

Cannabis use in Britain

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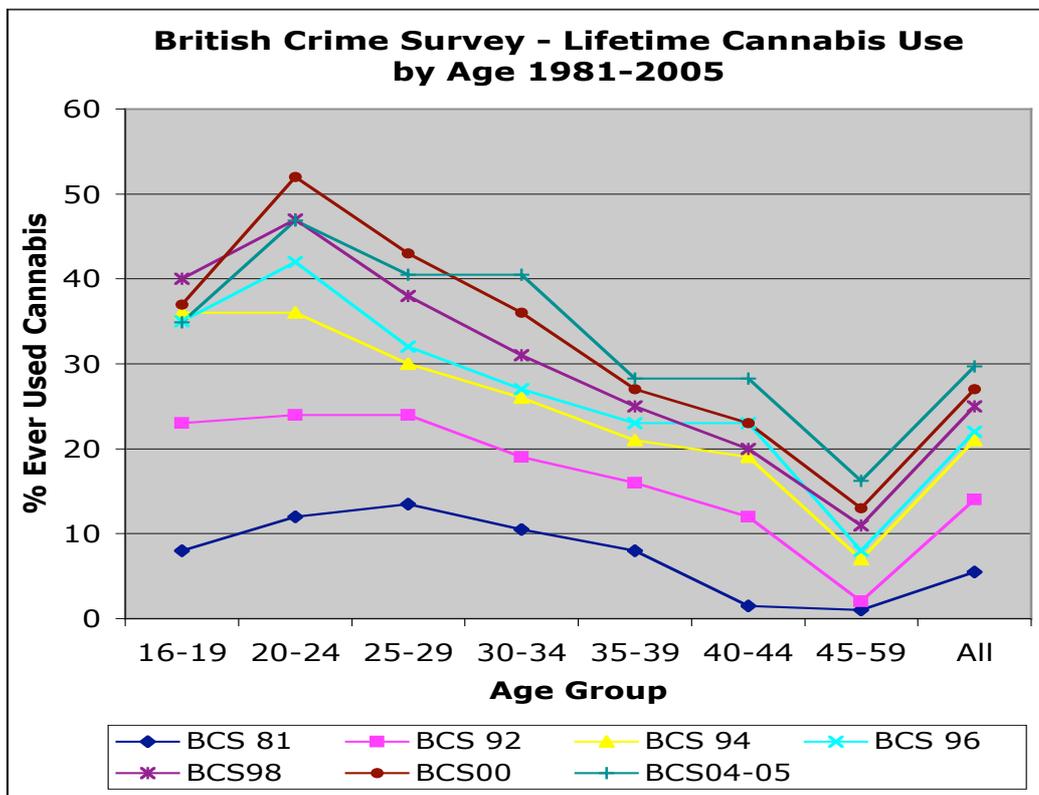
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1. Introduction

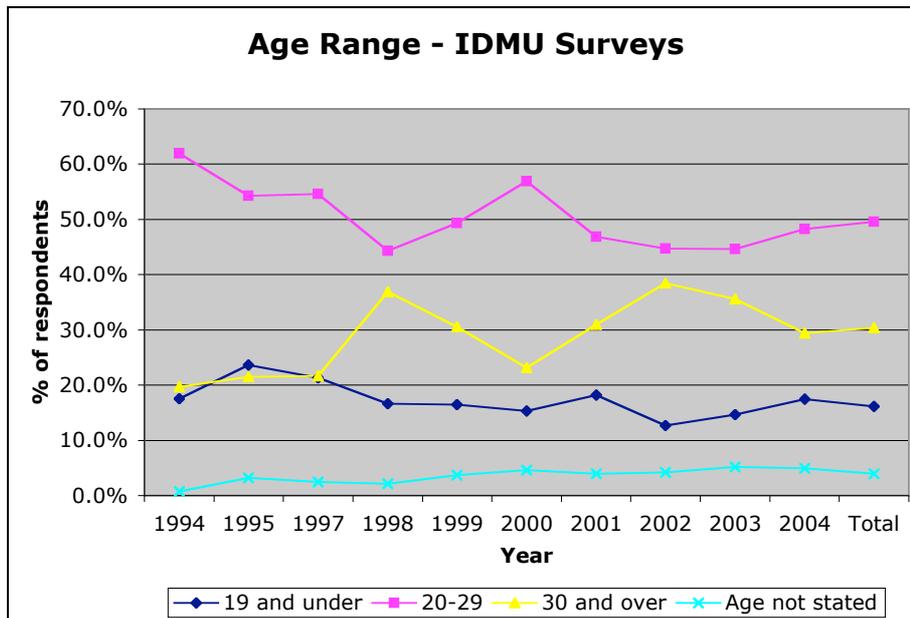
- 1.1 These lecture notes are intended as an introduction to Cannabis use in the UK. These briefly cover prevalence of cannabis use among different age groups, consumption patterns, initiation to drug use (the ‘progression’ theory), the types of cannabis available, methods of use, driving, medicinal use and possible future policy options.
- 1.2 Cannabis is the most widely-used illegal drug on the planet, and has been one of the most intensively-studied substances of all time. It is also the drug which causes the most controversy, and arouses the strongest emotions on both sides. The legalisation argument has been creeping steadily up the political agenda in recent years, with the opinion polls, once 6 to one against reform, now showing public opinion to be evenly divided between the reformers and prohibitionists.
- 1.3 The purpose of this lecture is to shed light where there is darkness, and critically analyse some of the misinformation, myths and half-truths on both sides of the argument.
- 1.4 This document presents some of our own research data, mostly in graphic or tabular form, and much of it for the first time. Commentary is generally kept to a minimum.

2. Prevalence of Cannabis Use

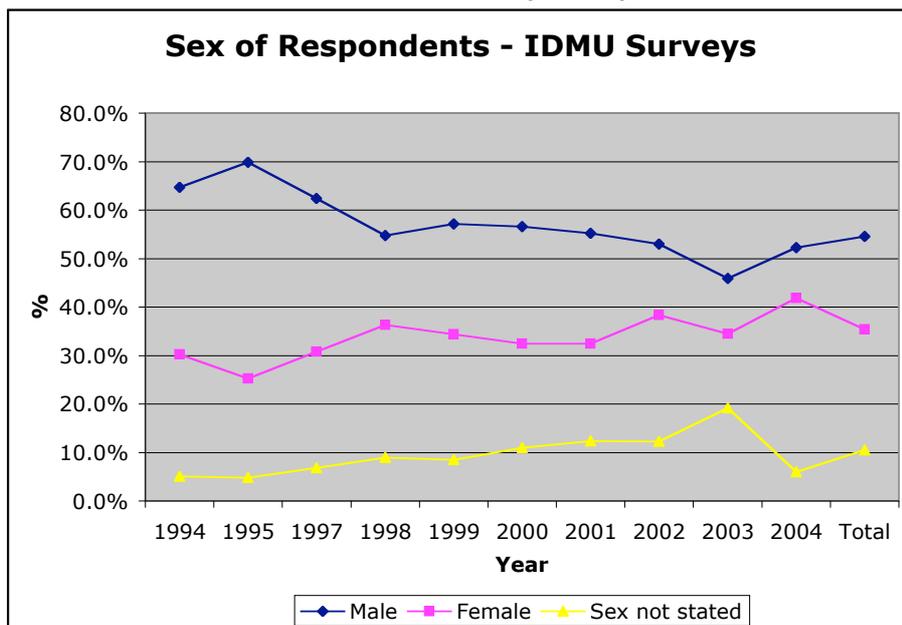
- 2.1 The Home Office conducts the British Crime Survey every 2 years, including questions on whether people have ever used a range of drugs, and if so whether they have done so in the past year or past month. The prevalence of cannabis use has been rising in these surveys since they were first conducted in the early 1980s. In the UK, around 15 million people would now admit having tried cannabis, with between 2 and 5 million regular users.



- 2.2 Cannabis use is highest in the 16-29 age group, although the rise in use is sharpest among older adults. Part of this is demographic, as existing or former users progress into the older age groups, although use among elderly citizens, particularly for medicinal reasons, is becoming more common.
- 2.3 **IDMU Surveys** - Our research is based primarily on our drug user surveys, which have been conducted in 1994, and in each year since 1997, as well as my own 1984 survey which pioneered the methodology. Respondents are asked to complete anonymous questionnaires, containing a number of core variables, with other questions varying from year to year. Surveys have been distributed primarily at pop-festivals and pro-cannabis rallies, although smaller batches have been distributed via subcultural magazines, snowballing, via direct mailings to members of pressure groups, and at other events. Development has been evolutionary, and response rates have been increased via use of our own stalls and provision of clip-boards at outdoor events.
- 2.4 The age range of respondents would appear to be broadly representative of regular cannabis users in the UK population, with the majority falling in the 18-30 age range.

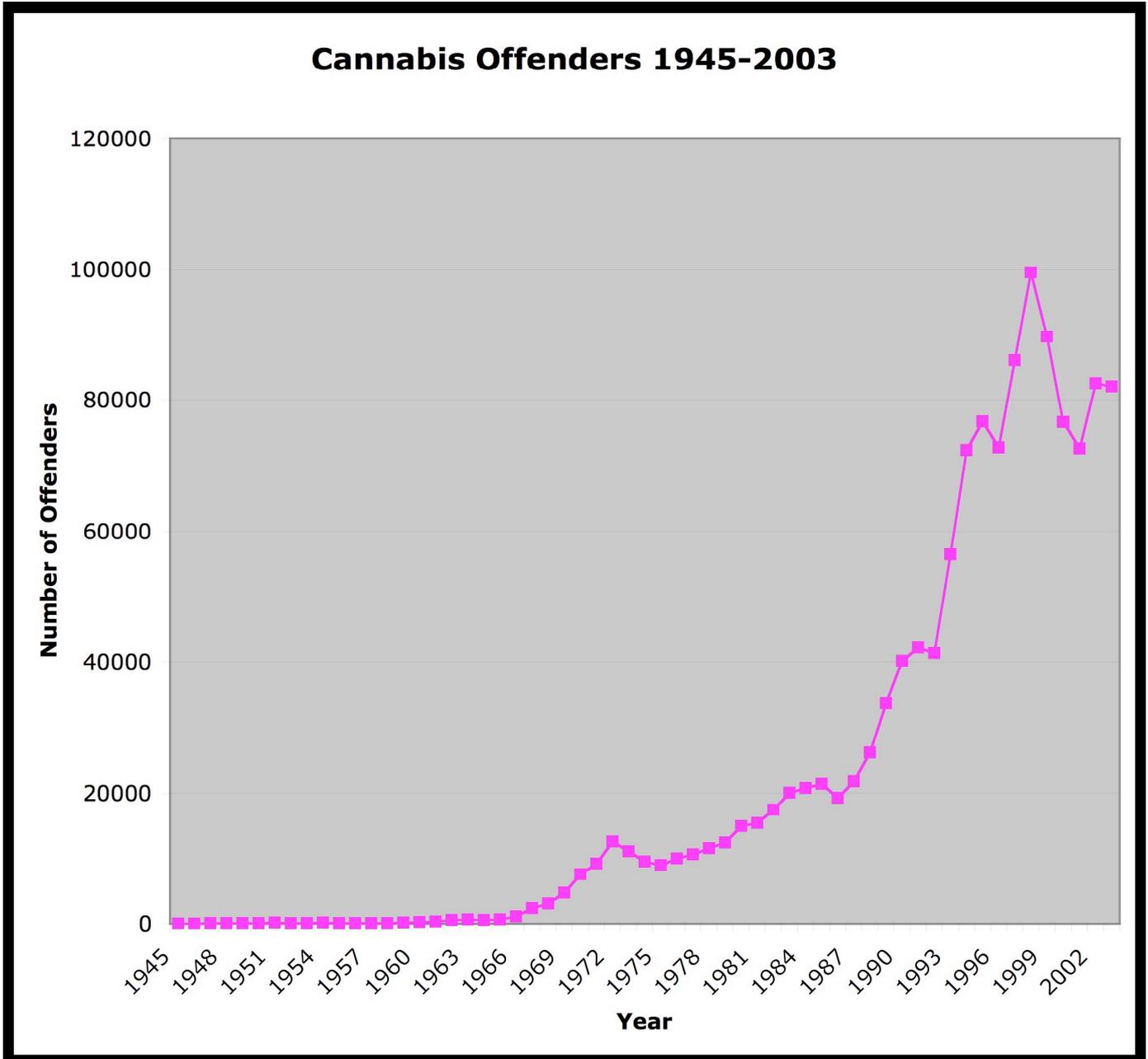


- 2.5 The male-female ratio has declined from 2:1 in early surveys to 3:2 or lower since 1998-99.



2.6 The Home Office published annual statistics on drug seizures and drugs offenders. These rose steadily from the end of World War II peaking the late 1990s, and falling back slightly since 2000. The millionth conviction would have occurred around December 1999.

Dangerous Drugs Acts 1945-1972 = 44,834,
 Misuse of Drugs Act 1973-2003 = 1,275,865,
 Total - **1,320,699**

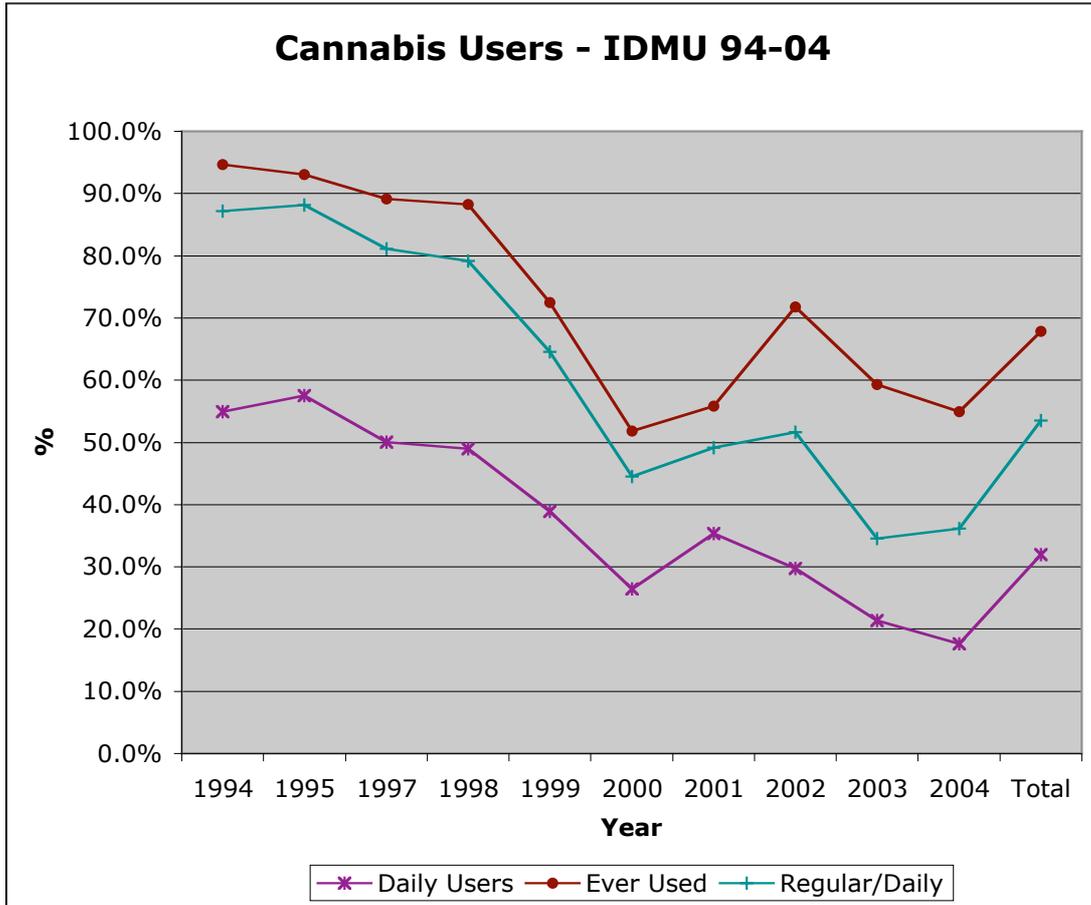


(includes Cautions and all formal disposals)

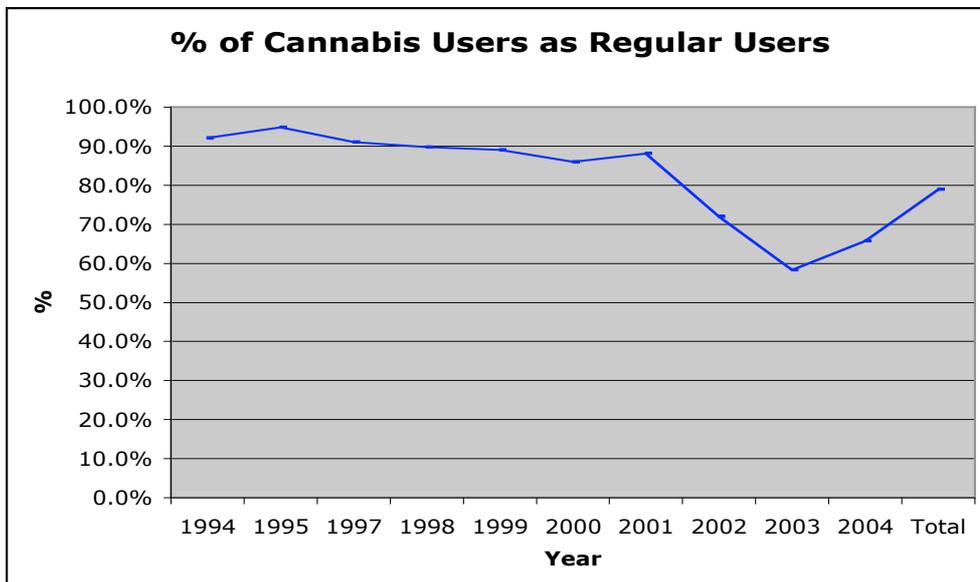
3. Frequencies of Cannabis Use

Frequency of Cannabis Use 1994-2004											
Year	1994	1995	1997	1998	1999	2000	2001	2002	2003	2004	94-04
Experimental	2.5%	2.7%	2.5%	2.4%	2.9%	2.3%	3.4%	5.1%	5.5%	5.2%	3.9%
Occasional	4.9%	2.2%	5.5%	6.6%	5.0%	4.9%	3.2%	7.0%	5.9%	6.0%	5.7%
Regular	32.2%	30.6%	31.1%	30.2%	25.6%	18.2%	13.8%	21.8%	13.1%	18.5%	21.5%
Daily	54.9%	57.5%	50.1%	49.0%	39.0%	26.4%	35.4%	29.8%	21.4%	17.6%	32.0%
Monthly Use	27.3g	31.32g	24.0g	20.7g	26.8g	31.5g	44.5g	28.2g	32.5g	24.2g	28.4g
User-Rating	8.78	8.48	8.75	8.38	8.28	8.4	8.57	7.74	7.61	7.65	8.08
Base (n)	1333	186	1136	1153	2173	2352	681	2825	2910	2959	17708

3.1 The majority of users in our surveys smoked cannabis regularly or daily, with the usage pattern more similar to that for tobacco and for caffeine than for other illicit drugs. The survey population would thus be broadly equivalent to the ‘used in past month’



3.2 There appears to be a decline in the proportion of survey respondents using cannabis, and using it regularly, since the mid 1990s. Part of this is due to methodological differences between surveys (e.g. question placement, demographics of event populations, recruitment methods & event locations). These effects may be controlled by considering the number of regular users as a proportion of lifetime users. This confirms a decline in regular use among cannabis users in 2002-2004. This decline is mirrored by user-ratings, which show a significant fall between 2002-2004.



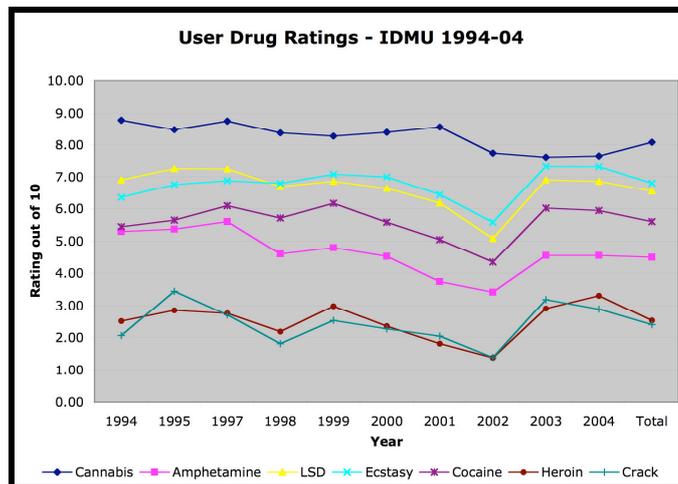
3.3 **National Prevalence Estimates & Reclassification:** Findings from the 2004 IDMU survey recorded the lowest year on year increase in regular cannabis use in the past decade, with user ratings (a key indicator of intention to use) remaining at a historic low. The average age of initiation to cannabis use was close to the 10 year average, and cannabis resin prices had bottomed out after years of steady decline. Far from leading to an explosion of use, declassification of cannabis appears to have had little or no effect on consumption or levels of cannabis usage, if anything the upward trend in cannabis use appears to have been halted. The estimate for regular cannabis users is derived from the average number of times an respondents have been ‘busted’ for cannabis, their duration of use, the number of cannabis arrests over the average duration of use (derived from Home Office statistics), and the proportion of regular cannabis users in each year’s survey.

Year	Regular Users	% Increase	Age 1st Use	User Rating	1/8oz resin
1994	961073	n/a	15.98	8.8	£14.41
1995	1005198	4.6%	15.92	8.5	£14.39
1997	1209383	20.3%	15.90	8.8	£14.06
1998	1753261	45.0%	16.29	8.4	£13.64
1999	2175048	24.1%	15.82	8.3	£12.88
2000	2516565	15.7%	15.75	8.4	£12.01
2001	3106950	23.5%	15.59	8.6	£11.29
2002	3273777	5.4%	16.29	7.7	£10.74
2003	3350801	2.4%	16.76	7.6	£9.96
2004	3366795	0.5%	15.93	7.6	£9.91

3.4 **Amounts used** - The majority of users smoke relatively small amounts of the drug, with mean consumption of 1g per day. Progressively smaller numbers use larger amounts, around one in 20 use 1oz per week, and one in 100 2oz per week. However, in the Caribbean Schaeffer et al described use of up to 2oz (56g) per day of herbal cannabis containing 8% THC.

Cannabis Use Percentiles (1994-2003 - n = 14562)					
Percentile	Monthly Use (g)	Daily THC @ 3% (mg)	Daily THC @15% (mg)	Reefers per day	Reefer content (mg)
Lower 1%	0.6	0.6	3	0.45	13
Lower 5%	1	1	5	0.65	29
Lower 10%	1.9	1.9	9.5	1	40
Lower 25%	5	5	25	2.1	71
Median (50%)	14	14	70	4	126
Upper 25%	28	28	140	7.2	234
Upper 10%	56	56	280	12.7	409
Upper 5%	112	112	560	18.1	569
Top 1%	225	225	1125	30.2	1632

3.5 **User Ratings** – The user rating is derived from asking respondents to rate drugs ‘overall’ with marks out of 10. Although a crude instrument, the ratings nonetheless predict usage, intention to use, and to some extent frequency of use – i.e. the higher the rating the greater probability that the respondent will be a user, or a regular user, of that drug. Ratings for all major drugs are shown.



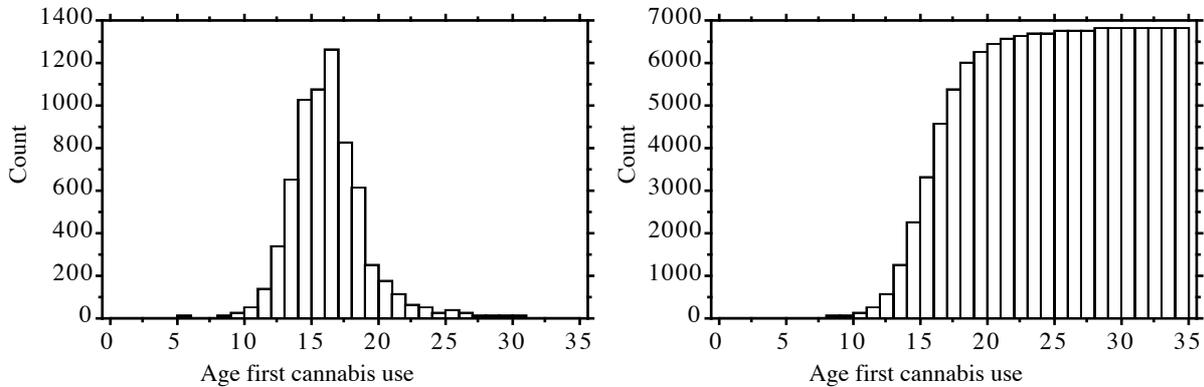
Ratings of cannabis show an overall decline over the survey period, cocaine and amphetamine seem to have swapped positions since the late 1990s, heroin and crack tend to have similar, low, ratings.

3.6 **Other Cannabis Indices** - Women as a whole tend to smoke cannabis less often than males, although differences in purchase and spending were not statistically significant. The difference is greatest amongst women who are experimental or occasional users, there was little difference between consumption of daily users of either sex. Those experimenting with cannabis will tend to buy or use more than occasional users. In couples, it is usually the man who buys the cannabis for both to use. Note also that many regular users grow their own, so spending alone is an imperfect measure of cannabis usage.

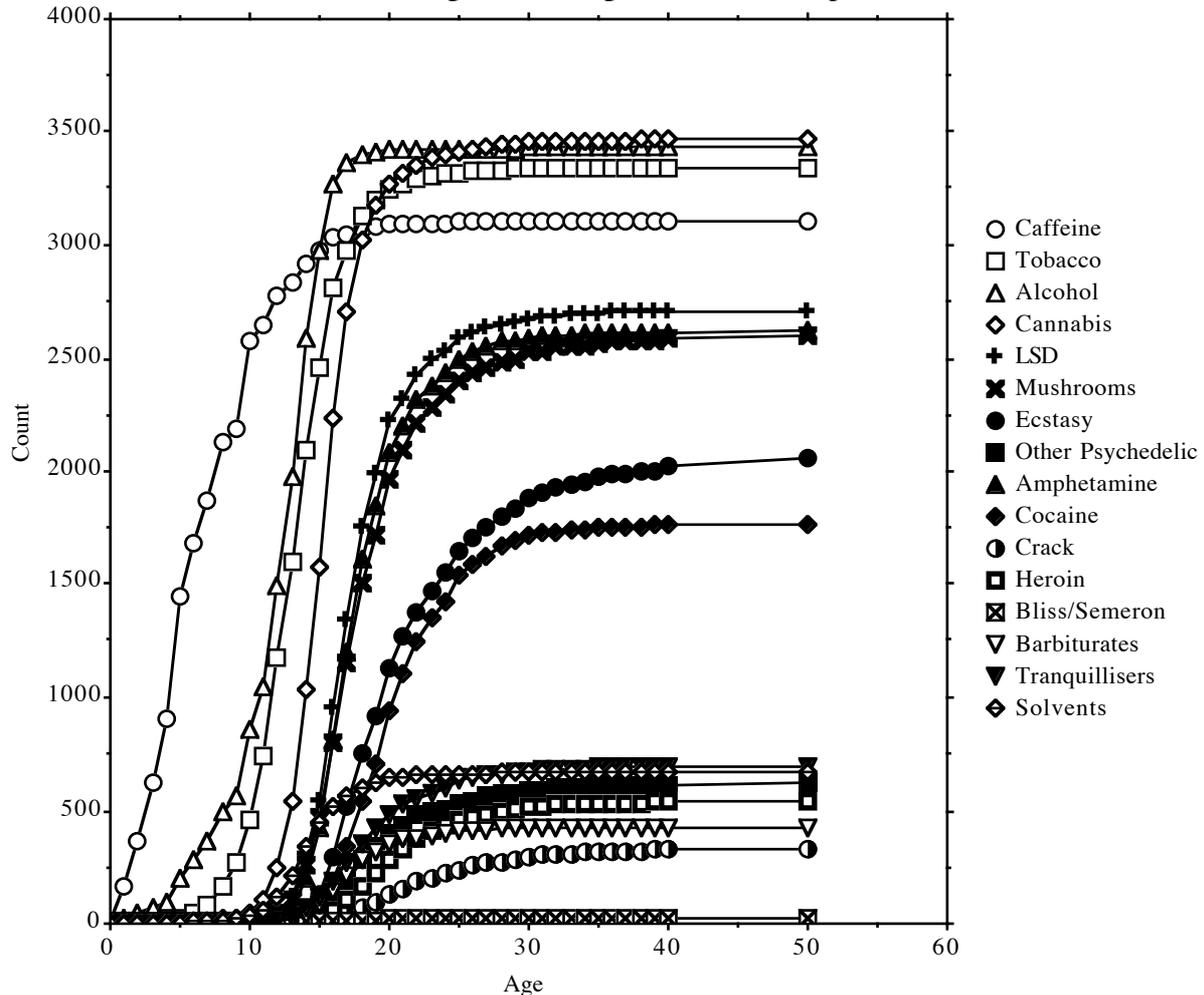
Cannabis Use Indices by Sex & Frequency of Use (94-00)				
Monthly Cannabis Spending (all drugs section)				
Frequency of use	Female	Male	Not Stated	Totals by freq: p<.0001
Experimental	£15.65	£32.12	£29.67	£25.22
Occasional	£6.98	£14.30	£18.76	£11.32
Regular	£18.23	£25.08	£28.74	£22.55
Daily	£59.67	£92.52	£133.92	£85.80
Totals by sex: p=.07	£30.14	£51.31	£52.02	£44.40
Monthly Cannabis Use (g)				
Frequency of use	Female	Male	Not Stated	Totals by freq: p<.0001
Experimental	6.83	15.64	19.60	12.32
Occasional	3.50	7.90	12.57	6.21
Regular	8.33	9.89	9.40	9.24
Daily	28.25	34.55	30.59	32.45
Totals by sex: p<.05	16.32	24.11	17.49	20.99
Monthly Cannabis Purchase (g)				
Sex:	Female	Male	Not Stated	Totals by freq: p<.0001
Experimental	6.32	20.17	23.07	14.72
Occasional	3.19	7.10	26.70	6.36
Regular	8.79	22.84	10.70	16.53
Daily	36.83	64.24	72.78	56.87
Totals by sex: n.s.	22.13	41.85	36.26	34.88
Monthly Cannabis Spending (Cannabis section)				
Frequency of use	Female	Male	Not Stated	Totals by freq: p<.0001
Experimental	£14.95	£45.56	£46.67	£33.13
Occasional	£8.60	£18.73	£20.71	£14.40
Regular	£18.48	£30.01	£32.74	£25.56
Daily	£73.24	£114.23	£136.06	£103.82
Totals by sex: n.s.	£43.35	£71.87	£67.00	£62.07
Reefers Smoked per day				
Frequency of use	Female	Male	Not Stated	Totals by freq: p<.0001
Experimental	1.06	3.67	1.59	2.45
Occasional	0.76	1.88	2.91	1.44
Regular	2.05	2.33	2.52	2.23
Daily	6.46	6.80	6.88	6.70
Totals by sex: p<.001	3.60	4.93	4.28	4.43
Freq x Sex p<.05				

4. Use of All Drugs

4.1 Initiation to drug use - the 'stepping stone' hypothesis reconsidered - The peak years of initiation to cannabis use are 14-18 years, at age 16, roughly half of those who will eventually try cannabis have already used it. Results from school surveys **should** take account of the initiation to drug use by older pupils and young people who have left school.

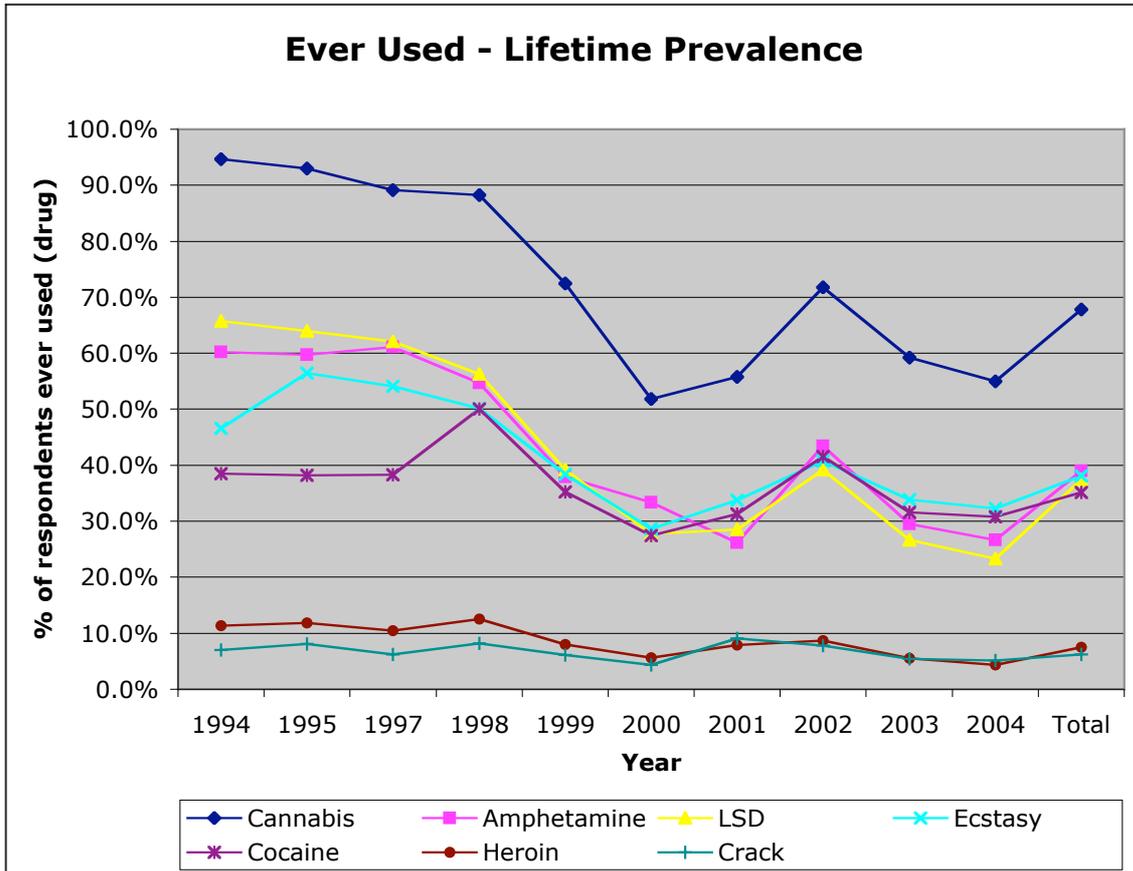


4.2 Initiation to Other Drugs – Acquisition Curves - The Drug Acquisition Curves show the numbers who had tried each drug by a given age. Very few people who have not tried a drug by age 25 will start using it afterwards, the only exception being ecstasy (and to a lesser extent crack cocaine), which both arrived on the scene when many existing drug users were in their 30s and 40s. Note - 'tea/coffee' was not included in the questions from one batch of surveys. 'Bliss' was included as a fictitious drug from 1994-98, when it came to our attention that a 'herbal high' was being sold under that trade name, for 1999 and 2000 we used the same 'bogus' drug as the Home Office (i.e. Semeron) which was given the bogus street name 'space'.



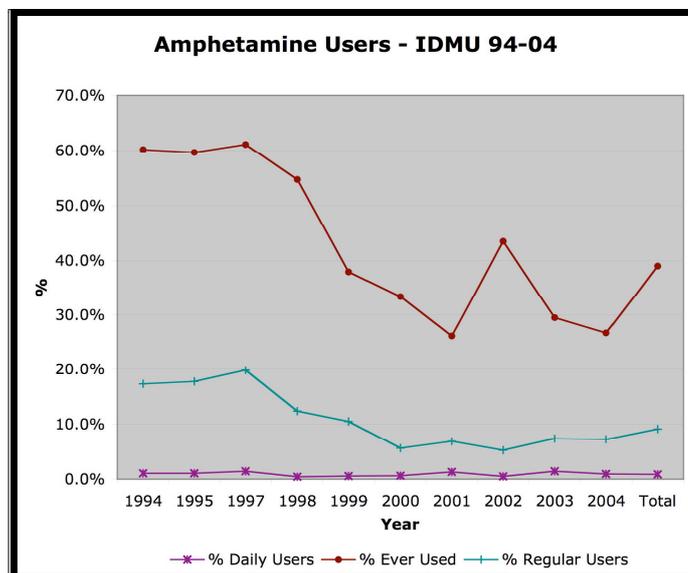
4.3 Drug Prevalence

4.3.1 The lifetime prevalence of using most drugs has remained relatively stable among the user population as a whole, however amphetamine and LSD appears to be declining steadily, whereas cocaine and ecstasy appear to be increasing slightly. Prevalence of magic mushroom use (not shown) is similar to that of LSD. Crack and Ecstasy were not listed options in 1984, although 1% mentioned MDA as a write-in option. Users of crack in 1984 (then known as freebase) did not report it directly, but some of the cocaine would have been used in that form.

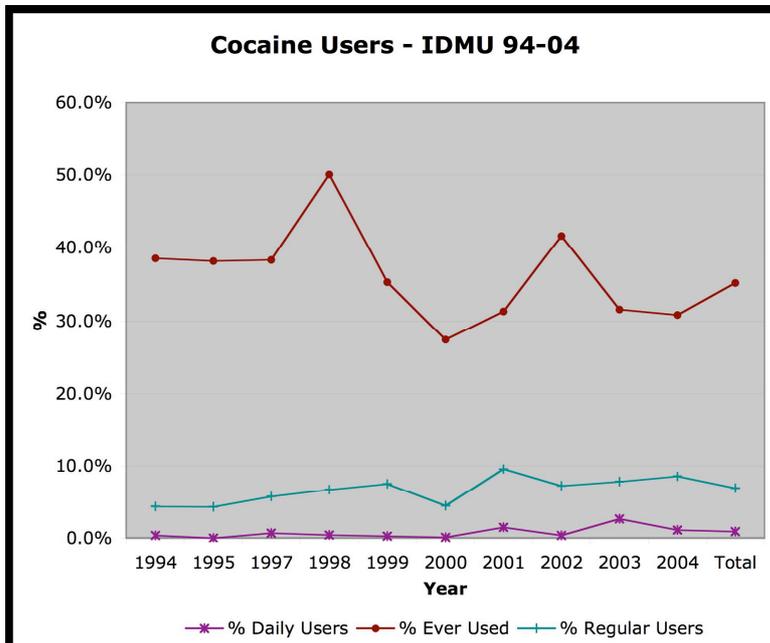
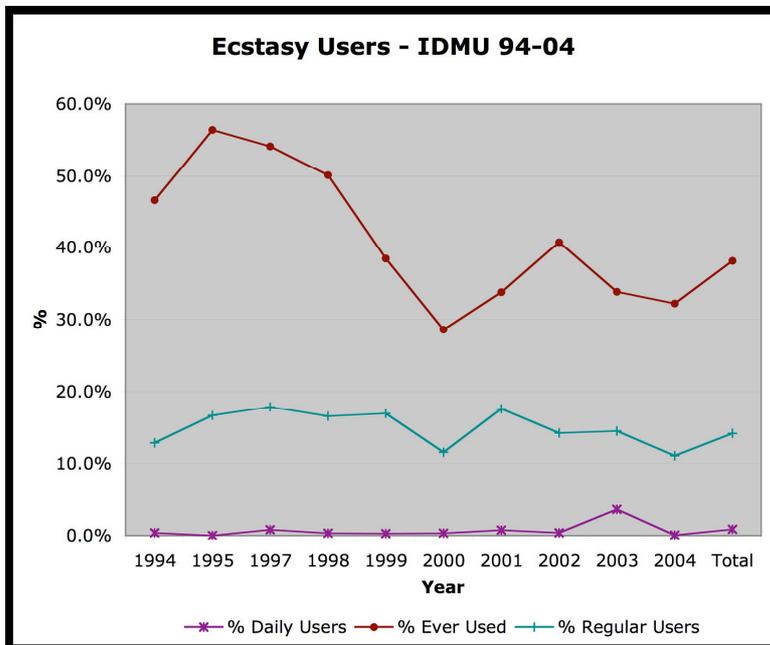
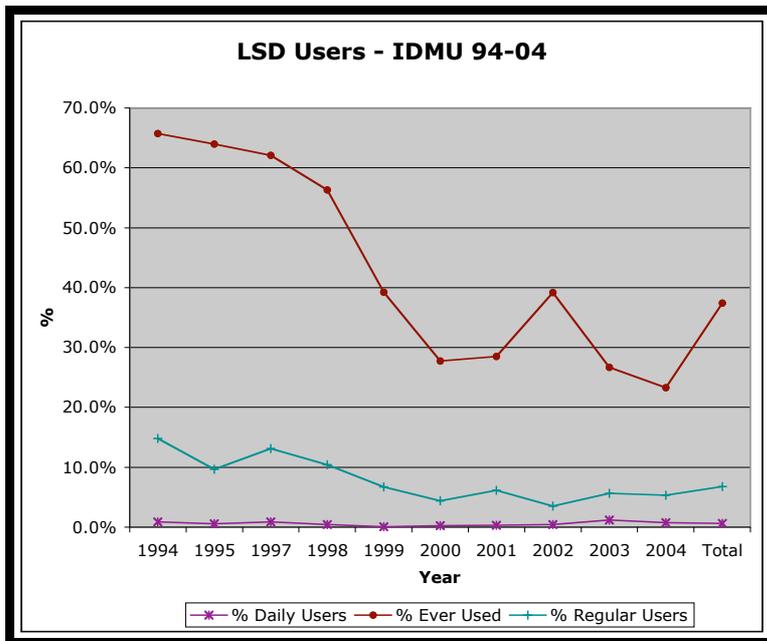


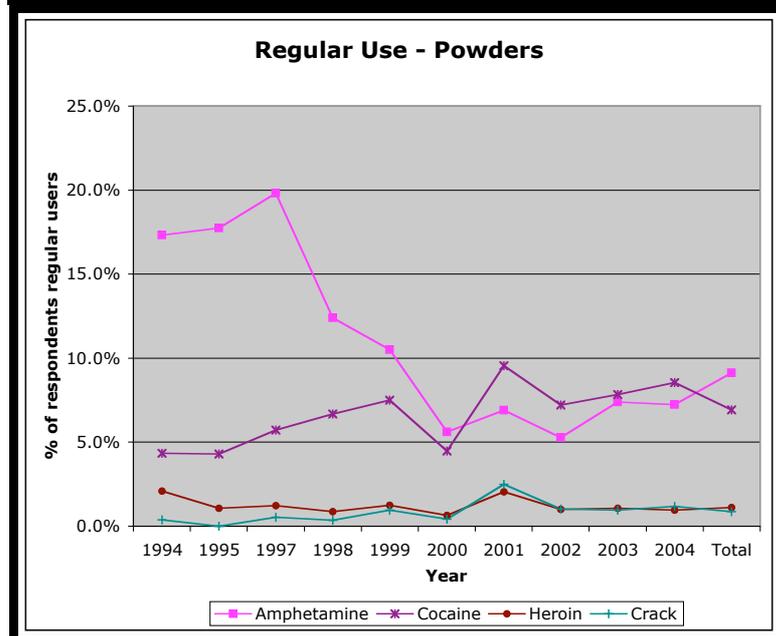
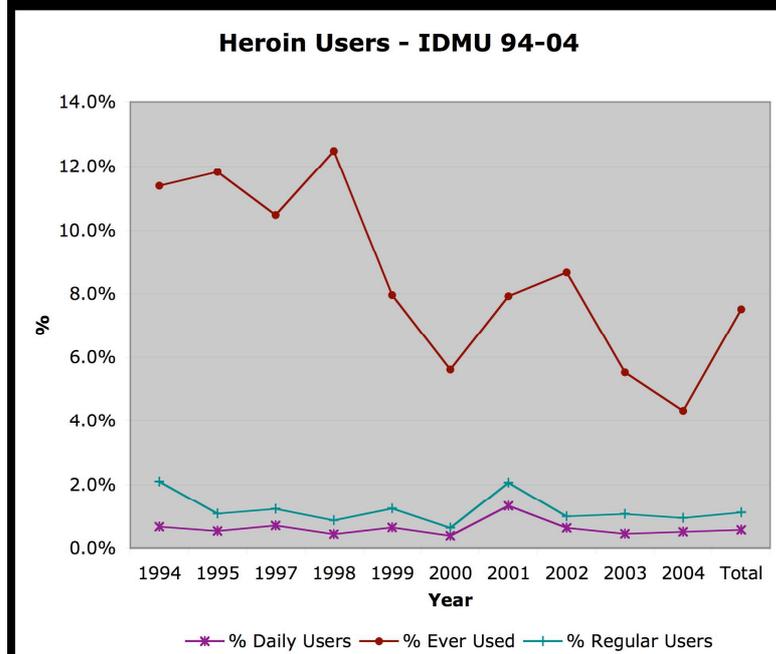
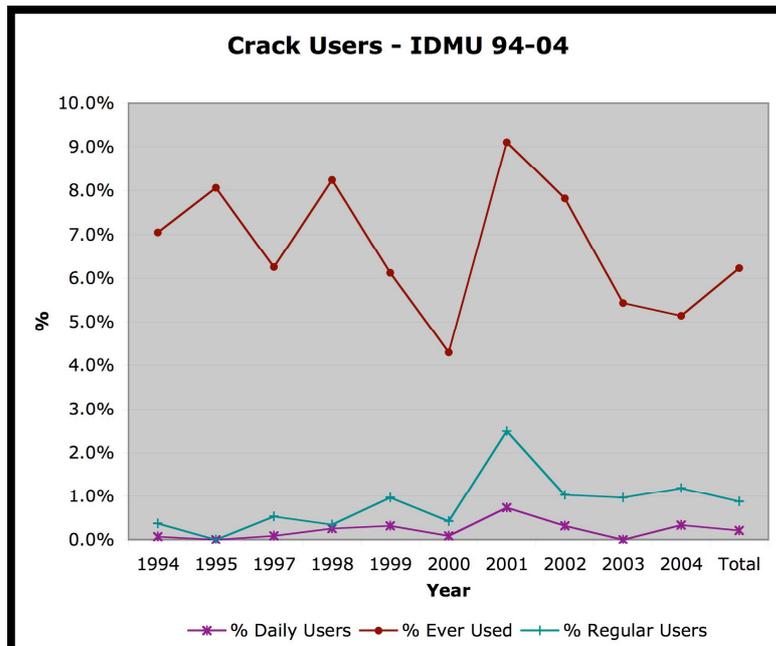
4.4 Frequency of use

4.4.1 Users of each drug were asked to state how often they used the drug. Other than cannabis and legal drugs (caffeine, tobacco, alcohol), there were few daily users, with experimental or occasional use the norm.



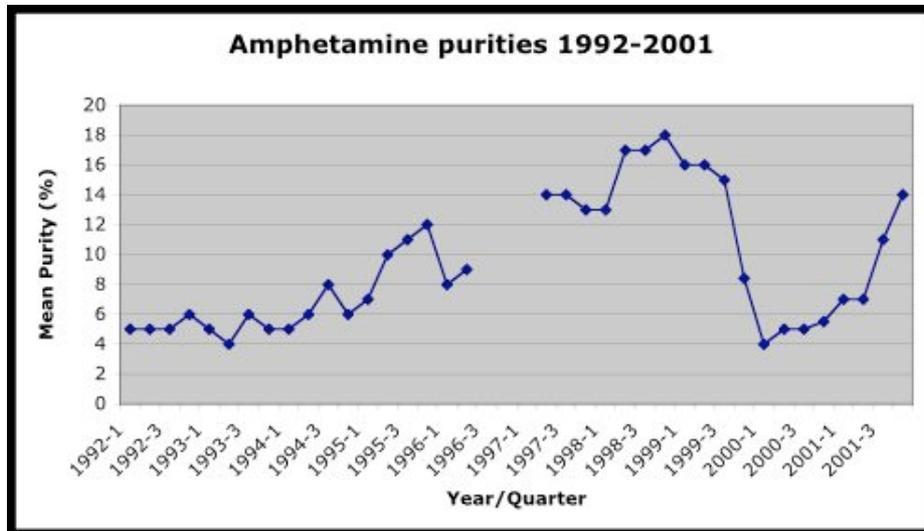
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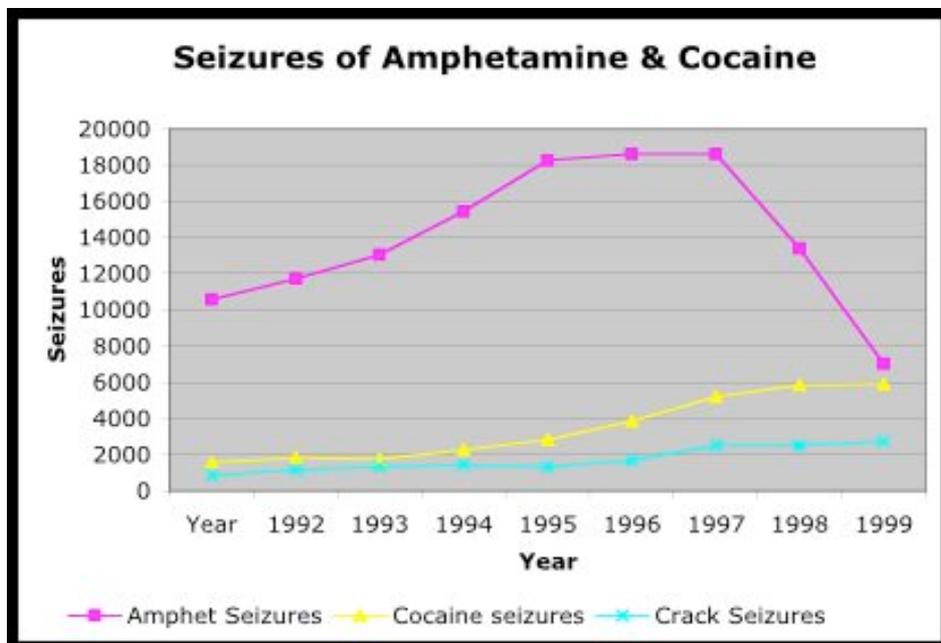


5. Supply-side Interventions - Operation Pirate

- 5.1 Operation Pirate led to the discovery in late 1998 of the largest illicit drugs laboratory operation ever uncovered on mainland Britain which saw 10 men sentenced for a total of over 40 years for being part of a multi-million pound amphetamine production conspiracy¹
- 5.2 While usage of amphetamine by young people had been increasing throughout the 1990s, with 8% of 16-29 year olds using the drug in 1998, by 2000 that figure had fallen to 5%, and the average purity had fallen from 16% to 5%, before returning to pre-operation levels towards the end of 2001.

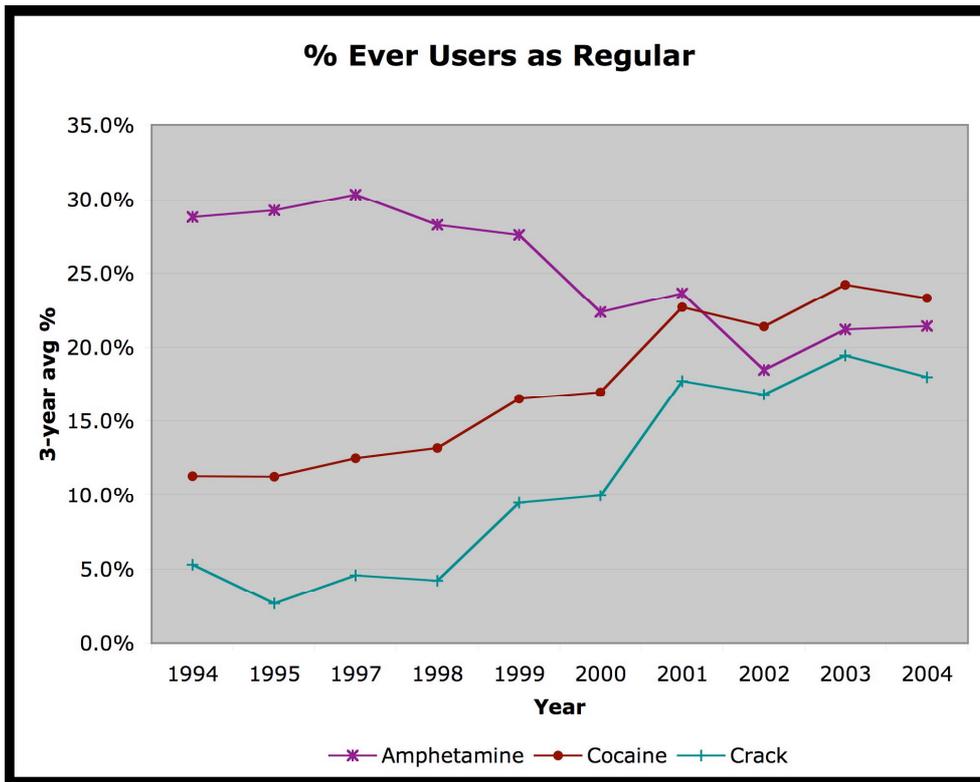


- 5.3 Prosecutions and seizures for amphetamine also fell sharply, with the total number of amphetamine seizures falling from over 18600 in 1998 to just over 7000 in 2000. A major victory in the War on Drugs – or was it?

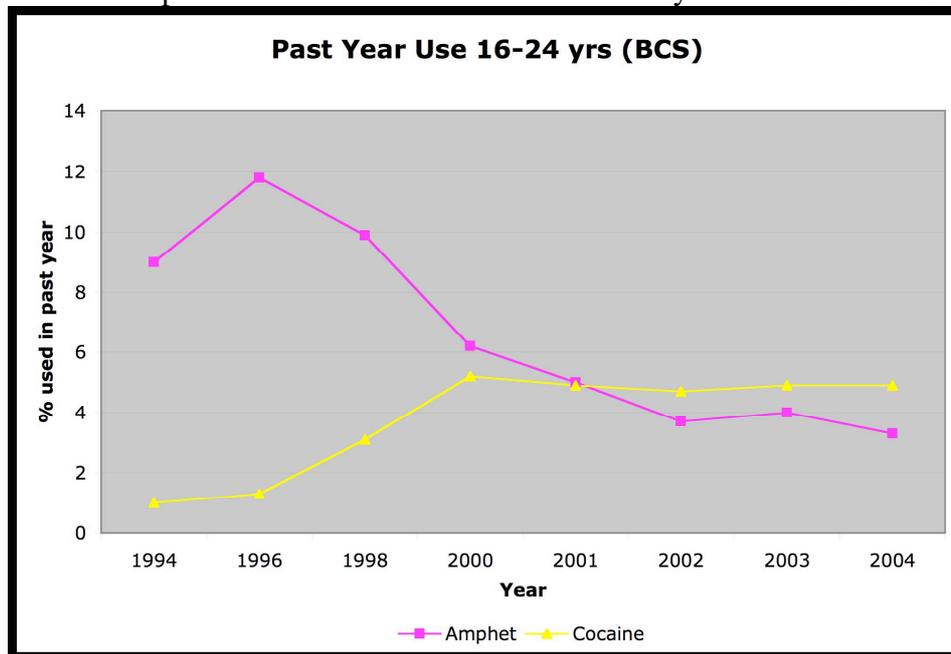


- 5.4 Britain's 'speed' users were suddenly left without amphetamine to satisfy their cravings, at the same time as record amounts of cocaine and crack were entering the UK. Consequently although use in the past year and past month of amphetamine halved between the 1998 and 2000 British Crime Surveys, usage of cocaine and crack had doubled, such that by 2000 an equal number had used amphetamine and cocaine in the previous 12 months.
- 5.5 Taking 3 year average figures to smooth annual variations, a clear pattern among stimulant users is a switch from amphetamine to cocaine. Although the lifetime prevalence of cocaine and crack among the survey population is essentially unchanged, the proportion of users of cocaine who used

regularly doubled from 11% to 23% and among lifetime users of crack the proportion of regular users increased from 5% to 18%. The proportion of amphetamine users who use the drug regularly fell from 29% to 21% over the decade.



5.6 The switch from amphetamine use to cocaine is confirmed by the British Crime Survey data.



5.7 The implications of this finding for supply-side control and interdiction policies are gloomy. The most successful anti-drugs operation in recent UK history merely resulted in a high proportion of amphetamine users switching to cocaine, and possibly also crack. One reason the UK never experienced the US ‘crack’ epidemic of the late 1980s and early 1990s, and for the relatively low historic prevalence of cocaine usage, was the wide availability of amphetamine, which provides a similar effect for a longer duration at a fraction of the cost.

5.8 The argument for ‘legalising’ amphetamine is undone by the propensity of the drug to cause aggression and violence if used to excess, as well as physical health risks associated with all

stimulants. Thus an unrestricted retail market would have adverse consequences for public order and safety. Nonetheless, a form of controlled availability - e.g. re a smart card for registered users specifying a maximum daily or weekly 'ration'/dose, or prescription by GPs of dexamphetamine tablets or linctus (to prevent injection) - might represent an alternative method of 'maintenance' treatment for individuals with cocaine or crack dependency problems.

6 Deterrence? – Effects of a cannabis 'Bust'

6.1 Laws prohibiting drug use and possession are frequently justified on the basis that they deter people from using drugs. However the effect of a drugs arrest tends to consolidate or stimulate drug use, rather than deterring the user from continuing or indeed experimenting with other drugs. Drug users who have been arrested for drugs offences typically use a wider range of drugs more frequently and more heavily than users with clean records. They also tend to give higher ratings to drugs.

Drug use frequency, purchasing, Subjective Ratings & other consumption patterns by whether ever busted (1994-98 Consolidated)									
Base (% of total)	Cannabis offence			Other drug offence			Other offence		
	No	Yes	<i>p</i>	No	Yes	<i>p</i>	No	Yes	<i>p</i>
	2831 78%	792 22%		3389 94%	234 6%		3181 88%	442 12%	
Age	25.71	29.01	.064	27.38	30.03	<.0001	26.24	28.52	<.0001
Caffeine									
Rating	5.98	5.79	<i>ns</i>	6.14	5.60	<i>ns</i>	5.97	5.68	<i>ns</i>
Frequency	3.15	3.30	<i>ns</i>	3.19	3.27	<i>ns</i>	3.18	3.20	<i>ns</i>
Spending	4.39	5.09	<i>ns</i>	4.41	5.05	<i>ns</i>	4.50	4.87	<i>ns</i>
Tobacco									
Rating	3.82	3.46	<i>ns</i>	3.72	3.56	<i>ns</i>	3.72	3.91	<i>ns</i>
Frequency	2.76	3.10	<i>ns</i>	2.81	3.20	<.01	2.80	3.13	<.0001
Spending	21.00	24.30	<i>ns</i>	18.56	24.35	<i>ns</i>	19.93	34.31	<.0001
Cigs/day	8.81	10.63	<i>ns</i>	10.14	10.82	<i>ns</i>	8.94	11.45	<.0001
Alcohol									
Rating	5.97	5.51	<i>ns</i>	6.68	5.22	.0001	5.90	5.62	.057
Frequency	2.63	2.65	<i>ns</i>	2.88	2.66	<i>ns</i>	2.63	2.70	<i>ns</i>
Spending	33.21	32.28	<i>ns</i>	38.71	34.54	<i>ns</i>	32.64	37.13	.066
Units/ week	18.43	18.21	<.001	25.46	23.00	<i>ns</i>	18.25	22.09	<.001
Cannabis									
Rating	8.51	9.11	<i>ns</i>	8.82	9.10	<.05	8.64	8.72	<i>ns</i>
Frequency	2.97	3.51	<i>ns</i>	3.19	3.53	<.0001	3.06	3.33	<.0001
Used/ month (g)	21.17	31.57	<i>ns</i>	21.56	40.27	<.05	23.06	87.13	<.05
Bought/ month (g)	42.18	101.7	<i>ns</i>	43.55	75.56	<.05	46.98	103.38	<.0001
£Spending 1	36.53	90.98	<i>ns</i>	29.88	79.22	<.05	44.54	78.8	<.05
£Spending 2	67.44	188.96	<i>ns</i>	59.53	99.29	.051	84.92	137.76	<.05
Spliffs smoked/day	5.05	6.86	<.05	5.72	8.57	<.0001	5.39	7.15	<.0001
Rolled/ day	4.82	6.24	<i>ns</i>	4.73	7.55	<i>ns</i>	5.06	6.60	<i>ns</i>
Pipes/ day	2.23	3.23	<.01	2.75	4.90	<.05	2.34	4.17	<.0001
Plants Grown	13.37	25.58	<i>ns</i>	11.38	65.13	<.05	15.68	43.95	<.0001
% bought for own use	69.06	73.03	<i>ns</i>	70.15	70.06	<i>ns</i>	69.86	70.41	<i>ns</i>

Drug use frequency, purchasing & other consumption patterns by whether ever busted									
	Cannabis offence			Other drug offence			Other offence		
	No	Yes	p	No	Yes	p	No	Yes	p
LSD									
Rating	6.74	7.55	<i>ns</i>	7.83	7.01	<i>ns</i>	6.97	6.68	<i>ns</i>
Frequency	1.01	1.31	<.0001	1.38	1.61	<.005	1.06	1.33	<.0001
Spending	1.38	2.75	<i>ns</i>	2.46	3.08	<i>ns</i>	1.54	2.92	<.01
% bought for personal use	81.25	80.89	<i>ns</i>	98.64	75.53	.052	80.12	86.39	<i>ns</i>
Ecstasy									
Rating	6.56	6.64	<.05	7.44	7.32	<i>ns</i>	6.62	6.74	<i>ns</i>
Frequency	.85	1.01	<.0001	1.17	1.54	<.005	0.89	1.11	<.0001
Spending	5.58	8.65	<i>ns</i>	6.92	11.64	<.05	5.73	11.38	<.0001
% bought for personal use	84.52	80.10	<i>ns</i>	86.94	80.54	<i>ns</i>	83.33	83.84	<i>ns</i>
Amphetamine									
Rating	5.21	4.82	<i>ns</i>	5.32	5.29	<i>ns</i>	5.15	5.05	<i>ns</i>
Frequency	1.05	1.27	<.01	1.33	1.47	<.05	1.07	1.41	<.0001
Spending (£)	4.13	5.83	<.05	12.38	8.19	<i>ns</i>	3.95	10.36	<.0001
% bought for personal use	76.30	78.54	<i>ns</i>	72.60	78.65	<i>ns</i>	76.74	77.26	<i>ns</i>
Cocaine									
Rating	5.51	6.09	<i>ns</i>	6.23	6.32	<i>ns</i>	5.68	0.83	<i>ns</i>
Frequency	0.56	0.93	<.005	0.85	1.10	<.0001	0.62	0.93	<.0001
Spending	3.34	9.43	<i>ns</i>	4.69	4.92	<i>ns</i>	2.83	16.16	<.0001
% bought for personal use	70.09	69.28	<i>ns</i>	80.00	76.18	<i>ns</i>	69.75	74.39	<i>ns</i>
Crack									
Rating	1.87	2.59	<.05	4.06	2.82	<i>ns</i>	2.00	2.83	<.05
Frequency	0.07	0.15	<.005	0.10	0.28	<.0001	0.08	0.19	<.0001
Spending	0.34	3.68	<i>ns</i>	6.25	2.55	<i>ns</i>	0.97	1.92	<i>ns</i>
% bought for personal use	45.83	37.50	<i>ns</i>	•	50.00	<i>ns</i>	42.11	50.00	<i>ns</i>
Heroin									
Rating	2.17	3.00	<.005	4.35	3.20	<i>ns</i>	2.28	3.35	<.0001
Frequency	0.12	0.26	<.0001	0.35	0.45	<.01	0.14	0.35	<.0001
Spending	1.32	3.70	<.0001	30.21	13.44	<.05	1.51	11.52	<.0001
% bought for personal use	62.38	60.71	<i>ns</i>	•	100	<i>ns</i>	62.00	77.78	<i>ns</i>
'Semeron/ Bliss'*									
Rating	1.88	1.44	<.005	5.60	1.70	<.005	1.92	1.27	.069
Frequency	0.01	0.01	<.0001	0.15	0.03	<.0001	0.01	0.03	<.05
Spending	0.01	0.09	<i>ns</i>	0.10	0	<i>ns</i>	0.02	0	<i>ns</i>
Tranquillisers									
Rating	2.71	2.62	<i>ns</i>	3.36	3.10	<i>ns</i>	2.63	3.21	<.05
Frequency	0.19	0.32	<.0001	0.50	0.55	.081	0.20	0.46	<.0001
Spending	0.12	0.21	<.001	0.83	1.01	<i>ns</i>	0.11	0.76	<.0001
Solvents									
Rating	1.51	1.49	<i>ns</i>	1.20	1.28	<i>ns</i>	1.36	2.17	<.001
Frequency	0.14	0.16	<i>ns</i>	0.19	0.18	<i>ns</i>	0.13	0.25	<.0001
Spending	0.07	0.13	<i>ns</i>	0.27	0.11	<i>ns</i>	0.06	0.29	<.0001

* The list of drugs on the multiple-choice questions changed in 1998. Ketamine was not previously specified, replacing 'Other Psychedelic'. 'Semeron' is a fictitious substance included as an error-detector, replacing 'Bliss' in earlier studies - a 'legal high' of that name now exists..

6.2 “Busted” users are much more likely - post arrest - to initiate use of heroin or crack cocaine, and also to be willing to try an unknown (fictitious) drug.

Prevalence Differences between ‘Busted’ and ‘Clean’ users									
Drug	Cannabis Arrest			No Cannabis Arrest			Odds ratios		
	Use(d) drug	Might use	Never/ Stopped	Use(d) drug	Might use	Never/ Stopped	Use(d) drug	Use or might	Never/ stopped
Caffeine	88.1%	0.0%	11.9%	81.4%	0.2%	18.4%	1.083	1.080	0.647
Tobacco	83.5%	0.0%	16.5%	78.9%	0.1%	21.0%	1.058	1.057	0.787
Alcohol	88.3%	0.0%	11.7%	87.4%	0.1%	12.5%	1.011	1.009	0.935
Cannabis	95.4%	0.2%	4.4%	89.6%	0.1%	10.2%	1.064	1.065	0.430
LSD	71.9%	1.2%	26.9%	62.1%	4.6%	33.3%	1.158	1.096	0.808
Mushrooms	75.6%	3.1%	21.3%	60.0%	7.6%	32.5%	1.261	1.165	0.657
Ecstasy	60.1%	6.8%	33.1%	47.1%	7.0%	45.9%	1.276	1.237	0.721
Amphetamine	66.2%	0.6%	33.2%	56.5%	2.1%	41.3%	1.171	1.138	0.803
Cocaine	58.3%	2.9%	38.8%	37.3%	7.1%	55.6%	1.565	1.380	0.697
Crack	13.1%	4.4%	82.5%	5.4%	3.3%	91.3%	2.413	2.012	0.904
Heroin	24.9%	3.8%	71.3%	8.5%	3.3%	88.2%	2.921	2.433	0.808
Bliss/Semeron	0.8%	3.5%	95.7%	0.6%	2.0%	97.3%	1.364	1.611	0.983
Tranx	22.4%	2.7%	74.9%	12.9%	3.5%	83.7%	1.739	1.539	0.895
Solvents	12.4%	0.6%	87.0%	10.1%	0.6%	89.3%	1.226	1.215	0.974
Base	840			2782					

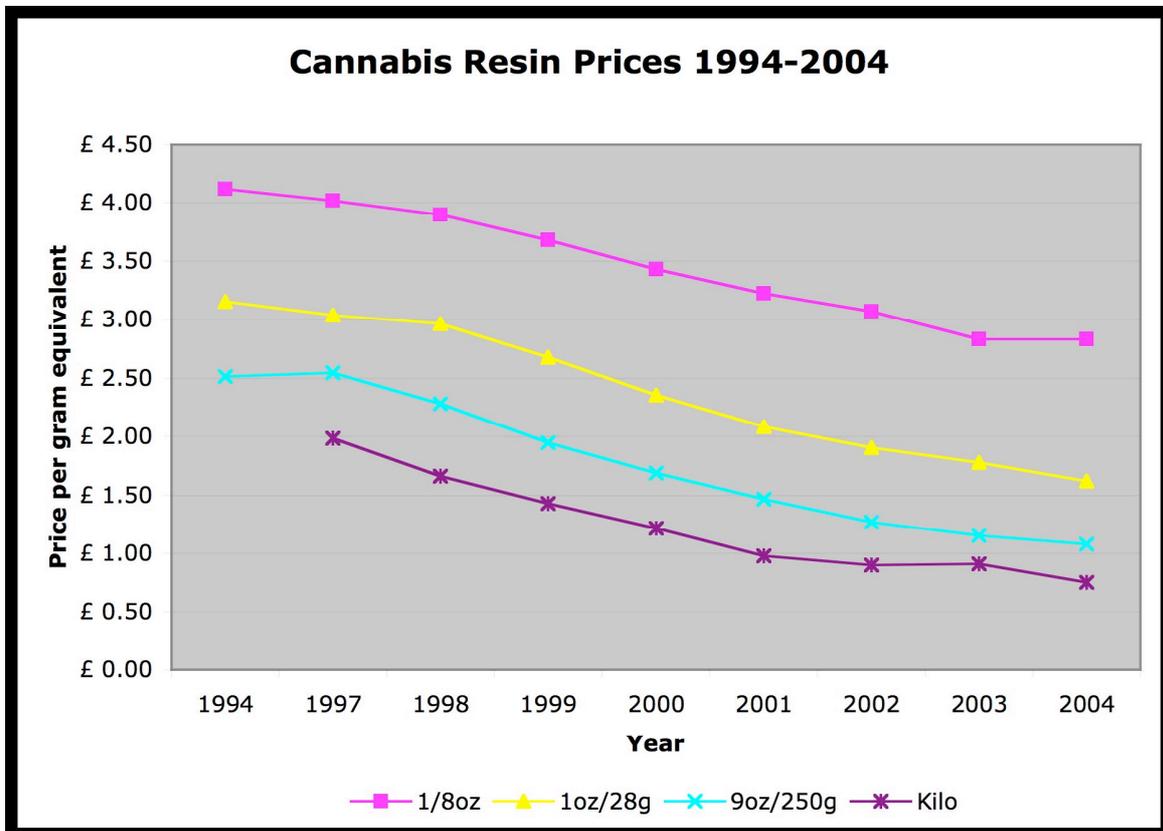
6.3 The prevalence data tells half the story, as this may simply reflect the greater tendency of police to arrest heavier users, particularly of Class A drugs. However, by comparing the age of initiation to particular drugs to the age of the first ‘bust’, it can be seen that initiation to particularly heroin and crack usually follows the first drugs bust, supporting the hypothesis of a causal effect.

Initiation to use of different drugs before and after first drug arrest (1998)									
Drug	Age First Use	Initiated before arrest		Initiated same age		Initiated after first arrest		Same age or older	
		n	%	n	%	n	%	% of busted	Total % after age 22.5 yrs
Mean age first bust	22.53								
Caffeine	7.91	228	97.5	4	1.7	3	0.9	2.6	0.7
Tobacco	13.85	238	97.1	4	1.6	3	1.2	2.8	0.7
Alcohol	12.41	248	98.4	1	0.4	3	0.8	1.2	0.4
Cannabis	16.29	238	94.1	12	4.7	3	1.2	5.9	1.4
Amphet.	18.58	172	78.5	18	8.2	29	13.2	21.4	5.5
Base Amph.	20.67	59	53.2	21	9.9	41	36.9	46.8	13.1
Cocaine	21.51	83	42.4	31	15.8	82	41.8	66.6	16.3
Opium	21.52	60	48.0	20	16.0	45	36.0	52.0	16.5
Mushrooms	19.99	135	61.6	25	11.4	59	26.9	38.3	10.1
Ketamine	23.60	12	20.3	9	15.3	38	64.4	79.7	24.9
Crack	24.03	7	13.5	7	13.5	38	74.0	87.5	35.2
Heroin	21.83	36	46.2	10	12.8	32	41.0	53.8	20.4
LSD	18.81	160	72.1	30	13.5	32	14.4	27.9	7.6
Ecstasy	22.79	69	39.7	21	12.1	84	48.3	60.3	15.8
Barbs	17.95	42	75.0	4	7.1	10	17.9	25.0	10.5
Tranx	19.77	59	67.8	7	8.0	21	24.2	32.2	10.7
Solvents	14.77	55	90.2	3	4.9	3	4.9	9.8	3.0

Totals based on 1128 of 1153 respondents (35 respondents gave no age data)

7. The Cannabis Market

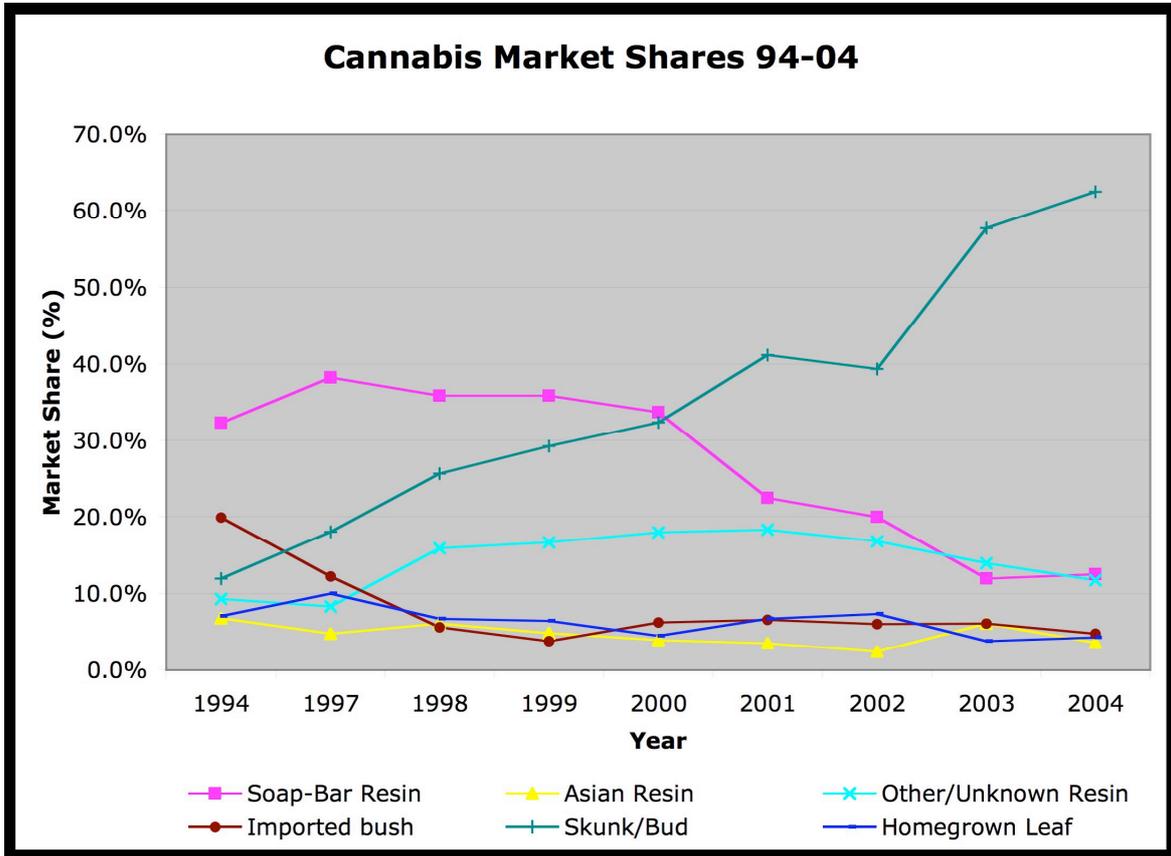
- 7.1 Prices of cannabis resin have been falling steadily since 1994, actually having peaked in the late 1980s, with the most substantial falls seen since 1998. Data for a range of cannabis resin and herbal varieties are available, only the most common Moroccan/Soap Bar resin is shown. Prices for imported herbal cannabis are also in decline, as is the market share, which has been overtaken by domestically produced cannabis (skunk). Skunk prices have remained relatively stable in the region of £5-6 per gram, with a price premium as compared to resin at all market levels.



- 7.2 Although Moroccan (soap-bar) resin and 'skunk' are the most common forms of cannabis found, other types do appear. Liquid cannabis (hash oil) is rarely reported (£10-£20 per gram), although much is reconstituted into solid form as 'formula/dink' resin (£0.34-£2.25 per gram eq).

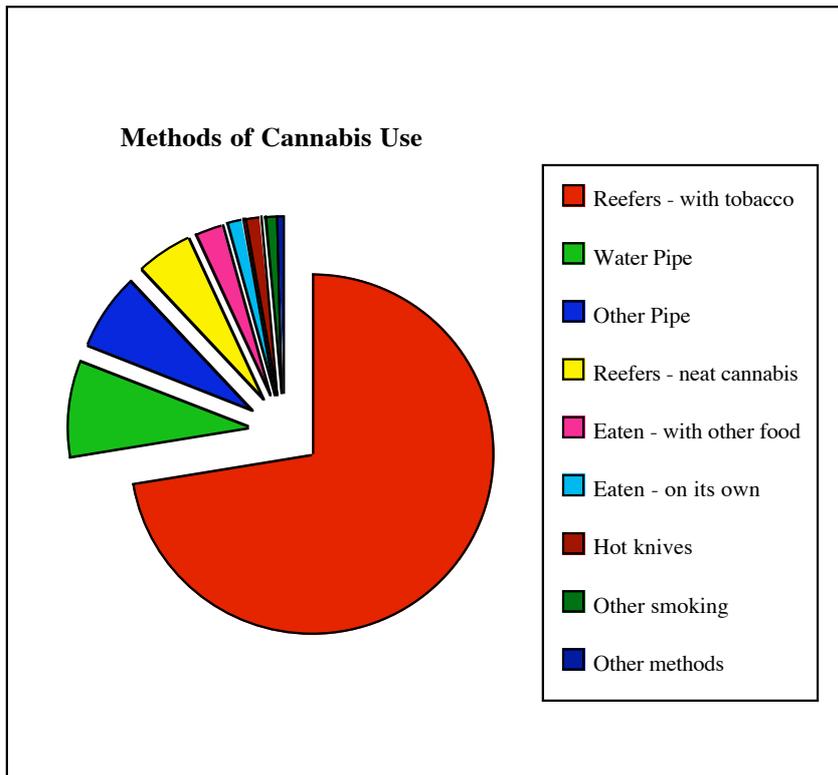
Types of Cannabis Available in the UK			
Cannabis Resin			
Type/Variety	Appearance (when intact)	Potency (% THC)	Price / gram eq (kilo-8 th)
Moroccan ('soap-bar')	Hard, mid-brown, 250g blocks/bars	3-7%	£0.75-£2.83
Asian ('Black', 'Red Seal')	Soft, dark brown, 500g-1kg slabs	3-7%	£1.46-£3.94
Exotic Resins (e.g. 'Pollen', Charas, Nepalese, Minali)	Soft light brown hand-pressed blocks or thin slabs (Pollen),	5-10%	£2.16-£5.17 pol
	Hard dark brown (Charas, Nepalese),	5-15%	£2.74-£6.20 cha
	Soft cylinders/medallions (Minali),	8-12%	£4.00-£6.36 nep
	Flat fibrous slabs (Slate)	2-10%	£3.80-£6.19 min £1.46-£4.53 sla
Herbal Cannabis			
Imported (e.g. African, Thai, Jamaican)	brown/green, usually compressed into 1-2 kilo blocks with stalk and seeds	3-7%	£0.95-£4.12 £1.07-£4.46 thai £1.85-£4.35 jam
Skunk	green, strong odour, seedless flowers, little or no leaf	8-20%	£2.69-£5.66
Homegrown	green, leaf only or whole plant with flower traces	0-5%	£0.03-£3.92

7.3 **Market Shares:** The market share of cannabis resin has fallen from a clear majority of the UK market, from 60% in 1999 to 28% in 2004. The share of imported bush has fallen from 20% of the market in 1994 to under 5% in 2004. The biggest factor is the increase in domestically produced cannabis grown indoors under lights, rising from 11% in 1994 to 63% in 2004. Note that the proportion of home-grown or leaf cannabis has actually fallen, despite such material comprising 30-50% of the cannabis crop, indicating that the vast majority of leaf is thrown away. Some growers are now using sieving or water extraction methods to separate THC-containing resin glands from leaf material and producing high-quality resins in small quantities (known as ‘skuff’ or ‘bubble’ hash)..



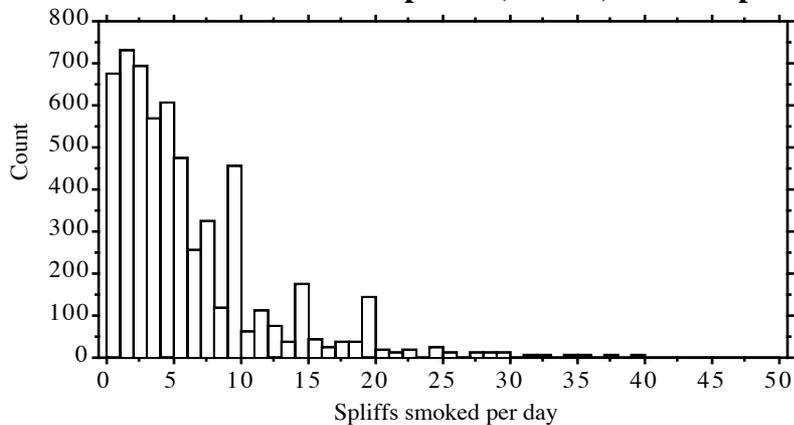
8. Methods of Cannabis Use

8.1 Around 75% of cannabis is smoked in joints/spliffs/reefers mixed with tobacco, 5% in pure cannabis reefers, around 15% in pipes, and around 5% eaten - either on its own or mixed in food (e.g. space cakes) or drink (e.g. bhang, cannabis tea), with small numbers smoking using other methods e.g. hot knives - where resin is pressed between red-hot knife blades and the fumes inhaled through a bottomless bottle, or ‘buckets’ where smoke is drawn into a large bottle and inhaled when cooler.



8.2 Although most users smoke between 1 and 6 spliffs per day, smoking up to 20 per day is not uncommon. Many of those smoking 20 reefers will be primarily addicted to the tobacco in their ‘weak’ reefers, but still claim they don’t smoke cigarettes in a state of denial. The mixing of cannabis with tobacco may explain why the proportion of daily users in our surveys are much higher than those found in the USA where cannabis is smoked ‘neat’.

Distribution of number of ‘spliffs’ (reefers) smoked per day

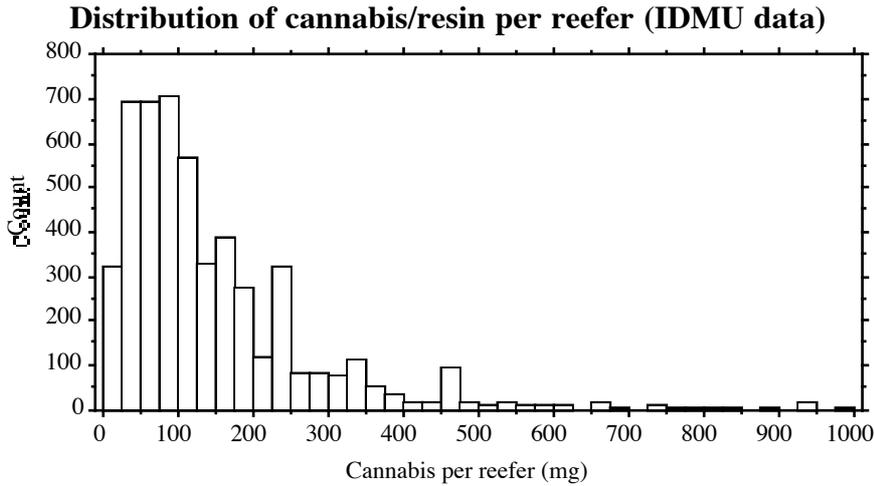


8.3 Users of both sexes tend to smoke nearly twice as many reefers per day at weekends than on weekdays. Many occasional users confine use to weekends only.

Differences in Daily Reefers Smoked Midweek & Weekends (2000 data)		
Sex	Weekdays	Weekends
Female	5.12	9.24
Male	6.12	11.88
Not Stated	6.74	10.32
Total	5.89	10.89

8.4 The Forensic Science Service has analysed unsmoked reefers, and typically quote 7 reefers per gram of resin, and 5 of herbal cannabis. The distribution of analysed reefers is similar to the predicted data derived from the monthly amount used and the number of reefers smoked per day.

Resin reefers typically contain 100-350mg resin, herbal reefers 100mg to around 700mg, or more in some cases using multiple papers.



9. Settings of use

9.1 Cannabis is mainly used in the home, although it is being smoked more frequently in public places, including pubs, clubs, parks, streets, gigs and pop festivals (2000 data).

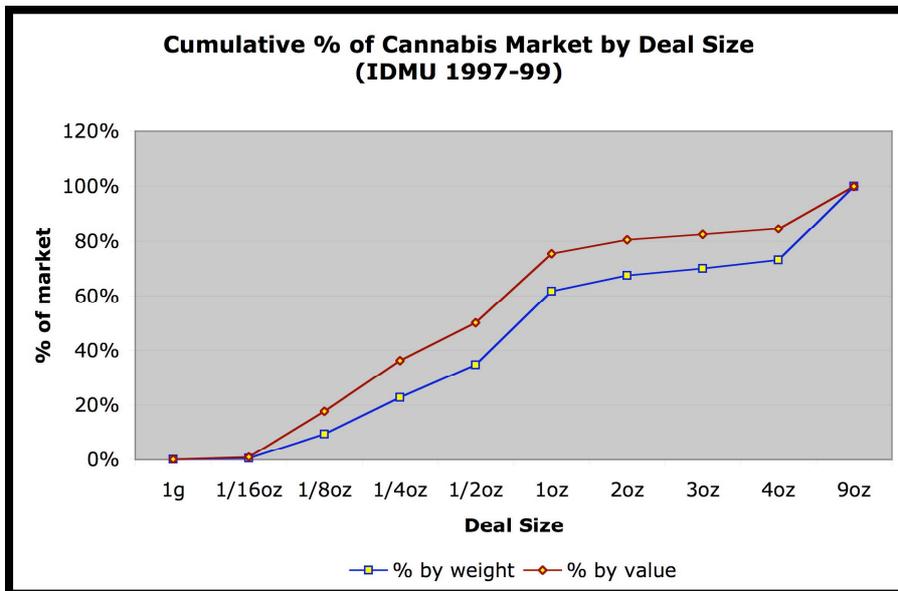
Settings of cannabis transactions		
Supply Offences	Count:	Percent:
Ever bought for others	1423	78.62%
Never bought for others	387	21.38%
Share Spliffs	1619	96.31%
Never share spliffs	62	3.69%
Never sold	673	39.59%
Ever sold	1027	60.41%
Sold at cost	421	24.76%
Sold for profit	261	15.35%
Sold both cost/profit	204	12.00%
Base (sale)	1700	
Cannabis Purchase	Count:	Percent:
Home Town Friends	839	45.0%
Other Town Friends	113	6.1%
Both Friends	115	6.2%
Total Friends	1067	57.2%
Home Town Dealer	598	32.1%
Other Town Dealer	99	5.3%
Both Dealers	100	5.4%
Total Dealers	797	42.8%
Base (Purchase)	1864	

9.2 The majority of users smoke cannabis socially, and virtually all will be technically guilty of supply offences merely by ‘passing the spliff’. Communal buying is another common form of social supply, where a group of friends ‘chip in’ to purchase a larger amount. Most cannabis is bought from friends in users’ own towns or cities, although commercial dealers are another common source. Around 10% of users will travel to buy cannabis.

9.3 **Purchase Quantity:** Our 1997-1999 surveys found the most common deals of cannabis to be 1/8oz, 1/4oz, 1oz and 1/2oz in that order, when prices were higher than today, with gram deals making up just over 1% of all reported transactions, and ‘teenth’ (1/16oz or 1.75g) deals also to be unusual (3%). Consequently, gram deals do not form a valid basis for valuation of cannabis or cannabis resin, and 60% of users purchased cannabis in amounts larger than 1/8oz during the survey period. Unfortunately, it is common for police officers to quote cannabis prices on the basis of sale in gram deals.

Most Common Cannabis Deals – UK 1997-99			
Unit	Weight	Price (2000)	% of deals
1/8oz	3.5g	£10-£15	33.0%
1/4oz	7g	£15-£20	24.5%
1oz	28g	£40-£60	12.4%
1/2oz	14g	£25-£35	11.0%
1/16oz	1.75g	£5-£7	3.27%
9oz	250g	£250-£450	1.38%
2oz	56g	£75-£100	1.34%
1g	1g	£3-£5	1.25%
3oz	84g	£100-£120	0.39%
4oz	112g	£125-£150	0.36%

9.4 When a drug is valued on the basis of maximum street value, this overstates the potential value as not all the cannabis reaches the end-user in the form of small street deals. Given the low cost of 9oz bars, these have come within the range of individual heavy users seeking 2-3 months supply. The median deal size (accounting for 50% of the market) by value is 1/2oz, the median by weight falls slightly higher - between 1/2oz and 1oz, thus ounce prices represent a more accurate estimate of the final value realised when a bulk quantity of cannabis is sold than gram or ‘eighth’ prices.



9.5 **Purchase Frequency:** The IDMU 1997-1999 surveys investigated drug purchase behaviour, with a total sample of 4461 respondents. Cannabis was most often purchased weekly, monthly or fortnightly. In most cases, cannabis purchase was related to the frequency of payment (e.g. weekly wages, fortnightly giro or monthly salary)

Cannabis Purchase Frequency		
How often bought?	Number	%
< Monthly	102	3%
Monthly	889	26%
Fortnightly	622	18%
Weekly	1110	33%
Several times/week	474	14%
Daily +	206	6%
Base	3403	100%

10. Reasons for use

10.1 The majority of users quote enjoyment or relaxation as the primary reason for using cannabis. Use for inspiration/creativity, and hedonism are more common than medicinal use.

Why Use Cannabis? (1994 data)	
No of reports	Reasons Given/ quotes
231	Enjoyment
32	Enjoy with ... general
14	Enjoy with ...
13	Sex - "Feel bliss out buzz erotic love play"
4 ea.	Music Art, other drugs/alcohol
196	Relaxation/ Calming/ Stress Relief
90	Relax and ... general
76	Relax and ...
43	Socialise
30	Enjoy
38	Pain/ hangover killer
9	Enlighten
	Music - "Reduce stress, boredom, and alcohol craving"
89	Inspiration, Perception, Meditation, Spiritual
8	Look at reality/ what's important
5	Know self, "Tool for life's events", "To turn on, tune in, drop out", "It seems to grow my ears, eyes, & heart/brain", "Not to commit moral suicide"
2	Closer to God
47	Get Stoned/High/Intoxicated/fucked/mullered , "Gets me fried, pumps my juice", "Love feeling like a gibbering mess", "Mong out"
42	Better than alcohol/ cigs
39	Medical uses (5 x Asthma, 1 x M.S., 7 x pain relief)
31	Why Not /Because/ I choose to
2	Because I can
14	Escapism - "It's better than real life"
9	Avoid boredom
6	Cheap
13	Habit
4	Sensual
6	It's nice/amazing/beautiful/heaven/ good shit
3 ea.	"It's part of life", "It makes common sense"
12	Happy/ Euphoric/ Laughter
11	Non aggressive
8	Tastes nice
5	Natural/ plant
4 ea.	Don't be stupid, try it and see
3 ea.	Anti-depressant, experimental, to smoke/ mainly in spliffs
2 ea.	Mild psychedelic, can't remember
1 ea.	Light relief, "Yes", "I'm a fool", "the illusion of clamping", "free & not fattening", "Family tradition", "It's the word", "live in London", "Gods gift", "hope," "same reasons as you", "minor offence", "What was the question again?", "not enough space", "various", "It's from Mother Nature, I like the effect, the world is too fast" "A complex mixture of bio-psycho-social causes, and I like it" "Love to chill, thrill, humble sinner" "Lesser of several evils" "Searching for real dope"
5	Don't use any more

11 Cannabis and Health

11.1 Health Problems:

10.1.1 Although many users experience health problems from cannabis use, in most cases these are occasional and of mild severity. Commonly reported problems include panic attacks, apathy, memory problems and paranoia.

Health Problems reported by Cannabis Users (includes problems attributed to other drugs - 1999 data)						
Frequency/ Severity	Headache	Paranoia	Chest Problems	Panic/ Freakout	Anxiety	Psychosis
Never	30.8%	19.8%	33.3%	42.5%	29.7%	55.4%
Once or twice	20.1%	17.6%	11.0%	13.7%	14.9%	2.6%
Occasionally	16.1%	22.0%	16.0%	5.4%	14.1%	1.2%
Regularly	1.5%	6.4%	3.5%	0.7%	3.8%	0.4%
All the time	0.3%	1.4%	1.2%	0.7%	1.0%	0.4%
Total ever	38.0%	47.3%	31.8%	20.6%	33.7%	4.6%
Not Applicable	20.8%	13.4%	20.5%	27.4%	18.8%	35.5%
Mild	23.3%	24.2%	16.5%	8.1%	19.4%	2.3%
Moderate	10.4%	15.5%	12.1%	6.3%	9.3%	1.4%
Severe	2.1%	3.8%	1.6%	4.8%	2.4%	0.8%
Total	35.7%	43.5%	30.2%	19.1%	31.2%	4.5%
Frequency/ Severity	Apathy	Running Out (of drug)	Withdrawal	Balance	Domestic accidents	Vomiting
Never	12.4%	20.7%	38.0%	20.8%	41.5%	30.0%
Once or twice	5.4%	9.9%	6.6%	13.2%	8.0%	18.3%
Occasionally	20.6%	17.3%	6.4%	18.9%	2.3%	8.4%
Regularly	20.9%	8.8%	1.5%	8.3%	0.5%	1.1%
All the time	6.9%	6.3%	0.6%	2.0%	0.3%	0.2%
Total ever	53.7%	42.3%	15.2%	42.4%	11.1%	28.0%
Not Applicable	7.9%	17.6%	25.0%	13.8%	27.2%	18.5%
Mild	16.9%	15.2%	7.4%	22.9%	8.0%	9.9%
Moderate	24.4%	8.6%	4.3%	12.9%	1.5%	12.0%
Severe	7.7%	9.6%	1.8%	2.9%	0.6%	4.0%
Total	49.0%	33.4%	13.5%	38.7%	10.0%	26.0%
Frequency/ Severity	Fatigue	Overdose/ 'Whitey'	Thinking	Memory	Halluci- nation	Other Problems
Never	14.1%	28.9%	19.4%	15.7%	30.2%	3.9%
Once or twice	9.6%	21.4%	10.8%	10.7%	14.0%	0.6%
Occasionally	20.2%	5.5%	15.3%	18.0%	8.2%	0.7%
Regularly	10.8%	0.6%	7.6%	10.3%	1.4%	0.9%
All the time	2.4%	0.0%	2.9%	3.9%	0.8%	0.4%
Total ever	42.9%	27.5%	36.6%	42.8%	24.5%	2.7%
Not Applicable	8.6%	18.1%	11.6%	10.6%	19.8%	2.6%
Mild	17.6%	9.2%	19.2%	21.4%	11.0%	0.2%
Moderate	18.2%	9.4%	11.8%	14.4%	8.7%	1.2%
Severe	3.2%	6.5%	3.3%	3.1%	2.3%	0.9%
Total	39.0%	25.2%	34.2%	38.9%	22.0%	2.3%

11.2 Medicinal use

- 11.2.1 Medicinal use of cannabis was first reported in 2737 BC in China, and 'hemp' has a western tradition as listed by Culpepper. O'Shaughnessy wrote the first modern medical paper in 1839. Tincture of cannabis was available in the UK as a medicine until banned by the Misuse of Drugs Act in 1971.
- 11.2.2 After over a century of research primarily aimed at discovering the dangers of cannabis, Cannabis was described by the British Medical Association as 'a remarkably safe drug with a side effects profile superior to many conventional medications'.
- 11.2.3 The cannabinoid receptor has been found in many areas of the nervous system and bodily tissues, including the skin and gut. It is suggested that the receptor, reacting to the body's own cannabinoids (e.g. anandamide) regulates the pain threshold. New research is emerging at an exponential rate, with papers being published at the rate of one a day into this developing field of pharmacology.
- 11.2.4 Conditions which may be improved by cannabis include:
- (a) **Multiple Sclerosis** - Recent research is very encouraging, suggesting the condition may result from disorders of the body's own cannabinoid metabolism, with many patients reporting dramatic improvement of symptoms.
 - (b) **Pain** - including arthritis, spinal injury, migraine etc and other forms of chronic pain
 - (c) **Asthma** - THC has powerful bronchodilator properties, although cannabis smoke can irritate the lungs.
 - (d) **Gastrointestinal** - THC slows the gut, and has been claimed to improve disorders such as Crohn's disease and irritable bowel syndrome
 - (e) **AIDS/Cancer** - THC or cannabis improves appetite and reduces nausea and the wasting associated with AIDS or cancer chemotherapy treatment. While several components of cannabis smoke have been found to be carcinogenic, some research has suggested there may be a protective effect of certain cannabinoids against breast or skin cancers.
 - (f) **Strokes** - Dexanabinol, a synthetic cannabinoid, has been found to dramatically reduce the death of brain cells following a stroke or severe head injury.
 - (g) **Glaucoma** - THC reduces intraocular pressure, although relatively high dosages and frequent repetition are needed. Glaucoma is the second most common cause of blindness.
 - (h) **Epilepsy** - Various cannabinoids (notably cannabidiol or CBD present mainly in resin) have powerful anticonvulsant properties.
 - (i) **Stress** - The most commonly-reported effect of cannabis is relaxation and stress relief. However cannabis increases heart rate, whilst reducing blood pressure via lowered smooth muscle tone in the arteries - the net effect being similar to changing down a gear when driving uphill.
 - (j) **Mental Health:** Several individuals claim to have reduced psychiatric symptoms after replacing prescribed medications (antidepressants or tranquillisers) with cannabis. However heavy cannabis use during adolescence has been linked to depression and psychosis
- 11.2.5 From 1998 until earlier this year, many cannabis defendants had escaped conviction using the defence of 'medical necessity'. However the Court of Appeal in R-v-Quayle and others [2005] held that a continuous medical condition, implying repeated or continuous use of the drug to avoid chronic symptoms such as pain, did not give rise to such a defence. The defence potentially remains open for acute conditions requiring a one-off dose or episodic possession, although this has not been tested in the courts. The decision of the court is believed to be under appeal to the House of Lords.

12 Cannabis and Driving

- 12.1 Drug driving has become a hot topic over recent years, with much ill-informed opinion from motoring organisations. The Transport Research Laboratory has been conducting tests, which confirm most previous findings that cannabis:
- (a) has no effect on reaction time
 - (b) marginally affects tracking ability
 - (c) drivers under the influence tend to be more careful, driving more slowly, leaving a larger gap, and undertaking fewer aggressive driving manoeuvres.
- 12.2 New users of cannabis, and inexperienced drivers, tend to be most impaired, whereas regular users or drivers show little effect on performance. Skunk tends to impair performance more than resin. Our results show that women tend to have a higher risk of impairment, as there may be less scope for improvement in 'driving behaviour', but that most drivers have similar, or even lower, rates of accidents compared to those expected for the same age and sex.
- 12.3 IDMU surveys have contributed to the debate by analysing the driving records of users of different drugs in relation to their frequency of use. While cannabis use only had an effect on women and younger or less-experienced drivers, the results from drugs like Ecstasy were far less encouraging.
- 12.4 Driving (or being in charge of a vehicle etc) whilst unfit through drink or drugs has long been an offence under the Road Traffic Acts. To prove this, the police have to show a driver is unfit, meaning that the ability to drive properly is impaired, and the presence of drugs which can cause impairment.
- 12.5 The police have been steadily improving their enforcement techniques (now using blood rather than urine tests) and have developed 'field impairment tests', based on tests used in the US for alcohol impairment - examining a drivers performance in a number of tasks:
- (a) Pupil size (cannabis has only a marginal effect on pupil diameter)
 - (b) Romberg test (head back, legs apart, eyes closed, asked to estimate when 30 seconds have passed - observe balance and accuracy of time estimation)
 - (c) Walk & Turn test - (heel to toe walk, swivel turn and retrace steps along straight line - observe accuracy of following instructions and balance)
 - (d) One-legged stand - (asked to stand on either leg, observe balance)
 - (e) Finger to nose test - (observe co-ordination, using correct hand etc)
- 12.6 IDMU has recommended that such tests be improved and made more objective - e.g. being recorded on videotape, and introduction of in-car simulators to test tracking and reaction times as objective measures of impairment. In addition, we have recommended that at least two blood samples be taken 15 minutes apart, in order to distinguish between acute intoxication and baseline levels, as cannabis metabolites can be detected in body fluids for up to a month after use.

13 Policy Options - Decriminalisation & alternatives

13.1 Is Decriminalisation Desirable?

13.1.1 If decriminalisation involves removing criminal penalties for possession (e.g. of less than a designated amount), but leaving supply of drugs in the hands of criminals, there would be some benefits, but many problems would remain.

(a) Benefits

- (i) The move would be popular among users of drugs, reducing the levels of conflict between young people, police and society
- (ii) Removing the threat of a criminal record (and/or expunging existing criminal records for simple possession) would reduce the financial impact of an arrest on the individual and society.
- (iii) The credibility of government messages among wide sections of society may increase. Our recent survey showed that the least trusted sources of drugs information were Government Ministers, the Drugs Czar, and the Police.
- (iv) Society as a whole could benefit from a more tolerant climate of individual rights and responsibilities, with a less authoritarian relationship between the government and its citizens.

(b) Problems

- (i) Leaving civil penalties in place for possession would not remove the 'naughty' or 'forbidden fruit' image of drugs, and would decrease the attractions of usage.
- (ii) Civil fines would be paid by a small minority of users (those who are caught), and would therefore represent a very inefficient form of taxation.
- (iii) If demand increases, the untaxed profits of drug traffickers would increase, and with this the levels of corruption and violence associated with any illegal trade.
- (iv) Decriminalisation would mean users still having to get their supply from a source. If the 'legal' source of drug (GP, licensing) is inferior in quality to the 'illegal' sources, then the criminal control of the drug trade would not be halted. To be effective the criminal element that controls the supply of drugs must be put out of business. This can be achieved by ensuring the supply of drugs is at least of a standard users are already accustomed to. In the case of cannabis the easiest solution would be to allow anyone to grow their own supply for own personal use only. This would enable relatively law abiding citizens who only smoke cannabis to avoid visiting criminal suppliers.
- (v) The government would not benefit from Excise Duty revenues payable on (particularly) cannabis. Our surveys have indicated that such duties, along with reduced enforcement costs, could generate between £2 Billion and £5 Billion per year for the exchequer.

13.2 What are the practical alternatives?

13.2.1 Status Quo - No change in legislation. Public opinion is steadily moving towards support of drug law reform and some form of liberalisation. Opportunities have been missed in the past (e.g. following Wooton Report and 1979 ACMD report) to reduce the criminal status of cannabis, and those failures are at least in part responsible for the levels of drug problems we face today (ten times as many drug users/arrests today as when the Misuse of Drugs Act was introduced)

13.2.2 Reduce penalties (reschedule cannabis to class C, Ecstasy/LSD etc. to class B) - These proposals from the Police Foundation in essence echo those of the ACMD in 1979. This would represent tinkering with the system, as the damaging effects of a criminal record for drugs on the individual and society would remain.

13.2.3 Regulation/Licensing: In the long term, some form of regulated supply of cannabis must be considered. The extent to which licensing could cover existing illicit preparations would depend on international agreements (i.e. for cannabis resin or herbal imported from countries where production remains illegal), although domestic production could supply the bulk of the UK cannabis market. The objective of such models would be to satisfy existing

demand without creating additional demand. Different models may be appropriate for different drugs:

- (a) *Prescription and dispensation from Pharmacy* - this could be appropriate for opiates, but would impact on NHS resources (GPs' time). Individual use could be regulated.
- (b) *Individual licenses to possess/purchase* - Users could apply for a licence (smartcard?) which would enable them to buy (e.g. opiates) in appropriate amounts at or near cost price.
- (c) *Licenses to produce* - cannabis growers could be allowed a 'duty free' surface area or lighting wattage, but could apply for licenses to produce larger amounts. Duty could be levied at quarterly intervals based on the available surface area, subject to regular inspection.
- (d) *Licensed supply*
 - (i) Outlets such as 'coffee shops' could be licensed to supply cannabis, with appropriate restrictions on advertising, age restrictions (as with alcohol or tobacco), and location (e.g. not within 1/4 mile of a school).
 - (ii) Alternatives would include a 'club' model whereby licensed clubs could supply cannabis to their members, who would have to produce a membership card. Reciprocal agreements could allow cards to be valid in all clubs within an association.

13.2.4 **Free Market (Legalisation)** - This would involve drugs being sold in normal retail outlets (e.g. supermarkets/tobacconists) without significant controls. Excise duties could be levied on producers and/or wholesalers as with tobacco or alcohol. This policy would probably lead to increased usage (particularly among middle-aged or elderly citizens), although this would also generate the highest duty revenues for government.

13.3 Empirical Evidence

13.3.1 IDMU was in a fortunate position both during the so-called Lambeth Experiment, - one of the survey locations being in Brixton - and to assess the impact of reclassification of cannabis from Class B to Class C in January 2004.

13.3.2 **Lambeth Experiment** - The May 2000 data provides baseline figures, June 2001 coincided with the start of the 'experiment' where cannabis use became effectively tolerated by the police, and May 2002 was a year into the experiment by which time any consequences of the policy should have started to take effect. The results showed average monthly cannabis usage, purchase and spending in 2002 to have declined slightly, as had the average rating of cannabis by users. Retail prices paid by Lambeth respondents showed a slight, but non-significant increase. Cooperative or commercial purchases were less frequent, with a higher proportion used by the buyer him/herself. The average age of initiation to cannabis use increased significantly, suggesting that usage would increase more among the older generation than among teenagers were the law to be relaxed further, also reflected in the older average age of the respondents. The Lambeth experiment made little difference to the consumption of cannabis users, and such effects as were found appeared to represent moderating influence on cannabis usage rather than encouragement. Fears of increased cannabis usage as a result of the experiment were not supported.

13.3.3 **Reclassification of Cannabis** - Our data shows the increase in regular users to have been halted, with user ratings having fallen, and remained historically low, since declassification was announced suggesting the drug to be losing popularity among the young. These figures are borne out by British Crime Survey data, which found a fall in cannabis use in their 2004-5 survey. The fruit, when no longer forbidden, loses much of its sweetness.

13.3.4 **Skunk?** Pressure has been evident, notably from the tabloids, for reclassification of Skunk to a higher category than 'normal' cannabis, with the advisory council asked to reconsider the issue in the light of reports of mental health problems among young skunk users. Such a move would be impracticable:

- (a) Skunk is NORMAL cannabis, by far the most common form currently available, having largely displaced imported forms of cannabis

- (b) Although some hybrids have been bred to increase THC content, there is no way for a user or buyer to know the potency of the drug before using it. Growers tend not to have access to forensic laboratory equipment, so any threshold of THC content would be difficult to enforce.
- (c) The costs of enforcement would be astronomical, with much more detailed lab examinations required to support a case, and expert evidence adding to the costs.

14 About IDMU Ltd.

14.1 Description

- 14.1.1 IDMU is a small independent research consultancy specialising in the study of illegal drug consumption patterns, prices and effects. Our mission is to provide accurate, up to date and impartial information on drugs to all parties to the debate over drugs policy.
- 14.1.2 IDMU is funded wholly via professional fees earned in providing expert evidence for the criminal and civil courts, with experience of over 1600 criminal cases since 1991. The evidence mainly covers personal consumption and drug valuations, but includes yields of cannabis cultivation systems, effects of drugs (re criminal intent, driving impairment etc.), and a range of other aspects, most notably therapeutic uses of cannabis.
- 14.1.3 Other than legal casework, we have provided consultancy for GW Pharmaceuticals, the House of Lords enquiry, the Home Office, Transport Research Laboratory, and various Police forces, as well as press journalists and broadcast media.

14.2 Student Placements

- 14.2.1 IDMU does not have the resources to fund writing up and publishing the vast majority of our survey data, and much has never been fully analysed. Each year we ask a number of core questions, concerning consumption and prices for a range of drugs, with core demographic data, but have also asked other questions including drugs education, driving records positive and negative effects, best and worst drug experiences, political affiliation and many more. Preparations are well advanced to put the survey on the internet.
- 14.2.2 We would be happy to welcome students seeking a research placement, with a view to preparing articles and research papers for publication. Longer term projects can involve inclusion of new survey questions. Much information could be distilled using multivariate analyses, if anyone is up to the task.
- 14.2.3 We are also seeking people working with drug users, particularly those using heroin, amphetamine and/or crack cocaine, to distribute surveys among their client groups, as we find that problem drug users are underrepresented.

14.3 Follow-Up

- 14.3.1 I am happy to answer your questions via e-mail (mail@idmu.co.uk). Please be patient, as it can sometimes take a few weeks to respond, particularly when we are busy. Please keep questions specific whenever possible.
- 14.3.2 Please also check the FAQ pages on our website, as someone may already have asked a similar question. Many of these pages (indexed by drug) contain unpublished data or literature reviews unavailable elsewhere.

15. Further Reading & Websites

15.1 General

- The IDMU website* - www.idmu.co.uk - Lots of frequently (and not so frequently) asked questions, on-line publications, legal information, links and much more.
- UK Cannabis Activists* - www.ukcia.org - The main cannabis information site in the UK, run by activists, but containing much information as well as argument
- Cannabis Culture - a journey through disputed territory* Matthews P (1999) Bloomsbury
- Potology* - Newcombe RD - Lifeline Publications - serious information presented in a readable and entertaining format
- Science of Marijuana* - Iversen L (2000) - Oxford University Press
- Hashish* - Clarke RC (1998) Red Eye Press - superb reference text re types and potencies.

15.2 Consumption & UK Market

- Regular Users - Self-reported drug consumption patterns and attitudes to drugs among 1333 regular cannabis users.* Atha MJ & Blanchard S (1997) - IDMU Publications - full 1994 survey results
- Regular Users II - UK Drugs Market Analysis, Purchasing Patterns & Prices 1997* - Atha MJ, Blanchard S & Davis S (1999) IDMU Publications
- Developing a methodology for measuring illegal activity for the UK National Accounts.* Groom C, Davies T & Balchin S (1998) Economic Trends 536 pp33-72 (July)
- Drugwatch - Just Say No* - Caplin S & Woodward S (1995) Corgi - early attempt at quantitative research
- How to get off drugs* - Mothner & Weitz (1984) Penguin - comparative info on amphetamines and opiates
- Mixmag* - always good for drugs articles, particularly the definitive ecstasy user surveys
- Cognition & long term use of Ganja*, Schaeffer et al (1982) Science - Heaviest cannabis users
- Hashish, studies of long-term use* - Stefanis, Dornbush & Fink (1977) Raven Press
- Cannabis in the Marketplace* - Legalise Cannabis Campaign 1980/1984 - analysis of different models of legalised cannabis distribution
- Drug Seizure and Offender Statistics* - Home Office Statistical Bulletin - published annually, with supplementary and regional tables, available as pdf formats on Research, Development & Statistics directorate website www.homeoffice.gov.uk
- Drug Misuse Declared* - British Crime Survey data 1992-2004/5 available as pdf formats on Research, Development & Statistics directorate website www.homeoffice.gov.uk

15.3 Law & Politics

- The Law on the Misuse of Drug and Drug Trafficking Offences*, Fortson R (1992) Sweet & Maxwell
- Bucknell & Ghodse on Misuse of Drugs* (1996) - Sweet & Maxwell
- Misuse of Drugs Act 1971* - HMSO
- Political opinions of drug users 1998-2000* Atha & Davis (2001) - IDMU Publications (on-line)
- Drugs and the Law* - Report of the Independent Enquiry into the Misuse of Drugs Act 1971 Police Foundation (2001)

15.4 Medicinal

- Therapeutic Uses of Cannabis*, British Medical Association (1997) Harwood Academic Publishers BMA
- Marijuana and Medicine - assessing the Science Base* US National Institute of Medicine (1999) National Academy Press
- Cannabis, the scientific and Medical Evidence* - House of Lords Science & Technology Select Committee (1998) The Stationery Office HL paper 151 (Report) and 151-I (Volume of written & oral evidence)
- Marihuana the Forbidden Medicine* Grinspoon L & Bakalar JB (1997) Yale University Press
- Marijuana Medical Papers* - Mikuriya T (Ed) (1972) Medi-Comp Press - contains many early studies from 1837 to 1971
- IDMU Submission to House of Lords Enquiry* Atha, Davis & Ganly (1998) - reviews of scientific evidence and analysis of relevant survey data - available on-line or in volume of evidence published by Lords Enquiry.

15.5 Driving

- Cannabis and Driving, a review of the literature and commentary.* Ward NJ & Dye L (1999) Road Safety Research Report No 12 London: DETR
- The Influence of Cannabis on Driving* - Sexton BF et al (2000) Transport Research Laboratory UK: TRL Report 477
- The Prevalence and role of alcohol, cannabis, benzodiazepines and Stimulants in non-fatal road crashes.* Hunter et al (1998) Adelaide: Forensic Science/Clinical & Exp. Pharmacology (Monograph)
- The Influence of Marijuana on Driving* Robbe HWJ (1994) Maastricht, University of Limburg
- Drugs & Driving* Atha, Blanchard, Davis & Liptrot (2001) IDMU - in preparation

15.6 Research Tools On-line

Drugscope - www.drugscope.org - Formed by merger of the National co-ordinating body for the voluntary sector (SCODA) with the UK's most comprehensive drugs library (ISDD).

Medline - <http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed> searchable database, usually with abstracts, of research papers in the biological sciences

Media Awareness Project - www.mapinc.org - searchable database of 100,000+ media articles on drugs, US and worldwide

Parliament - www.parliament.uk - written answers to parliamentary questions provide a rich source of drug-related information and statistics

Home Office (Research & Statistics Directorate) - www.homeoffice.gov.uk - Source of many on-line drugs research papers commissioned by the UK government, including British Crime Surveys.

Transform Drug Policy Foundation (TDPF) - exists to minimise drug-related harm to individuals and communities by bringing about a just, humane and effective system to regulate and control drugs at national and international levels. Raising the debate on the prohibition / legalisation (legalization) and regulation of all drugs including heroin, cocaine and cannabis. Latest book: *After the War on Drugs - Options for Control* - A major new report examining the key themes in the drug policy reform debate, detailing how legal regulation of drug markets will operate, and providing a roadmap for reform. - www.tdpf.org.uk

UK420 – *cannabis community forums*. Includes: Cultivation,(growing advice etc), Culture (new, views, politics), Medicinal (advice, the4ms, bud buddies etc). www.uk420.com



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