

Edited by Jim McVeigh  
Centre for Public Health  
School of Health and Human Sciences  
Liverpool John Moores University  
70 Great Crosshall Street  
Liverpool L3 2AB  
Tel: 0151 231 4485  
Fax: 0151 231 4440  
Email: [j.mcveigh1@livjm.ac.uk](mailto:j.mcveigh1@livjm.ac.uk)

## Acknowledgements

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# 1. Foreword

Cannabis remains the most commonly used illegal drug in the United Kingdom, with over a quarter of the adult population having used the substance during their lifetime. While more research is required to ascertain the long-term effects of cannabis, a Working Party of the Royal College of Psychiatrists and the Royal College of Physicians have already recognised that this substance is almost certainly less damaging to health than tobacco or alcohol.

In October 2001 the Advisory Council on the Misuse of Drugs (ACMD) were asked by the Home Secretary to review the classification of cannabis within the Misuse of Drugs Act (1971). In March 2002, the Council recommended the reclassification of all cannabis preparations to Class C. While the ACMD emphasised that cannabis is not a harmless substance, based on current scientific evidence they see cannabis as less harmful than other substances within Class B of the Misuse of Drugs Act (1971).

It is within the context of growing support for a change in the legislation relating to cannabis, that the conference "Cannabis: Shaping a new agenda", was held in Liverpool on 14th February 2002. The aim of the conference was to bring together representatives from diverse groups affected by cannabis use and the proposed change in cannabis legislation (Appendix 1). We hope that the conference and the published proceedings not only contribute to an informed debate on the often complex issues relating to cannabis use in the UK, but will also facilitate an on-going dialogue between individuals and organisations dealing with drugs and health issues.

**Jim McVeigh**  
**Centre for Public Health**  
**Liverpool John Moores University**

## 2. Introduction

Professor John Ashton CBE  
Regional Director of Public Health (North West)

It seems particularly timely that this event is taking place this week. We like to try and anticipate things in the North West to make sure we have got the right story for the week. Of course, this conference has come about because of the change in climate in relation to cannabis issues since the Home Secretary's remarks last autumn.

We in public health in the North West have always tried to create an environment where there was evidence-based discussion of policy issues. Some things we do through the Public Health Observatory, which is based at Liverpool John Moores University but also linked to the Medical School in Liverpool, The University of Salford and Lancaster University. Mark Bellis, the professor of Public Health at Liverpool John Moores University, is the director of the Public Health Observatory and there is a website for the Public Health Observatory which is at [www.nwpho.org.uk](http://www.nwpho.org.uk). We publish regular Public Health bulletins in the region, and we produced a bulletin on cannabis just before Christmas. We also produced a report on alcohol, tobacco and drugs in the North West of England. That was done quite deliberately to try and actually pull together the information that we have for the North West on all the different types of substances that people use that are mind altering in one way or another.

One of the problems with this whole area, is that people tend not to think about their own poison; so smokers may get very upset if you talk about tobacco in the same breath as illegal drugs, and people who regularly consume large quantities of Chianti and other similar substances tend to get very upset when the discussion lumps them together with people who might be using other types of chemicals. The reality is that the overwhelming majority of the public is actually using chemicals of one kind or another to modify mood, and to mediate their interaction with the environment. However, we do not look at this reality in the round very often, so that publication aimed to try and begin to do that.

What I really want to do in some preliminary remarks is to try and frame the discussion this afternoon. I hope we're going to have a really good time with the input from people who are experts in this field, but we also have the benefit of all of you in the audience who will have opinions, thoughts and experience of this topic.

What we want to do today, is to kick off a proper discussion about these issues at a public level; which is not about being patronised by people who think they know all about it, but which is actually about a democratic approach to a tricky problem, where there isn't a consensus, and where there are quite striking differences in views, particularly in relation to age. People over the age of 60 tend to have much different attitudes and experience with regard to this topic than younger people; who perhaps have grown up with it, been exposed to it, know about it, and who actually are perhaps much more sanguine about these kind of issues.

The starting point for my contribution this afternoon is really to refer to the paper published by John Strang, John Witton and Wayne Hall in the British Medical Journal just over two years ago called 'Improving the quality of the cannabis debate: defining the different domains'. The point about this paper is that it

identifies eight perspectives on cannabis, which the authors argue against, and which should be tested in discussion.

We want to discuss today whether different types of cannabis have different effects; whether there are long-term physical effects of harm from cannabis use, the psychological damage or otherwise of cannabis, dependence, whether it is a gateway drug, and the potential role as a beneficial therapeutic agent. We also want to hear about the experience of other countries, and we have Bob Keizer here from Holland who is going to talk to us about the Dutch experience.

When Mark Bellis and I read the Strang, Witton and Hall paper, we were moved to write a letter to the BMJ, in which we said that these eight domains were all very well but there was a ninth one which also needed to be considered; what we call the social context and the social impact of our current policies on cannabis. There are different approaches to dealing with cannabis in different parts of the country, depending on which police force area you live in, or which school children go to, whether they get expelled from school for possession of cannabis, imprisonment and so on. Additionally, there is the impact of the way in which we as a society have responded to cannabis over the past 25 years, and whether the negative aspects of that are actually more harmful than the hypothetical harm from using cannabis itself. So we identified that ninth domain to contribute to the discussion and I hope we get into that today.

The sort of ethical reference points which I as a public health practitioner bring to bear often draw heavily on the utilitarian kind of arguments that the Victorian public health people used; the 'greatest good' for the 'greatest number'. Obviously there are other kinds of arguments that people bring to bear on this discussion. People sometimes bring very strong moral positions or libertarian arguments to bear; they say 'why should anyone interfere with what I choose to do to my own body?' Surely that's all about the nanny state: 'if I do something which is only relevant to myself isn't that entirely up to me?' The Americans have an expression that 'your liberty ends where my nose begins', that you can do whatever you like as long as it doesn't affect me.

But there are very practical issues as well which I think we will get into this afternoon. For example, we know that for Merseyside Police in 1998 of 2240 police incidents directly involving drugs, 71% were related to cannabis and only 6% to heroin. Is that an appropriate use of police time given all the other pressures, given all the other concerns? We've heard a lot recently about street crime, street violence and gangs; is it appropriate that the police should be spending their time on cannabis related incidents rather than actually making it safe for us to live our lives in the cities of the country?

So these are some of the arguments. The lack of consensus is clearly an issue and I suspect we are not going to solve that this afternoon. I hope that what we will do is begin a proper debate where the facts are on the table and where people can begin to make up their own minds. I think that the level of media interest is very encouraging because hopefully we can begin to have an informed public. I think some of the issues that have been so topical recently, such as MMR, really indicate that the public are no longer

prepared to accept people telling them what is best for them. They really wish to be involved in discussions themselves, they wish to have the facts and to talk about things themselves, and we have to respond to that. We're living now within a democracy where we have an aspiration and a target that 50% of school-leavers will go to university within a very short time. We have a very educated population, yet we still have this legacy of people making decisions for other people and assuming that these people cannot actually participate in these discussions. So we need an open debate, we need to see how to move forward.

Finally, there are two other publications that I'll draw to your attention. Tony Lloyd who is the Member of Parliament for Central Manchester has chaired the North West Drug Treatment Commission over the last two years. I was sitting on that commission with Tony, and we published a report a few weeks ago, which identified that we have got a lot to do on the drug treatment side for people who are in difficulty with drugs. That's a very practical agenda, which we've really got to get to grips with. There's another document which is a lecture of my own about health, governance and citizenship which I think touches on some of the issues that I've been talking about; about the need to have a much more participatory and democratic approach to these questions where people feel much more involved in discussion and influencing policy.

### **Recommended Resources**

Ashton, J.A. (2000). *Governance, Health and the New Citizenship: Inaugural Lecture*. Public Health Sector, Liverpool John Moores University. <http://www.nwpho.org.uk/reports/ja04062001.pdf>

Ashton, J. A. and Bellis, M. A. (2000). Improving the quality of the cannabis debate. Social context should be added to domains being considered. *BMJ (letter)* **320**: 1671.

North West Drug Treatment Commission (2002). *Offering A New Tomorrow: Report Of The North West Drug Treatment Commission*. North West Drug Treatment Commission

Strang, J., Witton, J. and Hall, W. (2000). Improving the quality of the cannabis debate: defining the different domains. *BMJ* **320**: 108-110.

Hughes, K., Bellis, M. A., Kilfoyle-Carrington, M. (2001) *Alcohol, Tobacco and Drugs in the North West of England - Identifying a Shared Agenda*. Public Health Sector. Liverpool John Moores University. <http://www.nwpho.org.uk/reports/su&ph.pdf>

### 3. Cannabis: a review of the scientific evidence

John Witton

National Addiction Centre, Addiction Sciences Building,  
4 Windsor Walk, London SE5 8AF

#### **Biography**

*John Witton is a Research Co-ordinator at the National Addiction Centre (NAC) in London. Formerly Head of Information Services at the Institute for the Study of Drug Dependence library (now part of Drugscope), projects conducted at the NAC included the Cannabis Evidence Audit, a systematic review of the cannabis research literature.*

I've been invited to do a presentation on the harms of cannabis to psychological and physical health. Between 1998 and 2000 I was pursuing a systematic review of cannabis research at the National Addiction Centre, so my presentation this afternoon is based on that systematic review.

#### **Prevalence of cannabis**

The last British Crime Survey found that 27% of adults had tried cannabis in their lifetime and 6% had used it in the last month, and these figures are reflected in findings from similar studies in Australia and America. In Australia 39% of adults had tried in their lifetime, 11% had used weekly, and in the United States 35% of adults had tried and 5% are current users. Cannabis use is a pretty well entrenched part of leisure activity in Western societies and so it has given rise to a lot of the concerns about the harms associated with its use.

#### **Recent reviews of the evidence**

Cannabis has been researched since the late nineteenth century and anybody familiar with the cannabis research will know that there's been well over a dozen major commissions that have looked into the hazards associated with cannabis. Up until the late 1970s many of these commissions were prompted by political considerations, and then once the cannabis issue had gone off the political agenda the research around cannabis seemed to die away. There were some authors in the late 1980s writing 'whatever happened to the cannabis debate?', it seemed to have dropped off the radar screen of drug issues. There was a renewed interest in cannabis as scientists started finding out a bit more about cannabis receptors and exploring the potential of cannabis for use therapeutically. This is marked by these recent reviews of the literature; kicked off by the World Health Organisation's report in 1998, then the American Institute of Medicine produced a report on marijuana and health in 1999. The most recent study is one from Wayne Hall and his cohorts at the National Drug and Alcohol Research Centre in 2001. All of these reports are well worth looking up if you want to find the current state of knowledge, and to a certain extent my talk this afternoon is based on these reviews.

I should also add that I'm going to be writing a book about my systematic review which I expect to be out at the end of this year, and the working title is 'Cannabis: the facts'. As you will hear as I go through my talk this afternoon I think calling it 'Cannabis: the facts' is a bit of a misnomer, so you'll hear a lot of the words such as 'may cause' or 'perhaps cause' as we go through this session.

## **Interpreting the evidence**

Having read something like two thousand articles on cannabis whilst doing the systematic review, I suppose the main thing that I came away thinking was that there's still a lot more research needed. Some of the harms that people have been claiming are linked to cannabis are not that clear cut and that's because there are many problems in trying to interpret the evidence. This you'll find across the board in research on all of the illegal drugs. In the particular case of cannabis, as many of you probably know the main psychoactive constituent of cannabis is delta-9 tetrahydrocannabinol, THC for short, and you find that the dosage varies so much in the amount of cannabis that people are using. The cannabis used in some of the American research was government-supplied cannabis with a lower THC content than people are using on the streets. So the inferences we can draw from those studies are perhaps a bit limited.

As you're aware we live in a time of poly-drug use and many people are using cannabis along with other drugs, notably alcohol and tobacco. In the last ten years with the growth of the dance music scene people are using cannabis with cocaine and ecstasy, so it becomes very difficult to disentangle the effects of cannabis alone from this menu of different drugs that people use. If you want to try and identify the effects of drugs then controlled long-term studies are ideally what you would need. For reasons of the illicit nature of the drug, cannabis research is quite lacking in good long-term controlled studies. There is some work underway in Scotland led by Niall Coggans which we await publication of, but otherwise long-term studies are absent in the cannabis research literature. One of the reasons why there is a lack of controlled long-term studies is because the typical cannabis career follows a pattern identified by Kandell and colleagues in America. Most people start using cannabis in their late teens, peak their cannabis use around the early 20s and then as they move towards family-hood and getting jobs the cannabis use stops. So most people have stopped their cannabis use by the time they are thirty.

## **Short-term effects of cannabis**

Obviously millions of people wouldn't be using cannabis if they weren't having a good time with the drug. Cannabis is noted for producing euphoria, relaxation, helping people identify and enjoy things they might be doing like listening to music, making people more talkative, and just generally having a good time. Of course like other drugs the effects of cannabis depend on the setting, the company they're keeping and how much they've taken. If people are not aware of these surroundings, if they're new to cannabis then some of these people might experience adverse effects. I don't want to play this up too much because these adverse effects are relatively rare, but for example if a young person is new to cannabis or somebody takes too much then you do get some adverse effects like anxiety, dysphoria, panic and paranoia. Notably if you're taking cannabis you will see some psychomotor impairment, so you'll have problems with your attention but I'll move on to the implications of this when I talk about cannabis and driving. Also some people who take too big a dose may experience something like a psychotic reaction, and similarly mothers who are smoking cannabis through their pregnancy may be at risk of producing low birth-weight babies.

## **Cannabis potency**

The main constituent of cannabis that produces the psychoactive effect is tetrahydrocannabinol, THC for short. Cannabis contains sixty different cannabinoids like THC, and also has four hundred other constituents so it's a very interesting substance altogether. THC receives the most attention, and THC is the chemical constituent that you'll find mentioned most often in the studies of cannabis. In the age of increased homegrown cannabis producing varieties like skunk, these new forms of cannabis seem to be containing more THC. This has led many researchers and commentators to suggest that if THC content is on the increase then this must increase the harms associated with cannabis. If there's more THC content then perhaps there is an increased risk of adverse effects such as psychotic reactions, and more people are getting into dependence problems. However, there's very little research evidence to suggest that THC content is actually increasing. Certainly enforcement seizures are identifying strains with higher THC content, but the only real source of information we have on this is some American research. A research body of the University of Mississippi have been looking at cannabis samples over the last twenty years and their findings suggest that average THC content in the samples they were looking at in the 1980s was about 3%. The last research report they produced looked at the THC content for 1998 and found that it only increased to about 4.4%, so there is some doubt as to whether the THC content on average is increasing. It also leads onto a debate that cannabis users know what they're doing, so if they are experiencing some dose-related effects would they be like cigarette smokers and titrate their dose to ensure that they do not experience these adverse effects? So there are still plenty of questions remaining over the impact of the increase in cannabis potency.

## **Cannabis: psychological harm**

My workplace the National Addiction Centre is allied to the Institute of Psychiatry in London, and some of the researchers there are finding that more and more young people are coming through their doors with seemingly cannabis-related problems. This has become a practical issue where I work, but what does the evidence suggest about cannabis and psychological harm? There seems to be some evidence that cannabis does exacerbate the symptoms of schizophrenia. There are a number of papers that suggest that patients with schizophrenia who are taking cannabis at the same time will experience more cases of hospitalisation and have more problems keeping to their medication. So within the psychiatric wards cannabis can create a few problems. There's also some evidence that cannabis may precipitate schizophrenia in vulnerable people but again the evidence for that is fairly scant. There was some work by Phillip McGuire at the Institute of Psychiatry who looked at the genetic background of people who had schizophrenia and were smoking cannabis. It did seem that there was something about people who had some schizophrenic problems in their background and smoked cannabis that was leading them to have problems as well. There is also some uncertainty as to whether cannabis can actually cause schizophrenia. There was a frequently cited study of several thousand Swedish conscripts which was reported in 1987, and amongst that group of conscripts those who were smoking cannabis were 2.4 times more likely to be diagnosed as schizophrenic later in life. As I say this has been a running theme through my talk, but this study has been criticised by other commentators for some of its methodological shortcomings. Some people have said that the people diagnosed as schizophrenic may have been misdiagnosed, and that their cannabis use earlier

on might have been a symptom of schizophrenia that hadn't been diagnosed at that particular time. I think the point with this is that people feel there is something there but we're still uncertain as to what that link might be.

### **Cannabis and dependence**

Cannabis and dependence is another issue that has received prominence in the last five to six years. Cannabis was classically felt not to create dependence problems, and that you didn't actually see the signs of withdrawal that you'd see in drugs like alcohol and heroin. The definitions of dependence have changed in recent years; dependence is marked by symptoms not just including signs of tolerance and withdrawal but also signs like people trying to stop their drug use but finding that very difficult, that they're using more of the drug than they originally intended. Using these criteria has seen more people reporting a dependence syndrome in non-treatment samples, and I'm thinking particularly of the work of Wayne Hall and Wendy Smith in various groups of people in Australia. There was a major study of psychological problems in the States through the late 1980s and their study of the American population found that 4.4% of that population reported cannabis dependence.

Over the years there have been a number of laboratory studies which do report withdrawal symptoms related to cannabis use; things like irritability, difficulty sleeping, sweating, but again there has been some criticism of the methodologies they used. For example, the people in these studies would probably be showing these signs simply because they were in the laboratory, that they feel really uncomfortable being cooped up and being studied and so all the anger and irritability they're showing is a product of their setting rather than the drug itself. I suppose one question you need to ask throughout when you're looking at the evidence for harms related to cannabis is what is the clinical significance of these research findings? Certainly we can talk about statistical associations but the bottom line is: what is the clinical significance of this? Are we actually seeing more people coming to our treatment services with cannabis related problems? Certainly in Australia, America and the Netherlands they have set up some treatment clinics for cannabis which are attracting quite a few people, so there does seem to be something going on in this area but again we're not entirely sure what.

### **Cannabis as a gateway drug**

Cannabis as a gateway drug is an issue that is certainly politically loaded. The original idea was that cannabis acted as a stepping stone; once people started using cannabis then they were on a road which led to "harder" drug use, a road leading to cocaine and heroin. Over the years this idea has become a bit more nuanced, essentially what people are suggesting now follows the metaphor of a field where cannabis use is found. People might open a gate which leads to another field where you would find cocaine use, and there is a field leading on from that which leads to heroin use, or they may go backwards to alcohol and tobacco use. The research has identified that there is a sequence of drug use where people start off with tobacco, perhaps move on to alcohol, then cannabis, and then move on to other drug use. This sequence has been identified in research across the world; America, Australia and Canada, but still the role of cannabis in this sequence is unclear. Are there pharmacological reasons or genetic explanations why people

using cannabis move on to other drug use? Or are there more simple sociological explanations that those people using drugs are going to use other drugs anyway? Will people moving in circles where drug use is accepted use the other drugs as well? There is still a lot of work to be done in terms of understanding this relationship.

### **Cannabis and driving**

Laboratory studies do show that there are impaired psychomotor abilities after cannabis use. We're finding in research from America and other countries that road stops are finding more cannabis in blood and urine tests, but the role of cannabis in accidents is very hard to identify because, as you're probably all aware, cannabis stays in the bloodstream for rather a long time. Therefore, it's not clear as to whether people are actually under the influence of cannabis when they had accidents. We have seen some recent road laboratory studies and the major findings from those studies, and they've all been quite consistent, are that those people that are intoxicated with cannabis generally tend to drive more slowly and drive more cautiously. So they're aware that they're intoxicated and are taking due precaution by driving more carefully.

### **The respiratory system**

As I mentioned at the beginning of my talk most people who smoke cannabis are using cannabis with tobacco when they're rolling a joint to ease the smoking, and cannabis like tobacco has some very unhealthy and unpleasant constituents. The research has shown that there is increased tar deposits on the lung and people are experiencing increased symptoms of chronic bronchitis and impaired lung function. There is also research that demonstrates that there are changes in the bronchial tissue as a result of the cannabis smoke. I should add that a lot of these problems that have been identified with cannabis use relate to the smoke produced rather than the cannabis itself.

### **Cannabis and carcinogenesis**

There has been increased concern around cannabis and cancer but again a lot of the evidence is either weak or equivocal. There is some evidence that cannabis can cause cancer of the lungs and the aerodigestive tract and there has been some concern that cannabis use amongst mothers has been associated with childhood cancers. There is no evidence of any major impairment of the immune system and some studies amongst those people with HIV haven't found that cannabis in any way impairs their prognosis.

### **The reproductive system**

There is still some inconsistent evidence that cannabis can disrupt the male and female reproductive system. There is some evidence that suggests that cannabis use can probably lead to lower birth-weight babies, and a little bit of evidence that children of those mothers who continued their cannabis smoking through pregnancy may experience some behavioural and developmental effects.

### **Cognitive functioning**

I suspect that if you were to take any substance over a long time it's going to have some impact on your cognitive functioning, but there's no evidence of chronic brain damage and thus far there's no evidence that long-term use produces severe impairment of cognitive functioning. However, that may be a product of the lack of long-term studies of cannabis. There is some work undertaken by Nadia Solowij in Australia and she's identified amongst the samples she's been studying that there is a subtle impairment of memory and attention in some users of cannabis, but I think the jury's still out on the implications of her work.

### **Psychosocial development**

For many years people claimed that cannabis use was linked to an amotivational syndrome, which seemed to be backed up by some socio-cultural studies in places like Jamaica and Costa Rica. A further look at this evidence suggests that the amotivational syndrome isn't something that is a product of cannabis use but essentially was already there amongst the people; it's the people rather than the drug itself. It does seem that young people using cannabis at an earlier age may be at increased risk of some adverse psychosocial outcomes such as trouble with the law or trouble with their schoolwork; again it's another area that needs more work done on it.

### **Those at risk**

People that you would want to indicate as being most at risk if they were using cannabis are: adolescents with poor school performance or early users, mothers who smoke cannabis during pregnancy, and those people who have pre-existing health problems like schizophrenia or cardiovascular problems.

As I said when I began, the findings from the cannabis research are not as robust as many people would claim. If we are to see any changes around the legal status of cannabis I would expect that it's also going to prompt a larger research initiative so that we can answer some of the questions that have been raised in my presentation this afternoon.

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### **Questions and Comments**

#### **John Ashton**

"I suppose the amazing thing is that it shows just how much heat and how little light there has been about this, and the fact that we've had policies for 25 years when we don't really know much about it is just amazing really. I'm an editor of a public health journal, and one of the things that I know as an editor is that very often the people who publish scientific papers say at the end that more research is needed. This is 'more research is needed' writ large for this one, it's just amazing."

*"Is all the information you've been given on cannabis in conjunction with tobacco or is it cannabis used on its own, as in England we tend to mix it with tobacco?"*

**John Witton**

"That is one of the problems with the cannabis research literature. As you indicated most people are using cannabis with tobacco so it becomes very difficult to separate the effects of cannabis from the effects of tobacco. That's why I'm suggesting that there's still quite a lot of work to be done. A lot of the laboratory studies will be using just cannabis by itself, they won't be using tobacco, and a lot of the studies on, for example, cannabis and driving will be ensuring that it's just cannabis rather than the tobacco. But you're right that the fact that most people are using cannabis and tobacco at the same time does actually compromise a lot of the research."

*"I remember some research from many years ago that seemed to say that naïve users have problems with their driving but with regular users it seemed to have no effect on their driving. I wonder if you can remember that research and if you could comment on that?"*

**John Witton**

"I don't remember that piece of research; I should do because I've been in the field for a long time. That doesn't surprise me because I'd expect naïve users would be experiencing some problems with their cannabis use anyway. As I indicated in the talk, regular users will get used to the effects, they'll know that they're intoxicated and will take due caution when they're driving; that's a consistent finding through the road laboratory studies that drivers are taking more care."

*"I was wondering if you'd like to comment on the damage that the heat of the smoke might cause to people who use cannabis on a regular basis?"*

**John Witton**

"I can't, I haven't looked at that. I don't recall there being much research on that so I can't comment on that sorry."

*"What do you know of any research on the effects of passive cannabis smoking on children?"*

**John Witton**

"It was a concern some years ago that like tobacco smoke there was a risk to children, but I think the research literature is quite sparse and so it again is going to be inconsistent. I don't think there's been enough work done on this to actually say yes or no."

## 4. Cannabis, other drugs and young people

Professor Martin Plant.

Director, Alcohol & Health Research Centre, Centre for Research in Public Health & Primary Care Development, University of the West of England, Glenside Campus, Blackberry Hill, Stapleton, Bristol BS16 1DD

### **Biography**

*Martin Plant, a sociologist, has been engaged in research into the use of alcohol and other drugs since 1970. His main interests include epidemiology, HIV/AIDS, risk taking, young people, prevention, policy and harm minimisation. He is a consultant to the World Health Organisation and was a member of the Department of Health's Cannabis Committee. He is currently membership secretary for the charity The Addictions Forum and is Director of the UK 'ESPAD' research team. Books that he has written or edited include the following: Drugtakers in an English Town; Drugs in Perspective; AIDS, Drugs & Prostitution; Alcohol: Minimising the Harm; The Alcohol Report.*

The first drug conference I ever attended was in Liverpool in 1970 and in those days the whole idea of illicit recreational drug use was much newer than it is now; in fact I remember somebody standing up and asking a question referring to 'canarbis rosin' which is a phrase that's stuck in my head. I think it's interesting that over the period since the drugs scene emerged in this country around the 1960s a lot of the debate about drugs in general, and probably cannabis in particular, or 'canarbis' should I say has been a moral debate. Pharmacology has always been an issue but it's been really quite trivial. The Wootton Report of 1968 was one of a whole series of reports on the effects of cannabis, it was debated in parliament very much in terms of the values presumed to be associated with cannabis use. The point about this debate was not that it is a depressant drug that has certain effects, some of which are pleasant, and like any drug, depending upon the level of use and the pattern of use, it is often associated with problems. Instead the debate in parliament was very much about the social meaning of this; the fact that cannabis users were perceived to listen to dodgy music, to have too much hair and were regarded as subversive troublemakers. That's really what the debate was about, and I think it's fascinating that we're witnessing a major sea of change in UK drugs policy.

### **Psychoactive drug-related deaths in perspective**

The Addictions Forum organised a meeting in Edinburgh in October 2000 called 'Going Dutch', and at that point we were asking for people's views on UK versus Dutch policies. It's clear that a very high proportion of people working in the addiction field in Britain have been aware that the Dutch are much more sensible in relation to their policies on almost anything than the British are; the Dutch are wonderfully pragmatic and they're sensible. We tend to moralise and often operate from a very ideological perspective. I think much of the media debate about cannabis has been about values, and very often extreme positions have been taken in both ends of the debate. As an alcohol researcher I've always been impressed by the fact that the effects of a substance depend upon the chemistry of the drug: whether it's alcohol, cannabis or tobacco, the context of use and the characteristics of the user. The level and pattern of use has an awful lot to do with whether or not the use of anything leads into problems.

The big picture in terms of health damage in the UK is that every year tobacco-related deaths account for about 120,000 premature deaths. With alcohol you can debate this figure but it's somewhere in the region of between 20,000 and 40,000. Illicit drug-related deaths in the UK account for somewhere in the region of 1,000-2,000, yet the media debate and policy on these respective substances doesn't have very much

bearing on the true global public health scale of the harms associated with tobacco, alcohol and illicit drugs. A team from the Canadian Centre on Substance Abuse headed by Professor Eric Single produced a fine report on the economic costs of drugs in Canada a few years ago. They concluded that in any industrial country, because alcohol and tobacco are far more widely used they were associated with far greater health and social costs than were illicit drugs. They also concluded that by far the biggest proportion of economic costs associated with illicit drugs related not to treatment but to law enforcement.

### **'Addicts' notified to the Home Office**

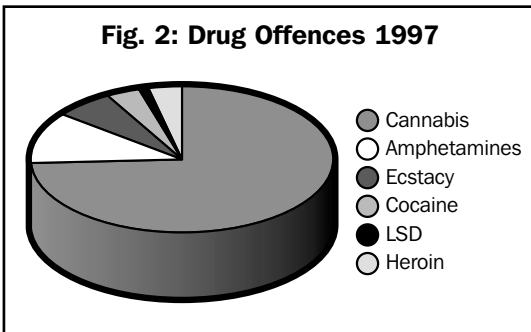
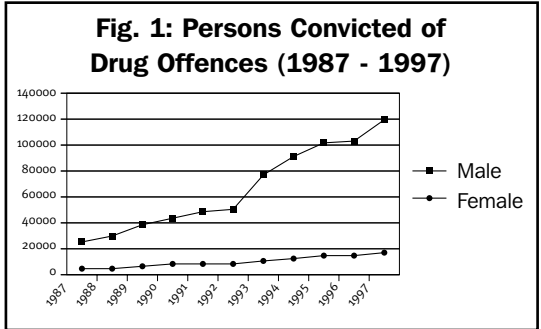
The Home Office up until very recently kept figures of so called notified addicts. People reported by doctors to be receiving prescriptions for opiates, usually methadone or sometimes heroin, really started going up: from almost none in the 1960s and early 1970s to very considerable numbers by the middle and late 1990s. The rise has been from very few in 1970 to about 33,000 men and about 10,000 women. In fact all of the indicators that we have suggest that since the 1960s there has been an increase across the board in most levels of recreational illicit drug use; and as use has become more widespread social drug-related problems have become more commonplace. I would emphasise however that if you look at each indicator closely they are far from perfect. Most people with drug problems are not necessarily reported as addicts, and many people who are drug users do not necessarily tell the truth when you try to pick them up in surveys. Surveys of any kind of behaviour are beset by sampling problems, bias and flaws such as under-reporting and over-reporting. Also surveys related to illicit behaviour might be more subject to these kinds of biases and problems than surveys of more commonplace or legal behaviour. The information from the Home Office suggests that even more than a decade after we became aware of HIV, a considerable proportion of reported addicts, around about one-third, continue to inject, and that drug-related deaths over the past decade or so have been relatively stable with most of them relating to drug poisoning. Deaths are attributable to drug dependence or non-dependence abuse, and a small but growing proportion is related to HIV and AIDS.

### **Drug deaths and type of drug**

Drugs deaths do not relate in general to cannabis. Overwhelmingly, recorded deaths associated with illicit drugs are related to opiates, which constitute the majority, closely followed by a variety of other substances. Cannabis does not really feature except very rarely for its implications in road traffic accidents.

**Drug offences**

Drug offences over the last ten years have gone up tremendously, particularly amongst men (Figure 1). Interestingly the proportion of women convicted for drug offences over the period 1987 to 1997 did not go up very much, but something very interesting has happened in relation to women, and I will come back to this later. Right the way through since the formation of drug squads and the establishment of drug control in the UK, at least 70% of drug offences have related to possession of relatively small amounts of cannabis.



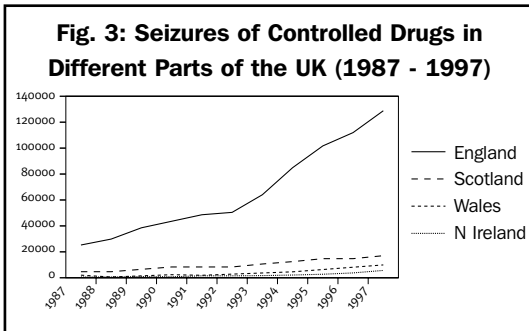
Amphetamines have consistently been the number two substance in this regard (see Figure 2) even though very often not much attention is paid to them. Only a very small proportion of overall drug offences or convictions relate to cocaine, heroin or other substances such as ecstasy (MDMA). So cannabis has essentially been the major concern of drug control apparatus.

**Persons convicted of drug offences**

I mentioned earlier the interesting position of women in relation to drug offences. Although only a small minority of convicted drug offenders are women (Figure 1), drug offences are now the biggest single reason why women in England and Wales are in prison; and about 37% of all women in prison south of Hadrian’s Wall are there for drug-related reasons. I think there’s a whole debate around the need for better provision for people in prisons with drugs and alcohol problems. Quite a lot of money has recently been invested in drug services in prison. I hope that in the next few years this actually leads to a much better provision for problem drug users in prisons. Certainly there is a rather bizarre situation of women being disproportionately at risk of imprisonment due to drug offences, which I think suggests there is something very strange going on here.

### Seizures of controlled drugs

Seizures of controlled drugs reflect an overall increase in use, together with an increase in recorded problems, the proliferation of drug agencies, an increase in seizures, and an increase in drug convictions.



The increase in seizures of controlled drugs appears to be going up more steeply in England than in other parts of the UK (Figure 3), I have no idea why that might be.

### The "ESPAD" surveys

Since 1994 my colleague Dr Patrick Miller and I have been involved in a study called "ESPAD": the European Schools Survey Project on Alcohol and other Drugs. This is a survey of nationally representative samples of 15 and 16 year olds. Originally when we did this for the first time in 1995 we had the

UK and twenty-five other countries. About ten months ago we reported on the results of the most recent study (carried out in 1999). This involved thirty European countries: ranging from Greenland in the West to Russia in the East. The results of this study attracted quite a bit of attention because they showed that self-reported levels of illicit drug use amongst British teenagers were higher than those reported in any of the other twenty-nine countries covered by this survey. The countries which came next in line were the Republic of Ireland, France and the Czech Republic. As a prelude to the next speaker, self-reported levels of drug-use by teenagers in the Netherlands were lower than they were in the UK. We also found that British teenagers were the most likely of any to say that they'd started smoking young, but when we looked at what they were smoking at the age of 15 and 16 it was middle of the road. Cigarette smoking has come down tremendously in this country during the last forty years, it's now down to around about a quarter or a third of the population. Teenage girls are more likely to smoke than teenage boys and smokers are much more likely to be those on low incomes than on high incomes. People on low incomes tend to have the highest proportion of health problems anyway, so smoking is part of a very unhealthy lifestyle package.

### Tobacco smoking

When we looked at tobacco smoking in the last thirty days for boys, we found that in all of these countries girls are more likely to smoke than boys and that was true of England, Scotland, Wales, and in Northern Ireland. Around 35% of the teenagers that we surveyed said that they had smoked within the last thirty days.

Lifetime tobacco smoking amongst girls had not changed in England, Scotland or Wales between the two surveys but had gone up in Northern Ireland. Boys' alcohol consumption between the two surveys stayed pretty stable; most teenagers drink and many teenagers, as part of learning to drink, get pissed and have hangovers. British teenagers, together with the Danes, the Finns, and the Irish are in the top rank of those

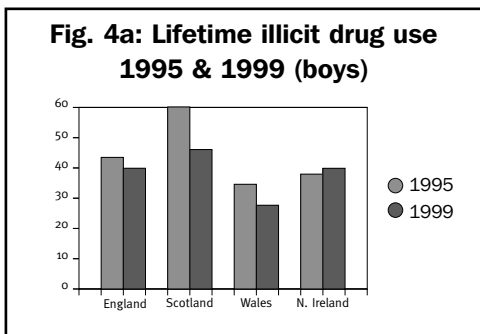
who most often reported drinking a lot at weekends and becoming intoxicated. Interestingly they also reported the most positive expectations of drinking and the highest rate of adverse consequences when they did. In a sense I think this is a paradox related to many things that people enjoy doing; if you like to climb mountains you have the highest expectations of it but you are probably more likely to slip and break your ankle. If you do something a lot then you probably like it a lot, but you are also exposing yourself potentially to greater levels of risk. I think in terms of prevention that is actually quite important. One issue is that there is very little good news as far as evaluations of health promotion campaigns to discourage young people from using psychoactive substances. It seems that such campaigns may change attitudes or raise awareness for some time. Changing behaviour is more difficult to achieve. There's not very much evidence that you can actually get a behavioural change or the right kind of behavioural change even with the best considered campaigns. Very few credible initiatives appear to have led to reduced drug use. There's a Nobel Prize in there somewhere but it is yet to be won.

**Alcohol consumption**

Something in the region of three-quarters of UK teenagers say that they have been intoxicated, it's part of the learning experience. I think what is interesting is that studies of alcohol consumption often ask about levels of use, and there is quite a lot of information about patterns of consequences. Studies related to illicit drugs are much less likely to do that, so even now several decades after people started doing this research the drug research is still fairly crude. Alcohol research generally explores patterns of use and its associated consequences in greater detail than that related to illicit drugs.

**Lifetime illicit drug use**

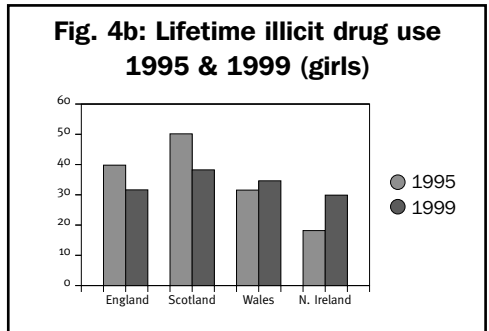
The two ESPAD surveys indicated that levels of illicit drug use were rather higher amongst Scottish teenagers than amongst those in England, Wales or Northern Ireland. In fact, use in England, Scotland and Wales amongst boys dropped slightly between 1995 and 1999 whereas in Northern Ireland it went up (Figure 4a).



Amongst girls we found a similar picture (Figure 4b). Drug use had fallen slightly in England and Scotland. Use had risen, though not significantly, in Wales. It had also gone up quite a bit in Northern Ireland.

The other thing we found was that in the Northern Ireland drug scene there is far more prominent use of glues and solvents than anywhere else we surveyed in the UK. Drug workers in Belfast for example say that this is an established pattern, and the drug scene is rather later in developing than was the case across this side of the water.

Drug use has been normative in this country to some extent since the 1960s. A low level of involvement, particularly smoking cannabis, has been accepted and has now passed the point of being unusual deviant behaviour: 'it's only funny people engaging'. Clearly if an individual is involved with using illicit drugs we know that they're more likely to be smokers and drinkers. If there is a stepping-stone or escalation theory it probably begins with mother's milk, moves on to Weetabix, followed by alcohol, tobacco, watching Star Trek and smoking cannabis. The other side of the coin is that the great majority of cannabis users do not become heavy or regular users and don't develop any problems associated with illicit drugs. The majority of cannabis users do not actually use other illicit drugs.



Whether you regard the 'escalation' or 'stepping stone' theory as having any mileage depends really upon which angle you walk at it. It's a bit like walking into a woolly mammoth in fog; your impression of what you've bumped into depends upon which bit you touch. I think your views about cannabis depend upon which angle you approach this from. What we do find is that some individuals are more inclined to engage in risky behaviours than others. Some people are more likely to drink heavily, smoke heavily, use illicit drugs, drive fast without safety belts and have unprotected sex. Professors Richard and Shirley Jessor described what they called "Problem-Behaviour Theory". Basically this theory states that often risk-taking comes as a part of a constellation of potentially dangerous behaviours. Very often there is a drug-using career whereby people will use cannabis or other substances in their teens and early twenties and surveys show that involvement with illicit drugs including cannabis generally tapers off tremendously beyond the age of 25 or 30. Recent surveys suggest that only a small proportion of people over the age of about 40 report that they still smoke cannabis.

We found with the ESPAD study that what distinguishes British teenagers from those in most other countries is that British teenagers are very likely to say that their parents haven't got a clue where they went on a Saturday night. French teenagers, who have almost the same level of illicit drug use as British teenagers tended to say overwhelmingly that their parents did know where they went on Saturday night. They were also handling alcohol in a much more sensible manner. In France it is more usual than in the UK for people to drink at meals while at home.

We do find in the UK that people who are heavy users are more likely to come from poorer backgrounds and very often this means families headed by a single parent. In the UK single parent households are low income and invariably poor, whereas that is not so often the case in some other countries. Problematic or heavy cannabis use is invariably associated with heavy smoking, heavy drinking, and very often the use of other illicit or prescribed drugs, and all kinds of other problems.

### **Recommended Resources**

Miller, P. and Plant, M.A. (1996) Drinking, smoking and illicit drug use amongst 15-16 year olds: a UK study. *British Medical Journal* **313**: 394-397.

Miller, P. and Plant, M.A. (2001) *Drinking, Smoking and Illicit Drug Use amongst 15 and 16 year old School Students in Northern Ireland*, (Report for Department of Health, Social Services and Public Safety, Belfast). Edinburgh: Alcohol & Health Research Centre.

Plant, M.A. and Miller, P. (2000) Drug use has declined among teenagers in the UK. *British Medical Journal* **320**: 1536-1537.

Plant, M.A. and Miller, P. (2001) UK youth are heaviest drug users in Europe-again. *Substance Misuse Bulletin* **14**: 2-3.

Plant, M.A. and Miller, P. (2001) *The 1999 European school survey Project on Alcohol & other Drugs*. London: Alcohol Education & Research Council, (Alcohol Insight no 11).

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### **Questions and Comments**

*"I represent the North West in the European Parliament. Just to pick up on Martin's point I think you did say that David Blunkett had actually reclassified cannabis from B to C. Unless things have changed very recently my understanding is that a statutory instrument has not yet been introduced into the House of Commons, although there seems to be a common assumption that this is taking place. I know that this has not yet occurred because I am currently on bail, having been arrested for the possession of cannabis when taking part in a political protest."*

### **Martin Plant**

"Well first of all condolences, and secondly I'm sorry I thought this actually had happened."

*"I have one query about the generalisations for the over-forties. If I, or anybody I know, had used it, they would lie because they don't want to admit to doing something illegal. I think that a lot of the figures where they ask people, everybody I know if they did use it would certainly lie."*

### **Martin Plant**

"Yes you're right. I emphasised at the beginning that surveys of self-reported behaviours are extremely dodgy. As a survey researcher I've often said my job is comparing one pack of lies with another, so you are right."

### **John Ashton**

"My favourite one is that however you do the survey about sexual behaviour whether by postal questionnaire or personal interviewer, men report that they have more sex than women. There's a real kind of arithmetical, algebraic problem here but it all makes sense if you consider that people only remember significant events!"

## 5. Dutch Drug Policy: experiences and future

Bob Keizer.

Drug Policy Advisor of the Ministry of Health, Welfare and Sports of the Netherlands, Parnassusplein 5, PO Box 20350, 2500 EJ The Hague, The Netherlands

### **Biography**

*Bob Keizer (1949) was the Head of the Addiction Policy Division of the Ministry of Health, Welfare and Sport of the Netherlands from 1992 till 2000. In this capacity he was a member of the management board of the European Monitoring Centre for Drugs and Drug Addiction of the EU and he still is the Dutch Permanent Correspondent in the Pompidou Group of the Council of Europe. In previous positions he was a.o. in charge of Health Education, Mental health care and Consumer policy. He graduated in medical law at the University of Leiden in 1977.*

*He is now a Drug Policy Advisor for the Minister of Health, especially charged with organising a Scientific Conference on cannabis and the co-ordination of the National Drug Monitoring Group.*

These are the items that I would like to tell you something about. Firstly something about the Netherlands because although we are neighbours I think it's good to realise a few of the characteristics of our country. Then I would like to tell you about the basic principles of our drug policy, followed by its implementation and how it is working in practise. I would then like to share with you some of the current issues of the drug debate in the Netherlands, followed by some conclusions and some words about the future.

### **The Netherlands**

I can be brief about the Netherlands. With sixteen million inhabitants we are one of the most densely populated countries in the world, in fact the Netherlands is one big city. Trade, transport and industry are the major branches of our industry. Rotterdam is the biggest seaport in the world and there are more than six and a half million containers handled each year in the harbour of Rotterdam. We have practically open borders; there is border control on the outside of the European Union but there is practically no border control to Germany and Belgium. We live with political diversity; there are now three political parties in government and about ten to twelve political parties in parliament. At each election we have to renegotiate the composition of the government, I would not be surprised if we have a completely different government following the elections in May. I think it's very important to realise that we live with coalitions, and it's a very diverse picture in a political way.

A characteristic of the Netherlands is that we believe in a strong separation between the church and the state. The state is not supposed to interfere in moral standards as long as the individual doesn't cause harm to other individuals, that is the starting point. This explains why we not only have this specific policy on drugs but also on abortion, euthanasia, prostitution; and out of these four, three have been legalised in the Netherlands. It stems from the basic idea that government have to refrain from interference with the moral standards of individuals.

### **Dutch drug policy**

These characteristics of the Netherlands are reflected in the basic principles of our drug policy. Since 1976 the main objective of our policy has been to prevent harm, a so-called harm reduction approach. The protection of harm or of health has the highest priority in our drug policy, and therefore the Minister of Health is the co-ordinating minister of drug policy in the Netherlands. Since 1976 we have had legislation

in which there is a distinction between cannabis and other types of drugs, we are talking about two different lists. We also have a distinction between possession for personal use, and other illegal acts such as production, trafficking and import-export. Drug use is not prohibited in the Netherlands and that's a very important principle. Having had a look at legislation in the UK I found that on paper it doesn't differ that much from the Netherlands, but I think there are two major differences in practise. First of all we do not arrest young people for the possession of cannabis and we haven't done that for more than 25 years. There are no youngsters in the Netherlands that have a criminal record just because they had some cannabis in their possession. The second thing is the toleration of the small-scale sale of cannabis in so-called coffee shops. I think that these are two very important distinctions between the Netherlands and the UK.

### **Implementation**

In practise although the Minister of Health is the co-ordinating minister, we work very closely together with justice and the Minister of Interior. Regarding addict care and prevention, we have invested a lot of money into improving the quality and effectiveness of addict care. We have also invested a lot into prevention because we believe that prevention is one of the most important tools for policy makers. Prevention is often over-estimated by politicians who expect too much of it, on the other hand prevention is underestimated in terms of how much it costs to develop proper and effective prevention activities. Methadone is freely accessible in the Netherlands and has been for the last twenty years, as are syringe-exchange programmes. We have also invested in the innovation of the healthcare system, the heroin project is one example; and several other very important projects have taken place in the Netherlands because healthcare and health protection are given the highest priority in our drug policy.

### **Justice**

Of course justice is responsible for the fight against organised crime. Disturbance of public order and public nuisance caused by addicts is a major point of discussion in the Netherlands. Therefore it is not only a matter of investing in addict care, but also at the same time you have to invest in the fight against organised crime, money laundering, and maintaining public order.

### **Research**

Research and monitoring are also considered to be very important in the Netherlands. We have a minister who has invested a lot of money during the last eight years in stepping up the monitoring systems in the Netherlands, and thanks to that we have a lot of very valuable data at our disposal. The research is also considered to be very important in practise; you will see not only a collaboration between health, justice and public order, but also very close collaboration between scientists, politicians and people who work in practise. I think that this is a very important principle for a proper drug policy. Each of those three sides has their own responsibility but they also have to work together. What you often see is that politicians think they are scientists, scientists think they are practical workers, and practical workers will think they are politicians. I think these three have to work together by definition, and indeed this does take place in the Netherlands.

### Coffee shops

Coffee shops are not legal, let me start with this remark. The sale of cannabis even in small quantities is illegal, but in the Netherlands we have the so-called expediency principle. This is a principle that allows the public prosecutor to refrain from prosecuting on weighty grounds of public interest. The public prosecutor can decide whether to prosecute or not and public prosecutors have developed guidelines under which the coffee shops are not prosecuted. Coffee shops are not legalised and it's not a legalised sale of cannabis, but they are tolerated in legal terms. The goal of coffee shops, and we have had coffee shops for more than 25 years in the Netherlands, is in fact to decriminalise cannabis use, and separate the markets. I must admit that the separation of the markets was the original intention at the beginning of the seventies when there were indeed only two markets; the cannabis market on the one hand and mostly heroin on the other hand. We have to be realistic in the nineties. Nowadays there are more different types of drugs, I'm especially referring to ecstasy that is classified as a hard drug. So we can't speak about two markets anymore, it's a mixture of several types of drugs. To be clear about this, coffee shops are only allowed to sell cannabis and they are absolutely forbidden to sell hard drugs. The following five points are the major guidelines for the public prosecutors. Coffee shops are not allowed to sell more than five grams per transaction per day, they're not allowed to sell hard drugs, they're not allowed to advertise, they're not allowed to cause a public nuisance and they're not allowed to sell to minors: people under 18.

**Fig. 5: Cannabis use:  
Last month prevalence 15 - 16yrs:**

• Netherlands	14%
• Ireland	15%
• UK	9%
• France	22%
• USA	19%

(EMCDDA, 1999)

### Statistics

These are statistics from the EMCDDA: it's the European Monitoring Centre on Drugs and Drug Addiction in Lisbon (Figure 5). They are from the 1999 report but it's just to give an indication of the trends. I know the debates about the reliability of statistics, but never the less it gives an impression, which I think is the most important thing. If you look at the cannabis used: last months prevalence with young people of 15 and 16 years old you will find that the Netherlands was

14%, Ireland 15%, the UK 16%, France 22%, and the USA 19%. These data are three years old and I know that these figures have risen in the last two or three years. On the other hand, if I'm well informed, in both the UK and the Netherlands the trend has stabilised in the last year. Also the use of ecstasy is sharply going down in the Netherlands, so it's not only a rising trend but you can see a decline at the same time.

**Fig. 6: Cannabis use  
general population,**

last year prevalence

- Netherlands 5%
- UK 9%
- France 5%
- USA 9%

(EMCDDA, 1999)

**Cannabis use in the general population**

Last year prevalence in the Netherlands was 5%, the UK 9%, France 5%, and the USA 9% (Figure 6). These are very interesting figures which show in comparative terms the results of our very liberal policy on cannabis, for example compared with the USA who are the champions of the war against drugs.

**Fig. 7: Hard drug use  
per 1000 inhabitants:**

- Netherlands 2.5
- Sweden 3.0
- UK 5.6
- France 3.9
- Italy 7.2

(EMCDDA, 1999)

**Hard drugs use per 1000 inhabitants**

The Netherlands 2.5, Sweden 3: they don't like this at all because the Swedes are very tough on drug policy, UK 5.6, France 3.9, and Italy 7.2. Again it's very interesting to see this figure (Figure 7).

**Fig. 8: Drug related deaths  
per 100,000 inhabitants:**

- Netherlands 0.5
- Germany 1.3
- UK 2.7
- Sweden 1.9

(EMCDDA, 1999)

**Drug-related deaths**

The Netherlands 0.5, Germany 1.3, UK 2.7, and Sweden 1.9 (Figure 8). In absolute terms this means that the number of drug-related deaths in the Netherlands is about eighty people per year. Again you have to be very cautious with the statistics, but I must say overall it gives the right impression.

**Current issues**

There is an ongoing debate about coffee shops, and I don't want to leave you with the impression that we have found the final solution or that we are perfectly happy with our drug policy. We have problems and we have ongoing discussion in the Netherlands about all drug related issues, I think that's a very positive point. I think each government and each parliament should continuously debate drug-related issues. The debate on the coffee shops is in fact two-fold. In the 1990s there were a lot of problems with coffee shops causing a public nuisance, cars running on and off in the streets created a nuisance to the neighbourhood and people felt unsafe. As a result of that we tried to convince the municipalities who are responsible for coffee shops to gradually reduce the number of coffee shops, and to find a proper solution for coffee shops. In legal terms there is a problem that coffee shops are still illegal and therefore can't be regulated like we have regulated pubs. That's a legal complication in the Netherlands. Nevertheless the net result is that in

the last three or four years the number of coffee shops in the Netherlands have been reduced from 1200 to about 800. The motivation behind that was the argument of public nuisance, so it was not a motivation from the health sector. If you ask the average policeman or mayor in the Netherlands, they are very happy with the coffee shops because it allows them to keep an eye on the small-scale cannabis trade in the cities.

The other problem with the coffee shop is the debate about the backdoor. When I explain the phenomenon of the coffee shop in other countries, the first question is 'where do the owners buy the cannabis?', and my answer is that they buy it at an illegal market. The next question is then 'do you think this makes sense?', and my answer is that it's better to solve half of the problem rather than solving nothing. This is the situation here in the Netherlands, we have tried to find a solution for the consumer but we haven't succeeded in finding a proper solution for the supply of the coffee shops. Last year about 60 Dutch mayors addressed the government about this issue saying 'why don't you start an experiment with a regulated supply of the backdoor?, why don't you allow one or two nursery plants that can take care of the supply for the backdoor which could make the circle round?'. The government studied this proposal very sincerely but finally decided not to start an experiment with this. Firstly on legal grounds we had doubts as to whether this was possible under the existing international treaties. Secondly, and personally I think this was a more important factor, we were very reluctant about the possible reactions of our neighbours, especially France, Germany and the UK as well. That was the end of this exercise but the positive result was that parliament said 'well if this is the situation we can't start an experiment, but let's find out whether we are the only country that is facing these problems with cannabis regulation'. As a result of that we organised the City conference in Utrecht last year, which was attended by representatives of 50 cities from 20 countries. The outcome was that we were not the only country that was facing this problem. Another significant outcome of this conference was that mayors, policeman and people in charge of public order were very unhappy with the situation in which they were forced to both forbid something and allow it at the same time. I think this is a very essential point when talking about cannabis policy. We should leave the damage to health caused by cannabis to the health authorities. The cannabis debate is not an issue on the specific regulations of the coffee shop backdoor and front door, but it's an issue on the reliability and the consistency of public governments in general. You can't go on forever with this illusion in which we have to allow something and forbid it at the same time. I think this is the essential point in the cannabis debate.

Large-scale drug dealing and production is an ongoing concern in the Netherlands, let there be no misunderstanding about the position of the Netherlands on this. We are fighting drug dealing and drug trade the most we can in the Netherlands. We are very successful in this, and this is a misunderstanding about Dutch drug policy. The seizures made by police and customs far exceed the average seizures that are made in Europe. Last year more than 40,000 kilos of cannabis were seized, more than 660,000 plants were seized, more than 1400 nursery gardens have been dismantled, and more than 5.5 million ecstasy pills have been confiscated. This provides an impression of how far we go in fighting the organised drug trade. The problem is that we are an open country, again I would like to remind you of those 6.5 million containers that are entering this year. It's a practical impossibility to find drug production and trade in the Netherlands, although we are doing our utmost. Even Mr McCaffrey had to admit that, and I think that's a reliable source on this.

## **Changing drug trends and changes in the addiction problem**

From the results of our health protection policy the average age of heroin users is rising each year by one year and it's now above forty. It goes up each year by one year because we've hardly any youngsters joining this group and we have hardly any drug-related death.

## **Nuisance**

Once we became aware of this we realised that we had to do our utmost to fight this problem. Civilians are entitled to feel safe in their neighbourhood and we've invested a lot of money in a very extensive programme to fight this nuisance. As a result the figures on public nuisance are going down.

## **The international context**

I haven't got the time to tell you about my experiences in the last ten years, about all the conflicts we had with Germany who were absolutely against our drug policy and were criticising us. Then France joined in and when Mr Chirac was attacked about atomic testing in the Pacific, he said 'well it's nothing compared with the Dutch drugs policy'. Then it was Sweden, and then it was the USA.

Germany is now even more progressive than the Netherlands. They have wide spread methadone dispensation; cannabis policy is in certain Bundeslander more liberal compared with the Netherlands. They are also starting heroin trials, there is a very close collaboration now with Germany and there are now no criticisms at all between us and the Germans. The same goes for France, the anecdote from Mr Chirac was maybe three or four years ago and we are now literally the best of friends. There is very close collaboration and we closed a contract to step up this collaboration only last week with Madam Maestracci.

The Dutch, the Belgians, the French, the Germans and the Swiss are working now very closely together organizing a scientific conference on cannabis, that will take place on 25th February in Brussels.

Sweden is another story, we didn't manage to convince the Swedes and neither did we manage to convince the USA. Personally I think that it's because it's not only a matter of science and knowledge. Some countries and their politicians have made a kind of a religion out of their whole drug policy, and in that case it's very difficult to communicate.

## **Conclusions**

Our cannabis policy has not led to a significant increase in cannabis use, especially when compared with other countries that have much stricter policies. Secondly, harm reduction policy pays off; if you look at the number of drug-related deaths in the Netherlands and HIV infections, the conclusion is inevitable that the more you invest in health the more it pays off. Thirdly, our cannabis policy has not led to an increase in the number of hard-drug addicts, so in practise the stepping stone theory did not work. Finally a good drug policy must consist of interplay between practise, science and politics; and I think that's the key to success.

## **The Future**

This is more or less a personal statement based on the experience I have had over the last ten years. The national and international drug debate is often politicised and not evidence based. If you look at the debates that are taking place both in the European Union and at the level of the United Nations it is about political opinion based on beliefs, it's hardly evidence based and I think that's a shame.

Another conclusion is that international opinions at the scientific and practical level differ less than politicians think. This is what I have found by talking with mayors and policeman in Germany, Switzerland and everywhere I go. You will find that we share the same types of problems, so we are not that different. I don't think it's a debate between people who work in practise, I think it's a debate between politicians. My conclusion is that a rapid process of bottom-up harmonisation takes place in Europe. Compared to ten years ago you will see much greater similarity between the ways problems are solved in Zurich, Frankfurt, Berlin or Paris, and I think that's a very positive element.

My final remark is that we can't leave the drug debate to politicians, I think you have to leave it to people who work in practise, and to scientists. We have to come to a proper open and fair assessment of the situation, an open exchange of common problems, and we have to strive for common alternatives and solutions. I think this is the only way out of the international debate on cannabis.

## **Recommended Resources**

*The Reports of the Dutch National Drug Monitor:* [www.Trimbos.nl](http://www.Trimbos.nl)

*The Reports of the European Monitoring Centre for Drugs and Drug Addiction:* [www.emcdda.org](http://www.emcdda.org)

*The Reports on Dutch Drug Policy:* [www.minvws.nl](http://www.minvws.nl)

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## **Questions and Comments**

*"Like, Mr Keizer I'm from Holland. I own three coffee shops there and I'm the co-founder of the coffee shop 'Dutch Experience' in Stockport. I know the figures that Mr Keizer comes up with and there is only one piece of information in this, and that's how the changes have been over the last fifteen years in the merchandising of coffee shops. Fifteen years ago we used to rely on 95% smuggling, my current turnover in the coffee shops in Holland is 75% homegrown marijuana. That means that most of the contraband smuggled into Holland is no longer necessary and I think that's a figure worth mentioning as well."*

## **Bob Keizer**

"Yes, I agree with that. You are a man from practise and there has been a shift indeed. Ten years ago it was maybe 10% homegrown cannabis and 90% imported, now it's more 50-50."

*"That is why I don't understand why the Dutch government still keeps prosecuting home-growers, because they successfully fought organised crime in Holland and practically excluded it. Now that we've got a system going, the Dutch government is trying to catch all the growers again, do they want hash smuggling back?"*

**John Ashton**

"Can we just register that question, I'm sure you can have that argument over tea! It sounds like a domestic one to me."

*"No it's not a domestic problem because in England most of what you sell on the streets is the most polluted hash in the world. So I think a homegrown system would be the best for England as well."*

**John Ashton**

"Point taken."

*"What I'd like to know is a plain and straight answer to this question. On its own without the use of alcohol or tobacco, can you overdose on cannabis? Whether it's in its rocky form which is a solid, whether it's in the weed form, or whether it's skunk; whatever form it's in, if you're only using it on its own can you overdose on it?"*

**John Witton**

"What do you mean by overdose?"

*"I've never come across any statistics that say 'so many people killed by cannabis', every time we talk about cannabis it's always mixed with something else. I just want to know as a plain and simple fact is whether you can overdose on cannabis when you're not using anything else with it?"*

**John Witton**

"I don't think there's any evidence to suggest that. You would have to take a lot of cannabis to have a heavy toxic reaction, and anything that might lead to death I don't think there's any recorded cases of at all."

*"Over the last fifteen years in Britain the drug trend's gone up from around 1800 to around a million registered addicts. I was interested about the slide in which you said that drug trends have not gone up as a response to cannabis. In England if you look at the CDT's: Community Drug Teams who bring people in for drug treatment, 98% of them will have started off on cannabis. So are you saying that your drug trend for hard drugs has not gone up in the last fifteen years?"*

**Bob Keizer**

"No, cannabis use went up; the use of heroin has stabilized."

*"You also said that because of cannabis this hasn't increased, so my question is how do you know that has been the key factor?"*

**Bob Keizer**

"Well it's a matter of comparing those two dates. If there was a sharp increase in cannabis all over Europe and all over the western world, and at the same time there was a stabilisation in the number of drug addicts in the Netherlands. I think it says something about the lack of a correlation between those two."

*"What's the increase been over the last fifteen years for hard drug use in the Netherlands?"*

**Bob Keizer**

"To prevent misunderstanding: the number of as we call it the "very problematic drug addicts", mainly heroin and cocaine addicts, has stabilized in the last 10 years. Of course, in the Netherlands like in all other countries the general consumption of hard drugs like ecstasy and cocaine has gone up, but I was talking about this group. Its number has been stable, in spite of the fact that the cannabis consumption has risen sharply."

## 6. Panel and Delegate Discussion: Current Issues – Future Options

### PANEL

- **Chair: Rod Thomson, Public Health Projects Manager, Sefton and Liverpool Health Authorities, also Joint Commissioning Manager, Sefton Drug Action Team**
- **Alun Buffry, Legalise Cannabis Alliance, UK**
- **Detective Chief Inspector Colin Matthews, Merseyside Police**
- **Dr Tony Quinnell, Senior Clinical Medical Officer, Stockport Community Drug Team**
- **Hywel Sims, Chief Executive, ADFAM National**
- **Brenda Fullard, Regional Tobacco Control Manager, NHS North West Regional Office**
- **Mike Ryan, Regional Manager, Drugs Prevention Advisory Service, North West**
- **'Keynote' speakers**

The following section comprises selected extracts from the panel and delegate discussion: **'Current issues – future options'**.

***Italicised text denotes questions or comments from delegates***

*"There are a lot of young people who have been excluded from school for possession of cannabis. What in the panel's opinion does more harm: cannabis, or exclusion and the stigma that goes with being a cannabis dealer in school?"*

#### **Mike Ryan**

"I think where any youngster is excluded from school for whatever reason, it's pretty evident that there's a potentially greater risk for that youngster to get involved in anti-social activities of some kind. I think we know that in the past when youngsters were excluded for whatever reason, there wasn't any intervention or back up of any kind. I think it's important now that education is beginning to recognise that we need to concentrate on those kids more than we have done, and I think to neglect them is probably a greater risk."

"Should they be excluded? Across the North West we know for a fact that something in the region of nearly 70% to 80% of the schools - both primary and secondary do have policies in place. As people will understand schools are quite autonomous in how they actually respond to drug misuse as it arises, and unfortunately we have quite a varied approach to that. A personal opinion of mine is that if a youngster is involved in any sort of substance misuse within school, you do more harm by kicking them out. I think they need to be worked with."

#### **John Ashton**

"My attitude to this is that by and large schools should consume their own smoke. Liz Hull from the Liverpool Echo isn't here at the moment, but the Liverpool Echo had a feature on this whole issue about a month ago. What seemed to be emerging was that whereas the state schools have generally got a policy of trying to cope with kids who have had problems with drugs - unless they're dealing and so on, a lot of the private

schools are expelling kids if they are possessing drugs. Those kids then have to get picked up by the state schools to cope with in addition to their own share of issues. Personally I think that is inappropriate and I suspect a lot of other people would think that too, I think schools should consume their own smoke."

*"There's been a number of links made today around tobacco as a gateway drug to cannabis use, and there's a lot of pressure around at the moment to help young people in schools to cut back on smoking and to give up tobacco. Yet when we try to access young people under the age of sixteen to smoking cessation processes within Tameside, there's no provision to actually supply these young people with nicotine replacement therapies. Does the panel see young people as being able to access nicotine replacement in the future? And what effect does the panel think nicotine withdrawal has on young people in schools, in terms of how it affects their behaviour and the possibility of them being excluded?"*

#### **Brenda Fullard**

"Nicotine replacement therapy is not on the prescribing list for young people under sixteen, and I think it's unlikely that it will be. I think what you've got here is a situation that is absolutely classic. We've got young people who are smoking tobacco - a legal substance and there isn't enough help for them to actually stop smoking. We're also looking at an issue around something that is illegal, and I think we're on a hiding to nothing by trying to decriminalise it at this moment in time without the support services there to help them. We have a real need to invest a lot more support for young people in both these areas of substance misuse, and I agree with you entirely that we are really seriously lacking there and we really haven't got the tools to support people with treatments like nicotine replacement therapy. In both instances of cannabis and tobacco, it's really immoral that young people are expelled from school when there is absolutely no treatment to support them in stopping the habit."

#### **Tony Quinnell**

"Smoking cessation is something that I actually don't get involved in, and it is something that even in adults is relatively new to being prescribed. As with all drugs, for under sixteens there is a significant problem that product licences do not exist for most things, and no company is willing to put the research in to generate product licences. I think one of the problems with smoking cessation and other drug prevention is that prevention is much better than cure. It is much better to stop people from starting smoking, which is about early education on the harms of smoking and getting consistent messages across about it. Once they start, if nicotine replacement is not available then the only strategies you've got are the more psychological approaches - the counselling approaches, and unfortunately these are not well established in smoking. There is more available if you're under sixteen and get involved in illicit drugs than if you get involved in tobacco, which is a slight skewing of the system."

*"This is really for Brenda. A complaint if you like about the fact that most people smoke cannabis with tobacco, and it is based on some projection of possible negative health consequences that people will face in the future as a result of mixing those two things. Don't you think that the cure for this problem, which is a criminal record for many of our young people, is actually worse than the problem itself?"*

**Brenda Fullard**

"Absolutely, I totally agree."

*"Given that, how can you continue to support..."*

**Brenda Fullard**

"I think that decriminalisation is something I would support in the long-term, but in the short-term are we ready for it? I just don't know whether we are, people in this room are but there are a lot of misconceptions about cannabis use out there. If people are being expelled from school because they're cannabis users then there's a serious misconception amongst the head-teachers. So there are a lot of attitude changes to take place."

*"From my experience though that is about the professionals. If you talk to people on the street; I was brought here today by a regular taxi driver who asked me where I was going to and not only was he completely abreast of the issues and arguments, but he was quite clear about what needed to be done. He was saying that he would legalise it, and I think people in professional positions are very cautious and very anxious because of the current legal state. I think that if you change this legal state then those problems will go away."*

*"An invitation and then two questions to the panel. My invitation is this: that our group at the moment is looking at drug testing in all its forms; at the roadside, in the workplace, in sport and in school. We have an inquiry running and we're taking evidence, so if anybody has any evidence at all to give us than we will include it in our current inquiry. The two questions are these, one perhaps to Mike Ryan. The drugs death statistics given by Martin Plant today of 1200 illicit drugs deaths are a gross underestimate. The Home Office Advisory Committee on Drugs Misuse has recommended GP certificates of death being changed, and coroners handling the whole process in quite a different way so that we can get absolute figures rather than fictitious figures for illicit drug deaths. Can Mike Ryan tell us how far that process has gone? The second question is that we are assuming that we're going to import the coffee shop model from the Netherlands. But there hasn't been any discussion in this audience today as to whether that would be the model that we would want to import into the British system. Would we want to use other licensed outlets: the pharmacies, the public houses or what? What does the panel think?"*

**Mike Ryan**

"There has been a recent publication which you're probably aware of into drug-related deaths, and without doubt I think it is well recognised that this is an area that has probably been neglected to some degree. I think you're quite right about the degree to which it has been reported, maybe an underestimate to some extent and again I think it depends on coroner's records. I know that this has been revealed in the North West where there's some significant levels of drugs related deaths. The Drug Action Teams who put together their own plans for tackling drug misuse within localities, will be tasked in the future with addressing this particular issue within their locality. Already some of the co-ordinators who support the Drug Action Teams are coming together to look at local plans for how they can address this particular area. As you quite rightly say it has been neglected and there may be some levels of underreporting, but it is something now that is rising up the political agenda."

"On the item of coffee shops, what can one say. I think it's an interesting concept for the availability of cannabis within Holland. I think within every country one has to look at how one manages the availability of certain substances, and that is one that maybe works there to some extent. It's not without its difficulties, I think they're well pointed out. I don't think one could easily transport an idea from one country to another and presume it will work. I can remember many years ago talking to someone from a South American country who came here and saw the availability of methadone and said 'oh we'll do that in South America'. Out there cops were getting killed and it was just chaos, most of the politicians and others lived behind walls. So you can't just simply transplant; there are cultural factors and a lot of other factors, which need to be taken into consideration. What I do think is of significant value is the degree to which within Europe there's a coming together around some of these issues. There's a sharing of ideas and a sharing of best practise that can only be supportive, and I think we need to be much more part of that process."

**Colin Matthews**

"On the coroner's death fix point, I think it's been a noble cause-effect. I think coroners have tried to protect families against putting down the cause of death, and to save the families feelings they've covered the cause of death by putting a medical cause, which may not tell the whole story. As a result we've had the underreporting that Mike's talked about."

"With regards to how to sell cannabis in public, all I can say is that if the Home Secretary moves it from a class-B to a class-C then that just simply isn't going to arise. It's one I'll throw back to the politicians and say people have got to sort this out; do you want us to enforce the law and keep cannabis within that framework, or are you going to take the brave step and move it out? But please give us a clear steer as to which way it's going to go."

**Hywel Sims**

"I'd agree with Mike about the dangers of importing cultural models from other countries without any kind of interpretation, and this is my problem with applying American models to this country. On the matter of the sale of cannabis; even though you're right Colin to point out that the current change under consideration would not have an effect of legalisation as has been made clear, the families we work with would

certainly welcome anything that would do what in part the Dutch model was designed to do, which is separate markets. That is the piece that we would support."

### **Alun Buffry**

"Well I agree with Colin here that there's going to be a reclassification and people are going to be less likely to be arrested and so on. Obviously it's going to be offered around more on the streets and we have to deal with this question of supply. There has to be some sort of supply, otherwise it's just going to be in the hands of criminals and all the profits are going to be in the hands of criminals. Once again I think the immediate step that we should take is to allow people to grow it at home, keep it at home and smoke it at home, provided they're not hurting anybody else or threatening society. I don't see that the law should come into it at all."

"As far as coffee shops are concerned, it's one of a few models that we have to compare with our present situation. I wouldn't call them coffee shops I'd call them cannabis shops. I don't understand why they're called coffee shops, maybe they supply coffee as well. I wouldn't say that pharmacists should not be allowed to supply it but it is a plant, it's not a pharmaceutical product so I wouldn't limit the supply to pharmacists. I would basically allow on-licence and off-licence cannabis shops where people could go and buy it and take it home, or they could go and buy it, share it and smoke it."

### **John Witton**

"Again I'd be wary of importing models from other countries. Holland's evolved its own relationship with cannabis, that's not to say it would work here. In positing all the varieties of different models we can adopt we have no evidence as to what would work, so we'd be very much in the dark."

### **Bob Keizer**

"I was not aware that I was making an advertisement for introducing coffee shops here! It's not up to me and I agree absolutely that it has to fit into a culture, it has to fit into a society. What I know is that we're talking about alcohol, cannabis, and tobacco, and all three of them are not innocent substances, they can cause health problems. Therefore I think it's an issue for the health authorities and we have to deal with it in an integrated way and come to a form of regulation. A major aim has to be to regulate and to reduce the health risk. So I don't think it's very relevant to discuss whether it has to be distributed via a coffee shop or pharmacy or whatever. I think it's the last question, I think we have to address the most important questions first."

### **Brenda Fullard**

"My view of the coffee shop is does it actually attract a small group of the population? For instance if elderly people or people from ethnic minorities want to use cannabis would they use a coffee shop? There are lots of cultural issues about how people actually access cannabis, which maybe wouldn't transplant into this country. I think there has to be a different approach in this country about everybody's access to cannabis."

### **Tony Quinnell**

"I think we may need a variety of models to meet different peoples needs. Part of the problem with this is looking at the whole supply chain. I know that I'm taking a very pragmatic point of view but it still means that the basic production and supply to the coffee shops is still illegal, and I don't see that working in quite the same way in the United Kingdom. So we may have to look at the whole supply chain, which could influence how we made it available. If you're going right down the route of the cannabis plant then the homegrown route is probably one way to go. If you're looking at cannabis products; bearing in mind what's likely to happen in terms of prescribed products there are possibly going to be some products out there which are going to be very much in the hands of the pharmaceutical companies, which may be more appropriate to have available via pharmacists. Again that would have to require decision from parliament to allow it."

### **John Ashton**

"I think it's interesting that we've started talking about equity of access to cannabis. On the death certification; because of the Shipman scandal there's a lot of work going on at the present time into strengthening the death certification process. I think that will help with this issue and also the measures that the government will introduce in due course about strengthening death certification."

"On this thing about models, coffee shops were big in England in the eighteenth century and apothecaries were a major player until the BMA squeezed them out in the 1860s. Apothecaries were a major source of primary care for people. There will be older males here who'll remember getting something for the weekend from Blake's rubber goods store in a plain brown envelope! So there is this notion of actually getting things in plain brown envelopes, not being permitted to advertise publicly, and having a level playing field for tobacco, and cannabis. And maybe even alcohol should only be advertised by the inn sign outside the pub rather than on television. In Finland tobacco cannot be advertised except at the point of sale - that's to say inside a tobacconists shop, and it seems to me that is a perfectly appropriate way to go with these things. That's partly why I feel very strongly that we shouldn't allow people to discuss them separately, because we've seen the statistics for the deaths from tobacco and alcohol. We're not starting from a zero baseline here. We know that it's not a choice between kids not using cannabis and then kids starting to use cannabis following deregulation; they're doing it and we've had the statistics. The issue is about regulation, harm reduction, civil rights, and all those kinds of trade-offs."

*"I am encouraged by some of the recent developments. I'm encouraged by the fact the conservative party refused to support Ann Widdecombe last year when calling for stricter penalties. I'm encouraged by the fact that my own Liberal Democrat party is in three weeks time going to be calling for the adoption of the Dutch model in this country. And I'm encouraged by the leaks of Chris Mullin of the home affairs select committee about that committees reports on the revision of the law. But David Blunkett the Home Secretary's changes have been described as timid by the chief constable of North Wales, who also described the current legislation as illogical and hypocritical. So I'm very conscious as someone who has spoken out about this issue in the past, but most politicians are very frightened to put their heads up above the parapet for the very good reason they're likely to get them shot off. There still is a great knee-jerk reaction from most*

*politicians against anyone who speaks out on this issue, most politicians are frightened. Does anyone on the panel see signs of real bravery starting to appear in government circles?"*  
*"It links to bravery really. If we wanted to have a truly open, up-front and radical conference today then should we not have had a presentation on the perceived or possible benefits of cannabis, not just medical but psychological or social?"*

### **Mike Ryan**

"I'm sure I don't need to spell this out, but I go by the obvious extent of which the media and hysteria has whipped up around this simple debate that's going on at the moment. Some of the more quality tabloids talk about cannabis on the NHS and this sort of thing. There's still a lot of hysteria and misinformation, and I think it is difficult for people to stick their head over the parapet. My heart goes out to them and I fully support them, but I do think that is the difficulty with so much of this. I think that reflecting public opinion when it is so often distorted in such a very unhelpful is really making it difficult."

"Regarding the other point, I think it was certainly interesting when John was going through much of the limitations of the research but maybe it could have been a bit one-sided. This is about an informed public debate and I think we need to be possibly more honest about it. People don't take cannabis because they dislike it and we know that. I think it might have been helpful to see that, but again what would the media have made of it?"

### **Hywel Sims**

"A combined effort above the parapet; I suppose the answer is that I don't see much bravery, I see a lot of fear. What I most often experience in the work that I do with different levels of government is that fear breeds on itself. An example would be that I used to run an HIV project, and I wasn't allowed to put a bowl of condoms out at a health fair because the most senior government official in that area was worried what the politicians would think. That's the kind of experience that I often have in some of the work that we do at ADFAM around drug issues, that there is a fear of offending somebody else. That 'somebody else' could be that mythical beast the public, it could be the politician in charge, and it could be, though interestingly it often isn't, the police force. This fear is often self-limiting and self-introduced, so because of this I don't actually experience much courage other than with some of my community partners; who as there's been evidence here speak the truth about the experience on the streets around drugs. Somebody said earlier that most of the people we work with in families and in everyday life have a very educated understanding of issues around drug use in general and cannabis maybe as well. They have clear opinions and are really quite forthright in what they expect to happen, so that's where I perceive most of the courage that I work with."

### **Tony Quinnell**

"In terms of politicians and bravery I don't see an awful lot of it unfortunately, and I think this is based on people needing to get re-elected. I think a lot of politicians have to adopt the view they perceive will get them elected, and it is an unfortunate consequence of the system we work within. It may be that as the perception of public changes then politicians' views will change also, but I think it will always lag behind."

**Alun Buffry**

"When I first became involved with campaigning in 1992 there was one MP who seemed to be in favour of legalisation and now there's a few more. So I think that's favourable and I think that the confessions of the Tory front bench maybe helped. I think that the political parties believe legalisation might be a vote loser, which in my opinion is wrong. I was debating at the Oxford Union last year and I was pleased to be standing between a member of the Labour Party: John Owen the MP for Cardiff, and Peter Lilly from the Conservative Party; so it is a cross-party issue."

"I was sad to hear Tony Blair say a couple of years ago that he was scared stiff of drugs, which presumably included cannabis; because I can't see that there is ever going to be a sensible debate if they're scared to talk about it. The beneficial uses of cannabis haven't really come up today. I'd be quite happy to talk about the beneficial uses of cannabis but it would probably take me about an hour and a half because there's quite a lot."

## 7. Summary

Mike Ryan, Regional Manager, Drugs Prevention Advisory Service, North West

When I first talked about this conference with Mark Bellis we were a little reticent that we were going to finish up with a lot of ranting and unhelpful comments about this particular issue. But I have to say that I've certainly enjoyed this afternoon, and I think it's only the start of what hopefully will be a very well informed debate on this particular issue. I think it's been very helpfully put into context by some of the information that's been provided today, some of the difficulties have been highlighted and there are many other areas that need to be practically addressed.

I think it was well touched upon in John Ashton's address when he spoke about the social context in which drug misuse is often found and the variations that are encountered. We talked about schools, and how schools and police forces will vary in terms of their responses. I think about how we would manage this and at the moment it's still very unclear.

John Witton's presentation was very measured, helpful and very informative, and again there remains a lack of research in many aspects of that. I thought the information about cautious drivers was interesting, I didn't realise that people who drive slowly may well be under the influence. I think it was very helpful and I just wish that people would be more aware of some of the evidence as it stands, weak as it is in some aspects. It is unfortunate that because we're talking about an illegal activity it does lack a research base. One hopes that this might open up the doors to look at something with a little more rigour and a little more opportunity to feel more confident about many of the areas that we hear about.

One point that does need to be made is that following the reclassification being addressed, 70-80% of all convictions are for cannabis. The amount of police time that is spent on that is just unbelievable. We talked about organised crime and how that can be addressed. With the amount that's going on at the moment, it has to be looked at channelling resources towards organised crime, and dealing with some of the class A drugs. Hopefully we must make some impact upon that.

Martin Plant touched on the prevalence of drug misuse among young people, and I think everything that he showed shows an upward trend. Some of the figures weren't as up to date as one would have hoped, but nevertheless we know that it's still a rising trend despite that. I was recently doing some work in Europe and they talk very highly of the strategy we have here and the work that's going on with the delivery of that strategy. One of the things that does worry me is that we still have the highest drug use in Western Europe, so something's not right. We have to think of some radical approaches, and I think we're in a climate and we have a particular government at this time that is prepared to look at it in more detail. Never in my time in the field have I worked with a government that's put the time, effort and resources into looking at the problem as they have now. So I think the time is right and I think the opportunity is there.

I think that Bob Keizer's Dutch view was very helpful and particularly informative. Again it comes from a moral base. There is a lack of interference in individuals to make their own decisions about what substances they want to use. There's a freedom to practise that, and I think the culture within Holland allowed that to develop.

I get a little confused about the back-door front-door business with coffee shops. I did ask at a conference once what happens when the 'artic' turns up? What do the police do? I'm not quite sure about it still but it's a grey area. I don't mean to criticise but I think it's a point that's not very clear. Again I think they have many areas that we're interested in developing; the support for the drug user and those with dependency problems, working on prevention, organised crime and so on. I think the evidence is strong, we've known for a long time now that in Holland the age of hard drug users has been rising steadily, and that must tell us something. Even now we know the figures here are still rising, and there is a need to expand and develop services to bring more people into treatment.

I think the three key points that Bob finished on were very helpful, that is the interplay between practise, science and politics. I think these are the three key factors that must drive this debate forward. We've got a lot to learn from our European colleagues and sometimes I think we tend to think we've got it boxed off here, but we haven't and we've still got a long way to go.

For me it's been a particularly helpful debate. I think it's just started the ball rolling and we need to have some open informed discussions and debate around this. I will feed back many of the points which have been made and I'm sure people are doing this for their own particular organisations, because this is a time to do that and a time where there is an open mandate to listen to some of the changes.

I think it just leads to me to say thank you everybody for being here. I think that the fact that we've filled the room today is particularly pleasing, it's evidence of the interest across all sectors. Without doubt I think we can repeat this again in some manner or means and continue this debate. Again I'd particularly like to thank the speakers: to Bob coming across from Holland, Martin Plant, and John Witton.

## 8. Recommendations

The following recommendations have been derived from the conference presentations and ensuing discussions. While the conference organisers and editor support these recommendations this does not necessarily mean that they will be able to undertake or resource the identified research and policy development.

- There is a need to clarify the current legal situation and enforcement policy regarding the personal possession of cannabis in addition to highlighting the legal implications of any change in legislation. Guidance needs to be provided to the general public, employers, schools and those engaged in the enforcement of legislation.
- A comprehensive health impact assessment of any change in cannabis legislation should be undertaken. This should incorporate the potential for changes in access to cannabis and any potential change in the prevalence of cannabis consumption.
- Research should incorporate an assessment of current cannabis use. This would include identifying the determinants and functions of consumption modes, the forms in which cannabis is consumed (herbal, resin and oil) and the extent to which cannabis is consumed in conjunction with tobacco. The potential impact of changes in cannabis legislation on current practices, changes in the potential levels of harm and opportunities for health promotion interventions should be identified.
- There is a clear need for increased research relating to the potential long-term detrimental effects of cannabis use.
- Research should identify groups at high risk of suffering negative effects of cannabis use. Additional studies should identify the extent of detrimental effects on groups of individuals where higher risk has been identified, such as in pregnancy and those suffering mental illness.
- A full assessment of the impact of any change in cannabis legislation relating to current strategies to prevent the commencement or escalation of smoking tobacco and deliver smoking cessation interventions.
- While lessons can be learned and overseas models should be studied, any change in cannabis legislation or changes in the level of enforcement of current legislation must be delivered within the social and cultural requirements of the United Kingdom.
- Information about the effects and risks of cannabis use and practical measures to reduce harm should be identified and incorporated within a public health strategy. Health promotion interventions should target young people, longer-term cannabis users, parents and a range of professionals affected by other people's use of cannabis (including health and education professionals).

## Appendix-1: Organisations represented at the conference

Alcohol & Health Research Centre University of the West of England	EDC Dukinsfield
Bolton Community Drug Team	Employment Services
BOSCO Project Liverpool	Faculty of Humanities and Social Science South Bank University
Centre for Health Promotion Stockport	Formby Clinic
Changing Properties Services Liverpool	Greater Manchester Police
Cheshire County Council	Halton Drug Action Team
Chester Community Drug Team	Hattersley Community Centre
Chester Diocesan Committee for Social Responsibility	Healthwise Liverpool
Child and Family Services Liverpool	HIT Liverpool
Chorley & South Ribble District General Hospital	House of Commons
Connect project Liverpool	The Jarman Centre Blackburn
Connexions Oldham	The Kevin White Unit Liverpool
CPS Greater Manchester	Knowsley Drug Action Team
Department of Public Health NW Lancashire Health Authority	Lancashire Constabulary Police
Department of Health Care Studies The Manchester Metropolitan University	Lancashire Postgraduate School of Medicine & Health
DPAS North West Region	Lancaster Community Drug Team
DPAT Liverpool	Legalise Cannabis Alliance Norwich
Drug Free Liverpool	Lets Get Serious Manchester
Drugs & Alcohol Research Unit Home Office,	Lifeline Young Peoples Services Calderdale
Drugscope	Lifeline Young People Services Huddersfield
Drugs Misuse Team Department of Health,	Lifeline Young People Services Manchester
Drugthroughcare Team HM Prison Walton	Lifeline Young People Services Oldham
Drws Care Gwenyn Gwynydd	Liverpool Drug Dependency Clinic Merseyside Probation Service
Dutch Experience Stockport	Ministry of Health The Netherlands
	Macclesfield Community Drug Team
	Manchester Drug Service

Manchester Metropolitan University	South Sefton Community Drug Team
Mental Health Services of Salford	S.S.P
Merseyside Drug Council	Fife
Merseyside Police	St Helens MBC
NACRO	Stockport Community Drug Team
Liverpool	Stockport Drug Action Team
National Addiction Centre	Stockport Young Peoples Drug Project
London	Substance Misuse Project
NHS Executive North West	Chester
Warrington	Tameside Young Peoples Centre
The National Probation Service	Trafford Youth Offending Team/Young
Runcorn	Persons Drug Service
National Treatment Agency for	Turning Point
Substance Misuse	Chester
North Cheshire & Merseyside Disabled	University of Central Lancashire
Drivers Association	Preston
Liverpool	University Hospital Aintree
North West Lancashire Health Promotion	Warrington Community Trust
North West Lancashire Substance	Warrington Drug Action Team
Misuse Service	West Lancashire Community Drug Team
Oldham Against Crime Partnership	Wigan & Bolton Health Authority
Oldham Community Drug Team	Wirral Christian Drugs Action
Oldham Drug & Alcohol Action team	Birkenhead
Project 8	Wirral Drugs Service
Liverpool	Wirral Education Centre
Public Health Sector	Wirral Health Authority
Liverpool John Moores University	Wirral Social Services
Public Health Unit	Wirral Youth Offending Team
Lancaster University	YMCA
Response	Liverpool
Birkenhead	YPAS
Sefton Health Authority	Liverpool
The Social Partnership/Transit	Youth Offending Team
Liverpool	Knowsley
Supportive Help and Development Organisation	Youthpoint Detached Project
(SHADO) Liverpool	Speke
South Cheshire Drug Action Team	
South Cheshire Drugs Service	
South Knowsley Community Drug Team	
South Ribble Borough Council	

# .SHAPINGANEWAGENDA



Centre for Public Health and North West Public Health Observatory  
Liverpool John Moores University  
School of Health and Human Sciences  
70 Great Crosshall Street  
Liverpool L3 2AB



HIT  
Hanover House  
Hanover Street  
Liverpool L1 3DZ

Drugs Prevention Advisory Service  
North West Region  
Room 2105 Sunley Tower  
Picadilly Plaza  
Manchester M1 4BE



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