, Martin SS, Johnson RJ, Robbins CA. Escalation of marijuana use: application of a general theory of deviant behavior. *J Health Soc Behav*. 1986;27:44-61.
35 Miller P, Plant M. Heavy cannabis use among UK teenagers: an exploration. *Drug Alcohol Depend*. 2002;65:235-242.
36 Kumpfer KL, Turner CW. The social ecology model of adolescent substance abuse: implications for prevention—special issue: preventive interventions for children at risk. *Int J Addict*. 1990;25:435-463.
37 Hays RD, Ellickson PL. Associations between drug use and deviant behavior in teenagers. *Addict Behav*. 1990;21:291-302.
38 Wills TA, Vaccaro D, McNamara G. Novelty seeking, risk taking, and related constructs as predictors of adolescent substance use: an application of Cloninger's theory. *J Subst Abuse*. 1994;6:1-20.
39 Newcomb MD, Maddahian E, Bentler PM. Risk factors for drug use among adolescents: concurrent and longitudinal analyses. *Am J Public Health*. 1986;76:525-531.
40 Wills TA, Cleary S, Filer M, Shinar O, Manani J, Spera K. Temperament related to early-onset substance use: test of a developmental model. *Prev Sci*. 2001;2:145-163.
41 Stevens MM, Freeman DH Jr, Mott J, Youells F. Three-year results of prevention

programs on marijuana use: the New Hampshire study. *J Drug Educ*. 1996;26:257-273.
42. Duncan SC, Duncan TE, Biglan A, Ary D. Contributions of the social context to the development of adolescent substance use: a multivariate latent growth modeling approach. *Drug Alcohol Depend*. 1998;50:57-71.
43. Hops H, Davis B, Lewin LM. The development of alcohol and other substance use: a gender study of family and peer context. *J Stud Alcohol Suppl*. 1999;13:22-31.
44. Sale E, Sambrano S, Springer JF, Turner CW. Risk, protection, and substance use in adolescents: a multi-site model. *J Drug Educ*. 2003;33:91-105.
45. Bachman JG, Johnston LD, O'Malley PM. Smoking, drinking, and drug use among American high school students: correlates and trends, 1975-1979. *Am J Public Health*. 1981;71:59-69.
46. Mensch BS, Kandel DB. Dropping out of high school and drug involvement. *Sociol Educ*. 1988;61:95-113.
47. Bray JW, Zarkin GA, Ringwalt C, Qi J. The relationship between marijuana initiation and dropping out of high school. *Health Econ*. 2000;9:9-18.
48. Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychol Bull*. 1992;112:64-105.
49. Brook JS, Whiteman M, Finch S, Cohen P. Longitudinally foretelling drug use in the late twenties: adolescent personality and social-environmental antecedents. *J Genet Psychol*. 2000;161:37-51.
50. Kosterman R, Hawkins JD, Guo J, Catalano RF, Abbott RD. The dynamics of alcohol and marijuana initiation: patterns and predictors of first use in adolescence. *Am J Public Health*. 2000;90:360-366.
51. Hofler M, Lieb R, Perkonigg A, Schuster P, Sonntag H, Wittchen HU. Covariates of cannabis use progression in a representative population sample of adolescents: a prospective examination of vulnerability and risk factors. *Addiction*. 1999;94:1679-1694.
52. Brook JS, Kessler RC, Cohen P. The onset of marijuana use from preadolescence and early adolescence to young adulthood. *Dev Psychopathol*. 1999;11:901-914.
53. Prinstein MJ, Boergers J, Spirito A. Adolescents' and their friends' health-risk behavior: factors that alter or add to peer influence. *J Pediatr Psychol*. 2001;26:287-298.
54. Colsman M, Wolfert E. Conflict resolution style as an indicator of adolescents' substance use and other problem behaviors. *Addict Behav*. 2002;27:633-648.
55. Siqueira L, Diab M, Bodian C, Rolnitzky L. The relationship of stress and coping methods to adolescent marijuana use. *Subst Abus*. 2001;22:157-166.
56. Brook JS, Whiteman M, Cohen P, Tanaka JS. Childhood precursors of adolescent drug use: a longitudinal analysis. *Genet Soc Gen Psychol Monogr*. 1992;118:195-213.
57. Coffey C, Carlin JB, Lynskey M, Li N, Patton GC. Adolescent precursors of cannabis dependence: findings from the Victorian Adolescent Health Cohort Study. *Br J Psychiatry*. 2003;182:330-336.
58. Arseneault L, Moffitt TE, Caspi A, Taylor PJ, Silva PA. Mental disorders and violence in a total birth cohort: results from the Dunedin Study. *Arch Gen Psychiatry*. 2000;57:979-986.
59. Ary DV, Duncan TE, Biglan A, Metzler CW, Noell JW, Smolkowski K. Development of adolescent problem behavior. *J Abnorm Child Psychol*. 1999;27:141-150.
60. Orr DP, Beiter M, Ingersoll G. Premature sexual activity as an indicator of psychosocial risk. *Pediatrics*. 1991;87:141-147.
61. Wills TA, Yaeger AM, Sandy JM. Buffering effect of religiosity for adolescent substance use. *Psychol Addict Behav*. 2003;17:24-31.
62. Crum RM, Lillie-Blanton M, Anthony JC. Neighborhood environment and opportunity to use cocaine and other drugs in late childhood and early adolescence. *Drug Alcohol Depend*. 1996;43:155-161.
63. Barnett JR. Does place of residence matter? contextual effects and smoking in Christchurch. *N Z Med J*. 2000;113:433-435.
64. Kandel DB. On processes of peer influences in adolescent drug use: a developmental perspective. *Adv Alcohol Subst Abuse*. 1985;4:139-163.
65. Kandel DB, Davies M. High school students who use crack and other drugs. *Arch Gen Psychiatry*. 1996;53:71-80.
66. Kaplan HB, Martin SS, Robbins C. Pathways to adolescent drug use: self-derogation, peer influence, weakening of social controls, and early substance use. *J Health Soc Behav*. 1984;25:270-289.
67. Johnson BD. *Marijuana Users and Drug Subcultures*. New York, NY: John Wiley & Sons; 1973.
68. Adler PT, Lotecka L. Drug use among high school students: patterns and correlates. *Int J Addict*. 1973;8:537-548.
69. Battjes RJ, Gordon MS, O'Grady KE, Kinlock TW. Predicting retention of adolescents in substance abuse treatment. *Addict Behav*. 2004;29:1021-1027.
70. van den Bree MB, Whitmer MD, Pickworth WB. Predictors of smoking development in a population-based sample of adolescents: a prospective study. *J Adolesc Health*. 2004;35:172-161.
71. Hu TW, Lin Z, Keeler TE. Teenage smoking, attempts to quit, and school performance. *Am J Public Health*. 1998;88:940-943.
72. Rutter M, Yule B, Quinton D, Rowlands O, Yule W, Berger M. Attainment and adjustment in two geographical areas: III: some factors accounting for area differences. *Br J Psychiatry*. 1975;126:520-533.
73. Rutter M. Family and school influences on behavioural development. *J Child Psychol Psychiatry*. 1985;26:349-368.
74. Kumar R, O'Malley PM, Johnston LD, Schulenberg JE, Bachman JG. Effects of school-level norms on student substance use. *Prev Sci*. 2002;3:105-124.
75. Webster-Stratton C, Taylor T. Nipping early risk factors in the bud: preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0-8 years). *Prev Sci*. 2001;2:165-192.
76. Kendler KS, Gardner CO, Prescott CA. Religion, psychopathology, and substance use and abuse: a multimeasure, genetic-epidemiologic study. *Am J Psychiatry*. 1997;154:322-329.
77. Chilcoat HD, Anthony JC. Impact of parent monitoring on initiation of drug use through late childhood. *J Am Acad Child Adolesc Psychiatry*. 1996;35:91-100.
78. Brook JS, Brook DW, Gordon AS, Whiteman M, Cohen P. The psychosocial etiology of adolescent drug use: a family interactional approach. *Genet Soc Gen Psychol Monogr*. 1990;116:111-267.
79. Kaplan HB. Self-esteem and self-derogation theory of drug abuse. *NIDA Res Monogr*. 1980;30:128-131.
80. Chen K, Kandel DB. Predictors of cessation of marijuana use: an event history analysis. *Drug Alcohol Depend*. 1998;50:109-121.
81. Kandel DB, Ravens VH. Cessation of illicit drug use in young adulthood. *Arch Gen Psychiatry*. 1989;46:109-116.
82. Sussman S, Dent CW. One-year prospective prediction of marijuana use cessation among youth at continuation high schools. *Addict Behav*. 1999;24:411-417.
83. van den Bree MB, Johnson EO, Neale MC, Pickens RW. Genetic and environmental influences on drug use and abuse/dependence in male and female twins. *Drug Alcohol Depend*. 1998;52:231-241.
84. Bachman JG, Johnson LD, O'Malley PM. Explaining recent increases in students' marijuana use: impacts of perceived risks and disapproval, 1976 through 1996. *Am J Public Health*. 1998;88:887-892.

# SB

# 74

# DOCUMENTS AGAINST (FILE 4)

**ADVISORY COUNCIL ON THE MISUSE OF DRUGS**
Home Office 50 Queen Anne's Gate London SW1H 9AT

Telephone Direct Line 020 7273 4131 Switchboard: 020 7273 4000 Fax: 020 7273 2671

The Home Secretary
Home Office
50 Queen Anne's Gate
LONDON
SW1H 9AT

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 $\Delta^9$-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 1998[1] 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 Survey[3] (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.

Ashton, CH (1998), *Cannabis: Clinical and Pharmacological Aspects*. The Department of Health: London

Corkery, JM (2001), *Drug seizure and offender statistics, United Kingdom, 1999*. Home Office Statistical Bulletin 5/01. Home Office Research Development and Statistics Directorate: London

Department of Health and Social Services (2001), *Northern Ireland Drug Addicts' Statistical Information Bulletin, 31 December 2000*. Department of Health, Social Services & Public Safety: Belfast

Department of Health (1994), *Drug Misuse Statistics for six months ending March 1993*. Bulletin 3/94. Department of Health: London

Department of Health (2001), *Statistics from the Regional Drug Misuse Databases for six months ending September 2000*. Statistical Bulletin 2001/18. Department of Health: London

Donnelly, N, Hall, W and Christie, P (1995), "The effects of partial decriminalisation on cannabis use in South Australia 1985 to 1993". *Australian Journal of Public Health*, vol.19, no 3, pp. 281–287

Donnelly, N, Hall, W and Christie, P (1998), *Effects of the Cannabis Expiation Notice Scheme on Levels and Patterns of Cannabis Use in South Australia. Evidence from the National Drug Strategy Household Surveys 1985–1995*, Commonwealth Department of Health and Aged Care: Canberra

Fraser F, *Drug Misuse in Scotland: Findings from the 2000 Scottish Crime Survey*. Scottish Office Central Research Unit: Edinburgh

Hague, L, Willis, M and Power, M (2000), *Experience of drug misuse: findings from the 1998 Northern Ireland Crime Survey*. Research and Statistical Bulletin 4/2000. Northern Ireland Statistics and Research Agency: Belfast

Home Office (1992), *Statistics of drugs seizures and offenders dealt with, United Kingdom, 1991*. Home Office Statistical Bulletin 25/92. Home Office Research and Statistics Department: London

House of Lords Select Committee on Science and Technology (1998), *Cannabis: the Scientific and Medical Evidence*. The Stationery Office: London

Iversen LL (ed) (2000), *The Science of Marijuana*. Oxford University Press: Oxford

Joy JE, Watson J and Benson JA (eds.) (1999), *Marijuana and Medicine*. National Academy Press: Washington DC

Johns A (1998). Psychiatric Aspects of Cannabis Use. The Department of Health: London

MacCoun, R and Reuter, P (1997), "Interpreting Dutch cannabis policy: Reasoning by analogy in the legalisation debate", *Science*, vol 278 pp. 47-52

MacCoun, R and Reuter, P (2001), "Evaluating alternative cannabis regimes", *British Journal of Psychiatry*, vol. 178, pp. 123-128

Mott, J and Mirrlees-Black, C (1995), *Self-Reported Drug Misuse in England and Wales: findings from the 1992 British Crime Survey*. Research and Planning Unit Paper 89. Home Office Research and Planning Unit: London

Nutt DJ and Nash JR (2001), *Cannabis: An Update 1999-2001*. The Home Office: London

Plant M (1998a), *Review of Research into the Effects of Cannabis: Epidemiology*. The Department of Health: London

Plant M (1998b). *Review of Research into the Effects of Cannabis: Social and Criminal Aspects*. The Department of Health: London

Police Foundation (2000), *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971*. The Police Foundation: London

Ramsay, M. Baker, P, Goulden, C, Sharp, C and Sondhi, A (2001), *Drug misuse declared in 2000: results from the British Crime Survey*. Home Office Research Study 224. Home Office Research Development and Statistics Directorate: London

Single, E 1989, "The impact of marijuana decriminalisation: An update", *Journal of Public Health Policy*, vol. 10, pp. 456-466

World Health Organization (1997), Programme on Substance Misuse. Abuse of Cannabis: *a Health Perspective and Research Agenda*. World Health Organization: Geneva

# 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.


# The classification of cannabis under the Misuse of Drugs Act 1971

Home Office
50 Queen Anne's Gate
London SW1H 9AT

**Annex A**

## ADVISORY COUNCIL FOR THE MISUSE OF DRUGS

### MEMBERS

Mr Vivian Ahman

Mrs Joy Barlow

Reverend Martin Blakeborough

Mr Raj Boyjoonauth

Mr Alexander Cameron

Dr William Clee

Dr Michael Donmall

Dr Anthony Duxbury

Professor Griffith Edwards

Ms Vivienne Evans

Dr Laurence Gruer

Ms Kim Hager

Mr Paul Hayes

Mr Russel Hayton

Ms Lorraine Hewitt

Mr Peter Housden

Mr Roger Howard

Mr Alan Hunter

Professor Ronald Jones

Professor Malcolm Lader

Professor Otto Meth-Cohn

Mr Michael Narayn Singh

Dr Diana Patterson

Mr Colin Phillips

Sir Michael Rawlins (Chair)

Ms Kay Roberts

Mrs Patricia Roberts

Dr Roy Robertson

Dr Sue Ruben

Mr Ian Sherwood

Professor John Strang

Mr Peter Walker

Mrs Barbara Whiteley

## CONTENTS

## OPTIONS FOR CHANGE

Legalisation and regulation of all drugs

Decriminalisation of personal possession

Possession with intent to supply and "social supply"

Reclassification

## DIFFERENT CONTROLS FOR DIFFERENT DRUGS

Cannabis

Drugs and driving

A gateway to harder drugs?

Medicinal use

Innovative policing

Possible reclassification

Conclusions on cannabis

Ecstasy

Cocaine

Crack cocaine

Heroin

Harm to users

Treatment

Methadone treatment in prison

Helping users into treatment

Diamorphine provision

Swiss and Dutch research

Diamorphine for persistent addicts who have not yet accessed treatment

LIST OF MEMORANDA

LIST OF APPENDICES TO THE MINUTES OF EVIDENCE

LIST OF UNPRINTED MEMORANDA

PREVIOUS REPORTS

*The following Reports have been published by this Committee since Session 1994-95, and are available from The Stationery Office:*

MEMORANDA OF EVIDENCE - VOLUME II (HC 318-II - published on 23 October 2001)

MINUTES OF EVIDENCE - VOLUME III (HC 318-III)

Tuesday 30 October 2001
Tuesday 6 November 2001
Tuesday 20 November 2001
Tuesday 27 November 2001
Tuesday 11 December 2001
Tuesday 18 December 2001
Tuesday 15 January 2002
Tuesday 22 January 2002
Tuesday 12 February 2002
Tuesday 12 March 2002
Tuesday 19 March 2002

APPENDICES TO THE MINUTES OF EVIDENCE - VOLUME III (HC 318-III)

## HOME AFFAIRS COMMITTEE

The Home Affairs Committee is appointed by the House of Commons to examine the expenditure, administration and policy of the Home Office and the Lord Chancellor's Department, and their associated public bodies; the administration and expenditure of the Attorney General's Office, the Treasury Solicitor's Department, the Crown Prosecution Service and the Serious Fraud Office.

### Current Membership

Mr Chris Mullin MP (*Labour, Sunderland South*) (Chairman)
Mr David Cameron MP (*Conservative, Witney*)
Mrs Janet Dean MP (*Labour, Burton*)
Mr Humfrey Malins MP (*Conservative, Woking*)
Bridget Prentice MP (*Labour, Lewisham East*)
Mr Gwyn Prosser MP (*Labour, Dover*)
Bob Russell MP (*Liberal Democrat, Colchester*)
Mr Marsha Singh MP (*Labour, Bradford West*)
Angela Watkinson MP (*Conservative, Upminster*)
Mr Tom Watson MP (*Labour, West Bromwich East*)
David Winnick MP (*Labour, Walsall North*)

### Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No.152. These are available on the Internet via www.parliament.uk.

### Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/commons/selcom/hmafhome.htm. A list of Reports of the Committee since Session 1994-5 on the inside front cover of this Report.

### Contacts

All correspondence should be addressed to The Clerk of the Home Affairs Committee, Committee Office, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 020 7219 3276; the Committee's e-mail address is: homeaffcom@parliament.uk.

### Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence published in Volume II are indicated by the page number as in 'Ev 12'. References to evidence published in Volume III are indicated as follows 'Vol III, Ev 12'.

**THIRD REPORT**

**The Home Affairs Committee has agreed to the following Report:**

## THE GOVERNMENT'S DRUGS POLICY: IS IT WORKING?

## INTRODUCTION

1. There are few subjects more emotive than illegal drugs. It is widely recognised that existing efforts to deal with them have failed, but as to solutions there is an absolute difference of opinions among experts of every relevant profession—doctors, police and social workers. Opinions—all advanced with equal passion—range from those who argue that prohibition has failed and should, therefore, be abandoned to those who argue that all drugs are harmful and that existing bans and proscriptions should be maintained or indeed tightened. In between there are many shades of grey.

2. The same division of opinion is reflected internationally between, on the one hand, countries such as Sweden which maintain a hard line against all forms of drug abuse and countries such as Switzerland and The Netherlands where the emphasis is cautiously moving away from law enforcement towards regulation and harm reduction. All three countries maintain that their policies are successful.

**3. With a handful of brave exceptions—Mr Paul Flynn and Mr Peter Lilley for example—drugs policy is an area where British politicians have feared to tread. To some extent, therefore, this report breaks new ground. Besides arriving at some conclusions, which we hope in due course to see reflected in government policy, we have also seen it as part of our function to give all sides of the argument a chance to set out their stall in the hope that their evidence will help to inform debate for some time to come. We hope to add to the "adult, intelligent debate" invited by the Home Secretary in July 2001.[1]**

**4. We have taken oral evidence from a wide range of expert witnesses covering the full range of views. These have included Messrs Keith Hellawell and Mike Trace, authors of the Government's original 1998 strategy, *Tackling Drugs to Build a Better Britain*, organisations representing all ranks of the police, members of the medical profession, and non-government agencies such as Transform—the Campaign for an Effective Drugs Policy, DrugScope and the National Drug Prevention Alliance, which have wide experience in this area.[2] We have also brought over experts from The Netherlands, Switzerland and Sweden to discuss their countries' drugs programmes. We have examined Ministers and officials from the Home Office and the Department of Health with responsibility for the Government's drugs strategy. Finally, we have taken evidence from the families of drug addicts about the impact of drug use on their lives and the difficulties of accessing local services. Some of our evidence sessions—notably those with the Home Secretary and Brian Paddick,**

the Metropolitan Police Commander in Lambeth—have already attracted widespread attention. We are grateful to the Home Secretary for choosing to announce his proposed changes to drugs policy at a public evidence session with our committee rather than on the *Today* programme. We hope this is an example that other Ministers will emulate.

5. We have taken oral evidence from 45 witnesses over a total of 11 evidence sessions. We are also grateful to the more than 200 people and organisations who provided written submissions and to Manchester Drug and Alcohol Action Team, which hosted our very valuable and informative visit to drugs services in the area.

6. Our terms of reference were as follows:

"The Committee expects to address these issues among others:

- Does existing drugs policy work?
- What would be the effect of decriminalisation on

a) the availability of and demand for drugs
b) drug-related deaths and
c) crime?

- Is decriminalisation desirable and, if not, what are the practical alternatives?

The inquiry will also examine the effectiveness of the ten year National Strategy on drug misuse launched in 1998 and the preliminary results of the three year research programme costing £6 million started in 1999/2000. It will look at the revised role of the UK Anti-drugs Co-ordinator and assess the effectiveness of Drug Treatment and Testing Orders (DTTOs)".

## INTERNATIONAL COMPARISONS

7. We have received evidence on the drugs policies of several European countries, in particular that of Sweden, Switzerland and The Netherlands. While we can learn from international experience, it must be remembered that the habits of the drug-using population are often peculiar to each country, and what works for one nation may not work for another. Mr Mike Trace, Director of Performance, National Treatment Agency, former Deputy UK Anti-Drugs Co-ordinator and current Chair of the European Monitoring Centre on Drugs and Drug Addiction, told the Committee about the Monitoring Centre's work looking into the correlation between the prevalence, or extent, of drug use and the relative harshness of a country's control regime:

"We could find no link across 15 Member States between the robustness of their policies and the level of prevalence. There are some countries with high prevalence, harsh policies, some countries with low prevalence, harsh policies, other countries with liberal policies and low prevalence. There is no link, there is no conceivable link".[3]

8. This makes it difficult to draw conclusions about the likely effects of different drugs policies, and recommend changes. However, it is necessary to distinguish between policy as it is enunciated, and policy as it is implemented. From the latter it is possible to draw some conclusions. As Mr Nicholas Dorn of DrugScope told us:

"The studies so far have only looked at the enunciation of policy at the formal level, they have not actually looked at what happens in practice...what they are doing in practice is not the same as their policy. You cannot read off policies onto impacts. I am afraid we need a more complicated model".[4]

## THE SIZE OF THE PROBLEM

9. At the outset it is important to keep a sense of proportion. Legal drugs, such as tobacco and alcohol, are responsible for far greater damage both to individual health and to the social fabric in general than illegal ones. It should also be borne in mind that not all drugs are equally harmful. While the inquiry has not specifically considered the social problems caused by alcohol or tobacco, our work has proceeded with these comparisons in mind.

10. Substance misuse is a continuum perhaps artificially divided into legal and illegal activity. Dr Colin Brewer, addiction psychiatrist and Medical Director of The Stapleford Centre, was of the opinion that:

"The big problem is that people are talking about drugs and alcohol as though they were somehow different...It is only in this century that the curious idea has grown up that it is all right to intoxicate yourself with some drugs but not with others".[5]

11. In *Tackling Drugs to Build a Better Britain*, Mr Keith Hellawell wrote: "it is clear to me that legally obtainable substances such as alcohol, tobacco, solvents and prescribed drugs used without medical control have close links with illegal drugs problems and should therefore be addressed, as appropriate, within the strategy".[6] The Welsh National Assembly has formulated a strategy which covers the misuse of both illegal and legal drugs, and we believe that there is merit in this approach.[7]

## TOBACCO AND ALCOHOL

12. In 1998, 27% of the population of adults aged 16 and over smoked cigarettes in England and in 1995, over 120,000 deaths were caused by smoking in the UK: 20% of all deaths.[8] The Royal College of Physicians has described cigarette smoking as "the single largest avoidable cause of premature death and disability in Britain" and "the greatest challenge and opportunity for all involved in improving the public health".[9]

13. In 1998, 75% of men and 59% of women had drunk alcohol in the last week, and 37% of men and 20% of women had drunk over the recommended amount in the last week.[10] The toll on health of alcohol misuse is difficult to quantify due to problems of how data is collected. The Department of Health's *Statistics on Alcohol: England, 1978 onwards*, notes that, depending on definitions, between 5,000 and 40,000 deaths a year can be attributed to alcohol abuse.[11] A report recently published by Alcohol Concern suggested that one in four emergency hospital admissions of men is alcohol-related and that alcohol plays a part in about half of serious road crashes and about half of the incidents of domestic violence.[12] Moreover, in about 40 percent of violent crimes committed in the year 2000 the aggressor was under the influence of alcohol [13]

1 *Daily Telegraph*, 9 July 2001. Back

2 Former UK Anti-Drugs Co-ordinator; former Deputy UK Anti Drugs Co-ordinator; *Tackling Drugs to Build a Better Britain: The Government's Ten-Year Strategy for Tackling Drugs Misuse*, Cm 3945, Cabinet Office, April 1998 (hereafter "*Tackling Drugs to Build a Better Britain*"). Back

3 Q. 703. Back

4 Q. 757 Back

5 Q. 565. Back

6 *Tackling Drugs to Build a Better Britain*, p. 6. Back

7 *Tackling Substance Misuse in Wales: A Partnership Approach*, National Assembly for Wales, 2000. Back

8 ONS General Household Survey, 1978-1998, cited in ev., p. 201; ONS Statistical Bulletin, *Statistics on Smoking: England, 1978 onwards*, Department of Health, 2000, (hereafter "*Statistics on Smoking*") p. 1. Back

9 *Nicotine Addiction in Britain: A Report of the Tobacco Advisory Group of the Royal College of Physicians*, 2000, p.183, cited in the Second Report of the Health

**Committee, Session 1999-2000, on *The Tobacco Industry and the Health Risks of Smoking*, HC 27-I, para. 2, p. xiii. Back**

**10 ONS General Household Survey, 1998, cited in Statistical Bulletin *Statistics on Alcohol: England, 1978 onwards*, Department of Health, 2001 (hereafter "*Statistics on Alcohol*") pp. 2-3. Back**

**11 ONS Mortality Statistics 1988-1999, cited in *Statistics on Alcohol*, p. 8. Back**

**12 *Your Very Good Health?*, Alcohol Concern, 2002. Back**

**13 *The 2000 British Crime Survey, England and Wales*, Home Office, 2000, cited in *Statistics on Alcohol*, p. 10. Back**

## THE GOVERNMENT'S DRUGS POLICY: IS IT WORKING?

### ILLEGAL DRUGS

#### The main drugs in Classes A, B, and C

*Class A*
Includes cannabinol and cannabinol derivatives, **cocaine** (including '**crack**'), **ecstasy** and related compounds, **heroin**, LSD, magic mushrooms, **methadone**, morphine, and opium.

*Class B*
Includes amphetamines, barbiturates, **cannabis** (herbal and resin), and codeine.

*Class C*
Includes anabolic steroids, benzodiazepines, and bupronorphine.

#### PREVALENCE OF USE OF DRUGS

14. The primary tool for measuring the extent of illegal drug use in the population is the British Crime Survey, which is a household survey based on a representative random sample across England and Wales. The main survey addresses questions of victimisation and other crime-related topics, and the drugs component is a self-completed section tacked on at the end. In 2000, 98% of the sample of 13,300 respondents completed the drugs section (13,021 in total).[14] The 2000 survey reached the following conclusions on prevalence of drug use (in brief):[15]

- Around a third of those aged 16-59 had tried drugs in their lifetime. However, only 11%

had used drugs in the last year and 6% in the last month.

- In the 16-29 group, 50% had tried drugs in their lifetime, 25% in the last year and 16% in the last month. This means that, of the nine and a half million young people aged 16-29 in England and Wales, at least 2.3 million would have used an illicit drug in the last year.

- Cannabis was the most commonly used drug: over a fifth of young people aged 16-29 reported using it within the last year, whereas only around 1% of 16-29 year olds had used heroin in the last year, 5% of 16-29 year olds had used cocaine in the last year and around 5% of 16-29 year olds had used ecstasy in the last year.

- In total around a fifth of young people have used Class A drugs in their lifetime, although only 8% reported use in the last year and 4% in the last month.

15. The Survey also revealed some lifestyle patterns of drug users:

- There were considerable regional variations in prevalence for particular drugs. London had consistently higher rates than other regions for Class A drugs, cocaine and ecstasy.

- There were uniformly higher levels of drug use among 16-29 year olds living in affluent urban areas, for cocaine and other Class A drugs.

- For most drug types, use did not vary significantly between income groups, but for heroin, the rate was notably higher in the poorest income group (3% compared with 0.5% in the intermediate and richest groups).

- Single people, those living in rented accommodation, and those who visited pubs and clubs and drank alcohol more frequently, were found to be more likely to have taken drugs.[16]

16. Over the four sweeps of the Survey in 1994, 1996, 1998 and 2000, some trends in drug use may be observed. The main trends were continued (but possibly decelerating) growth in cocaine use across all age ranges, including 16-19 year olds, and a drop by almost a half in use of amphetamine among 16-29 year olds since 1996-8. Among 16-19 year olds, use of "any drug" in the last year fell from 34% in 1994 to 27% in 2000.

17. In comparison with other European countries, the UK has high prevalence rates. Mr Mike Trace told us that in terms of overall numbers of people who have ever used drugs, and numbers who used drugs last month:

"the UK comes top of the European league. There may be six or seven other countries which are the same sort of level as us in overall prevalence, countries such as France, Spain, Portugal, Denmark and Holland, but three or four per cent below on most of these indicators".[17]

## AVAILABILITY OF ILLEGAL DRUGS IN SOCIETY

18. Illegal drugs are easily available in Britain, despite the large amounts of public money pumped into attempts to stem the supply of illegal drugs. The Home Office told us that the Government is forecast to spend £376m in 2002-3 and £380m in 2003-4 on the Reducing

Availability strand of the strategy. Mr Terry Byrne, Director of Law Enforcement, HM Customs and Excise, told the Committee:

"the principal outcome indicators of street price, crude though they are...show that the figures are as low as they have ever been here in the UK. There is no sign at the moment that the overall attack on supply side is reducing availability or increasing the price [of illicit drugs]".[18]

19. The Home Office Minister, Mr Bob Ainsworth, told the Committee that there was some room for optimism, however: "there is evidence that the wholesale price of drugs is higher than it has been for some time now".[19] Mr Byrne concurred that that policy seemed to be containing, if not reducing, the problem:

"there is a very clear indication that law enforcement is having an impact on the level of supply. What it is not doing at the moment is reducing the level of supply. What we do not know is what the level of supply would be were we to take the brakes off completely".[20]

## LEVEL OF DRUG RELATED HARM: PROBLEMATIC AND NON-PROBLEMATIC USE

20. While around four million people use illicit drugs each year, most of those people do not appear to experience harm from their drug use, nor do they cause harm to others as a result of their habit. Mr Ainsworth acknowledged that "there are people who manage, over fairly long periods of time (when they can slip into problematic drug use) to use drugs in a recreational fashion without becoming problematic drug users".[21]

21. Most harm is caused by and to the group of users commonly classed as "problematic". These are users who are often dependent on crack cocaine and/or heroin and perhaps other drugs, who live extremely chaotic lives with high levels of risk to their health and that of others, and are often involved in crime. The effect on their families of their use can be devastating. Preliminary conclusions from a study of costs of drugs to society, at York University, suggest that problematic users are responsible for 99% of these costs.[22]

22. We have heard arguments that the harm caused to and by this group are often symptomatic of—rather than caused by—their drug use. Mr Danny Kushlick, Chief Executive of Transform, told us that other problems lie behind their chaotic behaviour:

"those people who are involved in chronic misuse of drugs are generally damaged and it is the underlying causes we need to look at...most drug misuse is a symptom and not a cause. The same stuff will go on in those people's lives¼abuse, poverty, unresolved bereavements, being in care, drug-dependent parents¼the same stories come out again and again and again, and if you tackle those issues those people will not get into those problems in the first place".[23]

23. If government policy is to make a positive impact on this group, it must tackle these problems at root, rather than simply trying to target their drug use. Having said this, a number of recent cases has demonstrated that drug abuse can be a problem even among those from relatively affluent and stable backgrounds. In evidence to the Committee, the

Home Office estimated the number of problematic drug users as 250,000, of which 200,000 are problematic opiate users.[24]

24. **We believe it is self-evident that by focussing on the relatively small group of problematic drug users, the Government could have a significant impact on the harm caused by drug use.**

*Harm to the health of the drug user*

25. It is difficult to separate the different kinds of health problem experienced in connection with drug use and it is extremely difficult to provide data which marks clear levels of harm. The Police Foundation *Report of the Independent Inquiry into the Misuse of Drugs Act 1971* offered the following factors on which to assess personal harm of drug use:

"i) risks of the drug itself: acute (short-term) and chronic (long-term) toxicity
ii) risks due to the route of use
iii) extent to which the drug controls behaviour (addictiveness/dependency)
iv) ease of stopping".[25]

*Acute dangers*

26. The report of the Advisory Council on the Misuse of Drugs, *Reducing Drug-related Deaths*, offered the following picture of the span of deaths which may be drug-related,

"Immediate, or virtually immediate deaths, may arise directly from the pharmacological action of the drug. They may occur as the result of a "normal" dose, and accidental overdose or deliberate overdose (suicide) by the user. Less directly the drug may cause the taker to lose their normal judgement or control, leading to an accident".[26]

27. Problems with the way in which data is collected makes it very difficult to put an exact number on drug-related deaths. The Advisory Council found in their report that estimates of immediate accidental deaths as a result of drug use varied three-fold, between 1,076 and 2,922 in 1998, depending which of three approaches was used to calculate this "core statistic".[27]

28. While the number of illegal drug-related deaths per year does not, in the first instance, appear large compared with those who die from tobacco and alcohol use, the Advisory Council report made clear that, if the age of those dying is taken account of, the true toll of these statistics becomes clear. Perhaps the starkest way to put it is that a young person who injects heroin has about a 14 times higher risk of death than someone who does not.[28] It is also clear that "there has been a profound worsening over the last ten years" in terms of deaths, and that, if drug-related deaths from HIV/AIDS and other blood-borne viruses are taken into account, the figure is very much larger.[29]

*Long term harm*

29. The Department of Health statistics submitted to the Committee suggest that during 1999-2000, there were 8,505 hospital admissions with primary diagnoses of mental and behavioural disorders relating to drug misuse, although this may include some patients who were admitted more than once.[30] Long-term harm commonly associated with tobacco smoking, such as cancers and cardio-vascular problems, also attach to smoking of drugs such as cannabis (see paragraph 93 below). There is much we do not know about the long term harm caused by the use of illicit drugs.

*Harm due to risky drug-using techniques*

30. The UK has high levels of drug-related harm consequent upon risky using techniques, particularly injecting drug use. Perhaps the most significant are blood-borne viruses, spread by sharing needles. In its memorandum to the Committee, the UK Harm Reduction Alliance commented that:

"A potentially dangerous situation is now present where HIV transmission through injecting drug use could rapidly escalate, as has occurred in some other countries... Hepatitis B remains endemic among injectors, despite the availability of an effective vaccine. There is a major epidemic of [Hepatitis C Virus] infection in the UK. Estimates suggest that 400,000 of the population of the UK have been infected with [Hepatitis C Virus], 80 per cent of whom are believed to have obtained this infection through injecting drug use".[31]

31. As Professor Nutt, Professor of Psychopharmacology, Dean of Clinical Medicine and Dentistry, University of Bristol, commented, these infected users "will become a huge burden on the Health Service in the next ten years as their livers slowly decay".[32] The Advisory Council's report suggests that 30% of those infected with blood-borne viruses will die prematurely.[33]

*Harm to the health of others*

32. Drugs can cause damage to the health of not only those individuals who use them, but also to the health of their family and friends and of the wider community in which they live. ADFAM, a charity which represents and supports families affected by drug use, told us of "a clear and damaging link between poor physical and mental health and the presence of disruptive drug use in families".[34] Mr Fulton Gillespie, whose son died of a heroin overdose, described to us the effect of his son's habit on other members of the family: "apart from it being a decimating experience for the family, it was particularly hard for his brothers and sisters who had tried very hard to wean him off this and persuade him to take a different direction".[35]

33. It is clear that drug-related crime also has a malign influence upon the health of victims and communities. The Advisory Council's Report described how drug use might indirectly cause the deaths of others apart from the user:

"the taking of drugs may lead to violent behaviour which causes the death of others; to the deaths of children through accidental overdose of a drug which has fallen into their hands;

and to accidents, notably in road vehicles, killing third parties. Drugs can even contribute towards death without their being taken, when violent rivalry occurs between dealers".[36]

34. Having said this, Commander Brian Paddick of the Metropolitan Police in Lambeth told us:

"My view is that there are a whole range of people who buy drugs, not just cannabis, but even cocaine and ecstasy, who buy those drugs with money that they have earned legitimately. They use a small amount of these drugs, a lot of them just at weekends. It has no adverse effect on the rest of the people they are with either in terms of the people that they socialise with or the wider community. They go back to work on Monday morning and are unaffected for the rest of the week".[37]

*Harm to others—drug-related crime*

35. The relation between drug use and crime is a subject of much debate. To quote Mr Hellawell once again, "all drug takers do not commit crime".[38] However, there seem to be three relevant types of crime which are associated with drugs: organised crime involved with the supply of illicit drugs, acquisitive crime committed by some drug users to fund a habit, and violent crime committed by disinhibited stimulant users.

*Drug-related property crime*

36. On some estimates, one third of all property crime in the UK is judged to be drug related.[39] Preliminary data from the Home Office "demonstrate much higher reported levels of acquisitive offending among users of heroin and cocaine/crack than among those arrestees who use other types of drug, or who do not use drugs at all".[40] Overwhelmingly the users involved in crime tend to be the so-called problematic drug users who lead chaotic life styles and who are dependent on highly addictive drugs such as heroin or crack cocaine. These addicts each spend around £16,500 on their drugs a year, of which an average of £13,000 is the proceeds of crime.[41] This group commits very large amounts of shoplifting, burglary and other crime to finance drug purchases. We have been told that, if appropriate drug treatment is given to this group, they reduce their offending levels.[42]

*Drug-related violence*

37. We have not been able to assess the contribution of drugs towards violent crime levels although it is a matter of record that the recent upsurge of shooting in London and other major cities is related to drugs—principally crack cocaine. It is also self-evident that the estimated £6.6 billion spent on drugs by users each year represents a lucrative source of revenue to the suppliers—mostly organised crime—and it would be surprising if this did not generate considerable violence amongst drug dealers seeking to extend or protect their territory.[43]

38. **We believe that drugs policy should primarily be addressed to dealing with the 250,000 problematic drug users rather than towards the large numbers whose drug use poses no serious threat either to their own well-being or to that of others.** It follows that government policy should be examined in this light, and it is to this that we

now turn.

14 Baker Paul, Goulden Chris, Sharp Clare, Sondhi Arun and Ramsay Malcolm, *Drug Misuse declared in 2000: results from the British Crime Survey*, Research Study 224, Home Office, 2001 (hereafter "*Drug Misuse declared in 2000*") p. 3. Back

15 Figures for use "ever" are used to estimate the extent of experimental use, figures for use "in the last year" gives an idea of occasional use, while figures for use "in the last month" show the extent of more regular use. Back

16 *Drug Misuse Declared in 2000*, pp. vi-vii. Back

17 Q. 635. Back

18 Q. 714. Back

19 Q. 1207. Back

20 Q. 715. Back

21 Q. 1250. Back

22 Q. 1322. Back

23 Q. 282. Back

24 Ev 199. Back

25 The Foundation is financially independent of all government agencies and the police service. Financial support comes from a wide variety of corporate, charitable and individual

donors, including the Tomkins Foundation, The Zochonis Charitable Trust, the Hobson Charity and the Underwood Trust: *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971*, The Police Foundation, 2000, (hereafter "*Drugs and the Law*") p. 43. Back

26 *Reducing Drug Related Deaths: A Report by the Advisory Council on the Misuse of Drugs*, Home Office, 2000, (hereafter "*Reducing Drug Related Deaths*") p. 3. Back

27 *Ibid*, p. 59. Back

28 *Ibid*, p. 1. Back

29 *Ibid*, p. 51; p.1. Back

30 Ev 200. Back

31 "UKHRA is a campaigning coalition of health and social care workers, drug users, criminal justice workers and educationalists, established in March 2001 as a direct response to inadequacies of the UK national drug strategies", (Ev 188); Ev 189. Back

32 Q. 550. Back

33 *Reducing Drug Related Deaths*, p. 1. Back

34 Ev 22. Back

35 Q. 1345. Back

36 *Reducing Drug Related Deaths*, p. 3. Back

37 Q. 398. Back

38 *Tackling Drugs to Build a Better Britain*, p. 7. Back

39 *Drugs and the Law*, p. 22. Back

40 Ev 199. Back

41 Bennet Trevor, *Drugs and Crime*, Research Study 205, Home Office, 2000, cited in Wilkinson Francis, *Heroin: The failure of Prohibition and What to do now*, Paper No. 24, Centre for Reform, 2001, p. 11. Back

42 DrugScope, Ev 50. Back

43 *The Guardian*, 22 September 2001. Back

## THE GOVERNMENT'S DRUGS POLICY: IS IT WORKING?

### THE NATIONAL STRATEGY

39. The Government's response to illegal substance misuse has been to produce, in April 1998, a National Strategy, *Tackling Drugs to Build a Better Britain*, to target four main areas of drug-related harm in a concerted manner. While we appreciate that a ten-year strategy should not be expected to bear all of its fruit after only three years, we believe that the three-year appraisal provides a useful point at which to assess whether or not the original strategy aims are in need of adjustment.

40. The aim of the Strategy is to target the problems related to drug use pragmatically, through four main aims addressing Young People, Treatment, Communities and Availability. In 2000, targets were set for each aim as they became part of the Action Against Illegal Drugs Public Service Agreement:

- **Aim 1 Young people**—To help young people resist drug misuse.

**Target**—To reduce the proportion of people under the age of 25 reporting the use of Class A drugs by 25% by 2005 and by 50% by 2008.

- **Aim 2 Communities**—To protect communities from drug-related anti-social and

criminal behaviour.

**Target**—To reduce levels of repeat offending amongst drug misusing offenders by 25% by 2005 and by 50% by 2008.

- **Aim 3 Treatment**—To enable people with drug problems to overcome them.

**Target**—To increase the participation of problem drug misusers in drug treatment programmes by 55% by 2004, by 66% by 2005 and by 100% by 2008.

- **Aim 4 Availability**—To disrupt the supply of drugs.

**Target**—To reduce the availability of Class A drugs by 25% by 2005 and by 50% by 2008.[44]

TARGETS

41. The targets have been criticised for being unmeasurable and insufficiently grounded in evidence. A survey conducted for the Committee by DrugScope, of its 900 member organisations, found that drug strategy targets are "unrealistic and unworkable".[45] The Government appears to concede that the targets are flawed. Mr Ainsworth told us:

"When we drew up the Drug Strategy, I do not think anybody felt or claimed that every single piece of it was pinned down, that we had evidence to back up targets in every case¼some of the targets, it was openly acknowledged at that point, were aspirational and I do not criticise that because there was a necessity to get people focussed and to force them to work together...some of those targets are extremely difficult to apply a baseline and a form of measurability to be able to say in a critical way that we are or we are not on target...we need to develop credible baselines, we need to make certain that what we are reaching for is in some way achievable".[46]

42. **We believe it is unwise, not to say self-defeating, to set targets which have no earthly chance of success. We recommend (1) that the Government distinguishes explicitly between aspirational and measurable targets; (2) that it focuses on outcomes rather than processes as indicators of success and that where a process is intended to lead to a particular outcome, the basis for expecting this be explained, with evidence; and (3) that baselines are established as soon as possible for all targets.**

OUTCOMES

43. The Committee has been offered varying opinions on the success of government policy since 1998, as measured by self-imposed targets and other indicators. Mr Keith Hellawell told the Committee that the Government's work "is a strategy which is laudable, will take time to work and it is working".[47] In fact many witnesses have paid tribute to the success of the strategy in bringing together the disparate professions and fields of expertise working on different aspects of drug-related problems in an effective management structure. Mr Mike Trace, former Deputy UK Anti Drugs Co-ordinator, cited the National Strategy as an example to the international community: "The structure and approach of the UK strategy has been seen as a model by the international community which has been emulated since by many countries (eg [Republic of Ireland], Portugal, Czech Republic)".[48]

44. Witnesses have been less impressed, however, with outcomes. Mr Trace told the Committee in evidence that neither the target on young people nor that on availability was likely to be achieved.[49] Others have expressed similarly negative views:

"If we judge whether the existing drugs policy is working by measurable reductions in the number of people who use drugs, the number who die or suffer harm as a result, the supply of drugs, the amount of crime committed to get money to buy drugs and the organised criminality involved in transporting and supplying drugs, then we have to say that the results are not coming through" (The Association of Chief Police Officers).[50]

"The strategy had four main outcome objectives in 1998 and all four of those have moved in the opposite direction to the one the strategy said it would over the succeeding four years. There was not a single year in the 1990s when one could be hopeful about the progress of the drugs problem in this country. I see absolutely no rational basis for thinking that might be different in the next three years" (Mr Francis Wilkinson, recently retired Chief Constable of Gwent).[51]

45. While there has been a degree of consensus that the desired results have not yet transpired from the strategy, evidence has been divided on the reasons for this. Mr Conor McNicholas, editor of *Musik* magazine, told us that "the changes that Keith Hellawell made in policy really were moving deckchairs on the Titanic, the whole system is not working at all and what he was doing was just tweaking".[52] Those who agree with this see the only way of improving strategy is complete overhaul. Mr Danny Kushlick of Transform told us: "Given we know a prohibition-based, a criminal justice-orientated drugs policy is doomed to failure, what is the point of continuing with it, when it contributes to death, misery, crime, the funding of the international mafia, the destruction of developing countries?".[53]

46. Others disagree, seeing failure in implementation not principle, and therefore seeing the way forward in the redoubling of efforts and remaking of commitments. The National Drug Prevention Alliance told us:

"Does existing drugs policy work? Yes, as an adequate definition of goals and the means to achieve them. It suffers in the delivery, both by lack of commitment in some aspects as well as by assault from those who prefer a more libertarian approach...The alternative to law relaxation is to do the job properly...Effectiveness is being undercut by ideology and 'turf' disputes. Sort this and you will sort most of it".[54]

44 Ev 1. Back

45 Ev 81. Back

46 Q. 1304. Back

47 Q. 114. Back

48 Ev 181. Back

49 Ev 182. Back

50 Ev 23. Back

51 Q. 410. Back

52 Q. 199. Back

53 Q. 199. Back

54 Ev 138-9. Back

## THE GOVERNMENT'S DRUGS POLICY: IS IT WORKING?

## OPTIONS FOR CHANGE

47. We now present the various arguments made to us for changing the drugs laws. Our conclusions and recommendations for four key drugs follow.

### LEGALISATION AND REGULATION OF ALL DRUGS

48. The proponents of the most radical change to the drugs laws are those who suggest that the prohibition of currently illicit substances has not worked and cannot work. They argue that, far from limiting the harm caused by drug use, it is prohibition itself which causes the greater part of that harm. The argument here is that illegality militates against safe, open use and creates a dangerous environment in which drug use, criminality and social exclusion

become unnecessarily wedded together.

49. Perhaps the clearest statement of this stance came from Transform—the Campaign for an Effective Drugs Policy:

"All the evidence shows that UK drug policy has been an unmitigated disaster. Drug-related crime, death, destruction of inner city communities, billions in wasted expenditure and the loss of political autonomy of developing countries are the price we have paid for global prohibition. Prohibition is a recipe for disaster. We would be hard pressed to find a system with a higher propensity to lead to crime, social exclusion, violence, prostitution and general misery...In Transform's view prohibition has caused or created many of the problems associated with the use and misuse of drugs...drugs prohibition effectively hands the trade over to organised crime and unregulated dealers. Government abrogates all responsibility for the management of the supply side of the market and chaos prevails".[55]

50. *The Angel Declaration*, a manifesto for change of the drugs laws, uses similar arguments:

"the UK prohibition of controlled substances, now embodied in the Misuse of Drugs Act 1971, has proved ineffective in the achievement of its objects, counter-productive in its side-effects, wasteful of public resources, destructive in its cultivation of criminality and commercial abuse, and inhumane in its operation. The Act no longer constitutes an appropriate form of social regulation, consistent with the UK's Human Rights commitments".[56]

51. Other witnesses have pointed to the failure of alcohol prohibition in the USA in the 1920s, making an analogy with today's prohibition of drugs. Mr Nick Davies of *The Guardian* told the Committee:

"what drug becomes safer, in terms of health or social damage, if you make it illegal?... Look at what happened when they prohibited alcohol. Did that make people safer to have their alcohol brewed by gangsters using methylated spirits which made them blind? Did it help that there was an explosion of organised crime? Did they reduce alcohol harm by prohibition? No."[57]

52. The alternative proposed is the legalisation and regulation of all controlled drugs. Transform suggest that there are various distribution mechanisms, already used for the controlled supply of legal substances such as alcohol, tobacco and medicines, through which such a retail system could operate, including over the counter sales, licensed sales, pharmacy sales and prescription through a doctor. The various mechanisms offer different degrees of restriction of availability, and different drugs could be sold in different ways.

53. It is argued that making currently illegal drugs available in this manner would not preclude the provision of vigorous health education campaigns aimed at discouraging use of any mind-altering substance. Sanctions on the age of legal consumers would be enforced as they are for the sale of alcohol and tobacco. The marketing of all drugs with potential for harm, including alcohol and tobacco, would be strictly forbidden.

54. We have heard a range of arguments for such a system, encompassing philosophical and practical considerations. Liberty's submission to the Committee laid out the philosophical reasons for this being desirable:

"as part of a free, democratic society individuals should be able to make and carry out informed decisions as to their conduct, free of state interference, or in particular the criminal law, unless there are pressing social reasons otherwise. Liberty is of the view that the decision by an individual to take drugs is such a decision and comes within the ambit of personal autonomy and private life. John Stuart Mill argued that the state has no right to intervene to prevent individuals from harming themselves, if no harm was thereby done to the rest of society. 'Over himself, over his own body and mind, the individual is sovereign.' Such fundamental rights are recognised by government, both in allowing individuals to partake of certain dangerous activities, for example drinking, extreme sports, and also in international treaties".[58]

55. Dr Colin Brewer, Medical Director of the Stapleford Centre, put the argument to us in rather blunter terms:

"Until 1916 you could intoxicate yourself with whatever you liked. You could go to hell in your own handcart, but at least the law did not interfere. Personally I feel rather strongly we should go back to that set of Victorian values".[59]

56. On practical grounds, the argument has been made to us that a system of controlled availability of drugs would allow the Government to exert a much greater degree of control over the way in which substances are used, than is currently possible. Transform put it in this way: "drugs should be legalised because they are dangerous not because they are safe".[60] A legal system would, it is argued, allow the Government to regulate and guarantee the quality and dosages of drugs supplied, and to make available the safest equipment to administer the drug, all of which could be buttressed with health advice. Legalisation might take away some of the stigma of drug use, encouraging more drug addicts to seek treatment. Mr Fulton Gillespie, whose son died of a heroin overdose, said to us:

"how can we regulate supply if we are not in charge of the power station? We have to take control away from criminals and place it back where it belongs, with us".[61]

57. It is also argued that it would be easier to deter new users through truthful education policies if the laws on drugs were consistent with those on alcohol and tobacco, just as health education in the recent past has had a positive impact on prevalence of tobacco smoking. Even if legalisation did result in an increase in experimental drug use, we have been told, higher prevalence would be a small price to pay for all the other associated benefits of a legal and regulated market, as use does not necessarily lead to problematic use.[62] As many addicts also fund themselves through small-scale dealing, it is argued that, with the expense of a habit removed, this pressure to recruit new users would be removed, with a positive impact on prevalence rates.[63]

58. A legal supply system, it is argued, would take away a massive source of income for the organised criminals currently supplying the drugs market, and hence reduce organised crime.[64] The legalisers argue that, while it is no doubt true that an illegal market could not be completely eliminated, it is logical to assume that it could be reduced significantly by the

existence of a legal market, hence making the funding of organised crime more difficult, at least in the short-term.

59. It is also argued that legalisation and regulation of drugs would reduce crime committed by addicts to fund a drug addiction, as addicts could buy their supply relatively cheaply from licensed retailers. Dr Brewer commented: "many people who find themselves...dependent on heroin and therefore having to do frightful things in order to raise enough money to buy it, would either not need to commit crime or would commit far fewer crimes, like impoverished alcoholic patients".[65]

60. Others took a different view. The Minister, Mr Ainsworth, told us that "it is often the case that those who advocate legalisation advocate it as a potential panacea for many of the costs that are imposed upon the criminal justice system, without necessarily looking at the downside".[66] The Police Federation disagreed with the claim that legalisation would have a significant impact on organised crime:

"This assumes that the powerful international drug cartels would simply fade away into the night. More likely scenarios are that they would fight to maintain their lucrative street trading".[67]

61. Mr Ainsworth told us that the criminal market could never be entirely removed even within a legalised system, "unless you were prepared to sell it at a low price to almost anybody". He went on, "if you attempted to tax it, regulate the price, or prevented it getting into the hands of people whose hands you did not want it to get into then a secondary market would grow up around the legal market, and we would have some of the same problems of enforcement that we have now".[68] Mr Nicholas Dorn of DrugScope pointed out that organised crime is not dependent on the drugs trade for its survival:

"I do not think the enormous criminal conspiracy is going to collapse by the removal of drugs from it. If you look at your average UK drug trafficker or European-based drug trafficker, they are likely to be involved not exclusively in drugs trafficking but also in some other activities...We are not going to have a clean house and get rid of organised crime".[69]

62. Opponents also argue that a rise in new users and in problematic use would cancel out any harm reduction gains of a legalised and regulated system. The speculation that the removal of illegality would encourage more new users and make it easier for new users to experiment with drugs has been the most widely-held objection to legalisation heard by the Committee. Mr Ainsworth told us:

"I do not believe that heroin is as freely available to young people as it would be in the kind of regime you describe. I think it would be a lot more available".[70]

63. Sue Killen, Director of the Anti-Drugs Unit at the Home Office, told us that illegality carries a deterrent effect, and Mr Geoff Ogden, Co-ordinator of the East Riding and Hull Drug Action Team, told the Committee: "The word on the street for a long time about cannabis is the youngsters think it is going to be legalised...so it is cool to use it".[71] Mr Ainsworth told us that: "it is proven beyond all doubt that illegality discourages use; that legalisation would lead, to some degree, to an increase in use".[72]

64. Data on the deterrent effect is scarce, but a MORI poll conducted for the Police Foundation's Independent Inquiry found that the main reason why people do not take drugs is personal choice rather than a fear of the consequences or the legal implications. 56% of people questioned said the main reason people do not take drugs is they simply do not want to; 51% cited fears for health; 50% fear of death and 46% fear of addiction. 30% of adults and 19% of children felt that people did not take drugs because they did not wish to break the law; 17% (12% of children) said they did not because they were afraid of being caught by the police.

65. We have listened carefully to the arguments. We acknowledge that there is force behind some of those advanced in favour of legalising and regulating. The criminal market might well be diminished (though not eliminated); likewise drug-related crime. Harm may well be reduced, although this would have to be balanced against an inevitable increase in the number of drug abusers if drugs were more widely and cheaply available. It is inevitable too that, however tightly the sale of drugs was regulated, there would be a significant leakage to under-age abusers, as there is already with cigarettes and alcohol. We do not agree with the contention that illegal drugs are already as widely available to under-age abusers as they would be under legalisation. We agree with those who say that legalisation would send the wrong message to the overwhelming majority of young people who do not take drugs. We also accept that a significant number of young people—we can argue about the numbers—are deterred from drug abuse by the fact that drugs are illegal. Finally, we note that however forceful the arguments, no other country has yet been persuaded to legalise and regulate. Nor can we ever foresee a day when it would be possible to legalise a drug as dangerous as crack cocaine, which leads to violent and unpredictable behaviour.

66. **While acknowledging that there may come a day when the balance may tip in favour of legalising and regulating some types of presently illegal drugs, we decline to recommend this drastic step.**

## DECRIMINALISATION OF PERSONAL POSSESSION

67. A less drastic alternative would be to legalise, or at least to decriminalise, personal possession of some types of drugs.[73] Mr Dorn of DrugScope told us, "DrugScope's position in relation to users is a practical one, that in effect...drug use per se should not be criminalised".[74] Turning Point, one of the largest voluntary sector providers of substance misuse services, told us: "criminal procedures should no longer be initiated for the possession of small amounts of any scheduled drug".[75]

68. The main argument in favour of decriminalising possession is that it would remove the obligation of giving criminal records to large numbers of young people arrested for drug use who are, in all other respects, law abiding citizens. As regards cannabis we were told by Turning Point:

"prison is never an acceptable environment in which to deal with possession. It does not serve a useful purpose for individuals or society if recreational users are brought closer to the consolidating of their criminality. A criminal record makes education, employment and family relationships much more difficult at a crucial stage of a young person's life and they

are likely to learn more about drugs and more serious crimes inside prison than outside it".[76]

69. It is also arguable that the criminalisation of personal possession, where use causes harm to no-one other than the user, is the least justifiable part of the drugs laws on human rights grounds. Liberty argues:

"Article 8 of the European Convention on Human Rights provides: 'Everyone has respect for his private and family life, his home and his correspondence. There shall be no interference by a public authority with the exercise of this right except as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the county, for the prevention of crime, for the projection of health and morals, or for the protection of rights and freedoms of others'. In a society that respects fundamental freedoms of the individual, and in particular the right to individual autonomy and choice, general restrictions and criminalisation of taking of drugs, cannot be justified".[77]

70. It is also argued that decriminalisation would formalise a policing situation which already exists in relation to some drugs. The Police Federation, however, argued that no change was necessary as the police already have sufficient discretion to take a lenient view of possession of cannabis, for example:

"while it remains a criminal offence to possess or to supply cannabis, the police have been operating a reasonable approach. This recognises the reality of the current situation and takes note of the more relaxed attitudes of a significant section of the population. Such an approach is consistent with the principle of policing by consent. There is no real contradiction between a lenient police attitude to possession for personal use, and continuing to target the criminals who import and distribute the drug".[78]

71. At least two significant problems are presented by decriminalisation of possession for personal use. One concerns the "messages" which are sent out to young people, and the possible recruitment of new users (see paragraph 64 above).

72. The second problem posed by decriminalisation of personal possession is that it offers no solution to the problem of supply and in fact might give drug suppliers an incentive to seek to expand the user market. It would engage enforcement agencies in a murky grey area between the user and the supplier, particularly in respect to small scale "social" suppliers, and would add a further degree of confusion to policing drugs. It might also diminish respect for the law as it would embrace a fundamental inconsistency—that it is permissible to use drugs, but not permissible to supply them.

73. Attracted though we are by the prospect of avoiding giving criminal records to otherwise law-abiding young people, we believe that this problem is better dealt with by reclassification, which we address below.

74. **We accept that to decriminalise the possession of drugs for personal use would send the wrong message to the majority of young people who do not take drugs and that it would inevitably lead to an increase in drug abuse. We, therefore, reject decriminalisation.**

## POSSESSION WITH INTENT TO SUPPLY AND "SOCIAL SUPPLY"

75. We have heard that several practical difficulties are faced when determining whether an act constitutes simple possession or the more serious offence of possession with intent to supply (which carries much higher maximum penalties—see table below). First, we are told, intent to supply is very difficult to prove, and where proof is based upon the amounts of substances in question, much court time is taken up with expert witnesses giving evidence on the amount that one person might reasonably be expected to take him or herself. It has been suggested to us that some defendants are wrongly convicted of the more serious offence of possession with intent to supply due to a lack of understanding about drug-taking habits and the amounts of different substances involved. To overcome this problem, and lend greater clarity to both the courts and to users, a threshold could be set of the amount of a substance held to constitute simple possession only, above which an intent to supply would be presumed.

| Offence | Maximum penalty if tried on indictment (Class A drug involved) |
|---|---|
| Supplying a controlled drug | Life |
| Having possession of a controlled drug | 7 years |
| Having possession of a controlled drug with intent to supply it to another | Life |

76. Mr Ainsworth told us that he was not aware of the law falling down in this respect and that if penalties were given according to the amount of substance found on a suspect, "we would find systematically people were on the streets with just under that amount".[79] Mr Calvert-Smith, Director of Public Prosecutions, told us that "any attempt to define dealing or supply based on a given quantity [of substance] is likely to be extremely problematic", and explained:

"In determining whether the appropriate charge is Possession with Intent to Supply as opposed to Simple Possession, the prosecutor will consider the amount of the drug in the defendant's possession. However, our policy has long been that this is not a conclusive indicator, although it is recognised that large quantities are likely to be more consistent with supply than personal use. The prosecutor will, in addition, consider other factors such as the variety of drugs found, evidence that the drugs were prepared for sale, other evidence of preparation, evidence of large amounts of money in the possession of the defendant and evidence from diaries and other documents".[80]

77. **We are not persuaded that an intent to supply should be presumed on the basis of amounts of drugs found; we therefore recommend that the offences of simple possession and possession with intent to supply should be retained without alteration.**

78. The second problem put to us was that the law does not distinguish adequately between "social supply"—between friends and not for profit—and large-scale commercial supply. We note that this type of "social use" is the main cause of the proliferation of drug use. It seems likely that more new users are introduced to drugs by friends than by street dealers. However, the argument put to us was that these crimes are different not only in scale, but in kind. Mrs Hope Humphreys, whose son was imprisoned for supplying ecstasy to his friends, told us:

"Virtually everybody who has taken drugs has been a supplier. By passing a joint, you are a supplier; by getting the E for your friend for that night, you are a supplier. It is social supply, it is not a wicked, horrible person corrupting our youth. It is like buying a round of drinks to them".[81]

79. The Police Foundation Report identified this problem as follows:

"The current definition of supply does not distinguish between acts of different gravity, eg supply between friends, or for gain, or as part of an organised criminal group supplying in substantial quantities".[82]

80. The solution they offered was to create a separate offence of "dealing" which would be used to identify those who engage in a pattern of illicit transactions over a period of time, as distinct from those who commit a single act of supply. They further recommend that, for those engaged in "social supply":

"it should be a defence for a person accused of supply or possession with intent to supply to prove that he was a member of a small social group who supplied or intended to supply a controlled drug (other than Class A) to another member or other members of that group believing he was acting, or had acted, on behalf of that group, which shared a common intention to use the drug for personal consumption. This defence would only apply where the court was satisfied that the amount or value of the controlled drug was consistent with personal use within the group concerned".[83]

81. If the defence was proven, the defendant would then only be liable for simple possession. Mr Calvert-Smith told us that at present "the judge will distinguish between dealers and social suppliers in the sentence passed following conviction".[84]

**82. We do not agree with the Police Foundation. Those guilty of "social supply" should not escape prosecution for this offence on the basis that their act of supply was to their friends for their personal consumption. We believe that this act of "social supply", while on a different scale from commercial supply, is nonetheless a crime which must be punished.**

**83. We believe that while there are two different crimes of supply, the law only formally recognises one. We recommend that a new offence is created of "supply for gain", which would be used to prosecute large scale commercial suppliers. So-called "social suppliers" who share drugs between their friends on a not-for-profit basis should continue to be prosecuted for supply.**

## RECLASSIFICATION

84. A further step down from the radical options of legislative change would be to look again at the categories by which drugs are classified under the Misuse of Drugs Act 1971. The classifications of illicit drugs are designed to protect people from substances in a hierarchy of penalties which reflects their relative harmfulness. The indication by the Home Secretary, on 23 October 2001, that he would consider the reclassification of cannabis from Class B to Class C demonstrates the system's potential for flexibility and adjustment.

85. The Committee has heard numerous representations to the effect that the classification system prescribed by the Act no longer accurately reflects current scientific and medical opinion:

"the current system of classification lacks credibility as it is not based on the relative harm caused or dangerousness of use" (Turning Point).[85]

"There is a misalignment in the relative harms of certain drugs and their classification" (DrugScope).[86]

"The present tough penalties on the use of ecstasy, LSD and cocaine are inappropriate and counter-productive and should be reduced" (Release).[87]

86. The importance of correctly classifying controlled drugs does not rest purely upon the justice of the penalties attached to possession and supply. It also has a significant impact upon the educational "messages" communicated to current and potential drug users about the dangers of using particular drugs. The point continually reiterated to the Committee is that, if the law (and education) does not reflect the realities of risk, users and potential users are likely to assume that all warnings are similarly skewed. Nor will it escape the notice of users and potential users if the law does not reflect relative harm: many young people will be presented with evidence of others using drugs all around them, and come to their own conclusions. Turning Point is of the view that:

"changes to the drugs laws would also greatly enhance the credibility of drugs education work. For example ecstasy is classed alongside heroin and cocaine but is not perceived by some young people as being as dangerous and so when the police and other workers are talking about other Class A drugs, these more serious messages are also being discredited".[88]

87. Mr Ainsworth recognised this when he said:

"There is also an issue¼ of how we get the message across to young people. They are not stupid; they do know the basic facts in this area, or many of them do; and unless we have a credible message they switch off altogether to everything that we say".[89]

88. **We, therefore, conclude that the time has come to reconsider the existing classifications for the less harmful drugs and we address each in turn.**

55 Ev 184. Back

56 Retrieved from the World Wide Web on 23 April 2001: http://www.angeldeclaration.com/declaration.htm. Back

57 QQ. 155; 179. Back

58 Ev 126-7. Back

59 Q. 565. Back

60 Ev 185. Back

61 Q. 1374. Back

62 Mr Danny Kushlick, Q. 226. Back

63 Mr Nick Davies, QQ. 150; 162. Back

64 Transform, Ev 185. Back

65 Q. 578. Back

66 Q. 1204. Back

67 Vol III, Ev 241. Back

68 Q. 1233. Back

69 Q. 769. Back

70 Q. 1230. Back

71 QQ. 126; 452-3. Back

72 Q. 1204. Back

73 Decriminalisation: this term is used to mean the removal of imprisonment as a sanction for possession. Offenders could instead be punished by a fine, or another "civil" measure. Back

74 Q. 756. Back

75 Vol III, Ev 245. Back

76 Vol III, Ev 246. Back

77 Ev 127. Back

78 Vol III, Ev 241. Back

79 Q. 1217. Back

80 Vol III, Ev 273. Back

81 Q. 1392. Back

82 *Drugs and the Law*, pp. 62-3. Back

83 *Ibid*, pp. 63-4. Back

84 Vol III, Ev 273. Back

85 Vol III, Ev 246. Back

86 Ev 46. Back

87 Ev 166. Back

88 Vol III, Ev 246. Back

89 Q. 1208. Back

## THE GOVERNMENT'S DRUGS POLICY: IS IT WORKING?

### DIFFERENT CONTROLS FOR DIFFERENT DRUGS

#### CANNABIS

**89. According to the British Crime Survey 2000, cannabis was the most commonly used of all illegal drugs. Of all respondents aged 16 to 59, 27% said they had tried**

the drug in their lifetime, 9% had used it in the last year and 6% in the last month. Amongst 16 to 29 year olds, however, 44% had used it in their life, 22% in the last year and 14% in the last month.

90. Views on the risks of short and long-term cannabis use are variable. Professor Nutt of Bristol University assessed the risks of cannabis as:

"short term very slight; long term mostly equates to smoking of the leaf; addictiveness low to moderate....It may exacerbate schizophrenia in some people, may ameliorate some symptoms in other people. On balance there is probably a negative [effect] in schizophrenia".[90]

91. Baroness Greenfield, Professor of Pharmacology, University of Oxford, and Director of the Royal Institution of Great Britain, told us that cannabis users:

"are tampering with the most special part of their bodies and that is their brains and their minds over conceivably the long term. There is even evidence of long-term damage after one has given up smoking cannabis, and I think this is a very serious and big worry, not so much that you might die that night, but more that you could be under-performing and unfulfilled 30, 40 years on".[91]

92. In terms of mental health, it appears also that the strength of different "brands" of cannabis vary widely and that stronger varieties containing a greater proportion of the psychoactive ingredient, THC, have become increasingly available.[92] Mrs Mary Brett, Head of Health Education at Dr Challoner's Grammar School, Buckinghamshire, told us that "a joint today contains on average ten times as much THC as it did in the Sixties".[93]

93. The *smoking* of cannabis carries its own risks, which are analogous to those associated with tobacco smoking. While the available data is patchy, the Royal College of Physicians told the Committee that "marijuana smoking exposes the lung to toxic products of combustion more commonly associated with tobacco smoke, and is therefore likely to be associated with similar long-term health risks as tobacco smoking", including chronic bronchitis symptoms, airflow obstruction, cancers and cardiovascular disease. While the total amount of smoke inhaled by cannabis smokers appears to be less than that inhaled by tobacco smokers, this is off-set by the absence of filters in joints, which allows a higher proportion of tar to be inhaled. Cannabis smokers tend to inhale more deeply than tobacco smokers, and cannabis smoke is hotter than tobacco smoke, which is more damaging. Most cannabis in the UK is smoked in a mixture with tobacco, which means that smokers are also exposed to the dangers of tobacco smoking and nicotine addiction.[94]

94. The risks of cannabis need to be put into the context of the "acceptable" risks posed by alcohol and tobacco. DrugScope told us that "in relation to the millions of individuals who have been exposed to the drug in this country since the late 1960s, cannabis compares favourably (in terms of health implications) with legal drugs widely used such as alcohol and tobacco".[95] There is also, of course, the fact that most people tend to grow out of smoking cannabis.

*Drugs and driving*

**95. Our attention has been drawn to the increasing problem of persons driving under the influence of drugs. According to a recent study by the Transport Research Laboratory, the incidence of illicit drugs in casualties of fatal road traffic accidents has risen substantially, from 3% in the late 1980s to 18% in 2000. This has occurred over a period in which drug-taking generally has risen. Over the same period, the incidence of alcohol has declined from 35% to 31.5%. The most commonly detected drug is cannabis; incidence has increased from 2.6% to 11.9% over the period.**

**96. The contribution of cannabis to road traffic accidents is not entirely straightforward—the Transport Research Laboratory's report notes that:**

**"Cannabis remains traceable in the bloodstream for up to 4 weeks after it is taken by regular users, whereas its effect on driving is probably limited to a few hours at most after it is taken. Incidence in bodily fluids cannot therefore be directly related to any contributory role in accidents".[96]**

**97. Some witnesses have even told us that cannabis may improve some drivers' performance: the Independent Drug Monitoring Unit said that cannabis led to "increased risk for new users or new drivers, for established users/drivers [it] appears to reduce accident risk by improving driver behaviour (slower speeds, larger gap, fewer risky manoeuvres)".[97]**

**98. While the law prohibits driving while unfit through alcohol or drugs, it appears that police are not adequately equipped to detect drug use in drivers. The Police Federation told us that "relatively few police officers have so far been trained to use new equipment that enables motorists to be tested for drugs use".[98] The Independent Drug Monitoring Unit told us that a method of testing called "field impairment testing" which is currently being adopted by many police forces "represents an improvement on previous enforcement techniques, but fails to address abilities which are directly related to the ability to drive, in particular reaction time and tracking ability". They went on to recommend changes which would improve this, including in car simulators and video-taping of tests to reduce subjective judgements by police officers.[99]**

**99. We recommend that techniques to test drivers for drug-related impairment are improved, and that all police officers responsible for testing receive the necessary training.**

*A gateway to harder drugs?*

100. It is sometimes said that cannabis is a "gateway" drug to other substances, and higher prevalence of cannabis use would inevitably entail higher prevalence of other, "harder"

drugs, with all the consequent health and social problems following. DrugScope told us "The hypothesis that cannabis use leads to the use of other more harmful drugs has been, and remains, a key justification of past and present drug policy".[100] The Police Federation pointed out in evidence to us that most users of hard drugs start off using cannabis.[101]

101. Most witnesses, however, saw the issue as less clear cut. Sue Killen of the Home Office told us:

"the evidence is there overwhelmingly that the vast majority of people who take cannabis do not go on to take hard drugs; our feeling is that there are far more complex issues which lie behind who then goes on to become addicted. So it is not a straightforward link at all".[102]

102. Professor Rehm pointed out that alcohol and tobacco can also act as "gateways" to other drugs:

"There is, of course, a correlation of people going into cannabis which later on take other drugs. That is there. The same correlation is there for tobacco and other drugs, it is there for alcohol and other drugs".[103]

103. DrugScope supplied us with the following assessment:

"The weight of empirical evidence would suggest that a link between cannabis and more harmful drugs like heroin and crack does exist. The reason for this is not...a cause or a chemical process that cannabis started, it is rather that:

- Some cannabis users have common personality profiles or environmental conditions with the users of more harmful drugs.
- Once drugs, be they cannabis, alcohol or tobacco are used, if the harm ascribed to them is overrated or false, individuals using cannabis will dismiss harm information and are less likely to be concerned about moving to more "harmful" drugs.
- Cannabis use puts individuals in social situations and supply transactions where they are more likely to experience people using, accepting and supplying more harmful drugs than others in the population.

The gateway theory is often misunderstood. It is not about cannabis leading to harder drugs, it is about common profiles, environment, experience and access".[104]

104. If the gateway is to be closed, according to DrugScope, policy makers have two options:

"(a) Prohibition of all gateway drugs (logically including alcohol and tobacco) should be enforced and therefore the gateways shut through strict application of the law.

(b) If it is not possible (as current levels of cannabis use would suggest) or desirable to adopt a zero tolerance policy to cannabis... through prohibition and strict legal sanctions,

policy makers should narrow the Gateways as much as possible. This can only be done by producing more accurate harm information and by changing the legal status of cannabis (decriminalisation or similar) so that it is further differentiated from more harmful drugs in perception, culture and supply".[105]

105. We have heard that this argument of differentiation has been the driver behind The Netherlands' policy on cannabis, which is, in effect, toleration of personal use:

"If you look at the aggregate level, those countries which have changed their cannabis regime and have actually allowed cannabis to be tolerated in certain parameters did not have an increased incidence of hard drugs afterwards. The incidence and the harm which has been increasing in some of the countries were not in countries which have tolerated cannabis. The harm levels of The Netherlands or of Switzerland, in terms of overdosing and in terms of the hard indicators which we see, are less than for those countries which do not tolerate cannabis... it is just part of a larger picture".[106]

"What we see is that the incidence of new heroin addicts [in The Netherlands] has been stabilised. We think it is difficult to prove but we think it has to do with the separation of the soft and hard drugs".[107]

106. In Britain the last year has seen a lively debate around the status of cannabis as a controlled substance. While the Government has not entertained any idea of removing cannabis from the current system of control laid down by the Misuse of Drugs Act, it is considering a number of changes which suggest a new flexibility towards control of cannabis.

*Medicinal use*

107. These include clinical trials into the medicinal use of cannabis, currently scheduled to be completed in 2003. GW Pharmaceuticals, the company licensed by the Home Office to conduct the research into potential cannabis-based medicines, told us:

"Cannabis is expected to help patients suffering from a wide range of medical conditions, including those related to neurogenic pain or dysfunction such as multiple sclerosis, spinal cord injury, phantom limb pain and arachnoiditis and other conditions without a neurological cause including osteoarthritis, rheumatoid arthritis, AIDS, migraine, cancer pain, nausea and epilepsy".[108]

108. Should the trials prove successful, the Government has committed itself to licensing a cannabis-based medicine, which we believe would command widespread public support. The Home Secretary told us, in October 2001:

"We are now in the third phase of the testing, assessment and evaluation programme. Should—as I believe it will—this programme be proved to be successful, I will recommend to the Medical Control Agency that they should go ahead with authorising the medical use of this for medical purposes".[109]

109. **In the event of the successful completion of clinical trials and a positive evaluation by the Medicines Control Agency, we recommend that the law is changed to permit the use of cannabis-based medicines.**

*Innovative policing*

110. The second major policy shift over the last year has been the toleration, by Government, of a pilot, conducted by Metropolitan Police in Lambeth, South London, of a new scheme of dealing with cannabis possession offences. Officers in the area now no longer arrest individuals for possession but instead issue a verbal warning and confiscate the substance. The rationale behind the pilot is that arresting people for cannabis possession—the only formal procedure available to police officers—takes up an inordinate amount of police time when there are more serious crimes to be pursued.

111. Commander Brian Paddick, the senior police officer in charge of the scheme, told us that the pilot "has the practical effect of decriminalising the offence in those cases where the officer does not proceed by means of arrest".[110] While this may not represent much of a shift in de facto policing terms, the official status of the scheme has led to claims that this constitutes decriminalisation of possession of the drug "by the back door".

112. In fact, the legal status of cannabis has not changed in Brixton; rather, the policing approach has. Commander Paddick told the Committee that the scheme has actually seen more people dealt with for possession of cannabis than before, as the time released by the new procedures has allowed officers to process more offences.[111]

113. The pilot in Lambeth has been evaluated in two ways. PRS Consultancy Group examined the scheme in terms of police activity, while the Police Foundation commissioned MORI to survey public opinion on the pilot. The measures of police activity showed that the pilot released at least 1,350 hours of officer time, equivalent to 1.8 full-time officers. In comparison with the same 6 months in 2000, officers in Lambeth recorded 35% more cannabis possession offences and 11% more cannabis trafficking offences. This compared with drops in the number of the same offences recorded in neighbouring boroughs over the pilot period. Lambeth also increased its activity against Class A drugs over the period, relative to adjoining boroughs. However, the opinions of Lambeth police officers about the pilot were not positive. While only 51 officers responded to the questionnaire asking their opinions, a majority of those who did respond felt that the policy would lead to increased drug use in Lambeth and should be discontinued. They also felt that the pilot had not changed the way in which they spent their time on duty.[112]

114. The surveys of public opinion, conducted at the end of 2001, found that there was a considerable degree of confusion over what exactly the pilot entailed. However, 74% of people consulted felt that the scheme would result in police time being released to deal with more serious crime—but 17% felt serious crime would increase, and 21% felt use of hard drugs would increase as a result of the pilot. Despite this, 36% approved of the scheme unconditionally, a further 32% supported it provided the police spend more time on serious crime, and 15% approved provided it actually reduces serious crime. 71% of people thought the scheme offered a better way to deal with young cannabis users. Having said this, parents of primary school children are amongst the most likely to disapprove of the scheme.[113]

115. Mr Vic Hogg, from the Home Office, told us:

"under the current arrangements around 80 per cent of all people caught in possession of cannabis are disposed of by way of a warning, a caution or a fine. Within that 80 per cent figure, warnings and cautions account for around 55 per cent".[114]

116. The Home Office, in its second memorandum to the Committee, said:

"the existing range of criminal sanctions, applied with due discretion, are preferable to decriminalisation. Minor offences are normally dealt with by way of a warning or caution. The Government has accepted that cautions should become immediately spent under the Rehabilitation of Offenders Act, which will mean that the large majority of offenders will not get a criminal record. The courts and, ultimately prison, provide the severest sanctions for persistent or serious offenders. About 3 per cent of those dealt with for possession of cannabis are sent to prison. A sample analysis of this cohort showed, on average, 14 previous criminal convictions per offender. Sentencing data is not routinely collated to show secondary or tertiary offences, but this sample tends to confirm the views of the enforcement agencies, namely that where imprisonment is imposed for cannabis offences it is usually because of the seriousness of the offence itself or as a result of concurrent imprisonment for other criminal offences".[115]

90 QQ. 479; 481. Back

91 Q. 1072. Back

92 THC: tetrahydro-cannabinols. Back

93 Ev 30. Back

94 Ev 170-173. Back

95 Ev 71. Back

96 *The incidence of drugs and alcohol in road accident fatalities*, TRL Report 495, R J Tunbridge, M Keigan and F J James, Transport Research Laboratory, 2001, p. 1. Back

97 Ev 114. Back

98 Vol III, Ev 241. Back

99 Ev 113. Back

100 Ev 57. Back

101 Ev 241. Back

102 Q. 18. Back

103 Professor Juergen Rehm, Q. 813. Back

104 Ev 58-9. Back

105 Ev 59. Back

106 Professor Juergen Rehm, Q. 813. Back

107 Dr Van Santen, Q. 808. Back

108 Ev 103. Back

109 Minutes of Evidence taken before the Home Affairs Committee. Session 2001-02, on The Work of the Home Office, HC 302, Q. 5. Back

110 Vol III, Ev 240. Back

111 Q. 378. Back

112 *Evaluation of Lambeth's Pilot of Warnings for Possession of Cannabis - Summary of final report*, PRS Consultancy Group, 2002. Back

113 *Policing the Possession of Cannabis: Residents' Views on the Lambeth experiment*, The Police Foundation and MORI Social Research Institute, 2002, pp. 3-7. Back

114 Q 8. Back

115 Ev 197. Back

## THE GOVERNMENT'S DRUGS POLICY: IS IT WORKING?

*Possible reclassification*

117. In evidence to us on 23 October 2001, shortly after we began this Inquiry, the Home Secretary made his announcement that he would seek the advice of the Advisory Council on the Misuse of Drugs on the possible reclassification of cannabis from Class B to Class C. The Minister, Mr Ainsworth, explained to us the motives for this policy move:

"The motives...were not simple and singular; they were about trying to bring the law into line with that which was being practised in some police authorities in any case, and provide some consistency within police authorities; direct police resources a little more towards Class A drugs where the most damage was being done; and get a more credible message to send out to young people in order to get through to them about the damage that drugs do".[116]

118. On 14 March, the Advisory Council reported their view that cannabis should be reclassified as a Class C drug, as "the current classification of cannabis is disproportionate in relation both to its inherent harmfulness, and to the harmfulness of other substances, such as amphetamines, that are currently in Class B".[117]

119. Mr Ainsworth clarified to us what reclassification would mean, in effect, for the person caught in possession of small amounts of cannabis: "possession of small amounts

would not be an arrestable offence...the effects of reclassification would be very similar in terms of policing to what is going on in Lambeth at the moment".[118]

*Conclusions on cannabis*

120. **We accept that cannabis can be harmful and that its use should be discouraged. We accept that in some cases the taking of cannabis can be a gateway to the taking of more damaging drugs. However, whether or not cannabis is a gateway drug, we do not believe there is anything to be gained by exaggerating its harmfulness. On the contrary, exaggeration undermines the credibility of messages that we wish to send regarding more harmful drugs.**

121. **We support, therefore, the Home Secretary's proposal to reclassify cannabis from Class B to Class C.**

122. We stress that reclassification does not amount to legalisation. It simply means that in future the maximum penalties for the supply and possession of cannabis, among other offences, would be reduced from 14 years' imprisonment to five years (for supply) and from five years to two years (for possession) as the table below shows.[119] In addition, possession of cannabis would cease to be an "arrestable offence", which means that the offence would no longer attract the investigative powers which attach to arrestable offences, eg the power to enter and search premises without a warrant, and will leave the police free to concentrate on more harmful drugs.[120]

| General Name of Offence<br>Maximum penalty if tried on indictment |
|---|
| Class B drug involved<br>Class C drug involved |
| Production of a controlled drug<br>14 years<br>5 years |
| Supplying a controlled drug<br>14 years<br>5 years |
| Having possession of a controlled drug<br>5 years<br>2 years |
| Having possession of a controlled drug with intent to supply it to another<br>14 years<br>5 years |

## ECSTASY

123. While only 5% of men and women aged 16-59 had ever taken ecstasy, according to the British Crime Survey 2000, the proportion of 16-29 year olds who had was 12%. In the last year, 2% of 16-59 year olds and 5% of 16-29 year olds had used it; in the last month, 1% and 3% respectively. Mr McNicholas, editor of *Musik* magazine, estimated that about two million ecstasy tablets are taken every weekend, although it is obviously not possible to equate this directly to numbers of users, as some people take more than one tablet at one time.[121]

124. Ecstasy is a drug on a different scale from cannabis, as it causes a number of deaths every year. Having said this, the number of fatalities is relatively small in comparison to the number of people who apparently use it.[122] There is much we do not know about the effects of heavy, long-term use.

125. We were offered the following assessments of the harmfulness of ecstasy by Professor Nutt and Professor John Henry, Professor of Accident and Emergency Medicine, Imperial College School of Medicine at St Mary's Hospital, respectively:

"I personally think that ecstasy is relatively safe in the short term The long-term risk is to my mind unknown at present, although as each year goes by I get relatively more sanguine about the risk rather than less. I accept that there is still a great deal of uncertainty about the long-term effects on the brain. In terms of addictiveness, it is very low".[123]

"Quite clearly it causes about 20 something deaths per year and that is very small in terms of the large number of users. You could even use the word minimal for the short-term risks of ecstasy when you compare them with those of cocaine and heroin. Addictiveness is low. The other thing is that there is emerging evidence that it causes damage to memory processes. There are epidemiological comparisons of users versus non-users and even more recently we have seen studies which have followed up ecstasy users for a year and they have shown that aspects of memory function deteriorate during that year. Long-term use might lead to considerable impairment of memory".[124]

126. The Police Foundation Independent Inquiry consulted members of the Royal College of Psychiatrists' Faculty of Substance Misuse about the relative harmfulness of controlled drugs, and found that, in the resulting revised ranking, ecstasy fell into Class B. The report observed that "population safety comparisons suggest that ecstasy may be several thousand times less dangerous than heroin...there is little evidence of craving or withdrawal compared with the opiates and cocaine". They went on:

"Although deaths from ecstasy are highly publicised, it probably kills fewer than 10 people each year which, though deeply distressing for the surviving relatives and friends, is a small percentage of the many thousands of people who use it each week. Nor is it always clear whether the deaths are caused by ecstasy itself...or the circumstances surrounding its use...in many cases they are due to environmental aspects of the dance club scene, particularly overcrowding, overheating, poor availability of cool-out rooms, and restrictions on or the high cost of drinks".[125]

127. The Committee has heard that many problems with ecstasy result from the circumstances in which it is taken. Ecstasy is commonly associated with the clubbing scene, and is often taken by people who then go on to dance for hours in hot, crowded conditions. If the person forgets to drink water while dancing for long periods, they will experience extreme dehydration, "their blood vessels constrict to maintain blood pressure and they stop losing heat, their body temperature goes up and systems fail one by one".[126] Conversely, a mechanism in ecstasy means that a person who has taken the drug and who drinks a lot of water while not exerting themselves may in fact die from not being able to pass the excess water. Professor Henry told us:

"if I took a couple of ecstasy tablets...the kidneys would just not respond to that water and if I drank enough water, it would stay in my bloodstream and my brain would just swell up and it could be fatal. I would initially become confused and I might develop convulsions and I could die".[127]

128. It is important that every effort is made to detect and prevent ecstasy use in clubs. This is not always possible, however, especially when the drug is taken prior to entering the club. It is, therefore, essential to try to minimise the harmful consequences of use. We were told that providing information about safer ways in which to take ecstasy and drink the correct amount of water has already saved lives:

"The policy on ecstasy which the Home Office developed a few years ago...was helpful in that it was an educational policy and trying to reduce harm through improving the knowledge base of the users. There has probably been some evidence that that has helped and there are fewer deaths through water intoxication at least".[128]

129. **We believe that nothing should be done to imply that the taking of ecstasy is harmless, legal or socially desirable. Ecstasy is a dangerous drug. We recognise, however, that some young people will take ecstasy, and we want to reduce the numbers of deaths which result. We recommend that advice on the dangers of ecstasy and the ways to reduce the risks of death should be made available in nightclubs, and we welcome the recent publication by the Home Office of the guidance under the title *Safer Clubbing*. Police, club owners and licensing authorities should continue to aim for drug-free clubs and should work together to achieve this.**

130. Ecstasy does not present a major source of harm to communities. Commander Paddick, as a senior policeman, told us that ecstasy use was not high on his list of priorities:

"If I felt that my officers were going into nightclubs looking for people who were in possession of ecstasy then I would say to them, and I would say publicly, that they are wasting valuable police resources...I would say there are far more important things which cause real harm to the community in the way that ecstasy does not cause real harm to the community in Lambeth at this time".[129]

131. Islington Drug and Alcohol Action Team commented of cannabis and "dance drugs such as ecstasy":

"We cannot fail to note that users of these drugs are a very small minority of people

attending treatment services and coming to the attention of police as drug-related offenders. Consideration should be given to dealing with users of these drugs in ways which do not bring them into contact with the criminal justice system, or which minimise the chances of them risking employment or educational opportunities".[130]

132. We have also been told that the current classification of ecstasy hinders educational messages about the dangers of Class A drugs (see paragraph 86). However, Mr Ainsworth told us that "It is not my belief [that] the fact that ecstasy is in Class A is massively detracting from the message to young people".[131]

133. The suggestion of reclassifying cannabis has led some commentators to advocate a similar move on ecstasy: from Class A to Class B. Mr Ainsworth told us:

"Knowing what we know about ecstasy in terms of the immediate risk of, at worst, death; and not knowing...the long-term health consequences of ecstasy; and in the absence of any specific recommendation from the Advisory Council, it would be wholly wrong in my opinion for us to reclassify ecstasy¼I do not know, is the obvious answer, what the consequences of the reclassification of ecstasy might be. It could be we send a message to people that it is a safe drug to use; and that would be a very damaging message to send".[132]

134. Others disagreed. Mr Conor McNicholas told us: "If you apply the same logic to ecstasy as was applied to cannabis in this case, then immediately ecstasy must be classified as Class B, and possibly even as Class C".[133] The Association of Chief Police Officers demonstrated a flexible approach to policy on ecstasy: Deputy Assistant Commissioner Andy Hayman, Chair of the Sub-Committee on Drugs, told us that, should medical and scientific opinion be in agreement, then the Association would not object to the downgrading of ecstasy's classification.[134] The Police Foundation report concluded "ecstasy and related compounds are significantly less harmful than the other Class A drugs", and therefore recommended that ecstasy be transferred to Class B.[135]

135. **We agree with the Police Foundation and therefore recommend that ecstasy is reclassified as a Class B drug.**

136. To those who suggest that to reclassify ecstasy is somehow to condone its use, we emphatically reject this. Even as a Class B drug, the penalties remain severe, although obviously less than for a Class A drug. Whereas the maximum penalty for importation, production, supply and possession with intent to supply of a Class A drug is life imprisonment, the corresponding penalty in respect of a Class B drug is 14 years. As the table below indicates, the maximum penalty for possession of a Class A drug is seven years, whereas for a Class B drug it is five years.

| General Name of Offence<br>Maximum penalty if tried on indictment |
|---|
| Class A drug involved |
| Class B drug involved |

Production of a controlled drug
Life
14 years

Supplying a controlled drug
Life
14 years

Having possession of a controlled drug
7 years
5 years

Having possession of a controlled drug with intent to supply it to another
Life
14 years

COCAINE

137. According to the British Crime Survey 2000, 5% of 16-59 year olds had ever tried cocaine, although this included 10% of 16-29 year olds, and 2% (16-59 year olds) and 5% (16-29 year olds) had used it in the last year. 1% of 16-59 year olds and 2% of 16-29 year olds had taken cocaine in the last month. This marks part of an upward trend in use of cocaine since 1994, when only 0.5% of those aged 16 to 59 year olds and 1.2% of 16-29 year olds had used it in the last year.[136] The most dramatic trend, however, has been the rise in cocaine use amongst 16-19 year olds, which has risen from a static level of 1% during 1994-8 (use in the last year) to 4% in 2000. There has also been a significant increase in use by young men. A contributory factor to these rises may be the decline in cost of cocaine by almost 50% since 1994.[137]

138. Powder cocaine, or cocaine hydrochloride, is extracted from the coca leaf through a process of mashing and soaking the leaves and heating the resultant paste with hydrochloric acid. Use of cocaine carries both acute and long-term health risks. It is possible, however, to have different opinions about the level of risk: Dr Brewer of the Stapleford Centre judged that cocaine posed "a problem but still in comparison with alcohol quite small".[138] Professor Nutt however, offered this assessment:

"Short-term risk [is] quite high in relation to cardiovascular side effects and also to acute psychotic episodes. Long-term risk high, particularly in terms of dependence, cardiovascular damage and possibly psychiatric problems. Addictiveness high".[139]

139. Cocaine can also make users aggressive which means that they can present a risk to others: "Stimulants [such as] cocaine are associated with increased aggression and psychotic behaviour, particularly when used to excess".[140] The proportion of those presenting for treatment who admit to using cocaine has increased by 70% since 1993, and the numbers of recorded cocaine-related deaths has risen from 12 in 1993 to 50 in 1998 and 87 in 1999.[141] However, we have heard that the number of treatment places for stimulant users is small:

"The vast majority of treatment available in the UK targets opiate misusers, about 50,000 opiate misusers access treatment each year compared to 4,000 cocaine misusers. This

almost certainly reflects the availability of treatment rather than prevalence of problematic use. The identification of effective treatments for cocaine dependency and their widespread implementation is an urgent priority".[142]

140. Given the rapidly rising prevalence of cocaine use, and the lack of an effective treatment model, **we recommend that the number of treatment places for cocaine users is substantially increased. We recommend that resources are channelled into researching and piloting innovative treatment interventions for cocaine users.**

141. **We consider that the risks posed by cocaine to the user and to other people merit it remaining a Class A drug.**

CRACK COCAINE

142. Crack cocaine is usually made by mixing cocaine hydrochloride (cocaine powder) with baking soda, in water. The solution is then heated gently until white precipitates form. The precipitate is filtered, washed, dried, and cut or broken into small 'rocks'. Whereas cocaine powder is usually snorted through the nose, crack is heated in a pipe and the vapour inhaled. Crack cocaine use is lower than cocaine use, according to the British Crime Survey: amongst 16-59 year olds, less than 0.5% had taken it in the last month, the same proportion in the last year and 1% had ever taken it. Of 16-29 year olds, less than 05% had taken it in the last month, 1% had taken it in the last year, and 2% had ever taken it.[143]

143. Like cocaine, crack is associated with significant risks to the health of the user, including risks of psychotic episodes, dangerously high blood pressure and increased risk of heart attack, as well as risks of damage to the respiratory system because of the way in which crack crystals are smoked. To a much greater degree than powder cocaine, however, crack also seems to be associated with unpredictable and violent behaviour resulting in harm to other people. Many of those who deal in it have shown a willingness to resort to extreme violence. Like heroin, crack use is also associated with property crime. Mr Ainsworth referred to "the massive damage that [crack] is doing to certain communities and inner-city areas".[144]

144. Professor John Henry told us that using habits appear to indicate that crack is more addictive than powder cocaine: "there is a much larger number of regular crack users than occasional crack users, whereas there is a much smaller number of regular cocaine users than occasional users".[145]

145. As with powder cocaine, experience on how to treat addiction to crack is lacking. The Government, therefore, has asked a panel of experts to look at the problem of cocaine and crack, and expects them to report back by the end of 2002:

"we have decided in the absence of published evidence to bring together a group of people¼who do treat people who have crack cocaine problems, to explore with them what they do, what their best practice is, where they have success and then we shall work with the National Treatment Agency¼in order to spread around the rest of the treatment sector approaches which we feel are likely to work better than perhaps we know at the

moment".[146]

146. The lack of research evidence does not mean, however, that nothing can be done: interventions exist which seem to help. In addition, Dr Brewer told us that:

"there are several companies working on a kind of [antibody] for cocaine. In principle you can now make a blocking agent, an anti-body, an antidote to almost any drug of abuse... We hope that within a few years we shall actually have some drugs of this kind".[147]

147. **As with cocaine, we recommend that more treatment places are created for crack users and that resources are channelled into researching and piloting more effective treatments. We further recommend that in the meantime efforts are redoubled to extinguish supply of crack cocaine.**

148. **Where crack is concerned we see no prospect for compromise. We note that few of our witnesses argued outright for legalisation. We leave it to those who do argue for general legalisation to explain how this could be justified given that, unlike other illegal drugs, crack can trigger violent and unpredictable behaviour.**

## HEROIN

149. The proportion of the population using heroin is relatively small, but the damage caused to individuals, families and communities is enormous. The British Crime Survey 2000 found that 2% of its sample had ever taken heroin, 1% in the last year, and less than 0.5% in the last month. These proportions were the same within the 16 to 24 age group.[148] The number of problematic heroin users in the UK is generally agreed to be around 200,000.[149] These figures represent a huge increase on thirty years ago when the estimated number of known addicts was around 1,000.[150]

150. Between 1973 and 1996 (when the scheme was discontinued) doctors were required to notify addicts of Class A drugs to the Home Office, to be recorded in the "Addicts' Index". While the numbers notified are likely to be serious understatements, a graph of the data (see overleaf) illustrates the explosion in numbers of addicts from the 1970s to the 1990s:

116 Q. 1234. Back

117 Home Office Press Notice 070/2002, 14 March 2002. Back

118 QQ. 1237; 1242. Back