



The Debate Gets High

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The Cannabis debate

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Introduction by Professor John R Ashton CBE

The cannabis debate has begun. During the past few months many people from a wide range of backgrounds have entered the fray with their views on the decriminalisation, continued criminalisation or otherwise of this ubiquitous plant. Influenced by this process the Home Secretary has recommended that possession of cannabis for personal use should no longer justify arrest.

In one sense, concerns and the debate about all kinds of illicit drug use need to be considered as part of the globalisation of the economy, of trade, of culture and of every day life. Writing these words in the weeks following the attack on the World Trade Centre and with the spotlight on Afghanistan, one of the worlds leading producers of opium, all these things seem to be in the melting pot.

An objective consideration of the issues surrounding cannabis requires an organising framework. Strang et al proposed eight domains¹ for considering these issues (see Table 1). Professor Mark Bellis and I have added a ninth namely 'the social context' that takes into account the social opportunity costs and the blighting of people's lives and careers that arise as a consequence of the cannabis user becoming involved in criminal sub cultures. These include exclusion from school, university and employment; incarceration; and the effects on individuals and families of users. Cannabis should be considered against the health consequences of alternative drugs such as alcohol which compete with it for a social niche. We point out that current ethics do not provide an even handed assessment of alcohol which is the drug of choice for large numbers of people and cannabis which is the drug of choice for many young people. Testing alcohol against Strang's framework is an informative exercise.

This issue of the North West Health Bulletin is intended to inform the debate with the aim of producing better policy and optimising the health outcome of the organised efforts of society to substance abuse in the North West.

Table 1 Domains of the cannabis debate¹

- What is the importance of the different types of cannabis product composition, presentation, and usage?
- What evidence is there of physical damage from long term use?
- What evidence is there of psychological or psychiatric (acute and chronic) consequences?
- How widespread is dependence on cannabis and how important is this?
- Is cannabis a "gateway" drug and what is the importance of this?
- Do some cannabinoids have therapeutic potential and how best can this be used?
- To what extent, and in what ways, is fitness to drive compromised by cannabis use, and for how long?
- What can we learn from experiences with cannabis control policies in other countries?

What is cannabis?

Cannabis sativa, the plant cultivated to produce several commodities, including the psychoactive drug known popularly as cannabis or marijuana probably originated in an area of India north of the Himalayan



A Cannabis Plant

mountains. Although it is cultivated in many parts of the world, cannabis grows like a weed in countries with a warm climate such as India, Mexico and throughout Africa.

Cannabis has a long history. The earliest written record of its use can be found in a Chinese pharmacopoeia, where around 2737 - 2697 BC cannabis was recommended as a treatment for many common ailments

"I give you every seed bearing plant on the face of the whole earth and every tree that has fruit with seed in it. They will be yours ..."

Genesis 1:29

"The greatest service which can be rendered any country is to add a useful plant to its culture."

Thomas Jefferson



"Nothing is more destructive of respect for the government and the law of the land than passing laws which cannot be enforced."

Albert Einstein
1921

and was described as a 'superior herb' by Emperor Shen-Nung. The ancient Egyptians used cannabis to treat inflammation and sore eyes. Indian Sanskrit scripts of 1400 BC recorded that cannabis was considered a holy herb and was used in religious ceremonies and cultural activities. During 700 BC, The Assyrians used cannabis (Qunnabu) as incense. In 500 BC, Herodotus recorded that the Scythians produced fine linens and inhaled intoxicating vapours from burning the herb they named kannabis. By 100 BC the Chinese were using cannabis to make paper. The first recorded use of cannabis in Britain was as a 'useful fibre' during the Romans era approximately 2000 years ago.

What is it used for?

Industrial

Hemp, the fibre extracted from the cannabis plant has been used for many years to make clothing and ropes but is now also increasingly used as a food, e.g. hemp milk. Cannabis grown for industrial purposes contains virtually no delta 9 tetrahydrocannabinol (THC) the psychoactive component that gives people a pleasurable 'high'. The seed oil, rich in antioxidants contains two of the body's essential fatty acids and has a soothing action on the skin. Hemp rope and clothing have been valued for centuries for their durable properties.

Medicinal

Cannabis became widely used as a medicine during the 19th Century. In 1928 the Geneva Convention on the manufacture, sale and movement of dangerous drugs outlawed cannabis, but prescription in the UK remained possible until cannabis was finally prohibited under the 1971 Misuse of Drugs Act. Cannabis contains approximately 400 chemical compounds, including at least 60 cannabinoids that provide therapeutic benefits such as:

- Relief from nausea and vomiting in patients taking anti-cancer drugs.
- Reduction of spasticity and muscle pain, night leg pain, depression, tremor, anxiety and other related symptoms in people with multiple sclerosis.
- Stimulation of the appetite, particularly in people suffering from cancer and AIDS.
- Pain relief. Cannabinoids are effective analgesics, and there are anecdotal reports of benefits in bone and joint pain, migraine, cancer pain, period pain and labour. Cannabinoids may have considerable potential in neuropathic pain.
- Reduction in intra-ocular pressure in people suffering from glaucoma.

Preliminary research indicates that cannabis may have further therapeutic benefits relating to its ability to inhibit tumour growth as well as its anti-fever and anti-inflammatory properties.

Cannabis can be used legally for medicinal purposes in Australia, Italy, parts of the USA and more recently Canada. In all cases, cultivation and consumption can only be authorised by a medical doctor for defined therapeutic purposes.

In the USA, THC can be prescribed as an oral capsule Dronabinol - trade name 'Marinol'. However, absorption

is unpredictable and slow after oral ingestion and it may take up to three hours before the benefits are felt.

An under the tongue aerosol style spray that provides almost instantaneous pain relief proved highly acceptable to patients in a recent trial.

Controversy surrounds the interpretation and conclusion of many research findings into the therapeutic use of cannabis, but the US advisory committee from the National Institute of Health concluded that "for at least some indications, marijuana looks promising enough to recommend conducting new controlled studies".

The Royal College of Psychiatrists recently undertook a study to assess the therapeutic profile of cannabis and earlier this year concluded that "Cannabis and its derivatives; cannabinoids, show promise of beneficial effects in a number of medical conditions for which standard treatment is less than satisfactory".

A review of UK government funded research into cannabis, provides a useful collection of current conclusions and recommendations.²

Recreational

Cannabis is in demand for its psychoactive properties. It produces a degree of euphoria, feelings of detachment and relaxation. In many ways, cannabis has replaced alcohol as the drug of choice for the younger generation. The dried leaves and flowers can be mixed with tobacco and smoked as a 'joint' or 'spliff'. The effect is almost instantaneous. Dried cannabis can also be added to food such as cakes and cookies, but this is less popular and absorption into the blood stream is less predictable and slow.

Since cultivation of cannabis for recreational use is illegal, it is difficult to find data that accurately indicate either the level of personal use or the level of criminal activity associated with its cultivation and distribution. Estimates obtained from surveys of young people (aged 20 - 24 years) show that recreational cannabis use is increasing across Europe and in the USA. However, during 2000, reported cannabis use amongst Dutch school children (aged 10 -18 years) declined for the first time in 16 years. A similar decline was also found in the UK for 15 -16 year olds.

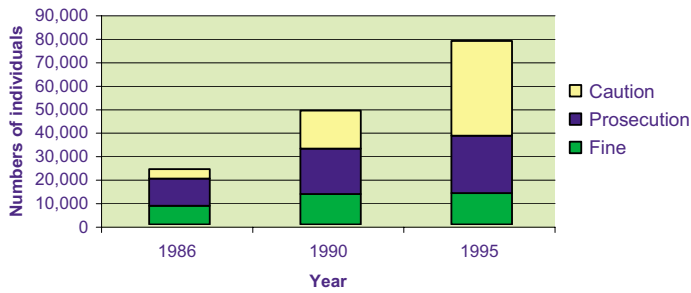
Problems associated with cannabis use

Legal

Under the Misuse of Drugs Act 1971, drugs are classified according to perceived level of risk to the individual or society and cannabis is classified as a Class B drug. Cannabis oil, like heroin is classified as Class A, and attracts even higher penalties. It is illegal to possess, cultivate or supply cannabis. The maximum penalty for possession is five years imprisonment and an unlimited fine. Attitudes of the police and the courts fluctuate and penalties handed down vary according to individual circumstances and local policies. In practice, many first time offenders arrested for possession of cannabis are only cautioned.

The number of prosecutions, cautions and fines associated with cannabis use has increased over the years. **(Figure 1)**

Figure 1
Criminal activity in relation to cannabis use



Source: Home Office Statistics 1986-95 Unlawful possession of cannabis in England and Wales.

Negative health effects

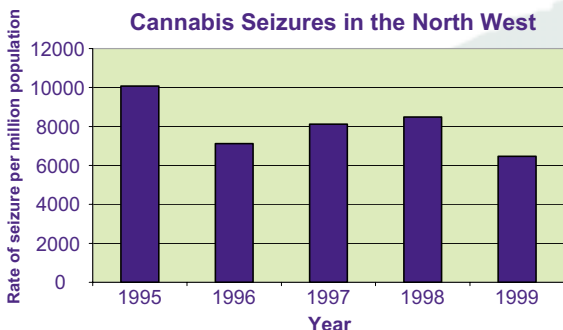
Cannabis use is associated with impaired perception, altered thought processes, impaired learning and memory capabilities, lack of concentration, increased heart rate and suppression of the immune system. Some cannabis users also report short lived adverse effects, including psychotic states following heavy consumption. Cannabis can also provoke a relapse or aggravate existing symptoms in people suffering from schizophrenia. When mixed with tobacco and smoked, cannabis use is coupled to health problems such as cancers, heart disease and dependency associated with tobacco. Excessive use of cannabis does not cause death directly. However, little is known about long term effects relating to the quality and quantity used, especially in relation to depression and schizophrenic illnesses. Psychological, rather than a physical dependency has been known to occur.

Risk of an accident associated with using equipment and driving a vehicle increases shortly after either inhalation or ingestion of cannabis.

The North West

Figure 2 shows the rate of cannabis seizures by the police in the North West, between 1995 -1999. Although it is estimated from self reported surveys that over this five years period, individual cannabis use increased, the rate of police seizures decreased. This could indicate that although it is not official policy, police in the North West are turning a blind eye to small scale individual cannabis use. The graph only represents seizure rate. From this data it is impossible to tell the amount of cannabis detained per seizure and whether police really are concentrating more on suppliers rather than individual users.

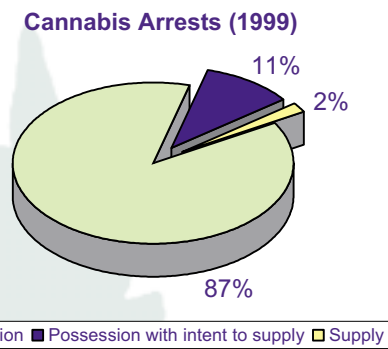
Figure 2
Cannabis Seizures in the North West



Source: <http://www.homeoffice.gov.uk/rds/hosbpubs1.html>

As part of the national arrest referral scheme, anyone arrested and detained in a custody suite in Merseyside is offered referral to a local drug worker. Between 1st April and 30th June this year, 754 individuals completed a questionnaire and requested referral to a drug worker. Of these, 120 individuals (approximately 16%) reported cannabis use within the last 30 days. In the North West, of the 11,835 people found guilty, cautioned, given a fiscal fine or dealt with for cannabis drug offences during 1999. Offences associated with cannabis made up 73% of all drug related arrests for the same period. Based on figures for Merseyside, possession made up the highest proportion of arrests. Arrests for possession with intent to supply and supply combined contributing only 13% of total arrests (see Figure 3).

Figure 3



Source: Merseyside Inter Agency Drug Data for 1st Jan - 31st Dec 99

The Debate

Drugs and the problems associated with them have become a global issue. Cannabis use across Europe has increased, more noticeably amongst the 20 -24 year old age group. It is the country that has the harshest penalties that has seen the most noticeable increase in use - the United Kingdom.

Decriminalisation

A survey carried out in the UK by the European Union Drugs Agency (2000) revealed a shift in attitude towards decriminalisation. The survey found that 49% of the public thought that cannabis should be decriminalised, 36% thought that it should not and 15% did not know. The debate about decriminalisation is complicated. Issues about freedom of choice have to be balanced against public health and legal concerns. Those in favour of decriminalisation point out that it is illogical and unfair to keep cannabis as an illegal substance when current research suggests that it is less harmful to health than legal mood altering drugs such as alcohol or tobacco. Problems for the individual and society associated with both tobacco and alcohol misuse are considerable. But this is over simplistic. A new drug with harmful effects similar to tobacco would probably not be legalised today. A Government that legalises cannabis could appear to be condoning the use of a substance associated with a public health risk. If cannabis were legalised would the Government accept responsibility for any harmful effects that might develop?

At the moment, as an illegal drug, cannabis cultivation and transport is in the hands of criminals. Anybody who wishes to use cannabis must either directly or indirectly

"Sale of cannabis should be legalised to take it out of the hands of criminals and a tax on the drug would help to pay for the treatment of all addicts."
Mo Mowlam
2001



"I think we are losing the war on drugs, so is every other country."
Police Commissioner
(Australia)

associate with the criminal element and this is a group of people that is likely also to be involved with the supply of harder, more dangerous drugs such as heroin and cocaine. There is a risk that through this association, young people who use cannabis may be drawn into using harder drugs.

Many of the potential disadvantages are based on the assumption that decriminalisation will lead to a sustained increase in consumption, but evidence from the Netherlands where consumption was decriminalised many years ago does not support this.

If its use was mainstreamed and more people started to use cannabis, then an increase in health associated problems could be anticipated. However, this increased risk should be weighed against the possibility that people might just switch drugs. Those who start to use cannabis might simultaneously reduce their misuse of potentially more dangerous mood altering drugs such as alcohol, which may reduce overall risk to public health. Unfortunately one of the problems associated with investigating the use of an illegal substance (and a strong argument for its decriminalisation) is that it is impossible to collect accurate statistics and make accurate predictions. For an outline of the potential benefits and disadvantages of legalising cannabis see Table 2.

Table 2
Benefits and disadvantages within the debate

Potential Benefits	Potential Disadvantages
For the individual	
Licensing or regulation of cannabis supply would allow for improved quality control	Increased risk of physical and mental health problems associated with cannabis use
Individual freedom to enjoy a recreational activity without the stigma attached to criminal activity	Increased risk of harm from accidents and accidental death. Psychomotor performance can be impaired for as long as 24 hours after smoking as little as 20mg of THC in cannabis
Easier to find and use for therapeutic purposes	Increased availability may lead to greater risk of dependence
For the community or society	
Easier to research the therapeutic potential and acquire better statistics about use and misuse	Costs of dealing with people suffering adverse health effects
Reduced policing costs. (Less spent on cannabis provides more to spend on the more dangerous harder drugs such as heroin and cocaine)	Cannabis use during pregnancy is associated with impaired fetal development leading to a reduction in birth weight
Potential for increased income from taxation of cannabis	Unknown risks associated with passive smoking of cannabis, e.g. people working in close proximity to cannabis smokers such as cannabis café workers.

International opinion is changing ...

International opinion is changing with a number of countries re-visiting their policies on cannabis.

In Jamaica a commission concluded that cannabis is 'culturally entrenched', and should be allowed within religious ceremonies.

Portugal has recently decriminalised cannabis use. The police will not arrest cannabis users, but will rather put their limited resources into combating the problems associated with the supply of 'harder substances' such as cocaine and heroin.

The Swiss are considering legalising the purchase of cannabis from licensed premises. The final decision to decriminalise its use, cultivation and possession will depend upon the outcome of a referendum. But it is anticipated that decriminalisation will occur by 2003.

The Scottish Executive confirmed in August (2001) that future police activities in relation to drug misuse would concentrate on heroin and cocaine rather than cannabis. Even here in England, the local police in Brixton decided that those in possession of small amounts of cannabis would only be given a verbal caution and the substance confiscated, but no arrests would be made.

Current policy

A recent House of Lords Select Committee report suggested that cannabis should remain a controlled drug, but the law should be changed to allow doctors to prescribe 'an appropriate preparation of cannabis', if they saw fit.

The Police Foundation Report (2000) recommended that:

- Cannabis should move from Class B to Class C. Thereby reducing the maximum penalty associated with cannabis use.
- Prison should NOT be an option for possession of a Class C substance for personal use.
- Penalties should reflect relative dangers of the drug in question (including the activity) and original intent.

The Government initially rejected recommendations from both reports, but called for an adult debate on the issues surrounding cannabis use, including its decriminalisation³. On the 23rd October Home Secretary David Blunkett recommended that cannabis be moved from Class B to Class C. If accepted this will mean that people will no longer face the threat of criminal prosecution for possession of cannabis for personal use.

References

- 1 Strang J, Winton J, Hall W. (2000) Improving the quality of the cannabis debate: defining the different domains. *British Medical Journal* 320:108-110
- 2 MacGregor S. (2000) Drugs Research Funded by Central Government Departments: A Review. Social Policy Research Centre, Middlesex University, London, UK.
- 3 Joseph Rowntree Foundation (2000) Drugs: Dilemmas, choices and the law. JRF, York.

Useful web sites

- | | |
|--|--|
| www.thetimes.co.uk | www.trimbos.nl |
| www.bmj.com | www.ccguides.org.uk |
| www.cnewsuk.cjb.net | www.hemp.co.uk |
| www.jrf.org.uk | |
| www.newscientist.com/hottopics/marijuana | |

"Make the most of hemp seed, sow it everywhere."

George Washington



"It is simply a question of facing up to social reality."

Ruth Dreifuss, Interior Minister, Switzerland 2001

Dave's Disaster Planning



When disaster strikes, you need to know that the people in charge are well experienced at handling the unexpected.

Almost nothing is unexpected to Dave Ward, Regional Emergency Planning Adviser to the Department of Health and Government Office in the North

West. If he has not already experienced the emergency, he has planned the scenario.

Preparing for events like the Commonwealth Games in Manchester, particularly in the current climate of international uncertainty, requires vision and experience.

Dave, from Astley, near Leigh, started his career in banking but soon got bored and looked around for something more exciting. Dave's father found an advertisement in the paper for emergency planners and that seemed to fit the bill. Dave's wife Beth, might sometimes feel, that her husband's life is a little too "exciting" but even when her kitchen table is turned into a centre of operations, as it was during the Kosovan crisis, she is very forbearing.

Back in 1984 and only four days after Dave began his career in emergency planning, working for Greater Manchester Council, the Littleborough Tunnel disaster occurred. This involved a train full of petro-chemicals, which could have exploded at any moment and the surrounding area had to be evacuated.

It was good grounding for the Airtours disaster at Manchester Airport, the IRA bombs in the city of Manchester, floods in the Irwell Valley and many more emergencies.

In 1986, Dave received a Department of Health scholarship to study disaster emergency systems in the United States. Taking Beth and their then three young children, he worked in Atlanta. It was at the Olympic Games held there that Dave experienced the disastrous

results of a bomb attack that killed two people and injured one hundred and eleven.

While in the States, Dave had the opportunity to work in public hospitals in New York and Washington and with the US Navy in Florida, which is where planning for hurricane disasters takes place.

As a result of his US experience, Dave wrote a paper proposing major changes to the way emergency services respond to disasters in this country. Many of his ideas have been used in the wake of disasters like Kings Cross, Clapham, Bradford and Hillsborough.

The World Health Organisation, impressed by his expertise, invited Dave to join an international team working on emergency planning for developing countries which means frequent trips to Geneva. At any given moment Dave can be called on to be an international troubleshooter for the UN to fly off to a major emergency anywhere in the world.

While the creativity of preparing and responding to disasters is as exciting as Dave had hoped, he has never become cynical about his work. Human tragedy still touches him, as it does the rest of us and when he looks back over the toll of disasters he has experienced, it is the Kosovan refugee crisis which stands out most in his memory.

"When we brought in the refugees to the Wythenshaw Forum, we quickly learned to recognise those who needed a hug and those who wanted to be left alone. I particularly remember one elderly man, dressed in ethnic clothes, who was fighting for breath but still wanted his cigarette. He turned out to be one hundred and six. Imagine being forced out of your homeland at one hundred and six."

Being off duty is not a phrase Dave Ward, a former hockey player, really recognises. When you are a high powered emergency planner, you are on duty all the time. But when things are quiet, Dave enjoys watching Manchester United and Wigan and having a drink in his local pub - with his mobile phone switched on, of course.

Dave's wife Beth, might sometimes feel, that her husband's life is a little too "exciting" but even when her kitchen table is turned into a centre of operations, as it was during the Kosovan crisis, she is very forbearing.

Hot off the press... Recently Published Reports

Merseyside Inter Agency Drug Misuse Database. Executive summary of Annual Report 2000.

Juliet Hounsome & Mark A. Bellis
Contact: Juliet Hounsome (j.hounsome@livjm.ac.uk)
www.phslive.com

Economics of HIV and AIDS in the North West of England (2001)

Peter Cosgrove, Mary W. Lyons & Mark A. Bellis
Contact: Peter Cosgrove (p.cosgrove@livjm.ac.uk)

Drug Services in Merseyside and Cheshire 2000/01

Prevalence and Outcomes: Specialist drug services, syringe exchange schemes and outreach services in Merseyside and Cheshire. Caryl Beynon, Rachel L Birtles & Mark A. Bellis

Contact: Caryl Beynon (c.m.beynon@livjm.ac.uk)

Drug misuse in the North West of England 2000.

Produced by: Public Health Sector, Liverpool John Moores University and The Drug Misuse Research Unit, University of Manchester.

Contact: Caryl Beynon (c.m.beynon@livjm.ac.uk) & / OR Petra Meier (petra.meier@man.ac.uk)



This and previous Bulletins
are available
on the
North West
Public Health
Observatory
web site

<http://www.nwpho.org.uk>

News & Views

Dear North West Health Bulletin reader,

The editorial team has been working hard to develop a new look to your bulletin, sorry for the break - but perfection takes time! Joking aside we would welcome news and views on this and past features of the bulletin. Please feel free to contribute by either emailing the editor at the above address or joining in with the online discussion forum at the www.nwpho.org.uk web site.

Enjoy...

The Editor

Wealthier but not Healthier

We are all healthier in these earlier years of the 21st century than ever before aren't we? Well, as a matter of fact, the health gap between those at the top and bottom of the social scale has widened. Despite increased prosperity and a reduction in mortality, social class differences have got broader since the mid-1970s causing health discrepancies. Through the NHS Plan, which aims to modernise prevention and treatment, the Government has committed itself to reducing these differences in health, which affects the well being of the nation. In the North West, the Inequalities and Public Health Task Force has recently been launched. It comprises representatives from health, education, local government, business, voluntary and community agencies and others, who will give support initiatives that are improving health and the quality of life in the region. These include housing improvement, smoking cessation, better diet, encouraging exercise, reducing teenage pregnancy, support for families with young children, improving educational and employment opportunities and enhancing the life of elderly people. The Government has been carrying out a consultation exercise on tackling inequalities which will conclude on November 9th, 2001. The consultation document, Tackling Health Inequalities: Consultation on a plan for delivery, can be read on the Department of Health website at: www.doh.gov.uk/healthinequalities

Water boosts brain power

Pilot studies being carried out in North West schools, through Health Action Zones, are showing that regular water intake throughout the day boosts children's performance in school and improves their health. Parents also notice that the children are less tired and 'difficult' at the end of the school day.

Employers might like to take note - more water intake at work can do the same for staff!

Flu data helps bosses plan

If flu is going to be inevitable, bosses might want to know that the flu data is published weekly on the North West Public Health Observatory website at: www.nwpho.org.uk It helps NHS managers plan for winter crises and can advise employers when they might be hit by large scale absenteeism so they can make contingency plans.

Did you know...? Recent research shows that as little as half an hour's exposure to passive smoking can set children on the train to heart disease.

Conferences 2001/2002

UK

Multicultural Seminars Series at Bolton Institute: Wednesday 7 November

Tom Derwin (Director of Social Services, Newcastle) will be speaking on the topic of 'Multiculturalism and Social Care' at the Bite Conference Centre, Deane Campus, Bolton Institute at 3.30pm.

Email: KKS1RES@bolton.ac.uk

Food Growing - How to Assess and Deal with Potential Land Contamination. Thursday 8 November

Foster Building, University of Central Lancashire, Preston.

Every Child Matters: Tackling Child Poverty and Child Health Inequalities. Friday 9 November.

Mechanics Institute 103 Princess Street, Manchester. 10.00am to 3.00pm.

The 14th Annual Conference of The Health for All Network (UK) 2001: A health odyssey the journey towards healthy communities. Wednesday 21 to Thursday 22 November.

Chester Race Course, Chester. Conference Organisers: Profile Productions Ltd., Northumberland House, 11 The Pavement, Popes Lane, London W5 4NG. Fax: 020 8832 7301. Email: info@profileproductions.co.uk

Globalisation; a Force for Good Health or Ill? Friday 23 November

The HDA is providing a one day forum to debate the issues at the Health Development Agency, Trevelyan House, 30 Great Peter Street, London, SW1P 2HW. Nominal £20 Fee. Email: emily.rickett@hda-online.org.uk

International

6th European Seminar (IREFREA) Drugs in Free Time Culture: The Invention of Fun. Mallorca, Spain 13 - 15 December 2001.

Conference Organisers: www.irefrea.org or Email: irefrea@irefrea.org

The 2nd International Conference on Nightlife, Substance Use and Related Health Issues

Club Health 2002 Rimini, Italy 24 - 27 March 2002.

For an information pack or to submit an abstract visit www.clubhealth.org.uk or contact the Conference Secretariat on; (Italy) Tel: +39 0546 602420 or Email: clubhealth@libero.it