THE CANNABIS CONUNDRUM:

a way forward for London

A report by the London Drugs Commission, March 2025

FOREWORD

Our Terms of Reference – to investigate implications of the non-medical use of cannabis in London and the impact of the current laws which govern it, and to make associated recommendations – poses a readily comprehensible task but one which has proved significant and challenging.

We have been presented with a vast amount of evidence both in person and on paper. We have conducted a more wide-ranging and detailed study of the best policy options in respect of cannabis than any other, in the UK or abroad, in recent times. The scale of our investigation is revealed by the very substantial list of people from whom we received evidence - over 200. In particular, we heard extensively from other countries and jurisdictions which have changed the legal position of cannabis in recent years.

We came to this investigation from different backgrounds and from different perspectives. Our Chair, Lord Falconer, has extensive experience of government responsibility for the administration of justice. He has previously called drugs prohibition a failure for working class communities. One Deputy Chair, Janet Hills MBE, had spent 30 years in the Metropolitan Police Service, providing strong leadership to the Black Police Association, and has spoken out about the detrimental impact of cannabis stop and search within the black community at both a local and national level. Our other Deputy Chair, Professor Virginia Berridge, is an academic historian who has written widely on the forces which position substance use as legal or illegal and what drives change in policy for different drugs. We did not start from the same positions or outlook. But we have had no trouble in reaching a consensus about what our conclusions in this report should be.

It is commonplace for legalisation to be seen as the panacea for all the problems associated with the prohibition of cannabis use. We have not come to that conclusion, but we do not make the case for retaining the status quo. We recommend instead moving the drug from the Misuse of Drugs Act to the newer Psychoactive Substances Act. This makes it possible to continue to police the production and supply of cannabis while not penalising its possession. In retaining the criminalisation of importation, production and supply we have paid strong regard to the evidence of those people dealing with the adverse effects of cannabis – educators, youth workers, medical practitioners and police. They strongly urged us not to legalise those aspects of the trade, because it would likely worsen the

position of those whose use is already problematic, and potentially increase their number.

The legalisation of possession however goes some way to addressing the racial disproportionality in the operation of stop and search, which particularly affects London's black communities. We have also put forward workable proposals which will help policing in London; bring some order to schemes which aim to divert people out of the criminal justice system; further develop coordination across parts of the health system and improve education on the risks and uses of cannabis.

Having considered all the evidence, we do not think the case can be made at the current time for legalisation beyond the extent accepted in the Psychoactive Substances Act. The arguments are rehearsed in detail in this report, but international evidence shows that legalisation does not have the effects often assumed. It does not eradicate the illicit market. The commercial model adopted in some jurisdictions has meant the replacement of 'Big Tobacco' by 'Big Cannabis'. The health implications of widely available cannabis, in particular modern high-strength skunk, and its use in the UK with tobacco, would be amplified by expanded availability. There are too many imponderables in terms of the evidence on legal change as it currently exists; and once the leap to legalisation is made it is difficult to row back.

But regulation need not be set in stone. Cannabis first came under legal regulation in the UK in 1928, nearly a century ago – not because of problems with use in Britain, but because of colonial power politics in Egypt which led to laws being applied to all countries. The drug was always an outlier in what was then called dangerous drugs legislation, an uneasy add-on to heroin and cocaine. That situation needs change. In this report we put forward what we consider to be achievable legal and practical proposals which will benefit both the population of London and the wider community.

The Commission wishes to express their profound thanks to everyone who submitted evidence to our inquiry. Their time, effort and contributions formed the invaluable foundation of this report.

We also wish to thank each member of our Expert Reference Group, namely Dr Arun Dhandayudham, Dr Marta Di Forti, Niamh Eastwood, David Gauke, Jason Harwin, Iona Lidington, Junior Smart OBE and Professor Adam Winstock. All of them are truly experts, all of them gave their time freely and without restraint, and all of them provided us with insight, lines of enquiry and true assistance. Responsibility for the report lies with the three members of the Commission, but we have been tremendously supported by this Group.

Finally, we have been hugely assisted by our secretariat. Jenny Cann, the Commission's head of secretariat, has been the person who has done the organisation, arranging and co-ordination of the evidence. She has guided and made possible all that we have done. Her deft and tactful skills lie behind the report; she brought the very best of civil servant expertise to the task. Our debt to her is incalculable. Our admiration and respect for all that she has done is huge.

Lord Falconer
Chair

Janet Hills, MBE
Deputy Chair

Professor Virginia Berridge
Deputy Chair

The London Drugs Commission, March 2025

ACKNOWLEDGEMENTS

In addition to those we have thanked in our Foreword, we would also like to express our gratitude to colleagues from University College London (UCL). Professor Ben Bradford and Professor Toby Seddon oversaw and guided the gathering and reviewing of a wide range of existing evidence regarding the control of cannabis in the UK and across the world. The outputs from this substantial exercise helped to inform and shape our focus and lines of inquiry.

We are similarly grateful to all those who undertook or otherwise supported these evidence reviews, namely Hannah Barnett (Imperial College London), Dr Nicola Bennett (UCL), Angus Chan (UCL), Dr Gonzalo Croci (UCL & Universidad ORT Uruguay), Dr Simon Flacks (University of Sussex), Gonzalo Garcia-Campo Almendros (University of Oxford), Dr Lucy Harry (University of Oxford), Dr Arabella Kyprianides (UCL), Dr Anna Ross (University of Edinburgh), Isabella Ross (Crest Advisory) and Dr Julia Yesberg (Victoria University of Wellington).

Finally, we would like to thank the Mayor of London for providing us with the opportunity to conduct this inquiry, and those staff from the Mayor's Office for Policing & Crime who provided support throughout the process.

ABBREVIATIONS

ACMD	Advisory Council on the Misuse of Drugs
ADPH	Association of Directors of Public Health
ASH	Action on Smoking & Health
BCU	Basic Command Unit
BMA	British Medical Association
BTP	British Transport Police
BWV	Body-Worn Video
CBD	Cannabidiol
CBPM	Cannabis-Based Product for Medicinal use
CoLP	City of London Police
CoP	College of Policing
CJS	Criminal Justice System
CPS	Crown Prosecution Service
DBS	Disclosure & Barring Service
DfE	Department for Education
DHSC	Department of Health & Social Care
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FSA	Food Standards Agency
GPhC	General Pharmaceutical Council
HHC	Hexahydrocannabinol
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire & Rescue Services
ICS	Integrated Care System
HAC	Home Affairs Committee
HO	Home Office
MDA 1971	Misuse of Drugs Act 1971
MDR 2001	Misuse of Drugs Regulations 2001
MHA 1983	Mental Health Act 1983
MPS	Metropolitan Police Service
MoJ	Ministry of Justice
MOPAC	Mayor's Office for Policing & Crime
MSHT	Modern Slavery & Human Trafficking
NCA	National Crime Agency
NICE	National Institute for Health & Care Excellence
NPCC	National Police Chiefs Council
OCG	Organised Crime Group
OHID	Office for Health Improvement & Disparities
ONS	Office for National Statistics
PCC	Police & Crime Commissioner
PSA 2016	Psychoactive Substances Act 2016
RCP	Royal College of Physicians
S&S	Stop and Search
THC	Delta-9-tetrahydrocannabinol
UNODC	United Nations Office on Drugs & Crime
WHO	World Health Organization

GLOSSARY & EXPLANATORY NOTES

We rely on a variety of specific terms and concepts related to cannabis and its use throughout this report. We explain these, and how we have used them, here.

Cannabis

- Refers to botanical cannabis used for non-medical purposes, unless otherwise specified. There are several other terms for the plant, including marijuana, but cannabis is the most commonly used across medical and non-medical settings, in the UK and around the world. Unless otherwise specified, when we refer to 'cannabis' we mean the drug in its herbal or 'flower' form.

Cannabidiol (CBD)

- A non-psychoactive component of cannabis that is associated with particular effects on the brain and the body. It can ameliorate some of the effects of delta-9-tetrahydrocannabinol (THC) and is increasingly used in products offered by the expanding health and wellness market.

Cannabinoids

- Are chemical compounds present in cannabis that, when consumed, bind to cannabinoid receptors on the surface of cells in the brain and immune tissue. There are more than 100 cannabinoids but the two most abundant are CBD and THC.

Concentrate

- Refers to cannabis flower that has been processed, resulting in a reduced concentrated mass that contains a far greater proportion of cannabinoids and terpenes (see below). Concentrates may be referred to as 'dabs' because 'dabbing' (see below) is a common way to consume forms of concentrated cannabis.

Dabbing

- Is the term given to heating a cannabis concentrate or extract (usually high-THC but can be high-CBD) using a device known as a dab rig, to produce a highly potent vapour for inhalation.

Delta-9-tetrahydrocannabinol (THC)

- Is the psychoactive component of cannabis that causes the consumer to feel 'high'. It exerts effects on the brain and the nervous system. While there are several forms of THC, such as delta-8-tetrahydrocannabinol, when we refer to the compound, we use the term to mean delta-9-tetrahydracannabinol.

Endocannabinoid System (ECS)

- Regulates the brain signals responsible for bodily functions including learning and memory, mood, sleep, appetite, pain control and inflammatory and immune

responses. Endocannabinoids become active when they bind with, or stimulate, a cannabinoid receptor.

Ethnicity

- We refer to people from different ethnic backgrounds throughout our report, as we have explored how the impacts of cannabis use and its legal status can vary according to ethnicity. We have adopted the government's preferred style, which is not to capitalise ethnic group (such as 'black' or 'white') unless that group's name includes a geographic place (for example, 'Asian', 'Indian' or 'black Caribbean').[1] Many of the statistics we have drawn on are produced using reference to people from a white, black, Asian or mixed ethnic background and for ease of reading we have replicated this approach. We recognise, however, that these terms aggregate many different groups; for example, included in the 'black' category are people of black Caribbean and black African origin, as well as those from any other black or black British background.

Illicit/illegal market

- Refers to cannabis produced, distributed, supplied and purchased in any non-legal setting. The terms are used interchangeably throughout this report.

Legal regulation

- Refers to a legal framework governing non-medical cannabis use by adults, in which regulations allow for the lawful possession, supply, transit and production of the drug. This is commonly referred to as 'legalisation'. The term 'legalisation' is used interchangeably with 'legal regulation' for ease of reading throughout this report.

Opiates and opioids

- Are used interchangeably in this report. Both can be used for medical treatment, both can also be used illicitly, but the difference lies in how they are made. Opiates are chemical compounds extracted or refined from natural sources and include opium, morphine, codeine and heroin. Opioids are largely designed and manufactured in laboratories and include fentanyl, oxycodone and hydrocodone.

Potency

- Is used to mean the strength of cannabis with respect to its psychoactive, or THC, content.

Terpenes

- Are organic compounds found in the cannabis plant. Over 400 terpenes have been identified and these are responsible for making strains of cannabis smell or taste different from others and influence how a person experiences their consumption of the drug.

[1] Writing about ethnicity – GOV.UK (ethnicity-facts-figures.service.gov.uk)

CONTENTS

EXECUTIVE SUMMARY

Our comprehensive examination of the nature and effectiveness of UK cannabis law involved taking evidence from over 200 witnesses from national and international settings, who brought significant knowledge and lived experience. Many are well-known, highly regarded experts in their respective fields. We also considered a substantial amount of wider data and research. Collectively, this led us to the following position and principal recommendation, with several underpinning conclusions and associated further recommendations set out subsequently:

The current law criminalises importation, exportation, production and supply of cannabis, with the possibility of severe associated punishments. It also criminalises cannabis possession and, in this, we find it not fit for purpose. The law therefore requires some modification.

- While use of cannabis can cause considerable harm to a minority of those who consume the drug, the severity of penalties for related offences, particularly possession, is, in our view, disproportionately high. This is relative both to risks posed by cannabis itself and to those posed by drugs classed alongside cannabis in the Misuse of Drugs Act (MDA).

- Moreover, the law with respect to cannabis possession is experienced disproportionately by those from ethnic minority (excluding white minority) groups, particularly London's black communities. While more likely to be stopped and searched by police on suspicion of cannabis possession than white people, black Londoners are no more likely to be found carrying the drug.

- In addition, evidence of any criminality, however serious (drugs-related or otherwise), is evidenced in only around one-third of stops overall. Taken together, these realities, in our view, mean that continuation of the law as it currently stands cannot be justified.

That said, we do not think wholesale change, whereby all (non-medical) cannabis-related activities become legal, either in a for-profit or non-profit framework, is the answer.

- We heard several times that legalisation has not been calamitous. While (at least so far) this seems to be the case, neither has it been a panacea in solving issues associated with prohibition, and those who have studied the experience of early adopters of legalisation urge caution. Risks remain and evidence does not suggest these, at least currently, are outweighed by benefits such as tax revenue rises (in commercial models) or reductions in pressures on criminal justice systems. Moreover, legalisation by no means abolishes the illicit cannabis market. Overall, in our view there remain too many unknowns about the longer-term impacts of legalising cannabis, particularly those relating to public health.

- Cannabis use is falling though it remains – as across the world – the most widely used illegal drug in England & Wales, and its market value is significant. Around 2.5 million

people aged between 16 and 59 reportedly consumed the drug at least once during 2022–2023. Prohibition thus seemingly does little to prevent access to the drug so, at the most basic level, legalisation simply changes how a person purchases cannabis (as well as the type and quality available).

- Most people who use cannabis suffer no adverse or life-limiting consequences. Evidence suggests however that at least 10% risk developing associated difficulties of some kind. While not always severe, in some cases very significant psychiatric, physical and/or societal problems (including a failure to engage productively or at all with education or work, or to sustain interpersonal relationships) can manifest. The increase in cannabis potency over recent decades has heightened the risk of problems developing. While that risk depends on several factors (including age at onset of use, frequency of use and genetic predisposition to certain health conditions), the number of users overall means the number of problematic users is not inconsequential.

- Drug treatment services are overwhelmed, in no position to deal with any rise in demand that legalising cannabis may create following an almost inevitable rise in the number of users. This is probably exacerbated in profit-based models, where encouragement of widespread, frequent consumption is incentivised.

- Moreover, in the UK cannabis is mainly co-consumed with tobacco. So, unless habits were to significantly shift, legalisation risks a wholly unwelcome reversal in the current declining rates of smoking. It would represent a somewhat illogical move, in light of wider plans to restrict use of cigarettes and e-cigarettes, and the intention for future generations never to be legally permitted to purchase them.

- Polling suggests a majority of the public do not support wholesale prohibition of production, supply and possession of cannabis. While people do not want to see lives ruined through cannabis addiction, nor do they wish to see lives ruined as a result of engagement with the criminal justice system for use of the drug. That said, for some there is considerable disquiet around its consumption in public spaces, with fears that a more permissive legal framework would worsen this.

While not a perfect solution, we therefore recommend natural (but not synthetic) cannabis be removed from the Misuse of Drugs Act (MDA). This will bring it under the Psychoactive Substances Act (PSA). We think this represents the best way of addressing key harms of the current law, without risking others that further relaxation, or legalisation, at least at the moment, would likely entail. It would mean:

- Cannabis possession for personal use will no longer be a criminal offence and stop and search (S&S) could not be deployed solely on suspicion of such. Use of the power remains where police suspect other offences, including those related to more serious cannabis offending, including trafficking offences.

- Importation, exportation, production and distribution of cannabis (including street dealing, or supply) remain illegal, but maximum sanctions are reduced (prison custody remains an option).

Two further outcomes may follow removal of natural cannabis from the MDA, namely:

- Concern regarding consumption of cannabis in public spaces may rise (although we think, as some evidence suggests, that consumption itself is unlikely to materially increase). This should be addressed through clear application of local anti-social behaviour regulations.

- Disparities in risk of criminal sanction faced by those who can and cannot afford privately prescribed medical cannabis – which in many cases resembles illicit forms of the drug – should ease. People who find the drug alleviates symptoms of ill health and who have a cannabis prescription are not at risk of such sanction. Those who rely on illegal cannabis to ease the same symptoms are, however, liable to be so – even where medical records evidence their ill health. This seems unjust: removing sanctions for possession of cannabis for personal use, irrespective of source, offers a solution.

Scope of our inquiry

Our terms of reference (see Appendix A) broadly guided our inquiries and our **overall approach** is laid out in our introduction (ch.1). We have explored not only how non-medical cannabis is dealt with in the **UK's legal system** (ch.3) but the **historical origins** of that approach (ch.2). We considered current and past **patterns of cannabis use** (ch. 4), the **illicit cannabis market** (ch.5), and **public attitudes** towards both use of the drug and its prohibition (ch.6).

How **cannabis interacts with the human body and mind** (ch.8) and **implications for health services** (ch.9) comprised a substantial element of our work. This led us also to consider the recently established UK market in, and demand for, **medical cannabis** products (ch.11).

The implications of cannabis prohibition for those who use the drug regardless formed a key plank of our inquiries: in ch.10 we set out our findings with respect to the **policing of cannabis use** and the way related offences are treated within the **criminal justice system**.

We refer throughout our report to evidence from **jurisdictions across the world** that have moved away from wholesale prohibition, with details set out in ch.7. Those considerations also led us to consider the advent of **Cannabis Social Clubs** (ch.13).

Finally, matters related to **education** – principally of children and young people but also of relevant healthcare professionals and others – are touched on throughout our report but ch.12 focuses on the specifics.

Conclusions

Our overarching conclusions speak broadly to public health, policing and the justice system, and education. The 42 recommendations (R#) to which these gave rise are set out at the close of this Executive Summary and largely follow suit. Some focus on London and are aimed at the Mayor and City Hall, others have broader application.

Conclusion 1: Cannabis can be addictive: irrespective of the current or future legal position, more explicit provision of services focused on problematic use of and addiction to the drug is needed, alongside greater join-up between relevant health services.

The majority of people who use cannabis experience few if any long-term adverse health consequences. But frequent use of high-potency cannabis, particularly from a young age, elevates risk. For some, this can be significant, especially where difficulties related to health, deprivation and poverty, trauma, education, interpersonal relationships and/or compliance with criminal justice sanctions feature heavily in a person's life. Synthetic cannabinoid receptor agonists (SCRAs), which often closely resemble natural cannabis and mimic the effects of its psychoactive component (THC)[2] but are many times more potent, are thought to pose substantially greater risk.

We heard time and again from practitioners across the justice, health and education sectors that increasing availability, choice and access to cannabis could worsen challenges faced by people already struggling to cope. While less concerned about a relaxation of the law regarding possession for personal use, they expressed significant concern at the prospect of any wider easing.

While less so than alcohol and opioids, cannabis (and the nicotine in tobacco with which it is commonly co-consumed) is addictive and regular use builds tolerance, meaning a person requires more and more to achieve the desired effect. The emergence of Cannabis Use Disorder (CUD), thought to affect at least 10% of those who use the drug (and possibly more in jurisdictions where it is legal, though evidence is mixed and reasons for both rises and falls remain unclear), is testimony to these properties. There is, too, increasingly clear evidence of a causal link between development of severe mental health disorders (namely psychosis and schizophrenia) and cannabis use, particularly heavy use of highly potent forms of the drug from an early age (generally conceived of as being before 15 or 16).

Cannabis-related problems, however, receive relatively short shrift in the underfunded and understaffed reality of drug treatment services. Posing as they do a greater risk of harm, opioids and alcohol tend to be prioritised. Not only can this leave parallel cannabis use unaddressed, those who use neither opioids nor alcohol but exhibit cannabis-related problems risk falling between the gaps: specialist care is very limited.

Inadequate join-up between services and poor understanding across wider health provision, including GPs and tobacco cessation providers, intensifies this and is further

[2] Delta-9-tetrahydrocannabinol (THC) is the psychoactive component of cannabis that causes a user to feel 'high'. While there are several forms of THC, in this report the term refers to delta-9-tetrahydracannabinol.

heightened in London by fragmentation of healthcare across boroughs. This means that cannabis is not identified as a factor in poor health as often as it might be. Compounding these challenges is a lack of detailed evidence regarding what works in addressing issues related specifically to cannabis addiction.

Legalisation could encourage help-seeking before problems become entrenched and more difficult and costly to treat. There is so far, however, inadequate evidence of such behaviour being encouraged. Thus, a change that risks increasing demand on already stretched services – because it increases numbers in need, or numbers willing to admit they are in need, or both – will be neither welcome nor achievable at the current time.

While legal for use to treat a number of specified medical conditions since 2018, cannabis remains on the fringe of modern medicine in the UK – although CBD-based[3] products in the wellness industry are now mainstream. This means the market is taking some time to become established and until relatively recently has relied on importation of the drug to meet demand, which in itself has brought challenges.

Use by the NHS is limited, in part due to evidence of medical impacts of the whole plant (therapeutic and side effects) so far failing to meet standards required for licensed medicines. Unlicensed cannabis-based products for medicinal use (CBPMs) are available via the private sector to treat a wider range of conditions, but costs can be prohibitive for many who claim cannabis offers relief of their symptoms.

Our recommendations regarding cannabis and healthcare (see R4–13, 15, 34 and 37) seek to:

- Reduce inadvertent consumption of more dangerous synthetic cannabis products.
- Expand awareness among health professionals of how cannabis affects the body and brain.
- Develop the evidence base regarding:
  - How cannabis users understand potency and risks, and the impact of this on consumption choices.
  - Interplay between consumption of legal CBD products and illegal cannabis.
  - Treatment of addiction to non-medical cannabis and other symptoms of ill health related to its use, including any possible therapeutic role for medical cannabis.
  - The efficacy of unlicensed CBPMs in treating physical and mental health conditions, including side effects.
- Improve join-up between healthcare providers, including pharmacists, tobacco cessation and drug treatment services, to better identify and care for those whose symptoms of ill health might be associated with, or worsened by, use of cannabis.
- Ensure law enforcement officers understand the law surrounding use and possession of cannabis for medical purposes and are familiar with its prescription.

[3] Cannabidiol (CBD) is a non-psychoactive component of cannabis that is associated with particular effects on the brain and the body. It can ameliorate some of the effects of delta-9-tetrahydrocannabinol (THC).

Conclusion 2: Any model of legalisation involves challenging trade-offs. But while undoubtably it is possible for gains to be realised fairly swiftly, including tax takes and reductions in criminalisation, the extent and nature of harms, principally (but not limited) to public health, with associated personal and societal costs, are yet to be fully understood.

While we see opportunities to reap benefits, we also see potential for harms, and are unconvinced that current knowledge is sufficient to manage those adequately. Until the picture is clearer, wholesale change to the legal framework in the UK – which similarly is not without associated harms – would be unjustifiable and irresponsible. It is too great a risk and – as demonstrated by the alcohol and tobacco industries – tightening regulations and governance to respond to emerging risk once markets are in place is difficult. Once the law changes, the genie cannot easily be put back into the bottle.

No jurisdiction that has adopted a more liberal position than the UK considers they have achieved the perfect balance, and it remains unclear as to what the optimal regulatory model might be. While, as is broadly accepted, cannabis is not a harmless drug, wholesale prohibition does not, in our view, present the best, or least problematic, option. But we are not persuaded that a balance between policy aims to raise tax revenue, shrink the illegal market and reduce criminalisation can be achieved in such a way that does not, for example, unduly threaten public health through making cannabis consumption as commonplace as coffee drinking.

In our view, the case cannot currently be made that legalising cannabis for non-medical use brings a net gain across society, and we are not convinced that any current model adequately safeguards risks to health. Whether such a model exists or can ever exist remains, to our mind, unclear. We do not rule out the possibility of such in the future, though equally accept it may never be a realistic prospect for this country, bearing in mind, too, our unique social, political and cultural context.

As legalisation becomes more established elsewhere and more jurisdictions embrace different models, however, evidence will expand and solidify: consequences will become clearer in time. The Mayor, or government, might wish to undertake a further review in five years to explore whether a more convincing case for legalisation has emerged (see R3). Such a review would be usefully informed by parallel work to fill various associated evidence gaps we also recommend be addressed (see R1, 2, 33, 41 and 42).

It should consider how to prioritise aims of any alternative to prohibition, and whether some form of commercial or non-profit model offers the best way of ensuring benefits relative to those priorities outweigh risks, or costs. The evidence base is currently dominated by early indications of the impact of commercial approaches: in time, we expect more research will emerge from jurisdictions that have adopted more limited or non-commercial models, offering a more comparative picture of relative costs and benefits.

Conclusion 3: Wholesale prohibition under the Misuse of Drugs Act (MDA) treats cannabis in a manner that is disproportionate to its harms, particularly in the case of possession for personal use. While use carries risks, particularly for some people in some

circumstances, we consider those to be insufficiently widespread to justify the sentencing options available while it remains governed by the MDA.

The possibility of a custodial prison sentence of any length, but certainly up to the current maximum of five years, for possession of cannabis for personal use feels excessive. While in reality those sentenced to custody for such serve only a matter of weeks, the negative consequences of serving any time in prison are significant.

Moreover, cannabis possession is very often identified by police through use of S&S, a practice that continues to be utilised in a racially disproportionate way. This means people from ethnic minorities (excluding white minorities), particularly those of black heritage, are not only at greater risk of being subjected to what can be an intrusive, traumatic process, they end up over-represented throughout the justice system for cannabis possession offences.

The potential to receive a custodial sentence for up to 14 years for possessing enough cannabis to supply others similarly feels extreme, relative to the dangers of cannabis itself (as compared to other drugs alongside which it is classed in the MDA).

Our recommendation that, as a psychoactive substance, cannabis should fall under the auspices of the Psychoactive Substances Act (PSA, see R30–32, 36), seeks to:

- Expose fewer people to S&S (suspicion of cannabis possession alone will no longer be legitimate cause to deploy the power).
- Help tackle the persistent racial disproportionality seen in use of the power.
- Ensure that, where illegal cannabis activity is proven, sanctions are commensurate with the risks posed relative to other controlled drugs.
- Ease the risk of criminal sanction for those who find cannabis addresses symptoms of ill health but who cannot afford to purchase it via legal prescription.

We recognise that changing how the law treats possession of cannabis for personal use does not address the fact that those who use the drug depend on the illicit market to access it, with all the inherent risks that entails. Close attention should be paid to jurisdictions that permit limited home cultivation, to understand whether this measure reduces demand for product offered by illegal dealers (see R33). In future, the legal definition of cannabis production could be amended to exclude limited home cultivation.

Conclusion 4: Cannabis policing, particularly via Stop & Search (S&S), continues to focus on particular groups with damaging, long-lasting consequences for individuals, wider society and police–community relations. Grounds are often poorly justified and, in London, the risks of criminalisation and harsher outcomes where possession of small quantities of the drug are found are borne unfairly by black communities.

The risk of criminal sanction associated with (suspected) possession of cannabis can be greater than risks associated with use of the drug and is one of the most widely felt consequences of prohibition. Criminalising those who choose to use cannabis neither makes communities safer nor, in our view, meaningfully discourages use.

The possession of cannabis is not, as far as we understand, a stated priority for S&S (the power is asserted to be one which targets those suspected of carrying knives and other weapons). We recognise, however, the somewhat invidious position into which criminalising possession of the drug puts the police. Duty bound to maintain law and order and prevent crime, where police have evidence to suggest a person is breaking the law, or reasonable grounds to suspect they are doing so, they are expected to investigate. With respect to possession of cannabis, it is difficult to see how else they might do this, other than through exercising their power to S&S. Given the ubiquitous nature of cannabis use, this – perhaps inevitably – means significant numbers of people risk criminalisation.

With that risk borne disproportionately by people from ethnic (excluding white ethnic) backgrounds. In London, this is felt particularly by those of black heritage, who are more likely to be S&S on suspicion of cannabis possession than white people despite little clear evidence of any parallel disparity in use of the drug. Moreover, the practice of S&S does not result, in our view, in a high enough cannabis find rate to justify the extent of its use – even were it to represent a proportionate response to a police priority (which cannabis possession is not). More importantly still, that find rate appears to be no different for black suspects than white.

Racial disparities in use of S&S persist despite much attention over the years, many recommendations for change and relatively widespread public acknowledgement – and dislike – of unjust practices. The issue affects not only individuals but wider police–community relations: trust and confidence in police show worrying declines, particularly among black communities across London.

Ensuring a person can no longer be stopped solely on suspicion of cannabis possession is no magic bullet and is not the solution to root causes of disproportionality. Indeed, while legalisation undoubtably reduces the number of people criminalised for cannabis-related activities, evidence shows that racial disproportionality remains with respect to those which remain illegal.

Similarly, while we expect bringing cannabis under the PSA will reduce the number of people subjected to S&S for possession, it will not put an end to racial disparities in the justice process. We hope, however, it will be a meaningful start.

We do not intend the removal of possession of cannabis for personal use from criminal law to interfere with wider S&S practice. We recognise the power plays an important role in, for example, police endeavours to find and remove dangerous weapons, including knives, from the streets of London and elsewhere. But it must be deployed responsibly, and we make several recommendations intended to support this, as well as to inform and progress other aspects of cannabis policing (see R16–29), in particular to:

- Clarify how S&S should be used with respect to suspicion of cannabis offences.
- Ensure the power is used fairly and in line with guidance.
- Better understand police practices and outcomes regarding drug-related offending.
- Improve access to and delivery of criminal justice drug diversion schemes.

- Improve police–community relationships.

The impact of these measures, along with the consequences of removing criminal sanctions from possession of cannabis for personal use, should be monitored.

Conclusion 5: The content and timing of education about cannabis are inadequate. Provision largely fails to acknowledge the realities of drivers of use and is delivered too late, if at all, in both medical and statutory education settings. In the latter, it is often led by providers who lack sufficient credibility and insight.

School guidance focuses on illegality and risks to health, with material often delivered by teachers perceived to have little relevant or credible lived experience. Failure to explicitly acknowledge the many drivers of cannabis use (including as self-medication for mental health issues), or its widespread availability, probably does little to help those who will try (or have already tried) the drug to make safer choices, or to convey the very real health risks cannabis can bring.

Indeed, by the time children and young people are educated about cannabis, many have tried it, or are at least familiar with it through family and friends. Some will have become regular users. This is concerning particularly because the earlier regular use begins, the greater the impact on brain development and risk of long-term consequences.

While not a palatable subject for many parents and guardians, the system as it stands is not serving children well in equipping them to make informed decisions, as and when confronted with cannabis. We recognise the inherent tensions in proactively educating young people about use of an illegal drug, but consider the risks of not providing them with tools to make more informed decisions to outweigh those tensions.

Among the mainstream medical community, knowledge of the health consequences (positive and adverse) of cannabis use is low – not surprising as the endocannabinoid system does not systematically feature in training. This means opportunities risk being missed in healthcare practice to confidently ask about and identify problematic cannabis use, and conversely to accept that in some cases cannabis may offer relief of symptoms.

Alongside our recommendations aimed at healthcare professionals (R14, 35) we make several more designed to improve education for schoolchildren in partnership with a range of stakeholders (R38–41), specifically to:

- Evaluate existing drug education programmes to better understand their impact and inform future offers, in primary, secondary and post-16 settings.
- Involving key stakeholders (including parents, schools, police, substance use and youth services), explore what and how to communicate cannabis education in meaningful, age-appropriate ways that reflect modern realities of exposure to the drug for many children and young people.

RECOMMENDATIONS

Our recommendations are presented in context throughout our report, but we bring them together here for ease of reference. Numbers in parentheses indicate the paragraph in the main body of the report in which the recommendation is presented.

Chapter 4: Cannabis use in the UK

Recommendation 1: The Home Office (HO), together with the Office for National Statistics (ONS) and the Mayor's Office for Policing & Crime (MOPAC), should consider how data collections could be boosted to facilitate more nuanced understanding of cannabis use among different ethnic groups in London and other regions. (*para.4.46*)

Chapter 5: The UK cannabis market

Recommendation 2: The government should commission an updated assessment of costs and benefits that could be realised through a legal market for non-medical cannabis. This needs to be a net benefit assessment and include potential for additional public health and other costs associated with different models of legalisation. *(para.5.72)*

Chapter 7: International approaches to cannabis regulation: Part a – Alternatives to prohibition in regulating non-medical cannabis

Recommendation 3: Changing international practice and associated outcomes, including those related to public health, levels of wider crime, size of the illegal market, burdens on criminal justice systems and economic considerations, [should] be monitored, ideally by an independent body that reports into either City Hall or central government or both. *(para.7.128)*

Chapter 8: The effects of non-medical cannabis on physical and mental health

Recommendation 4: The Mayor of London should expedite considerations to introduce a drug testing service in London, which includes the capability to test cannabis, as soon as practicable. *(para.8.126)*

Recommendation 5: The Home Office (HO) and Department for Health & Social Care (DHSC) should consider commissioning independent research to explore how those who use cannabis view potency and do or do not adapt their consumption accordingly. *(para.8.133)*

Recommendation 6: The Department for Education, in partnership with the DHSC, HO and Food Standards Agency (FSA), should consider the issue of consumption of legal CBD alongside illegal cannabis further, with thought given to how educational materials regarding cannabis use might raise awareness of the potential risks of CBD consumption. *(para.8.144)*

Chapter 9: The health policy response to non-medical cannabis use

Recommendation 7: The DHSC should explore what works in cannabis treatment, for whom and under what circumstances, to support development of guidance and ultimately services to meet specific needs of this group. *(para.9.25)*

Recommendation 8: [The] National Institute for Health & Care Excellence (NICE) [should] review the content of both guides covering drug misuse prevention and treatment. They should account for changes in the nature of modern-day cannabis and its use and have regard to evidence that relates specifically to the treatment of problematic use of cannabis. *(para.9.29)*

Recommendation 9: The DHSC should consult with the medical cannabis industry to explore potential to utilise cannabis produced for prescription products, where levels of THC and CBD are strictly controlled, in treating those with problems associated with non-medical use. *(para.9.31)*

Recommendation 10: A programme of work [should] be developed to explore how physical and mental health services could better join up with treatment and addiction services, irrespective of which borough they operate within. This should consider mechanisms of delivery, commissioning practices and how to reduce inequalities in service access and be jointly led by the London Health Board and London Drugs Forum (LDF). *(para.9.71)*

Recommendation 11: The Association of Directors of Public Health (ADPH), together with NHS England, those responsible for healthcare within prison and probation, and local government (including Integrated Care Services'), should investigate creation of a 'single point of contact' advisory service. *(para.9.82)*

Recommendation 12: We recommend the ADPH, in partnership with the DHSC and the Office for Health Improvement & Disparities (OHID), should consider how tobacco cessation practitioners can be supported to explore clients' cannabis use. A requirement for them to do so should in due course be built into commissioning of such services. Assessment and recording systems should be duly adapted, with training developed on how to establish appropriate treatment plans for co-users. *(para.9.88)*

Recommendation 13: The OHID, in partnership with the ADPH, Action on Smoking & Health (ASH) and providers of tobacco cessation and drug treatment services, should explore the barriers to more integrated provision and how these could be overcome to better meet the needs of co-users and improve the chances of successful treatment outcome(s). *(para.9.90)*

Recommendation 14: The General Pharmaceutical Council (GPhC) should explore the feasibility of including in their syllabus content that covers the endocannabinoid system and the way in which cannabis exerts effects on the body. *(para.9.97)*

Recommendation 15: The Mayor should consider, in partnership with the GPhC and local drug treatment services, implementing a small-scale pilot of this nature in one or more

London boroughs, whereby pharmacists provide a link into services for those struggling with cannabis use. *(para.9.99)*

Chapter 10: Cannabis, policing and the criminal justice system

Recommendation 16: i) All relevant guidance should explicitly set out that the smell of cannabis alone cannot ever lawfully be used to justify a stop and search: ii) A clause be inserted into PACE Code A to state the smell of cannabis alone cannot be used to lawfully justify a stop and search. *(para.10.37)*

Recommendation 17: The Home Office, in partnership with the College of Policing (CoP) and National Police Chiefs Council (NPCC), should seek to update data recording systems nationwide to allow officers to record:

- The suspected nature of drugs seized via S&S.
- The ethnicity of persons found in possession of broad drug types.
- The outcome of an S&S when it results in finds of i) illegal drugs excluding cannabis, ii) those including cannabis and iii) illegal items excluding drugs. This must be linked to the ethnicity record. *(para.10.56)*

Recommendation 18: The Metropolitan Police Service (MPS), in partnership with MOPAC, should ensure evaluation of the Precision S&S pilot includes recording:

- When an officer is directed to undertake S&S using the Precision approach.
- Reason for S&S and, where drug-related, the type of drug suspected.
- The type of drug found.
- Number of drug-related S&S that end in no further action (NFA) as well as positive outcomes.
- Driver for each stop (self-generated, third-party information or intelligence).
- Views of those subject to S&S by officers receiving enhanced training, alongside views of the wider community. *(para.10.79)*

Recommendation 19: MOPAC should ensure the MPS engage with the City of London Police (CoLP) to explore the possibility of trialling a similar approach to involve and build trust among young communities. *(para.10.123)*

Recommendation 20: MOPAC should explore how the MPS can record the specific type of S&S about which a complaint is made, and link the ethnicity of the complainant to that record. *(para.10.129)*

Recommendation 21: The MPS [should] work with the HO and MOPAC to make better use of data concerning cannabis-related demand where these exist, and to start collating such where they currently do not. In all cases, the ethnicity of the persons reporting or being subject to police action should be recorded, and areas of demand include:

- Intelligence submissions linked to both public reporting and officer generation.
- Number of calls for service from the public linked to cannabis, as well as complaints related to local cannabis activity.
- Enforcement action following execution of warrants, including the number of closure orders issued.

- Drug driving.
- Volume of police seizures of cannabis. *(para.10.131)*

Recommendation 22: MOPAC should mandate those charged with scrutiny of the MPS and CoLP to review a random sample of body-worn video (BWV) of drug-related S&S at least quarterly and report any concerns to the force and MOPAC. *(para.10.148)*

Recommendation 23: The HO, in partnership with the CoP and NPCC, should ensure use of outcome 22 is recorded in such a way that allows for i) it to be counted as a positive outcome and ii) full analysis of use across forces. This must be implemented in such a way that records do not show up in a basic or enhanced Disclosure & Barring Service (DBS) check, given there is no admission of guilt. *(para.10.177)*

Recommendation 24: MOPAC, in partnership with the MPS and Turning Point, should explore how this [diversion] pilot has operated for people referred for cannabis offences, including any identified via S&S. *(para.10.208)*

Recommendation 25: All service providers contracted to support deferred prosecution referrals should be mandated to inform the police as to whether associated conditions have been met. Alternatively, a third party should be appointed to manage the process. *(para.10.212)*

Recommendation 26: MOPAC should ensure ADDER evaluators collect data on characteristics of those diverted (including ethnicity), the route of referral (whether via S&S, for example) and the nature of offending (where drug-related, which drugs). The impact on provision of services for those who use drugs more widely should be monitored. *(para.10.215)*

Recommendation 27: MOPAC and the London Drugs Forum (LDF), together with the MPS and CoLP, should consider expanding this planned pilot for young adults across London, and across age groups. This should be in partnership with ADDER to ensure join-up and learning, and to reduce the risk of duplication. *(para.10.219)*

Recommendation 28: MOPAC [should] publish a list of schemes currently in place, and the LDF explore whether a city-wide model would be more effective. As a minimum the LDF, in partnership with MOPAC and the MPS, should draw up clear guidance regarding eligibility for diversion schemes. *(para.10.220)*

Recommendation 29: Requiring police to specify why they choose not to refer an eligible individual to a diversion scheme would shed light on the use and efficacy of these schemes, and MOPAC should work with the MPS to ensure this happens. *(para.10.223)*

Recommendation 30: Natural cannabis should be removed from the MDA, meaning as a psychoactive substance it would fall under the auspices of the PSA. (para.10.306)

Recommendation 31: Local regulations (byelaws) should be deployed to prohibit and therefore prevent consumption of cannabis in public spaces, including parks, squares, beaches and pedestrian pavements. *(para.10.315)*

Recommendation 32: The regime governing disclosure of criminal convictions should be amended so that cannabis possession offences are protected from disclosure, regardless of the date of offence. *(para.10.324)*

Recommendation 33: Central government [should] explore the possibility of permitting limited home cultivation, drawing on evidence from jurisdictions elsewhere that allow it (such as Washington D.C.). But home cultivation should not be legalised until such time as there is clear evidence it significantly reduces connection with illegal suppliers, and has public health benefits. (para*.10.334)*

Chapter 11: Cannabis for medical purposes

Recommendation 34: Research programmes such as the T21 and Cannabis & Me studies should be funded to explore the effectiveness of CBPMs in treating a wider range of conditions, including but not limited to chronic pain. These must be funded and led by independent, objective bodies such as the Medical Research Council. *(para.11.25)*

Recommendation 35: Health bodies should consider how recommendations in the Canadian Review to provide information and evidence on the use of cannabis for medical purposes could be drawn on and actioned in England. This should include use of both licensed and unlicensed CBPMs. *(para.11.38)*

Recommendation 36: Forces across England & Wales, including the MPS, should routinely ensure officers are aware of the law surrounding use and possession of cannabis for medical purposes, and are familiar with its prescription. *(para.11.75)*

Recommendation 37: We therefore recommend, if sufficiently robust, favourable conclusions emerge from research recommended in R34, further research be undertaken into training and cost implications of equipping the NHS to provide unlicensed CBPM product scripts more widely, where (initially) sanctioned by a doctor on the Specialist Register. This should consider the potential burden on those doctors in the context of their overall burden as front line practitioners, as well as the opportunity costs of prescribing traditional medicines (including opiates) over unlicensed CBPMs. Findings should inform decisions as to whether the current system should be changed and the implications of doing so for medical cannabis supply chains should be considered. *(para.11.82)*

Chapter 12: Education and cannabis

Recommendation 38: The City of London Corporation should commission independent evaluation of DART and, if appropriate, the Mayor should explore potential for it to be delivered in primary schools across London boroughs. *(para.12.37)*

Recommendation 39: The Mayor should consult with parents, schools, youth workers, substance use services and other organisations such as Cranstoun to consider how more comprehensive content focusing on risks of cannabis use could be systematically introduced to younger children, and revisited during post-16 education, in meaningful, age-appropriate ways. Existing resources, including the DART material, should be considered, as should the efficacy and appropriateness of police involvement in delivery. *(para.12.40)*

Recommendation 40: The Mayor should consider ensuring all establishments across London that provide education post-18 are aware of and have access to such [harm reduction] materials, and signpost this to all students at the point of entry. *(para.12.62)*

Recommendation 41: Representatives of schools, parent bodies, substance use services and other organisations involved in localised endeavours, as well as developers of material designed for post-18 students, [should] form a working party. This should aim to produce detailed, age-appropriate guidance for use across London's schools, to help young people better understand the risks and make more informed choices. *(para.12.71)*

Chapter 13: Cannabis Social Clubs

Recommendation 42: Given the central role played by Cannabis Social Clubs in approaches being developed in Malta and Germany, City Hall should maintain a watching brief on how those proceed. Consideration should be paid to any indications of a subsequent rise in prevalence of cannabis use and adverse health outcomes, as well as any reduction in demand or burdens on criminal justice systems and changes in take-up of other illegal substances and alcohol. *(para.13.14)*

1. INTRODUCTION

Background

1.1 In his 2021 London Mayoral campaign manifesto,[4] Sadiq Khan committed to establishing a panel of independent experts to explore the nature and effectiveness of the UK's drug laws, focusing on cannabis used for recreational, or non-medical, purposes. With an emphasis on harm reduction, leading figures from public health and criminal justice, alongside experts from the third sector, politics and academia, were brought together to form the London Drugs Commission (LDC).[5]

1.2 The Mayor is not empowered to change drug laws: this responsibility rests with central government. It is our intention, however, for this report to inform and further the debate regarding those laws which govern production, supply and possession of non-medical cannabis in London and across the UK.

1.3 Our inquiries were guided by our terms of reference (Appendix A), which, briefly, tasked us to explore the impact of current laws governing non-medical cannabis. We focused particularly on health and criminal justice-related outcomes associated with use of cannabis, and considered evidence from London, the UK and across the world.

Our approach

1.4 Our aim has been to determine, based on the best available evidence, whether prohibition of cannabis for non-medical purposes represents the most effective way to minimise individual and societal harms. To draw on terminology rooted in economics, we explored whether prohibition achieves the best balance of 'benefits' set against 'costs', or disbenefits, in comparison to alternatives, namely decriminalisation (de facto and de jure) and legalisation (see chapter 3 for fuller descriptions).

1.5 We adopted a broad definition of 'harm', with regard principally to health and interactions with the criminal justice system following suspected involvement with cannabis. We also considered public attitudes, the size and nature of the illegal cannabis market and implications for public services in responding to cannabis use.

1.6 We explored these matters as they manifest in the UK and within other jurisdictions that have adopted (or are considering adopting) different legal frameworks to govern production, supply and possession of non-medical cannabis. As part of this, we also examined the economic implications of non-prohibitive approaches.

[4] Sadiq-for-London-Manifesto-.pdf
[5] The London Drugs Commission | London City Hall

1.7 The scope and focus of our enquiries were guided by our terms of reference. We have, however, been led by the evidence presented to us, meaning we necessarily explored associated matters such as the role of medical cannabis, made legal in the UK in 2018 and which we consider in chapter 11. Similarly, while we concentrated on botanical cannabis, we considered synthetic forms of the drug where relevant. We describe cannabis, and how it is consumed, in chapter 4.

1.8 As per our task, we sought to focus where possible on the London context, particularly with regard to policing and public opinion. Recognising, however, that laws governing cannabis reach nationwide and many issues apply irrespective of geography, much of our thinking and many of our recommendations apply UK wide. Where helpful we have drawn on evidence from across the country and, in our recommendations, sought to clarify those which have broader applicability beyond London.

1.9 We have taken neither a moral nor a philosophical perspective (though have brief regard below) but one of public policy: what are the positive and adverse consequences of the current position and can, or should, the balance of these be altered by changing the legal framework.

What have morals got to do with it?

1.10 It was put to us that, like cannabis, alcohol and tobacco are drugs that can cause harm, incite addiction and lead to forms of intoxication. Yet both are legal. We reflect on this in chapter 2 in a brief history of the UK's approach to cannabis, considering the role of the Misuse of Drugs Act 1971 (MDA)[6] and how views about cannabis influenced, at least in part, the way the drug was legislated. Concerns about its effects (positive or harmful, individually or societally), alongside a perspective that it was somehow morally objectionable irrespective of whether it caused harm, were important.

1.11 We consider public attitudes in chapter 6 but polling shows more liberal approaches to cannabis are gathering support, highlighting one of the challenges of any morality-based approach to law and public policy. Namely, that public views tend to change over time, as, for example, with respect to abortion, homosexuality and capital punishment.

1.12 And of course, moral opposition to drug use, or any other behaviour, does not mean it should be criminalised. Libertarians would likely argue the only reason to limit a person's freedom (prohibit their ability to use cannabis) is to prevent harm to others. Paternalists on the other hand would probably argue that if something (cannabis) harms a person then state interference, i.e. prohibition, is justified because it is in their best interests.

[6] Misuse of Drugs Act 1971 (legislation.gov.uk)

1.13 But cannabis-related 'harm' can be difficult to define and may manifest differently for different groups. And not all behaviours or drugs that risk harm to an individual or others are prohibited. As we note, alcohol undeniably causes health harms and is a consistent factor in public disorder and violence, yet is legal in the UK and large parts of the world. The 'right' to consume it remains intrinsic to many societies and cultures.

1.14 The notion of rights is similarly relevant to cannabis. Protected under an array of legal instruments and treaties, many have argued the right to privacy[7] means those who choose to use any illicit drugs should be protected from interference in what is their private decision to do so.

1.15 It is not, however, an absolute right, meaning it is subject to qualification. Article 8 in the European Convention on Human Rights (ECHR), for example, sets out '*…the right to respect for his private and family life, his home and his correspondence'* can be subject to interference '…*in the interests of natural security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others*.'

1.16 This raises questions such as what constitutes a risk to health, how can morals be defined and protected, and how might the rights and freedoms of others be threatened by a person's use of cannabis. Some would almost certainly argue that given its role in disorder, detrimental impact on health, and in some cases adverse effect on others, the right to consume alcohol should be subject to 'interference'.

1.17 Whether prohibition of cannabis or adoption of some other approach represents the most appropriate way of protecting the human rights of all persons is fraught with complexity and, in our view, there is no clear right or wrong solution.

1.18 The right to freedom of religion (protected by Article 9 of the ECHR) is also relevant. For Rastafarians, of whom there are at least 6,000 in England & Wales,[8] cannabis is part of their practice, an important part of spiritual expression. Several have attempted to challenge criminal charges of cannabis possession or supply by invoking their right to religious freedom, but have thus far failed because of a similar qualifier under Article 9(2).[9] Rastafarians who use and supply cannabis may have associated sentences reduced, but they will not avoid prosecution or conviction.[10]

1.19 We touch on the interplay between a decision to use, or grow, cannabis and the law in our description of the legal position in Mexico (chapter 7). The notion of human rights has played a central role in development of the current situation.

[7] Set out, for example, in Article 8 of the European Convention on Human Rights, Article 12 of the Universal Declaration of Human Rights and Article 17 of the International Covenant on Civil and Political Rights.
[8] Religion, England and Wales – Office for National Statistics (ons.gov.uk) *Accessed 10th August 2023.*
[9] See for example *R v Taylor* [2001] EWCA Crim 2263.
[10] See for example *R v John-Lewis* [2013] EWCA Crim 2085.

Our methodology

1.20 In attempting to unpick the many complex and varied matters relevant to our task, we deployed a multi-methods approach to gathering evidence:

- **Oral evidence sessions** with over 200 experts and other stakeholders from London, around the UK and across the world, and receipt of **written submissions** from several more (Appendix B).
- An independent **qualitative research study**[11] to explore lived experiences of cannabis among a small sample of Londoners.
- An **opt-in survey** available to those living or working in London to investigate perspectives on cannabis use and views of legal approaches (Appendix C).
- **Questions in the quarterly survey** run by the Mayor's Office for Policing and Crime to canvass Londoners' views of approaches to cannabis (Appendix D).
- In partnership with University College London, a series of **desk-based literature reviews** summarising evidence from the UK and elsewhere. These informed our evidence sessions and focused on:
  i. Cannabis markets (legal and illegal).
  ii. Health impacts of cannabis use.
  iii. Legal approaches to non-medical cannabis use.
  iv. Patterns of non-medical cannabis use.
  v. Philosophical positions relating to cannabis.
  vi. Policing of cannabis.
  vii. Public attitudes towards cannabis.

Constraints in understanding the impact of changes in legal frameworks

1.21 We heard directly, or otherwise received, a vast amount of evidence and our inquiries led us to consider even more. This enabled us to undertake substantial exposition of a wide range of issues, which we discuss throughout this report.

1.22 Despite the amount of evidence, however, we must acknowledge the difficulties in drawing firm conclusions, particularly with respect to the precise impact of changes to legal frameworks elsewhere. The limitations of research and real-world contexts merit setting out, and we do so below.

1.23 In exploring whether prohibition of cannabis is the most effective way to reduce associated harms, we needed to first understand the nature and extent of those harms. The causal impacts of cannabis, however, particularly on health (both positive and adverse), are in some cases difficult to reliably determine (and to distinguish from reverse causation, where use is a consequence of a health condition rather than a cause).

1.24 Similarly, the impact of alternatives to prohibition on such things as prevalence of cannabis use, public health and the size of the illegal cannabis market are difficult

[11] Thinks Insight & Strategy (2023). *Lived experiences of cannabis among Londoners*. MOPAC. Available at MOPAC academic research | London City Hall

to causally attribute. Different approaches across US states, and variability in the way legalisation was implemented in Canadian provinces and territories (see chapter 7), arguably form a series of 'natural experiments' enabling some comparison of outcomes under different models. Inherent contextual and situational variance, however, means attribution of cause and effect is no less challenging.

1.25 We cannot be confident that reported outcomes are caused by the particular legal approach to cannabis rather than other things, nor which element of an approach caused which effect, nor indeed whether that effect might have happened anyway without legislative change.

1.26 We are mindful, too of national context and culture. While we learnt a great deal from examining approaches adopted elsewhere, what is deemed successful in other jurisdictions may not translate as such in the UK. Indeed, outcomes may not manifest in the same way. Despite similarities, the UK is neither culturally nor economically equivalent to those international jurisdictions with which we engaged. And while geographically closer to our European neighbours, distinctions between societal structures and broader legal frameworks remain. These include current use of medical cannabis and public acceptance of such, the history of cannabis use and governance, and approaches to wider permissions, regulation and compliance.

1.27 These realities are compounded by limited methodologies and small samples characteristic of many studies, which restrict scope to draw inferences for application in a wider context. Furthermore, some of the work we were directed towards was funded by backers with a vested interest in a particular outcome, so their findings cannot be considered truly independent or objective.

1.28 This means that, while there are several learnings that offer important guiding principles and on which we relied in drawing our conclusions and recommendations, we cannot translate wholesale the evidence regarding impacts of non-prohibitive policies and laws implemented in other parts of the world.

1.29 Moreover, legal markets for non-medical cannabis have existed only for a little over ten years. The earliest adopters were Washington State and Colorado in the US – both voted to legalise cannabis for non-medical adult use in 2012. While in many policy areas this would be ample time in which to reliably evaluate impact of any change, effects on some outcomes of interest to us (particularly health) take time to materialise and require collection of comprehensive data from the outset.

1.30 And it takes time to effect behaviour change. People who use cannabis do not, for example, switch from illegal dealers to legal suppliers overnight. Several eminent

researchers in the field note the importance of longer-term evaluation in determining the impact of moves away from prohibition.[12]

1.31 Pre-legislative trends are important. For example, cannabis use in Canada had been rising before legalisation in 2018 (see chapter 7), so growth post-legalisation cannot necessarily be attributed (entirely) to the new approach. Not only does this highlight the limits of a pre-post design in outcome evaluation, it is also testimony to the need for baseline data to understand and accurately interpret those which are gathered subsequent to legislative change.

1.32 Finally, much evidence on the impact of legislative change on prevalence of cannabis use, important particularly from a public health perspective, derives from survey data. As pointed out by many experts in the field, any apparent increase post-legalisation may also simply reflect a greater willingness to report use of a now legal substance.

1.33 Consequently, robust evidence of the impact of more liberal approaches to cannabis use is in its infancy. As a result of our inquiries, however, we consider there to be several reasonably strong indications of likely results were a change to be made in this country, to which we have had regard in reaching our own conclusions and recommendations.

[12] See for example Manthey, J., Armstrong, M.J., Hayer, T., Myran, D.T., Pacula, R.L., Queirolo, R. … & Zobel, F. (2023). How to interpret studies on the impact of legalizing cannabis. *Addiction, 118*(11). doi.org/10.1111/add.16314 *Accessed 16th August 2023.*

2. A HISTORY OF CANNABIS REGULATION IN THE UK

With its roots in Central Asia, cannabis and its derivatives have been in use around the world for millennia, harnessed for rope and textiles, food and a range of medicinal purposes in addition to psychoactive properties. Evidence suggests it played a role in religious practices and ceremonies, as well as general recreation, as early as 3000 BCE,[13] and of course it continues today to be associated with both Rastafarianism and Hinduism.

Regulation of cannabis is, therefore, comparatively recent. In this chapter we examine how the drug first came to be regulated through drug control laws, at both the international and national level. This had little to do with any inherent dangerousness of the substance but was rather the outcome of colonial power politics played out in the international sphere.

Prohibition, which tied cannabis to opiates and cocaine firstly under international and subsequently national UK legislation, was more an 'accident of history' than the rational process based on assessments of harm that has sometimes been assumed. This history has led to the uneasy association between cannabis and other 'dangerous drugs' which persists to the present day – becoming of particular significance in the 1960s. To understand how this came about, we need first to look at the colonial politics of cannabis.

Regulation of cannabis in the colonial world

2.1 Colonial states in the nineteenth century derived income from cannabis cultivation and trade. Between the 1790s and 1850s in India, for example, the East India Company raised significant revenue from the drug, although without direct intervention: cannabis retailers were required to buy a Company licence before they could purchase from a producer and sell on.

2.2 Mid-nineteenth century the system changed, meaning wholesalers located in the place of business rather than production or sale became liable for taxation. In addition, licences also became required for cultivation. Cannabis duties duly became a significant source of revenue for the Indian government, in particular in Bengal where one-fifth of overall revenue was raised from these internal customs.[14]

2.3 Other colonial states acted similarly and found it quite acceptable to derive revenue from cannabis. Indeed, the principal issue for some became how to

[13] Lawler, A. (2018). Cannabis, opium use, part of ancient Near Eastern cultures. *Science*, *360* (6386). doi.org/10.1126/science.360.6386.249

[14] Mills, J. (2003). *Cannabis Britannica. Empire, Trade and Prohibition*. Oxford University Press.

protect the then legal trade from smugglers and abolitionists in order to maintain that revenue.

2.4 The UK government, however, became concerned about the effects of cannabis in Bengal, and the Indian Hemp Commission of 1893–4 was convened to look into the matter. They concluded that moderate consumption of the drug was not unduly harmful (noting excessive use could result in harm but suggesting this was confined to the user rather than society) and proposed four main planks of cannabis-related policy, namely: i) adequate taxation; ii) licenced-only cultivation; iii) limits on the number of retail outlets and iv) limits on the extent of legal possession.

2.5 Those conclusions, however, have to be seen in light of the prevailing climate at the time, i.e. one in which cannabis was an important revenue source. The report had been heavily influenced by the Indian government's need to maintain the cannabis trade, with objections of some members of the Commission swept aside.

2.6 Despite the report's findings and proposed policy of regulation rather than prohibition, attempts at eradication of the trade began in some Indian states. Behind these lay international labour market migration patterns, which saw 5.5 million Indians emigrate as labourers between 1834 and 1938, principally to 12 colonies within the Empire including Natal,[15] Jamaica, Trinidad, British Guiana,[16] Fiji and French Réunion. These migrations were stimulated by both the British authorities in receiving nations and by India itself, in order to meet labour demands of the imperial economy.[17]

2.7 The migrant labourers took their cannabis habits with them, leading the Union of South Africa,[18] soon to become important in terms of international restrictions, to develop controls over the drug from the 1880s. State governments were concerned about perceived efficiency of their Indian labourers, their obedience as subjects and their relationships with African neighbours, who often supplied cannabis to the incoming migrants.

2.8 In the early twentieth century, cannabis prohibition ultimately contributed to strategies of white nation-building, racial rule and imperatives of segregation.[19] Colonial and post-colonial elites effectively wielded and gained power in attempts to control cannabis, whether with intent to eradicate the trade or gain profit from it.

[15] A former province of South Africa.
[16] A former British colony, since 1966 it has been known as the independent nation of Guyana.
[17] Mills, J. (2007). 'Colonial Africa and the International Politics of Cannabis: Egypt, South Africa and the Origins of Global Control'. In J. Mills & P. Barton (Eds). *Drugs and Empires. Essays in Modern Imperialism and Intoxication, c1500–c.1930.* Palgrave, pp.165–84.
[18] Established in 1910 to unify the provinces of the Cape, Natal, Transvaal and Orange River.
[19] Waetjen, T. (2021). Dagga: How South Africa Made a Dangerous Drug, 1902–1928. In L. Richert & J. Mills (Eds). *Cannabis: Global Histories.* The MIT Press. doi.org/10.7551/mitpress/12102.001.0001

Medical usage and the origins of the connection between cannabis and insanity

2.9 The overall medical as well as recreational (non-medical) use of cannabis was part of ongoing colonial discussions about the drug. Although used widely for both purposes in non-Western societies, its medical use in the West was non-existent in the early nineteenth century. It was not until the late 1830s in Calcutta, when the physician W.B. O'Shaughnessy praised the drug as a painkiller and anti-convulsive, that the West was alerted to its medical properties.

2.10 Cannabis was not embraced equally across Western nations, however. In France, for example, it had fallen from favour as a medicine by the mid-nineteenth century.[20] Conversely, it enjoyed a vogue of sorts in British medicine, being used to treat labour pains, combat tetanus and even to treat symptoms of insanity. There is, however, no evidence that Queen Victoria used the drug during childbirth, as is often claimed.[21]

2.11 Alongside a partial medicalisation in some parts of the West came an opposite reaction, namely a connection between cannabis use and insanity, or mental illness. On the basis of scant evidence and a great deal of cultural stereotyping, British doctors in India identified what they termed 'cannabis with insanity', claiming a large proportion of asylum inmates were cannabis users and that their poor mental health was directly related to its use.

2.12 Other colonial nations followed a similar path. For example, use of hashish, or hash, (compressed cannabis resin) among the Muslim population in French North Africa had, it was argued, produced a wide range of behaviours that were irrationally violent and threatened the social order, epitomised in the history of the Hachichins (Assassins).[22]

2.13 It was this twin-track background – the significance of cannabis to the colonial economy and concerns about its use and perceived link to insanity in native populations – that ultimately led to the belated arrival of cannabis on the international drug regulation scene.

The arrival of cannabis in the international control system

2.14 The origins of widespread international control lay in US power politics and moral entrepreneurship (namely a desire to expand US influence in South East Asia), as well as in the concerns of American missionaries in China about the opium trade. Britain, already in the throes of bringing the Indo-Chinese opium trade to an end, was – at least initially – a reluctant participant.

2.15 Cannabis was not originally part of the system of international drug control, which arose in the early twentieth century and led to a raft of domestic drug control

[20] Guba, D. (2020). *Taming Cannabis*. Montreal: McGill-Queen's.
[21] Berridge, V. (2003). 'Queen Victoria's cannabis use…' *Addiction Research and Theory, 11*(4), pp.213–15.
[22] See footnote #20.

legislation across the globe. The focus at this stage was opium, with the 1912 Hague International Opium Convention the initial vehicle of control – although this did not apply internationally until three years later when it entered into force in five countries.[23]

2.16 Focus soon widened to include cocaine, which became part of international control concerns during World War I due to its use by troops (with cocaine smuggling a principal driver of later domestic controls in the UK). International control of both opiates and cocaine subsequently became a global system when the Hague treaty was adopted as part of the peace settlement after the War, in the Treaty of Versailles. This led to worldwide implementation of laws covering dangerous drugs and, in Britain, the first Dangerous Drugs Act of 1920, with the Home Office (HO) the lead government department.

2.17 Thus, cannabis played little part in the early history of international drug control. It had featured briefly in 1912 at The Hague, introduced by the Italians, but did not appear in international discussions again until 1923. By then drug control was under the aegis of the League of Nations, which had appointed an Advisory Committee on Traffic in Opium. A letter to that Committee from South Africa drew attention to cannabis.

2.18 From there, the issue transferred to the Second Opium Conference, which met in 1924. This was intended to deal with administrative matters related to control of opiates and cocaine. But Dr Mohamed El Guindy, head of the Egyptian delegation, successfully forced cannabis into the deliberations of the meeting and subsequently into a new agreement made at that time.

2.19 El Guindy may have been genuinely concerned about the effects of cannabis. But much of his agenda came from a British report on cannabis and insanity in the Cairo asylum system, and his enthusiasm was bolstered by the fact that the subject would embarrass the British, his former colonial masters.

2.20 British representatives at the 1924 conference had tried to keep cannabis off the agenda, as did the British Indian delegation, because of the financial importance of cannabis to the colonial economy. Their opposition, however, proved fruitless, and cannabis became part of the system of international control.[24]

Cannabis in UK drug laws from the 1920s

2.21 The extension of international control legislation to cannabis led automatically to domestic control and the UK's Pharmaceutical Society included the drug on the Poisons Schedule in 1924. After the League of Nations incorporated cannabis in 1925, obligations were finally implemented in the UK under the Coca Leaves and Indian Hemp Drug Regulations of 1928.

[23] See The 1912 Hague International Opium Convention (unodc.org) *Accessed 15th May 2024*.
[24] See footnote #14.

2.22 There was no public discussion about the legislation. The HO concluded there was no evidence of abusive use of Indian hemp among the UK population, and only perhaps occasional use among 'Oriental seamen'. The only group to voice opposition were corn plaster manufacturers, who used it in their product.[25]

2.23 This, then, was the state of play regarding cannabis on the domestic scene in the interwar years. The US and UK remained the core actors in international drug diplomacy and represented the two main policy strands within the system: prohibition and regulation respectively.

2.24 During this time the international system was as much about regulation as prohibition and those advocating the latter were rarely allowed a substantial platform before the 1960s. The system was run in the interwar years in the interests of the colonial drug-producing powers anxious to protect their monopolies.[26]

2.25 So, despite now being subject to (some) regulation, cannabis was of relatively little importance in terms of control at both national and international levels. But the colonial politics of the 1920s meant it was inextricably linked to opiates and cocaine through the system of international control and required domestic legislation.

World War II and beyond: a time of international system change.

2.26 In the decades after World War II, much changed. The League of Nations opium control apparatus moved to New York during the war and American influence became strong. Pressure was brought to bear on the colonial powers to drop their drug monopolies.

2.27 The United Nations (UN) 1961 Single Convention on Narcotic Drugs[27] (amended by a 1972 protocol and hereafter 'the Convention') limited *'exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs'* (Art. 4c). Cannabis was listed in Schedule I, alongside substances with addictive properties considered to present a serious risk of abuse.

2.28 It was also listed in Schedule IV. This contains a subset of Schedule 1 substances that were thought to be particularly harmful and to offer extremely limited or no medical or therapeutic value. Drugs included under Schedule IV were subject to a number of additional control measures.

2.29 The UK ratified the Single Convention in 1964, leading to further amendments to the Dangerous Drugs Act that same year – and the banning of cannabis cultivation. Like most eventual signatories, the UK introduced associated criminal

[25] Mills, J. (2013). *Cannabis Nation. Control and Consumption in Britain, 1928–2008*. Oxford University Press.
[26] Collins, John. (2021). *Legalising the Drug Wars. A Regulatory History of UN Drug Control*. Cambridge University Press.
[27] FINAL ACT OF THE UNITED NATIONS CONFERENCE (unodc.org)

sanctions for possession or use of those drugs it now prohibited, including cannabis.

2.30 The US, on the other hand, did not ratify until 1967, advocating the 1953 Opium Protocol in its stead. The Convention, it has been suggested, developed as a hybrid regulatory system underpinned with prohibitionist aspects – arguably it represented a victory for the UK-led regulatory strand over the US-led prohibitionist strand.[28]

Cannabis in the UK in the 1950s and 60s: the Wootton Report

2.31 Meanwhile, in the UK, the cultural significance of cannabis was changing. With the wave of migration from the British Empire in the 1950s came new music and cultural habits, including cannabis smoking. Increasingly adopted particularly by young people and students, cannabis became associated with the emergence of 1960s youth subculture and wider counterculture (with its challenge to social and political order) as well as with the colonised citizens of the British Empire.[29]

2.32 These subcultures built up significant pressure for the liberalisation of drugs laws after ratification of the Convention criminalised drug-related activity. Support for the cause came from several high-profile public figures including the Beatles, Mick Jagger and Keith Richards (the latter two were both convicted – later overturned – in 1967 for drug offences).[30]

2.33 In 1967, responding to increasing calls for a rethink including those from the Advisory Committee on Drugs (ACD),[31] the government set up a separate committee, chaired by Lady Wootton, to review the laws on cannabis. Use of the drug continued to attract significant public and media attention, with the curtailment of civil liberties inherent in prohibition, the sentences received by Jagger and Richards (largely seen as excessively harsh) and the way cannabis laws were enforced of particular focus.

2.34 A 'Legalise Pot' rally was held in London later that year, shortly after which a group of 64 high-profile musicians, artists, writers and academics (including the Beatles, David Dimbleby, Graham Greene and Dr R.D. Laing), alongside two sitting Members of Parliament (MPs) took out a full-page advert in *The Times.* Entitled '*The law against marijuana is immoral in principle and unworkable in practice*', it urged the government to reform cannabis laws and control, rather than prohibit, the drug.[32]

2.35 The arguments put forward in the advert were ones which have become familiar since. Cannabis use had become ubiquitous, was less risky than alcohol and

[28] See footnote #26.
[29] Seddon, T. (2020). Immoral in Principle, Unworkable in Practice: Cannabis Law Reform, the Beatles and the Wootton Report. *British Journal of Criminology, 60* (6), pp.1567–84. doi.org/10.1093/bjc/azaa042
[30] Green, J. (1999). *All Dressed Up: The Sixties and the Counterculture*. Pimlico. Cited in ibid.
[31] Set up to offer independent, evidence-based advice to government on drug dependence, misuse and policy.
[32] See footnote #29.

contained properties thought to be of medicinal benefit. It also addressed what it saw as the misconceived 'gateway theory' (those who become addicted to more serious drugs are said to begin with cannabis; see chapter 4), pointing out that, by prohibiting cannabis, users had to access the illicit market, which in itself could expose them to harder drugs to which they would otherwise have no access. Finally, it drew attention to the threat to civil liberties and the harms of criminalisation of large numbers of people.

2.36 The Wootton Report[33] was published in early 1969. It recognised cannabis as a dangerous drug but considered that: '*The association in legislation of cannabis with heroin and the other opiates is inappropriate and new legislation to deal specially and separately with cannabis and its synthetic derivatives should be introduced as soon as possible.*' (para.81).

2.37 Moreover, in essence the report also called for de-penalisation, suggesting that '*Possession of a small amount of cannabis should not normally be regarded as a serious crime to be punished by imprisonment.*' (paras.87, 90). It recommended a general review of police powers of search and arrest in relation to all drugs offences, especially cannabis, but recognised that the law alone could not deal with the problem. Education also had a part to play.[34]

2.38 The Labour Home Secretary at the time, James Callaghan, rejected the conclusions of the Report in a Commons debate, through a speech focusing principally on opposition to the rising tide of perceived permissiveness. Little of that debate was about cannabis itself or the work of the sub-committee: with just over a year to go until a general election, his response has been characterised as 'playing to the gallery' about the counterculture for which cannabis had become a symbol.[35]

2.39 The related Bill introduced by the Labour government in 1970, however, in fact contained several recommendations from the Wootton Report. These included the separation of cannabis from other more dangerous drugs, and the differentiation of possession from supply offences.

The Misuse of Drugs Act 1971

2.40 The Conservative Party came to power following the 1970 general election and quickly took the Labour-initiated Bill through Parliament, resulting in the Misuse of Drugs Act 1971 (MDA). Based in part on the UK's treaty obligations under international conventions on drug control, the MDA regulated the production, supply, possession, importation and exportation of controlled drugs.

2.41 Drugs were classified according to the harm they were considered to cause, with Class A (which included cocaine and heroin) the most harmful. The severity of

[33] The Wootton Report Table of Contents (druglibrary.net) *Accessed 1st September 2023.*
[34] See footnote #25.
[35] Ibid.

criminal penalties followed the classification system, with those attached to offences involving Class A drugs being the harshest. Cannabis was placed in Class B, along with some amphetamines.

2.42 Alongside the classification system, the MDA placed into law several recommendations of the Wootton Report, including reduced maximum sentences for cannabis offences and the differentiation between possession for personal use and possession with intent to supply.

2.43 The Act also increased penalties for trafficking and supply, and established what is known today as the Advisory Council on the Misuse of Drugs (ACMD). A non-departmental advisory public body (sponsored by the HO), like its predecessor the ACD, the ACMD is charged with advising and making recommendations to government on the control of dangerous or harmful drugs, including classification and scheduling under the MDA. The government may choose to accept or reject that advice as it sees fit.

The end and the beginning of medical use

2.44 Medical use of cannabis in the West was undermined by the new drug control system. In the UK, the MDA meant it could no longer be prescribed by doctors or dispensed by pharmacists (though could be used for research purposes under an HO licence). This put cannabis in a more restrictive position than, for example, morphine (a strong opiate), which had established and widespread use in Western medicine.

2.45 The prohibition of cannabis for medical use ironically took place at a time when the possibilities for such began to expand in Western medicine, in particular through the discovery of THC (the principal psychoactive component of the drug) by Raphael Mechoulam at the Hebrew University in Jerusalem in 1964.

2.46 This belatedly brought cannabis into a potentially more significant role in Western medicine. By contrast, the alkaloids of opium (including morphine and codeine) had been isolated in the nineteenth century and so were already well established in medical practice.[36]

The 'British compromise': 1971–1990s

2.47 What one historian has called the 'British compromise'[37] was implemented after the MDA. Possession of cannabis remained illegal but maximum sentences were reduced and a less than severe application of the laws was openly advocated. Indeed, Lord Hailsham, the Conservative Lord Chancellor who had attacked the Wootton Report in the Commons in 1968, advised magistrates to adopt moderation in sentencing cannabis offenders found guilty of simple possession.

[36] Taylor, Suzanne. (2022). *Remedicalising Cannabis.* Montreal: McGill-Queens.
[37] See footnote #25.

2.48 Cannabis dropped from legislative attention during the 1980s as greater consideration was paid to heroin and cocaine. By the end of the decade, the vast majority (75%) of cannabis offenders in the UK received nothing more serious than a police caution. However, there was considerable regional variation across police forces. The Metropolitan Police Service (MPS) in London, for example, issued cautions in 88% of cases, whereas Avon and Somerset did so in only 20%.[38]

2.49 What was also noticeable by the end of the decade was the increasing number of drugs offences being dealt with by the police, and the significant proportion that involved cannabis. The rise was driven principally by concern about other, harder drugs, meaning people who used cannabis ended up in a net designed really for people using those other substances. This led to the re-emergence of cannabis on the political agenda in the 1990s, but it proved difficult to wrest power back from enforcers of the law.

Reclassification (and reclassification) in the twenty-first century

2.50 Under the MDA, cannabis remained a Class B drug until 2004. This meant conviction for possession could lead to a maximum custodial sentence of five years with an unlimited fine. A conviction for trafficking, growing or knowingly operating premises in which cannabis is consumed could attract up to 14 years in custody.

2.51 In 2004, however, in line with recommendations set out in the Runciman Report[39] and advice from the ACMD,[40] the government reclassified cannabis as a Class C drug. Supported by a majority of the public, the move was designed to enable police forces to concentrate resources on other (more serious) offences, including those involving 'harder drugs'.

2.52 Both Runciman and the ACMD recognised cannabis can pose a risk of harm in several respects. Their recommendations for a lower classification, however, reflected their conclusions that placing cannabis on a par with amphetamines and similar in Class B was disproportionate in relation to that harm. Reclassification to Class C would also mean possession of cannabis would no longer be an arrestable offence.

2.53 However, senior police officers intervened in the HO position, in favour of the right for police to decide when and how the law should be enforced. The meaning of Class C was redefined: possession of drugs in that category was made an arrestable offence and the maximum sentence for supply was increased. Nonetheless, arrests for cannabis possession reportedly fell by one-third in the first

[38] See footnote #25.
[39] An independent inquiry commissioned by the Police Foundation (a UK policing think tank), and chaired by Viscountess Runciman, this investigated whether revisions to the MDA were necessary in light of changes that had taken place in society since it was passed. *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (2000). The Police Foundation.
[40] ACMD (2002). *The Classification of Cannabis under the Misuse of Drugs Act 1971*. Home Office Crown Copyright.

year following reclassification, saving an estimated 199,000 police hours[41] – although some of those savings were likely offset by a parallel rise in the number of police-issued cannabis warnings.

2.54 Three years later, the government asked the ACMD to review cannabis classification once again. They recommended it be retained as a Class C drug, on the grounds that it more closely equated with other substances in that class than with those in Class B.[42] The government, however, rejected this and proceeded to reclassify cannabis as a Class B drug with effect from early 2009. The decision to do so was, it has been argued, not about the advice of experts, but rather because a failure to reclassify carried too great a perceived political cost.[43]

2.55 Then in 2012, the Home Affairs Committee (HAC) reported on the UK's drugs policies.[44] They once again revisited the classification of cannabis, explicitly stating their position to be one of regret that government had reclassified the drug. They agreed with recommendations elsewhere that it should be Class C.

2.56 It remains, however, a Class B drug to this day, with calls (so far resisted by government) in the latter part of 2022 for it to be upgraded still further. This would place it in Class A, i.e. the same category as heroin, cocaine and ecstasy, with consequently harsher penalties for production, supply and possession.

2.57 The most recent HAC inquiry into drugs[45] did not consider cannabis classification. We note, though, its concerns regarding the risk of harm caused by use of the drug for non-medical purposes (particularly in relation to young people) and subsequent conclusion that cannabis should not be legalised and regulated for such use. These are matters that have been a significant focus of our own inquiries.

2.58 No brief journey through the history of cannabis law in the UK would be complete without reference to the comprehensive review recently led by Dame Carol Black.[46] While this covered illegal drugs more widely, its considerations with respect to use of cannabis and associated markets, harms and medical treatment are relevant to our inquiries, and we return to these in chapters 5, 8 and 9. Suffice to say here that the government's current drug strategy[47] draws heavily on findings from the Black Review, which advocated widespread investment in drug- and alcohol-related services – although cannabis tends to have little place within mainstream treatment provision.

2.59 Finally, we return once more to modern-day obligations upon signatories to the 1961 Single Convention on Narcotic Drugs. In 2018 the World Health

[41] Cannabis Reclassification | Home Office (archive.org)
[42] ACMD (2008). *Cannabis: Classification and Public Health*. Home Office Crown Copyright.
[43] See footnote #25.
[44] Microsoft Word - HC 184 Drugs Report CRC v8 - FINAL.docx (parliament.uk) *Accessed 4th September 2023.*
[45] Home Affairs Committee (2023). *Drugs: Third Report of Session 2022–23*. House of Commons. Available at Drugs - Committees - UK Parliament *Accessed 4th September 2023.*
[46] Available at Independent review of drugs by Professor Dame Carol Black – GOV.UK (www.gov.uk)
[47] From harm to hope: A 10-year drugs plan to cut crime and save lives – GOV.UK (www.gov.uk)

Organization (WHO) Expert Committee on Drug Dependence (ECDD), responding to direction from the Commission on Narcotic Drugs (CND, the United Nation's central drug policy-making body), undertook a scientific review of the health effects of cannabis.[48]

2.60 The evidence they considered did not, in their view, suggest that cannabis (plant or resin) was liable to cause ill effects akin to those produced by other substances listed in Schedule IV of the Convention, reserved for substances with the highest potential for abuse and limited if any therapeutic value. Akin (although not directly equivalent) to substances listed in Class A in the MDA, those in Schedule IV attract the very strictest controls.

2.61 The ECDD concluded that listing cannabis and cannabis resin in Schedule IV may not be consistent with the category's inclusion criteria and recommended they be removed. And in 2020, CND member states subsequently voted (by a narrow margin of 27 to 25, with one abstention) to do so. The UK voted in favour.

2.62 The drug has since been removed from Schedule IV – although it remains in Schedule I and thus subject to all wider controls exercised by the Convention. This means production, distribution and possession of cannabis are highly restricted activities and, while medical and scientific uses are permitted, they are subject to very strict regulation.

2.63 Opinions are mixed as to whether removal from Schedule IV makes much material difference to the lawful use of cannabis with respect to compliance with international obligations. Some argue it has little consequence because Schedule I drugs remain so highly controlled. Others suggest it will help facilitate access to and availability of medical cannabis through removal of barriers in domestic frameworks to research and development.

2.64 Arguably it has had little effect in the UK because as a Class B drug under the MDA cannabis is not considered among the most dangerous of drugs and medical use is permitted in some (limited) circumstances. We explore the medical use of cannabis in chapter 11.

2.65 Either way, both before and since the removal of cannabis from Schedule IV, an increasing number of jurisdictions around the world have legalised cannabis for non-medical purposes. None have withdrawn from the Single Convention to do so, despite cannabis effectively remaining under prohibitive control, and none are considered to be in overt violation of international law. We explore the position in some of those jurisdictions further in chapter 7.

[48] *WHO Expert Committee on Drug Dependence: Fortieth Report*. Geneva: World Health Organization; 2018 (WHO Technical Report Series, No. 1013). Licence: CC BY-NC-SA 3.0 IGO.

Cannabis, alcohol and tobacco

2.66 The question is often raised as to why some drugs are illegal while others – with alcohol and tobacco most commonly cited – are governed via far less stringent systems of legal control. This apparent conundrum has led some scientists and others working in the area to call for more 'rational' systems of drug control overall.[49] If tobacco or alcohol were to be discovered now, so the argument goes, on the basis of their potential for harm and abuse there is no way they would be legal substances.

2.67 The point we have sought to make in this chapter is that the legal pathways taken by drugs of all types have been historically determined, affected by a range of interests such as the role of the state, vested economic industries (including those of tobacco and alcohol), activism of different groups, varying professional interests and the role of international obligations, networks and treaties.

2.68 Culture too has been bound up in the process. Substances with widespread cultural legitimacy such as alcohol and tobacco are not easily made the subject of stringent systems of control.[50] Cannabis, originally and chiefly a drug of Eastern medicine and culture, became bound up in a system of Western-led international control primarily designed for the opiates and cocaine.

2.69 But legitimacy can change in either direction. Back in the 1950s no one would have countenanced a ban on tobacco smoking on public transport, in offices, shops and other public venues. Now in 2024, the end of the legal sale of tobacco to certain age groups in the UK is in sight. Substances can decline and they can also rise in terms of public and legal legitimacy, but rationality arguably often has little part to play in the process.

[49] Nutt, D., King., L.A., Saulsbury, W. & Blakemore, C. (2007). Development of a rational scale to assess the harm of drugs of potential misuse. *Lancet, 369*, pp.1047–53.
[50] Berridge, V. (2016). *Demons. Our changing attitudes to alcohol, tobacco and drugs*. Oxford University Press.

3. NON-MEDICAL CANNABIS, UK LAW & ALTERNATIVE LEGAL APPROACHES

The starting point for our exploration of whether prohibition of non-medical cannabis is the most effective way to minimise individual and societal harm was the current legal framework.

This chapter summarises the law governing cannabis production, supply and possession in the UK (the relevant legislation applies to all four nations, thus non-medical cannabis is prohibited across the UK). It also briefly describes non-prohibitive alternative legal frameworks adopted in a variety of other jurisdictions (illustrated in chapter 7).

UK legislation and penalties for cannabis-related offences

3.1 Since 2018, it has been legal for a limited number of cannabis-based products to be medically prescribed to treat a range of physical and mental health symptoms (see chapter 11). But using cannabis for non-medical, or recreational, purposes remains illegal in the UK.

3.2 As we introduced in the previous chapter, the prevailing legislative instrument covering non-medical cannabis in the UK is the Misuse of Drugs Act (MDA) 1971, which governs activities associated with prohibited drugs.

3.3 Under the MDA 1971, non-medical cannabis is a Class B drug. This means for unlicenced dealing, unlicenced production (including home cultivation) and unlicenced trafficking of cannabis, an individual could face up to 14 years in prison, an unlimited fine, or both. The maximum penalty for possession of cannabis is five years in prison and/or an unlimited fine.

3.4 Custodial sentences for possession of cannabis are, however, rare. Between 2007 and 2017, 3,861 people received a prison sentence in England & Wales for the offence[51] and on 30th June 2024, 33 people were held in prison custody for possession of cannabis.[52]

3.5 Very many thousands more, of course, have been prosecuted or given a police caution. We go into more detail regarding the criminal justice system response to cannabis offences in chapter 10, from police activity through to sentencing and conviction. We also consider the implications for individuals who come into contact with police on suspicion of cannabis-related offending.

[51] Garius, L. & Ali, A. (2022). *Regulating Right, Repairing Wrongs: Exploring Equity and Social Justice Initiatives within UK Cannabis Reform*. London: Release.
[52] Ministry of Justice & HM Prison and Probation Service. (2024). *Offender Management statistics quarterly: January to March 2024. Annual Prison Population: 2015 to 2024*. Table 1.A.11 Available at Offender management statistics quarterly: January to March 2024 - GOV.UK (www.gov.uk) *Accessed 29th August 2024.*

Dealing with cannabis possession: the current law (in England & Wales)

3.6 Possession of cannabis (non-medical, see para.3.13 for the law in relation to medical) is by far the most common cannabis related offence. Having caught a person in possession, police have a degree of discretion (dependant on the circumstances) with respect to whether they pursue prosecution or deal with the offence without recourse to the courts.

3.7 In 2017, the National Strategy on Charging and Out of Court Disposals was introduced, which enabled police to deal quickly with low-level offending of this nature using one of six disposals, namely: Simple Cautions; Conditional Cautions; Penalty Notices for Disorder (PND); Community Resolutions, and Cannabis and Khat[53] Warnings.

3.8 A cannabis (or khat) warning, introduced in 2004, can be issued under the following circumstances:

> *'A cannabis or khat warning may be given where the offender is found in possession of a small amount of cannabis or khat consistent with personal use and the offender admits the elements of the offence. The drug is confiscated and a record of the warning will be made on local systems. The warning is not a conviction and should not be regarded as an aggravating factor when sentencing for subsequent offences.'*
>
> (Sentencing Council, 2023).[54]

3.9 A warning can only be issued for a first-time possession offence, when the individual has no prior convictions, is not known as a persistent offender and has complied with the police process. While a record of the warning is made locally, this would not be revealed by a standard criminal records check (but could be disclosed as part of an enhanced check, which can be necessary for employment in particular organisations or roles).

3.10 On a second occasion, police may issue an on-the-spot fine (Penalty Notice for Disorder, PND) to someone found in possession of a small amount of cannabis. Notably, however, and in line with the guidance regarding cannabis warnings, there is no maximum amount that legally constitutes a 'small amount… consistent with personal use': guidelines state only that '*Police can issue a warning or an on-the-spot fine of £90 if you're found with cannabis'.*[55]

3.11 This lack of legal definition is contrary to common belief. Several participants in our research (see chapter 6 and full report[56]) thought being found in possession of up to one ounce (around 25 grams) of cannabis would be unlikely to attract sanction beyond a fine and/or a formal warning.

---

[53] A stimulant that is illegal in the UK and a Class C drug in the Misuse of Drugs Act 1971.
[54] 2. Cannabis or khat warning – Sentencing (sentencingcouncil.org.uk) *Accessed 5th October 2023.*
[55] Drugs penalties – GOV.UK (www.gov.uk) *Accessed 4th October 2023.*
[56] See footnote #11.

3.12 While this may be the case in practice – at least in some circumstances (we discuss the matter in more detail in chapter 10) – it is not a legal position, although inaccurate media reporting may serve to strengthen such misperceptions among the public.[57]

3.13 Under current law, there is one exception to application of sanctions for cannabis possession. Where procured via proven medical prescription, the law allows a person to possess the drug in the form of a licensed cannabis-based medicine or an unlicensed cannabis-based product for medicinal use (CBPM).

3.14 Those unable to afford such prescriptions but who find cannabis alleviates their symptoms of ill health may turn instead to the illicit market. We discuss the legal implications of doing so in chapters 10 and 11, and explore the difference between CBPMs and licensed cannabis-based medicines.

Dealing with cannabis possession: forthcoming changes (for England & Wales)

3.15 The Police, Crime, Sentencing and Courts Act 2022 (PCSC) introduced changes to the way in which cannabis possession and other lower-level offences committed by those aged 18 and over will be dealt with. These centre around a simplified statutory framework for Out of Court Disposals (OOCDs) which, if enacted as designed,[58] are expected to replace five of the six disposals detailed above with just two, namely an upper tier Diversionary Caution and lower tier Community Caution. The existing Community Resolution will be retained alongside the new cautions framework.

3.16 As with the current system, an offender will have to admit their offence in order to be eligible for a caution of either type. A key change, however, is that whichever the police administer, one or more 'conditions' must be issued alongside it. These will focus on rehabilitative and reparative activity aimed at tackling the underlying causes of the offence (which could include treatment to help with substance use) or providing restitution to any victim(s) or the local community. Financial penalties will also be available where an officer considers such to be appropriate.

3.17 This approach clearly hinges on availability of appropriate rehabilitative and reparative services. Fulfilment of a caution for cannabis possession that depends on, for example, attending an educational and/or treatment programme requires that programme to be available (locally) and have capacity. This is an important consideration and one to which we return briefly in chapters 9 and 10.

3.18 Low-level offences will be eligible for either type of caution (or the Community Resolution). Breaches, however, will be dealt with differently. Breach of a Community Caution could result in a fine, whereas breach of a Diversionary

[57] See for example Is cannabis illegal in UK and where is weed legal to smoke and buy? – The Sun | The Sun *Accessed 4th October 2023.*
[58] At time of writing, the Ministry of Justice had issued a public consultation on the details. A response is expected in 2024; see Diversionary and Community Cautions – Code of Practice (publishing.service.gov.uk) *Accessed 4th October 2023.*

Caution may result in prosecution for the original offence. If convicted (highly likely given admission of guilt is a criterion for deployment of the original caution), an individual will be left with a criminal record and its associated consequences. We discuss this further in chapter 10.

3.19 Importantly, neither type of caution will be considered appropriate for street administration (unlike a Community Resolution). This means an offender will need to attend a police station, court building or other suitable location, with implications for their wider experiences of the police and the justice process.

3.20 In terms of formal record and disclosure, the Community Caution will be considered spent immediately upon being given. This means it would not be disclosed through a basic criminal record check and an individual would not have to disclose (to a potential employer, for example) that they had received it. A Diversionary Caution will be spent a maximum of three months after the date of issue, or earlier if attached conditions are fulfilled. However, it would require disclosure under any basic check during that period.

3.21 Both types of caution would, however, show up in an enhanced criminal record check for six years after issue. This means that, for employment requiring checks above basic level, the caution would need to be disclosed during that period. As both types represent a formal criminal justice disposal, they will be recorded on the Police National Computer.

3.22 There are therefore obvious implications for anyone issued with a caution under the new framework, namely that offending must be disclosed in some circumstances. Those caught with cannabis may therefore feel the consequences for a longer period than under the current system.

Alternative legal approaches to cannabis for non-medical use

3.23 At time of writing, around 30 countries and over 50 jurisdictions have adopted an alternative approach to non-medical cannabis.[59] Notable examples that we consider in chapter 7 include Uruguay, Portugal, many US states and Canada.

3.24 Broadly speaking there are four different models or legal frameworks that can govern non-medical cannabis use. All are technically forms of market regulation and we briefly describe each below. Our inquiries led us to consider all four with respect to the most effective way to minimise individual and societal harm related to cannabis use.

i. **Prohibition**: the model of control across the UK, until recently this represented the global status quo. It means the production or cultivation, transit, supply and possession of cannabis for non-medical or non-scientific purposes is illegal, thus

[59] https://idpc.net/themes/decriminalisation *Accessed 4th Oct 2023.*

associated activities are subject to punitive sanctions including criminal penalties. In effect, the criminal law is used to 'regulate' the cannabis market.

ii. **De-penalisation**: also known as 'de facto decriminalisation', under a de-penalisation model, activities related to production or cultivation, transit, supply and possession of cannabis for non-medical or non-scientific purposes remain illegal and liable to criminal sanction. The penalties, however, for possession of small quantities of cannabis are no longer applied (though remain in law) or are very substantially reduced in severity and police are usually guided to treat the offence as low priority and not suitable for proactive policing. Alternatively, police may divert an individual to an education or treatment programme, instead of proceeding with a charge of possession.

iii. **Decriminalisation**: also referred to as 'de jure decriminalisation', this means (usually) possession of small quantities of cannabis is no longer a criminal offence, so criminal sanctions are removed. They may (or may not) be replaced with administrative sanctions (e.g. a civil fine or therapeutic response) – in some jurisdictions these will be mandatory, in others they will be advisory only.

iv. **Legal regulation:** commonly referred to as 'legalisation' but more accurately legal regulation, under this framework cannabis can be legally produced, supplied and purchased. The term *'describes the way in which government authorities intervene to control a particular legal drug product, or activities related to it. This control can take the form of regulations on, for example, a drug's price, potency and packaging, as well as various aspects of its production, transit, availability, marketing and use'.*[60]

3.25 Within these models there is substantial variation with respect to the breadth of prohibited activities, the nature and severity of criminal sanction and the existence and nature of civil penalties. Regulatory frameworks differ in terms of permissions regarding marketing, advertising and product availability, as well as minimum age limits, whether the industry is profit-making or designed as not-for-profit, and the extent of state involvement in production, supply and retail. We consider several examples in chapter 7.

3.26 We note, though, that models based on a 'de facto' rather than 'de jure' approach (i.e. what happens 'in practice' compared to what is set out in law) can (and do) lead to inequities in how the guidance for sanctioning any offence is applied. That said, any model where possession of cannabis for personal use leads to diversion into education or treatment rather than entry into the criminal justice system is, to our mind, positive.

3.27 In our view, where cannabis possession remains a criminal behaviour, diversion is far more commensurate with the nature of the offence. It may, too, serve to highlight the existence of support services to those who might be in need (we

[60] Rolles, S. (2017) *Legalizing Drugs: The key to ending the drug war*. New Internationalist, p.52.

discuss treatment for people who have developed problematic use of cannabis in chapter 9).

3.28 On the other hand, diversion not only requires services to be available, a one-size-fits-all approach risks those not in need being required to access them in order to avoid formal criminal sanction. Not only does this mean such individuals are likely to get little from whatever programme they attend, it will increase pressure on access and delivery to those with greater need.

3.29 De jure approaches, however, shift the societal lens through which cannabis possession (in this case) is treated. Because they require formal legislative change, those who use cannabis for personal use are no longer treated as criminals, with potential implications for the stigma commonly associated with use, treatment-seeking behaviour and harms that can result from a criminal conviction. We discuss these considerations in more detail elsewhere.

4. CANNABIS USE IN THE UK

In this chapter we consider prevalence of cannabis use in the UK. It is abundantly clear, from available statistics and evidence put to us directly, that those who wish to consume the drug for non-medical purposes, including children, can access it without difficulty despite its illegal status. We set out what statistics tell us about the demographics of those who choose to use cannabis and explore some of the drivers behind that use.

We consider what can happen when the drug is used to excess and explore the implications of co-consumption with tobacco. Finally, we touch briefly on the 'gateway theory', which suggests that cannabis use increases the likelihood of use of more serious drugs such as heroin and cocaine (though evidence remains scant).

We begin, however with a description of cannabis and how it can be consumed.

What is cannabis?

4.1 In simple terms, cannabis is a botanical plant known by a myriad of names including marijuana, ganja, weed, pot, hash, dope, grass and herb (hereafter referred to as cannabis). The two most widespread species, or strains, are cannabis sativa and cannabis indica and it is these with which we are principally concerned, given their propensity to be cultivated to produce variants higher in psychoactive components (see below).[61] While sativa plants are also the source of hemp (cultivated for both oilseed and fibres), variants used for this purpose contain little to no psychoactive properties.

4.2 Cannabis contains over 100 different chemical compounds known as cannabinoids (or more accurately, phytocannabinoids, to distinguish them from cannabinoids produced by non-plant living organisms). When consumed, they bind to receptors (CB1 and CB2) in the human endocannabinoid system[62] to produce a range of effects.

4.3 The two most abundant cannabinoids are the most well understood and the cause of much of the contention surrounding cannabis: namely delta-9-tetrahydrocannabinol (delta-9-THC, hereafter THC) and cannabidiol (CBD).

4.4 CBD is non-psychoactive so on its own will not cause a user to become 'high'. In other words, it will not cause any significant alteration in perception or senses. Usually present in higher proportions in medical than non-medical cannabis, it also

[61] Cannabis ruderalis is a variety of cannabis with low levels of psychoactive compounds, so tends not to be used for non-medical purposes.

[62] Discovered during the late 1980s, the endocannabinoid system (ECS) regulates the brain signals responsible for bodily functions including learning and memory, mood, sleep, appetite, pain control and inflammatory and immune responses. Endocannabinoids, or endogenous cannabinoids, are produced within the body, phytocannabinoids derive from plants and synthetic cannabinoids are produced in laboratories. Experts are still trying to fully understand the ECS and its interaction with cannabinoids of all types.

features in a wide range of CBD-based products sold legally in the UK (see chapter 8).

4.5 It is the psychoactive THC that causes the 'high' commonly associated with recreational, or non-medical cannabis use – although like CBD it is also thought to possess some medicinal properties (e.g. pain relief). THC can, however, be addictive and is associated (particularly at higher concentrations) with a range of adverse effects on mental health, which we discuss in chapter 8.

4.6 Levels of THC in cannabis have been steadily increasing over recent decades. While varying according to the particular strain and method of consumption, on the whole cannabis available today is substantially stronger in terms of THC than that available in the latter decades of the twentieth century.

4.7 Concentrates (see below) have seen a particularly marked rise (now 40–90% THC[63]) and levels in herbal cannabis, the most common form of the drug, have risen from around 4% to around 15–20% THC on average,[64] with some strains claiming nearer 30%.

4.8 Working synergistically with cannabinoids are terpenes, which are organic compounds found in plants.[65] Cannabis contains over 400 terpenes, which are responsible for making strains smell or taste different from others. While not intoxicating in themselves, they likely interact with CBD and THC in what is known as the 'entourage effect',[66] which influences how a person experiences their consumption of cannabis.

How is cannabis consumed?

4.9 The method of consumption depends on the form of cannabis used. Smoking the herbal dried flower/bud, or hash, (compressed cannabis resin) in cigarette-like joints/spliffs or cigar-like blunts is the most common. When consuming cannabis this way, it is usual – though not necessary – to combine it with tobacco. Cannabis can also be smoked, or inhaled, via a bong (a water pipe that acts as a filtration device).

4.10 The drug is also increasingly being ingested. The market for cannabis edibles (foodstuffs and drinks) is growing rapidly as legalisation is increasingly being adopted in many parts of the world and includes baked goods, sweets, butters and oils alongside cannabis-infused coffees, teas and carbonated drinks.

---

[63] If you use cannabis, do it safely - Harvard Health *Accessed 23rd August 2023.*

[64] See for example Cannabis Potency Data | National Institute on Drug Abuse (NIDA) (nih.gov); Freeman, T.P., Craft. S., Wilson, J., Stylianou, S., ElSohly, M., Di Forti, M. & Lynskey, M.T. (2021). Changes in delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) concentrations in cannabis over time: systematic review and meta-analysis. *Addiction*, *116*(5). doi.org/10.1111/add.15253 *Accessed 23rd August 2023.*

[65] Responsible for the aromas, flavours and colours associated with various types of vegetation, terpenes are the primary constituents of essential oils such as peppermint or lavender and many are thought to possess a range of biological and pharmacological functions (including anti-inflammatory, anti-viral and antioxidant properties).

[66] See for example Hanuš, L.O & Hod, Y. (2020). Terpenes/Terpenoids in Cannabis: Are They Important? *Med Cannabis Cannabinoids, 3*(1). doi.org/10.1159/000509733 *Accessed 23rd August 2023.*

4.11 With the advent of e-cigarettes, or vaporisers/vape pens, in recent years, vaping has become an increasingly popular way to consume cannabis. Flower or extract is heated to a high temperature (but below the point of combustion) in a dry herb vape, and then inhaled. This is also the principal method by which cannabis used for medical purposes is consumed.

4.12 Then there is concentrated resin produced for 'dabbing' (as opposed to hash, which is smoked). This involves vaporising the resin to a high temperature and the user inhaling the vapour, emitted as it cools, using what is known as a 'dab rig' (a form of water pipe). Alternatively, vape pens can be used to consume concentrates, with a small amount – a 'dab' – heated using the device and the vapour inhaled.

4.13 Finally, cannabis extract can be infused with some other liquid (such as alcohol, glycerin or oil) to form a tincture. Usually consumed orally, it can also be applied to the skin.

Overall use in the twenty-first century

4.14 Cannabis is the most used drug worldwide; the United Nations Office for Drugs and Crime (UNODC)[67] estimated the global number of past-year cannabis users in 2022 aged 15–64 years to be 228 million (around 4% of the world's population). This represents a 34% rise on the 170 million users estimated in 2010, likely due in part to an increase in the global population and the Covid-19 pandemic (many countries reported a rise in use during that period).

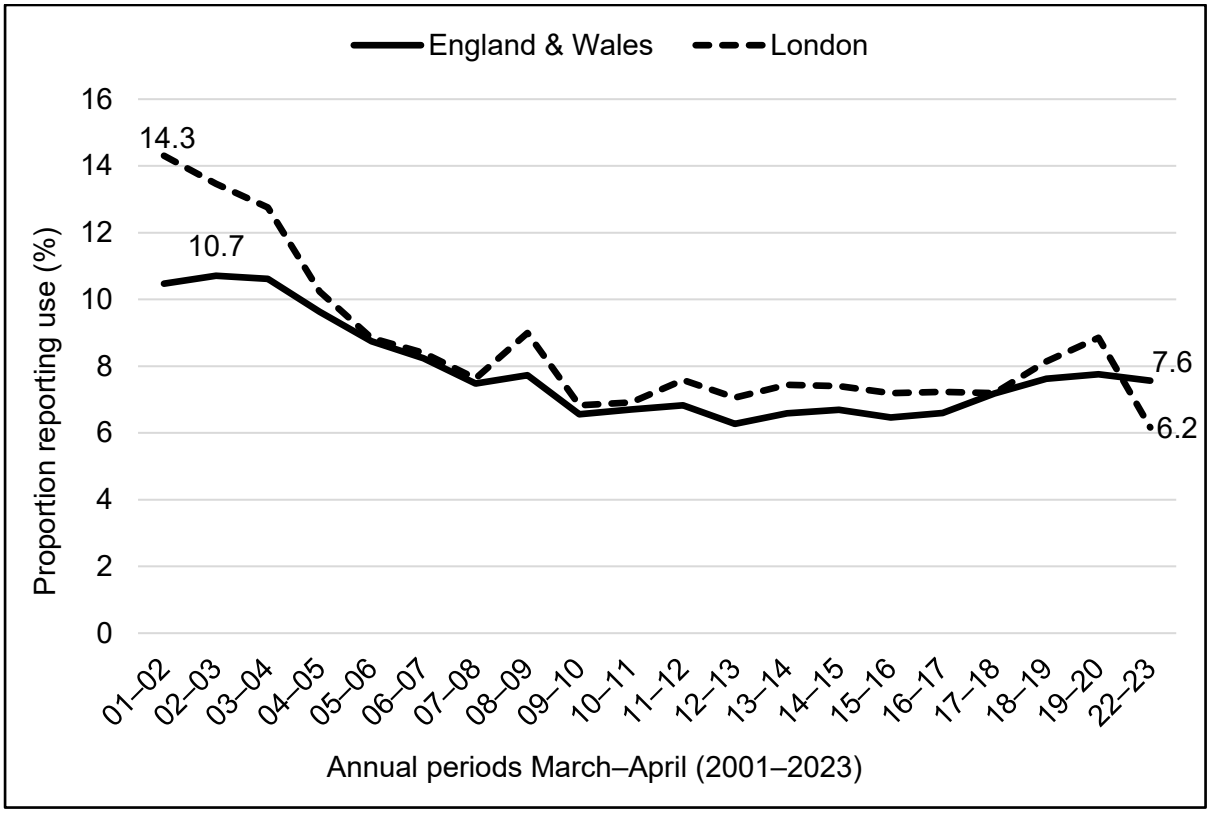
4.15 While increases are observed regardless of race, income or ethnicity,[68] the UNODC notes significant variation in rates of use across the world. That said, much of these data derive from self-report surveys, which may lead to artificially small prevalence rates, particularly in countries with more punitive repercussions for drug use. Broadly, though, irrespective of region, cannabis use tends to be higher in adolescents and young adults.

4.16 In line with the global picture, reported use of cannabis in England & Wales is almost three times that of the next most common illegal drug (cocaine). It remains, however, far less widespread than use of tobacco or alcohol (see paras. 4.28–4.29) – though we acknowledge that measures of illegal drug use almost inevitably underestimate consumption.[69]

[67] WDR24_Key_findings_and_conclusions.pdf (unodc.org) *Accessed 23rd July 2024.*
[68] Hasin, D. & Walsh, C. (2021). Trends over time in adult cannabis use: A review of recent findings. *Current Opinions in Psychology*, 38, pp.80–85. doi.org/10.1016/j.copsyc.2021.03.005
[69] See for example European Monitoring Centre for Drugs and Drug Addiction & Europol (2024). EU Drug Market: Cannabis — Retail markets. EU Drug Market: Cannabis — Retail markets | www.emcdda.europa.eu *Accessed 9th April 2024*

4.17 Almost one-third of 16–59-year-olds in England & Wales reported cannabis use at least once in their lifetime,[70] and over 7% reported consumption during the year to March 2023.[71] While statistics suggest use is falling (from a 20-year high of almost 11% in the year to March 2003,[72] see Figure 1, and even more so in London where it dropped by over half from the beginning of the century), estimated prevalence equates to an estimated 2.5 million people[73] (aged between 16 and 59).

Figure 1: Proportion of 16–59-year-olds reporting past-year cannabis use in England & Wales and London, 2001–2023



Source: Drug misuse in England and Wales – Appendix table – Office for National Statistics (ons.gov.uk) Table 1.02.

4.18 The position is similar across Great Britain (GB),[74] with around 7% of those aged over 18 (around 3.7 million adults) reporting past-year cannabis use in early 2023.[75]

[70] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 1.01: 31.1%. *Accessed 16th January 2024.*
[71] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 1.02: 7.6% of those aged between 16 and 59 in England & Wales used cannabis in the year ending March 2023. *Accessed 16th January 2024.*
[72] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 1.02. *Accessed 16th January 2024.*
[73] See Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 1.05. *Accessed 16th January 2024.*
[74] Data collections differ with respect to geographical coverage, reporting periods, age parameters and sampling strategies, so care must be taken when comparing figures.
[75] Action on Smoking and Heath (ASH) (2024). *Available at* committees.parliament.uk/writtenevidence/129570/pdf/ *Accessed 24th July 2024.*

4.19 Comparing levels of cannabis use in this country with other jurisdictions is complex. A lack of systematic data, variations in measurement, age groups, reporting years and periods, distinctions between medical and non-medical use of cannabis (or not), price and legal status of the drug all affect the statistics available. This means comparisons often likely compare apples with pears, which limits our ability to predict what might happen to levels of use if the legal framework here were to be changed.

4.20 Acknowledging these limitations, we note prevalence rates across the European Union (EU) are similar to those in this country. Almost 30% (29.3%) of those aged 15–64 are estimated to have used cannabis at least once in their lifetime,[76] broadly in line with England & Wales (31.1% among 16–59-year-olds in the year to March 2023.)[77]

4.21 Based on data reported up to 2019, 7.7% of those aged 15–64 in the EU had reportedly used the drug in the past year, also in line with England & Wales (7.6% in 2018–19 for those aged 16–59, see Figure 3).

4.22 While direct comparisons are difficult due to variation in reporting year, prevalence of cannabis use is reportedly higher across younger Europeans (15–34 years) than those in England & Wales, with average past-year rates estimated at 15.4% and 13.4% respectively.[78] The difference is likely to be driven at least to some extent by higher-than-average rates in a handful of European countries, namely Spain, France, Italy, Germany, Croatia and Czechia.

4.23 Indeed, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported that Europe's two largest illicit cannabis retail markets are France and Italy, followed by Germany and Spain. They note too that, while central and eastern EU countries tend to report lower levels of past-year use, prevalence rates in Croatia and Czechia are among Europe's highest.[79]

4.24 Overall, the prevalence of cannabis use in Europe has remained relatively stable over the past decade, as in England & Wales (see Figure 1), although, based on data from countries that have conducted surveys since 2019, the EMCDDA noted a rise in four with decreases in a further five.

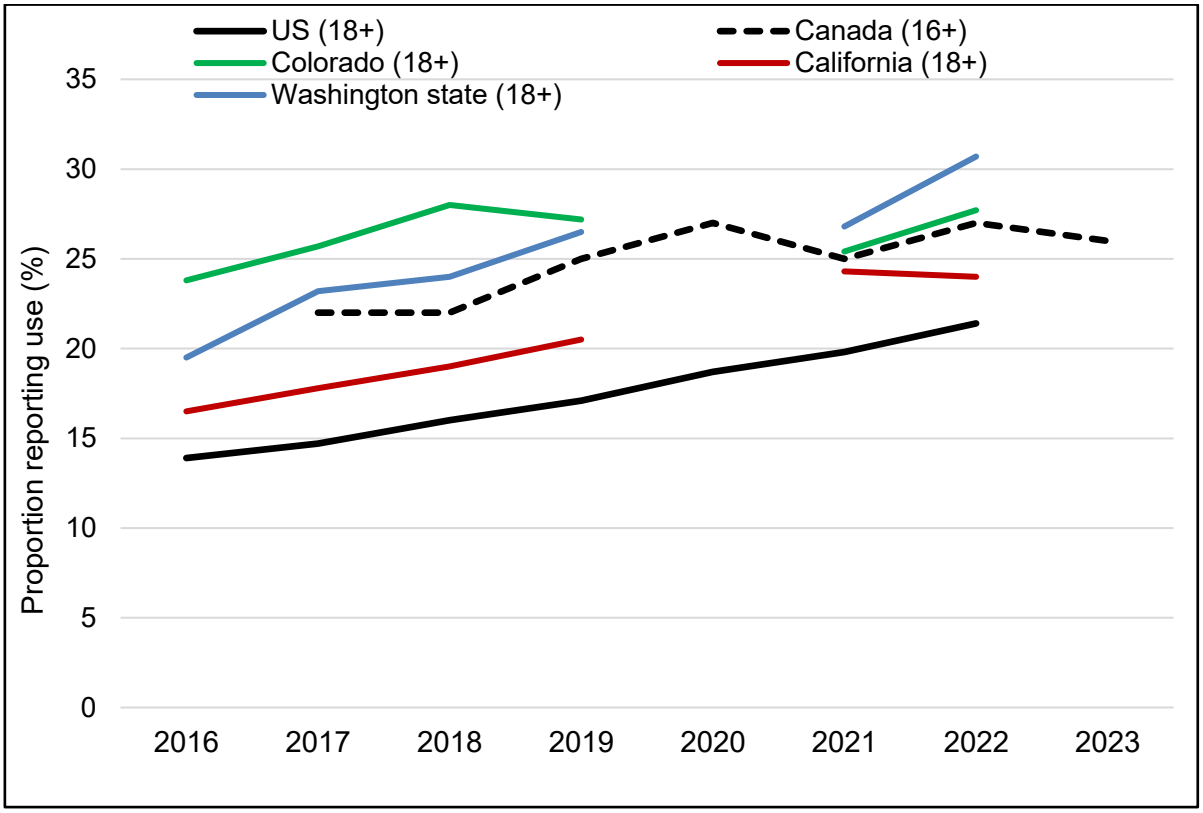
4.25 Looking to the US and Canada, prevalence has risen over the past five years or so. Figure 2 shows average past-year rates of use in Colorado and Washington state, which both legalised non-medical cannabis in 2012, in California, which

[76] See footnote #69. *Accessed 13th May 2024.*
[77] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 1.01: 31.1%. *Accessed 16th January 2024.*
[78] European Monitoring Centre for Drugs and Drug Addiction (2021). *European Drug Report 2021: Trends and Developments*. Publications Office of the European Union, Luxembourg. See Table A5.
[79] See footnote #69. *Accessed 10th April 2024.*

legalised its use in 2016, and Canada, which followed suit in 2018. Average past-year prevalence across the US is presented by way of comparison.

4.26 We consider these jurisdictions in more depth in chapter 7, where we explore evidence about the impact of legalising non-medical cannabis on levels of use.

Figure 2: Proportion of adults (aged 16+ / 18+) reporting past-year non-medical cannabis use in selected jurisdictions, 2016–2023 (where data permits*)



2020 data collection affected by the Covid-19 pandemic and 2021 figures to be treated with caution due to change in methodology.
Sources: See annual US state tables at National Survey on Drug Use and Health (samhsa.gov) National Survey on Drug Use and Health (samhsa.gov); https://www.canada.ca/en/health-canada/services/publications/drugs-health-products/canadian-cannabis-survey-2017-summary.html; https://health-infobase.canada.ca/cannabis/

4.27 After cannabis, the next most commonly taken illicit drug in England & Wales is cocaine, though it is used by far fewer people. In the year to March 2023, 2.5% of individuals aged 16–59 reported some use of the drug.[80]

4.28 Conversely, cannabis users are outnumbered by users of tobacco and alcohol. Across the UK in 2022, almost 13% of those aged 18 years and over (around 6.4 million people) smoked cigarettes (though numbers are in decline),[81] with alcohol consumption higher still.

[80] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 1.02. *Accessed 13th November.*
[81] Adult smoking habits in the UK - Office for National Statistics (ons.gov.uk) *Accessed 13th November.*

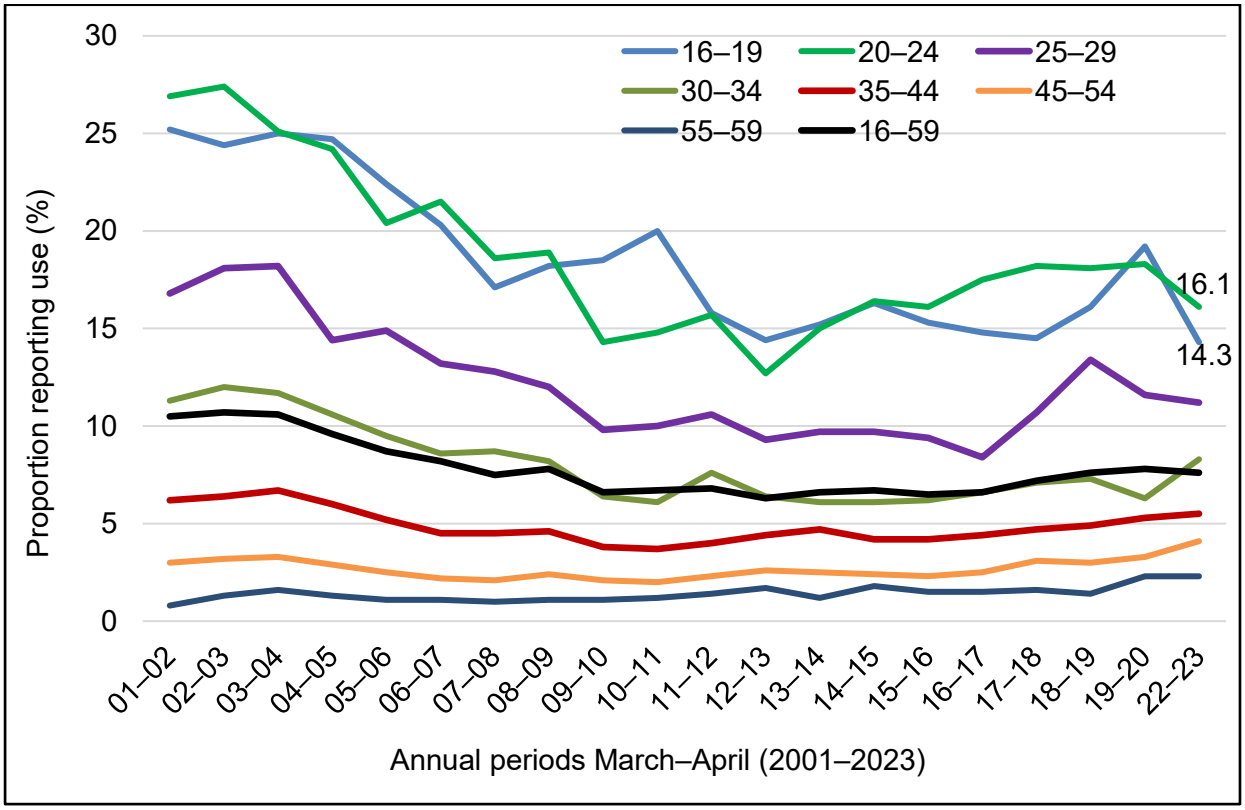
4.29 The Health Survey for England reported that in 2021, over three-quarters (79%) of those aged 16 and over reported drinking alcohol at least once in the past 12 months, and around half (49%) drank at least once a week.[82] In comparison, in 2023 18% of adult cannabis users across GB reported consuming the drug at least once a week.[83]

Characteristics of cannabis users in the UK

Age

4.30 Cannabis is used predominantly by youth and young adults. While reported use overall has fallen in England & Wales over the past 20 years (except among older age groups, where it has risen slightly recently), it is consistently more common among younger people. Around one-sixth of those aged 20–24 and one-seventh of 16–19-year-olds are reportedly recent users – see Figure 3.

Figure 3: Proportion of 16–59-year-olds reporting past-year cannabis use in England & Wales by age group, 2001–2023



Source: Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 3.03.

4.31 While cannabis is used by school-aged children, as with adults it is less prevalent than alcohol or tobacco. In 2021, seven per cent of 11–15-year-olds in England reported having tried the drug, compared with 12% who had tried tobacco and

[82] Part 3: Drinking alcohol - NHS Digital *Accessed 13th November.*
[83] See footnote #75. *Accessed 24th July 2024*.

40% alcohol. While use rose among older children, with one-fifth (19.2%) of 15-year-olds reportedly having tried cannabis, more (25%) had tried tobacco and almost two-thirds (65%) alcohol.[84] A similar pattern has been reported elsewhere for 16–17-year-olds.[85]

Gender

4.32 Cannabis use is higher among men than women: among those aged 16–59, over 9% reported use in the year to March 2023, compared with a third fewer women (6%). The difference is less marked among young adults with around one-sixth of men (17%) aged 16–24 reporting use, compared with around one-seventh of women (14%) of the same age.[86]

4.33 Among children, slightly more girls reported trying cannabis in 2021 than boys (7.1% vs 6.8% in 2021). As smoking cannabis with tobacco is the most common means of consumption, higher rates of cigarette smoking among girls than boys (13% vs 10% reported having ever smoked)[87] may be partly responsible. We discuss school-based cannabis education in chapter 12 and cannabis sources in chapter 5, but note the role of both peers and dealers in providing cannabis to children (around three-fifths got it from a friend on the first occasion, and around one-fifth from a dealer[88]).

Ethnicity

4.34 Various surveys report differences in prevalence of cannabis use between ethnic groups. However, there is little convergence in patterns, meaning we cannot be confident in drawing conclusions with respect to genuine variation in use according to ethnicity. This is compounded by methodological limitations (e.g. small samples of respondents from ethnic backgrounds other than white mean confidence intervals around those estimates are larger[89]).

4.35 One survey reported cannabis use in the year to March 2023 in England & Wales to have been highest among those of mixed ethnicity (11.2%), followed by those from a white background (8.6%). Among those of black ethnicity, use was recorded at 4.6% and at just over 2% it was lowest among those of Asian origin.[90]

---

[84] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Tables 1.2, 5.2 and 8.7c. *Accessed 13th November 2023.*
[85] See footnote #75. *Accessed 24th July 2024.*
[86] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 3.04. *Accessed 16th January 2024.*
[87] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Tables 1.2 and 8.8. *Accessed 13th November 2023.*
[88] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Tables, Table 9.4. *Accessed 14th November 2023.*
[89] The larger the confidence interval around an estimate of cannabis prevalence, the less precise the estimate, and the true prevalence of cannabis use among one group may be more similar (or indeed equal) to another than estimates suggest.
[90] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 3.01. *Accessed 15th January 2024.*

4.36 Elsewhere, however, past-year prevalence was reportedly highest among black populations in England when compared to white British and other ethnic groups, with higher rates too among those from Asian and Arab backgrounds.[91,92]

4.37 The relationship between ethnicity and cannabis use is no doubt complex. And there is some evidence, too, that apparent variation might be explained by factors other than ethnicity,[93] namely age[94] and deprivation. After controlling for both, one analysis reported levels of past-year drug use among black and mixed/other ethnic groups to be statistically no different from the white British group.[95]

4.38 Given a potential link with deprivation, it is not surprising that prevalence of cannabis use varies by socio-economic status. While used across society, both prevalence and frequency of use[96] tend to rise as income falls.[97] Cannabis users overall, as well as those using frequently (daily), are also more likely to live in rented housing than their own home, and to be unemployed or otherwise not in work.[98]

Cannabis in London

4.39 Reported cannabis use in London has fallen substantially over the past 20 years, with just over 6% of Londoners claiming to have used the drug during the year ending March 2023 – below the national average across England & Wales of 7.6%[99] (see Figure 1). Estimates from Action on Smoking & Health (ASH), however, put the figure in London higher at almost 10% – the highest of all regions across England, Scotland and Wales.[100]

4.40 Among London's schoolchildren, use of cannabis and/or exposure in the home was thought relatively commonplace among those we heard from who worked with young people. Use was described as having become a social norm to a much greater extent than for older generations, almost a rite of passage or a milestone in youth, with consumption among peers and in wider social settings reportedly

---

[91] McManus, S., Bebbington, P., Jenkins, R. & Brugha, T. (eds.) (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. Table 11.3. *Note: this survey runs every seven years, at time of writing the next iteration was in preparation.*

[92] Bespoke analysis undertaken by Action on Smoking and Health (ASH) for the London Drugs Commission, which aggregated data on cannabis use reported in the 2020/21, 2021/22 and 2022/23 waves of a survey of adults aged 18+ across GB.

[93] Pinto, C., Yates, K., Weston-Stanley, P., D'Arcy, A., Bennetto, R., Sawdon, E., Lau, R. & Khambhaita, P. (2024). *Non-opiate and cannabis drug use in minority ethnic groups*. National Centre for Social Research.

[94] See also Shiner, M., Carre, Z., Delson, R. & Eastwood, N. (2018). *The Colour of Injustice: 'Race', drugs and law enforcement in England and Wales*. StopWatch & Release.

[95] See footnote #93.

[96] See footnote #75. *Accessed 24th July 2024.*

[97] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 3.02. *Accessed 11th April 2024.*

[98] See footnote #75. *Accessed 24th July 2024.*

[99] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 3.07. *Accessed 15th January 2024.*

[100] Action on Smoking and Heath (ASH) (2023). Unpublished written submission to the London Drugs Commission: 9.8% of those aged 18+ in London reported past-year cannabis use. Figures from the Smokefree GB Adult survey.

sometimes continuing for several years. Family members of a number of young people were also known to be users of cannabis and other illicit drugs.

4.41 The difficulties with comparing levels of cannabis use across different ethnic groups are compounded at regional level because prohibitively small sample sizes mean data is not published at this granularity. Bespoke analysis of ASH data, however, showed rates of past-year use to be highest among Londoners of mixed ethnicity or from another ethnic group (18%). It was next highest among black Londoners – of whom 11% had used the drug in the past year, mirroring the rate found by the same survey in black populations across England. Among the white ethnic group, 8.5% reported past-year cannabis use, with use among Asian/Arab ethnic groups the lowest at 7.7%.

4.42 In terms of lifetime prevalence, however, the pattern was slightly different. Among Londoners of mixed ethnicity or from another ethnic group, it stood at 42%, with the next highest rate reported for those from a white background (36%). Among black Londoners, 27% reported ever having used cannabis, as did 18% of those from an Asian/Arab background.[101]

4.43 As our own research indicated (see Appendix C and research report)[102] and as we heard in testimony from MPs, Council Leaders, senior council officials and other stakeholders across London, cannabis use is widespread, even normalised, in some areas. Among some communities it is considered part of cultural practice[103] and we heard about intergenerational use where families share knowledge of different cannabis strains and products, advising others on safer consumption.

4.44 While we heard about hotspots, and characteristics of local cannabis markets and users do vary across boroughs, public dealing and consumption is consistent and commonplace. It was put to us by several witnesses, however, that the police response is less consistent. While identifiable in wealthier boroughs as well as more deprived parts of London, there is a perception (borne out by statistics; see chapter 10) that police action regarding cannabis, including stop and search (S&S), is more likely in the latter.

4.45 London's more deprived neighbourhoods tend to be home to higher proportions of residents from ethnic minority (excluding white ethnic) backgrounds than its less deprived areas.[104] Together with the finding that deprivation might explain at least some of the variability in cannabis use among ethnic groups, this suggests to us the potential for some ethnic disparity in the policing of cannabis.

4.46 We return to the issue in chapter 10 but consider the lack of routinely collated data showing use of individual drugs by ethnicity below national level to be unhelpful. The Home Office (HO), together with the Office for National Statistics (ONS) and

[101] Action on Smoking and Heath (ASH) (2023). Unpublished written submission to the London Drugs Commission.
[102] See footnote #11.
[103] See also footnote #93, p.22.
[104] See Census 2021 deep dive: ethnicity and deprivation in London | Trust for London *Accessed 30th November 2023.*

the Mayor's Office for Policing & Crime (MOPAC), should consider how data collections could be boosted to facilitate more nuanced understanding of cannabis use among different ethnic groups in London and other regions (R1).

4.47 While experiences of cannabis being consumed in public are widespread, this does not mean the public are accepting of it (although whether levels of concern are as high or extensive as authorities and some parts of the media believe is not clear; see chapter 6 for discussion of public views).

4.48 We heard overt cannabis use can be associated with wider indications of anti-social behaviour, which can act to compound feelings of general lawlessness. It was, however, also put to us that smoking cigarettes, or vaping, or being drunk in public, are behaviours that many would prefer did not happen but often accept are part of life – although smoking is increasingly seen as less acceptable.

4.49 Law enforcement officers from the UK and US told us that anti-social or violent behaviour resulting from excessive cannabis use is relatively minor compared with that driven by use of alcohol and other types of illegal drugs. Lawbreakers high from cannabis at the point of arrest, for example, pose less risk of violence than those who are high on crack cocaine, or drunk. Indeed, one officer described alcohol as the worst drug he had ever experienced in several decades of policing in terms of its propensity to incite violence.

4.50 That said, there is some evidence that persistent use of cannabis, particularly when begun at an early age, can be associated with an increased risk of physical violence, although the role played by factors including potency and pre-existing mental health factors is unclear.[105] While we did not consider the mechanisms involved, frequent cannabis use may cause a user to process emotional stimuli differently in comparison to non-users, which might lead to negative interpretations of otherwise neutral events and potentially a heightened risk of an aggressive response.[106]

4.51 And while they act very differently to organic cannabis, which makes direct comparison difficult, the use of synthetic or adulterated forms of cannabis (see chapter 8) may also raise the risk of violent behaviour. While adverse consequences are largely physical in nature (including extreme dizziness, nausea and vomiting), we heard reports of increased paranoia in consumers of synthetic cannabis, which can manifest in erratic and unpredictable behaviour and responses to those around them.

[105] See discussion in University of West London & ARCS Ltd (2024). *Cannabis, violence and policing in London – assessing current practice, modelling future approaches*. Available at MOPAC academic research | London City Hall.
[106] Ibid.

The 'Lambeth experiment'

4.52 For one year, beginning in July 2001, the Lambeth Cannabis Warning Scheme (LCWS) operated in the London Borough of Lambeth.[107] This de-penalised possession of 'small quantities' of cannabis (what constituted a small amount was police officer-determined), meaning that, while still recorded, it was no longer a prosecutable offence, and the individual was not arrested. Instead, they were given a warning and their cannabis confiscated. All other boroughs retained their usual policing policy towards cannabis.

4.53 Overall, around 80% of residents supported the scheme (although backing was higher among white than black or Asian residents)[108] and evaluations suggested the policy led police to reallocate effort towards non-drug related crimes. This saw a reduction of over 9% in those crimes (and a consequent fall in total crime)[109] with improvements in overall effectiveness as measured through arrest and clear-up rates – including for cannabis supply offences (which rose during and after the experiment).

4.54 Arrests for possession not surprisingly fell substantially, although the number of recorded possession offences rose during the experiment and remained elevated for some time following its cessation.[110] The role played in this rise by 'drugs tourism' into Lambeth from neighbouring London boroughs, a concern for many at the time, is unclear. Some analysis suggests it was a significant factor,[111] evidence elsewhere reports it played no role.[112]

4.55 Concerns that the experiment would lead to a rise in the dealing and use of cannabis in Lambeth's schools were unfounded.[113] There is some evidence, however, that the experiment was associated with both a fall in local house prices, particularly in areas where the illicit drug market was most active,[114] and a rise in harder drug-related hospital admissions among young men.[115]

4.56 While the drivers of this are unclear, some witnesses told us the illegality of cannabis can increase its appeal among young people because it is perceived as 'risky': using, sourcing and supplying it can attract a certain social status, affording a badge of honour. If de-penalisation removed some of that status, this may have

[107] For background, see Crowther-Dowey, C. *The Police and Community Justice: The Lambeth Policing Experiment*. Available at 7970 BJCJ Insides.qxd (mmuperu.co.uk) *Accessed 15th November 2023.*
[108] Lambeth Cannabis Policing Experiment | Ipsos *Accessed 15th November 2023.*
[109] Adda, J & Rasul, I. (2011). *Crime and the Depenalization of Cannabis Possession: Evidence from a Policing Experiment. London*: IFS. https://ifs.org.uk/publications/crime-and-depenalization-cannabis-possession-evidence-policing-experiment *Accessed 15th November 2023*.
[110] Adda, J., McConnell, B. & Rasul, I. (2014). Crime and the Depenalization of Cannabis Possession: Evidence from a Policing Experiment. *Journal of Political Economy, 122(5)*, pp.1130–1202.
[111] See footnote #109.
[112] See footnote #107.
[113] Ibid.
[114] See footnote #109.
[115] Kelly, E. & Rasul, I. (2014). Policing Cannabis and Drug Related Hospital Admissions: Evidence from Administrative Records. *Journal of Public Economics, 112*, pp.89–114. doi.org/10.1016/j.jpubeco.2014.01.008

encouraged some to look to other, harder drugs, to push boundaries and elevate their peer standing.

4.57 If nothing else, outcomes from the Lambeth experiment demonstrate the complexity of understanding the effects of changes in the application of criminal law. Improvements in one measure (e.g. reduction in some crime types) may be unintentionally countered by deterioration in another (e.g. measures of wider social functioning such as house prices.)

4.58 Whether the net outcome was one of overall reduced harm, with neither creation nor exacerbation of existing disproportionality or inequalities, is a thorny question with, in our view, no clear answer. That said, during the period in which cannabis was de-penalised Lambeth did not descend into the chaos and lawlessness that some had predicted.

Drivers of cannabis use

4.59 We did not set out to explore drivers of cannabis use in depth, thus did not seek to hear from users directly.[116] That said, the issue arose several times and indeed, the top reasons for use cited by Londoners responding to our survey (Appendix C) were thought to be relaxation, management of stress and anxiety, and pain relief. While not necessarily users of cannabis themselves, it is striking that only a quarter (26%) thought having fun was a driver. Even fewer cited being sociable or getting 'stoned' (high) as a reason to take the drug.

4.60 We heard from several witnesses about the role of peer pressure in initiating and sustaining use. And both young people and professionals who work with young people in a range of settings told us self-medicating through cannabis to soothe symptoms of anxiety and stress, often linked to deprivation, trauma, neglect and violence, is common.

4.61 For many, it forms a coping mechanism, a means of emotional self-regulation, and it was put to us by several experts that this is more likely where wider community services to support young people with mental health conditions and other significant life challenges are absent, or very limited. We heard cannabis can become a crutch – one which is vastly more accessible than professionally administered support.

4.62 Indeed, it was put to us that significantly more investment has been made in cannabis policing than in wider support services, particularly in the wake of the global pandemic. And that this has served to compound a range of issues, particularly among young people.

4.63 We heard levels of anxiety have risen substantially in recent years, with increased nervousness attached to interacting with others, particularly for LGBTQ+ youth

[116] Reasons for cannabis use have been thoroughly explored in many previous government and non-governmental reviews and a wide range of research.

who have not yet, or have only recently, come out. Cannabis has become, for some, an easy tool in the box for young people to draw on to ease tensions, as well as deal with feelings of loneliness and isolation:

'It [cannabis] is a huge coping mechanism… [young people say] 'it will help me be calm in social settings'… maybe they use because they have an underlying chronic anxiety disorder that arises from trauma in early childhood…'.

'…they continue to live in a horrible home environment, surrounded by poverty and deprivation. And they're constantly living in fear because they're actually in a community where they do feel at risk, then they're not going to stop because it's what makes life tolerable'.

4.64 As reported by, among others, the British Medical Association (BMA), rates of mental illness have been rising for some time, particularly among children and young people – a trend exacerbated by the Covid-19 pandemic. In 2017 around one in eight young people aged 7–16 suffered with a probable mental illness, increasing to more than one in six by 2022. For those aged 17–19, rates rose from one in ten to one in four.[117]

4.65 Overall, the number of people seeking treatment has grown rapidly. Services in England received a record 5 million referrals in 2023 (a rise of 33% from 2019)[118] – more people than ever are asking for help. But the sector is not resourced to meet demand.

4.66 Long waiting lists mean sufferers can remain undiagnosed for long periods of time, and once diagnosed can face exceptionally long waiting lists to be seen by a health practitioner. Thresholds for treatment can be high[119] and, where not met, or where waiting times leave someone suffering, it is not inconceivable for them to turn to alternative ways of achieving relief. For some, this might be cannabis.

4.67 The dynamic between cannabis and adverse mental health more widely is extremely complex, as we set out in chapter 8. While there is certainly some association, it is by no means consistent across all users and, as we heard, many people turn to cannabis to alleviate existing symptoms of poor mental health, which can result from a wide range of traumatic life experiences. For others, cannabis use might bring on symptoms of mental ill health that may not otherwise have materialised.

4.68 We also heard that underfunding and in some cases closure of young people's services across London more broadly (i.e. not just in the health sector) has meant a fall in community provision of meaningful activities. These typically help reduce the risk of children and young people being drawn into drug use and other criminal or anti-social behaviour. Reducing or ceasing provision has, it was argued, left

[117] Mental health pressures data analysis (bma.org.uk) *Accessed 16th November 2023.*
[118] Ibid. *Accessed 23rd July 2024.*
[119] Ibid. *Accessed 16th November 2023.*

young communities vulnerable, with the risk of becoming involved in drug use, or increasing existing use, rising.

4.69 Many of those who work with young people described a process of considered cost–benefit analysis. The risks and costs of getting caught for using cannabis (related to parents, schools and the police) are weighed up against the benefits – a calculation that often comes out in favour of the latter, meaning there is little motivation not to start using, or to desist. Cannabis can help those who choose to use it feel life is tolerable; for some it can ease a boredom associated with a lack of employment or education opportunities.

4.70 But it is of course used not just to help people cope, but for enjoyment. We heard about it heightening feelings, aiding creativity and, especially for young people, oiling social wheels and breaking down barriers that they otherwise struggle to overcome. Indeed, the Global Drugs Survey reported maximising pleasure to be the most important aspect of cannabis consumption reported by respondents who used the drug, followed by avoiding harm and having fun with others.[120] (Which contrasts with findings from our survey in which respondents – not necessarily users of cannabis – cited relaxation as a primary reason to consume the drug, see para.4.59.)

4.71 This means (as we discuss in chapter 12 on education) focusing communications around cannabis on harm can disenfranchise many whose experiences do not chime with that message. Indeed, we heard of some who, in seeking to understand the risks, had disregarded information from sources including the NHS, which were described as unbalanced with no recognition of the broader drivers and positive effects of the drug.[121]

4.72 And as we heard from experts across sectors, a large number of people who use cannabis experience no adverse or life-limiting consequences. They are able to study, work and socialise as effectively as those who do not use the drug. While difficult to estimate the proportion who remain wholly unaffected by negative effects, evidence suggests at least 10%[122] and possibly up to around 20%[123] might develop symptoms of Cannabis Use Disorder (CUD) and/or other symptoms of adverse mental health that can be associated with use of cannabis (see chapter 8).

[120] Winstock, A.R., Maier, L.J., Zhuparris, A., Davies, E., Puljevic, C., Kuypers, K.P.C. … & Barratt, M.J. (2021). *Global Drug Survey (GDS) 2021 Key Findings Report*. Report2021_global.pdf (globaldrugsurvey.com) *Accessed 27th November 2023.* Note this surveyed 32,022 people who use drugs from 22 countries so findings cited are not specific to the UK unless stated.
[121] Walsh, H. (2023). Unpublished PhD findings shared with the London Drugs Commission.
[122] Connor, J.P., Stjepanović, D., Le Foll, B., Hoch, E., Budney, A.J. & Hall, W.D. (2021). Cannabis use and cannabis use disorder. *Nature Reviews Disease Primers 7*(16). doi.org/10.1038/s41572-021-00247-4
[123] Leung, J., Chan, G.C.K., Hides, H. & Hall, W.D. (2020). What is the prevalence and risk of cannabis use disorders among people who use cannabis? a systematic review and meta-analysis. Addictive Behaviours, 109. doi.org/10.1016/j.addbeh.2020.106479

4.73 While these are certainly not insignificant proportions, the fact remains that the majority of people who use cannabis are unlikely to end up with poorer health or a lower quality of life as a result. That said, those who use highly potent forms of the drug on a very regular basis almost certainly run a much greater risk of adverse consequences, as we discuss below and further in chapter 8.

Excessive use of cannabis

4.74 We heard powerful stories from a small number of people who had become addicted to cannabis and developed symptoms of psychosis that were highly likely to be associated with their use of the drug. We heard, too, exceptionally moving accounts about the impact of extreme cannabis consumption, particularly from parents who tragically lost children to drug overdoses, or who watched a loved one's mental health deteriorate while using cannabis and/or other drugs to the point where they tried, sometimes successfully, to take their own life.

4.75 We heard from representatives of charities that support those who use drugs and their families, who spoke poignantly of the challenges experienced by the people they work with, of difficulties in securing treatment, and of dealing with increasing demand.

4.76 Cannabis is among the top four substances causing concern for those reaching out (alongside alcohol, cocaine and heroin) – both as a primary drug of choice and, often, alongside alcohol. But while these charities provide a lifeline – sometimes literally – to those who use drugs and their loved ones, they cannot take the place of properly funded treatment and rehabilitation services. We return to this matter in chapter 9.

4.77 Equally, the support that charities provide to those wishing to reduce or stop cannabis use, and to put in place alternative activities in response to triggers that drive it, cannot succeed without such activities being available. Employment, for example, or other forms of structured activity, were cited as crucial. Purposeful activity fills time that would otherwise be spent consuming cannabis.

4.78 But we heard how the illegal status of the drug can prohibit opportunities. For example, many industries now require applicants to employment and training schemes to undergo a drug test. For users of cannabis, including those weaning themselves off the drug, this can present a problem because of the length of time the drug remains identifiable in the body. It remains detectable in urine for up to a month (depending on strength and frequency of use) whereas heroin and cocaine are not identifiable beyond around four days post-use.

4.79 As described to us by those who had experienced cannabis dependency, the drug was the only thing they cared about, wholly normalised in their lives. Indeed, one former user of cannabis described how growing up with parents who used the drug not only meant exposure from an early age but instillation of a belief that it posed no harm. This chimes with some of the concerns expressed to us from

experts in jurisdictions that have legally regulated non-medical cannabis, i.e. the act of doing so can suggest its use is risk-free.

4.80 There were mixed views with respect to whether the illegal status of cannabis does more to hinder than help those who develop problematic use. Broadly speaking, those working to support people who use cannabis and their families tended to feel that illegality deters both groups from acknowledging a problem and seeking help, often until it is too late. And that without a legal market, people who choose to use the drug are subject to elevated risks from unknowingly consuming contaminated product.

4.81 From a harm-reduction perspective, some thought legal products might encourage safer practices because health professionals might be better informed about what people are actually taking. That said, it was acknowledged that many would likely still source cannabis from the illicit market, driven by personal preferences and allegiances to dealers.

4.82 But some who have been problematic users are more nervous, describing the risks of unwittingly ending up addicted and unable to motivate oneself to engage in life or reap reward from anything that does not involve cannabis. *'The world doesn't come into existence until one's had a joint'* was how one person described his former life to us. Engaging with others and the world around him became impossible without cannabis, until he sought treatment and stopped using the drug. Another told us, *'When you think you have no choice but to take your own life, things have got out of hand.'*

4.83 The personal stories of the dangers of becoming cannabis-dependent, and those of families who have lost loved ones, are a profound reminder that this is not a harmless drug. But those we spoke with acknowledged, too, that cannabis prohibition is not harm-free and suggested legal regulation might remove at least some of the negative judgement and stigma associated with its use, and with associated help-seeking.

4.84 Accusatory fingers are pointed at people who use and sell cannabis; society denotes them as bad people. But as was pointed out to us time and again, that this judgement is not levelled at those who use, sell and manufacture tobacco or alcohol is arguably, at least to some degree, hypocritical. The fact that tobacco and alcohol are perfectly legal, however, despite the well-documented huge health risks, led many we heard from to question how likely it is that non-medical cannabis could ever be made legal in a responsible way.

4.85 The perceived failure of education and information campaigns to focus on messages about safer consumption and how to manage health risks was cited as a roadblock to helping those who try cannabis to do so in a way that limits the risk of harm. The principle of *'conversation not confrontation'* to support people to stop or reduce use was considered fundamental – but one which is doomed to fail if cannabis continues to be dealt with primarily through the lens of criminal enforcement rather than public health.

4.86 We explore the importance of trusted, credible voices in chapter 12. But it was put to us that celebrities and other influencers who routinely endorse cannabis across social media platforms and other mediums (despite the illicit status of the drug in this country, such material is perfectly accessible) could be drawn on to encourage safer use.

Cannabis use and perceptions among young people

4.87 We heard from young people and those who work with them that cannabis is normalised among large swathes of the youth population. Musical references are commonplace, use is openly discussed across social media channels and influencers, and, alongside the range of usage statistics, we were pointed to surveys of schoolchildren, nightclub and festival-goers that routinely show cannabis to be the most commonly reported illicit drug. If young people wish to access cannabis they can, and there is a general feeling that very many have tried it or are frequently around others who use it.

4.88 Some young people are also involved in selling cannabis, often known as 'grinding' or 'hustling'. It was put to us that the culturally popular idea of 'being your own boss' has effectively encouraged some to become entrepreneurs through growing, sourcing and dealing cannabis. Those involved in growing are very aware that producing popular strains, swiftly, can offer a substantial source of income. As a result, some will actively study how to maximise yields through the most effective horticultural practices.

4.89 The reality is that the cannabis trade can earn someone far more than legitimate work, and far more easily – notwithstanding the inherent risks. For some young people, dealing leads to consuming, while others begin dealing to fund their use. Still others take on elements of the 'business' from older siblings who, we heard, will sometimes pass down responsibilities – especially where they are involved in county lines activity (see chapter 5) and are unable to fulfil their commitments.

4.90 Cannabis use is a topic of conversation with which, it was suggested to us, young people across London are largely familiar. Those we heard from directly were knowledgeable and all knew someone who used the drug, whether among their friendship circles or family or both.

4.91 Many (though by no means all) were aware of at least some of the risks in sourcing illegal cannabis – whether related to the product (unknown substances being mixed or sprayed on), the purchase (visiting unsafe areas) or criminalisation (after being caught by police). Moreover, cannabis dealers often sell other drugs and we heard about young people being offered harder substances when picking up cannabis.

4.92 As a result, some young people would like to see cannabis for non-medical use made legal, to help reduce these risks. We also heard from several youth workers who highlighted how the risk of criminalisation is heightened for those young

people who use cannabis whose home life is challenging, who are often living in houses of multiple occupancy and who as a result frequently spend much of their lives outside. This means they are more likely to use cannabis in public, with the associated heightened risk of coming to the attention of police.

4.93 Then there are the overlaps between race and deprivation. As referred previously, London's most deprived neighbourhoods house disproportionately more people from a minority ethnic background than their wealthier counterparts. We explore the relationship between criminalisation, wealth and ethnicity further in chapter 10.

4.94 Youth workers also told us they were seeing rising numbers of children and young people experiencing cannabis-induced psychosis. Increasing consumption of edibles may be partly responsible – we heard about young people, unaware of the strength and delayed onset of effect (as compared to smoking cannabis), taking far more than they might intend in the mistaken belief that nothing is happening. The increase in potency (levels of THC) of street cannabis is also likely to be a factor (which we discuss further in chapter 8).

4.95 With their American-style packaging designed to mimic that of typical sweets and chocolates, edibles (which, like other cannabis products, are available via the internet despite their illegality in the UK) are becoming increasingly popular among young people. Attractively and professionally packaged, they are easier to carry and use than herbal cannabis and emit no smell, meaning they are less likely to attract police attention.

4.96 But it was put to us that such illegal products, which of course undergo no quality assurance processes, often contain little or inaccurate information about potency levels. The THC content can, we heard, often be much higher than labelled, meaning dose regulation is difficult and adverse effects more likely as a result.

4.97 Clearly, a legal market would facilitate sale of regulated, quality-assured products with accurate labelling and use instructions. And over time, as we heard from jurisdictions that have legalised non-medical cannabis, the reduction in stigma associated with the drug can encourage help-seeking behaviours among those with problematic use.

4.98 The counter, of course, is that not everyone who uses cannabis switches to legal products. Added to this is the fact that more easily available cannabis in a legal market probably increases the number of users (see chapter 7). Even if the proportion who develop problematic use, or wider symptoms of poor health including psychosis, remained the same, the number suffering from such would rise in line with a rise in prevalence of use.

Co-use of cannabis with tobacco

4.99 As in other European nations, in the UK smoking cannabis in a joint alongside tobacco (co-use) is by some significant margin the most common method of consumption among all age groups. Herbal cannabis tends to be cheaper and

more readily available than other forms of cannabis available in the illegal market, and co-use enables the drug to go further.

4.100 For those conscious of harm reduction, co-use may also be deployed to dilute the psychoactive effects of cannabis – although of course consumption of tobacco brings its own health-related collateral damage.

4.101 Whatever the driver, a majority of UK cannabis users mix their cannabis with tobacco, although the proportion has fallen in recent years from around three-quarters in 2019[124] to under 60% in 2023.[125] While substantially lower than the almost 90% of users co-consuming in Italy, the figure is significantly higher than in countries with the lowest rates of co-consumption, namely Canada (around 10%), parts of South America, and the US – where fewer than 5% of users in 2022 reportedly consumed their cannabis with tobacco.[126]

4.102 Co-consumption is particularly high among daily cannabis users – in 2023, almost three-quarters reported smoking the drug with tobacco. And while those who use cannabis who are also cigarette smokers are more likely to co-consume (78%), over a third (36%) of daily users who do not smoke cigarettes do the same.[127] Culturally, for very many cannabis users in the UK, tobacco features heavily in their use of the drug.

4.103 Evidence on the nature and extent of harm caused by co-consumption compared to smoking cannabis in isolation is relatively limited. It is reasonable to assume, however, given incontrovertible evidence of adverse health impacts of tobacco, that smoking both substances together will compound the risk of health harms. And tobacco smokers, too, are far more likely to be past-year cannabis users than ex-smokers (25% and 6% respectively), with those who have never smoked tobacco the least likely to have used cannabis (3%).[128]

4.104 In considering which legal framework could best minimise cannabis-related harm in the UK context, the high rate of co-consumption with tobacco is a significant consideration. Cannabis use tends to rise following legalisation (see chapter 7), so it is reasonable to assume the same would happen – at least to some extent – here.

4.105 While some users, particularly those who are not already tobacco smokers, might well limit their intake to edibles and other non-smoking means of consumption, there is at least some risk of a rise in tobacco use. Reliably estimating by how much, however, is difficult. Currently, those jurisdictions which have implemented

[124] Lisbon Addictions Conference paper (2022). Winstock, A., Strating, T., Ferris, J., Barratt, M. & Puljevi, C. *What would it take to get you to stop skinning up your joints with tobacco?* PowerPoint Presentation (lisbonaddictions.eu) The Global Drugs Survey reported around 55% of UK cannabis users co-consuming cannabis with tobacco in 2022, down from around 75% in 2019. *Accessed 27th November 2023.*

[125] Ibid. And see footnote #75: 57% of past-year cannabis users aged 18+ in GB in 2023 smoked cannabis with tobacco.

[126] See footnote #124.

[127] See footnote #75. *Accessed 24th July 2024.*

[128] Ibid.

full-scale legalisation are those where cannabis, when smoked, tends not to be mixed with tobacco, or at least is less likely to be so.

4.106 And we note that introduction of any policy that carries a risk of increasing tobacco use, however small, is completely at odds with wider public health attempts to limit tobacco consumption, with plans to phase it out completely currently in train. Proposed legislation (covering England) will, if passed, make it an offence for anyone born on or after 1st January 2009 to be sold tobacco products.

4.107 There is also rising interest in vaping cannabis (as well as consumption via edibles). THC vapes are increasingly available through the illicit market (including through social media – see chapter 8) and of course are used, in combination with CBD, in the medical cannabis market (see chapter 11).

4.108 A key driver, particularly for younger users, is reportedly the enhanced discretion that vaping permits. Not only is the practice increasingly normalised and the range of 'flavours' an attraction, but it also allows consumption of cannabis more discreetly when out in public or in social settings because the smell emitted is less pungent than that associated with smoking the drug alongside tobacco.

Cannabis: a 'gateway drug'?

4.109 The view that use of non-medical cannabis increases the likelihood of use of drugs such as heroin and cocaine was expressed to us by a number of those we heard from. Equally, we heard from just as many witnesses who believed there is no robust evidence in support of the so-called 'gateway theory'.

4.110 The theory is discussed at length within the wider literature and was not a specific line of inquiry for us, but we cover it briefly because it is important. The theory is founded on several principles, chiefly that:

i) Most users of other drugs are also users, or have been users, of cannabis.
ii) Cannabis dealers encourage users to try other drugs to increase profits.
iii) The pharmacological action of cannabis predisposes users to try other drugs.

4.111 While true that use of heroin, cocaine and other serious drugs is almost always preceded by cannabis use, it is also true that the vast majority of cannabis users do not become users of those other drugs. Were there a significant causal relationship then, as the Runciman Report points out,[129] the population of those who use heroin and other more serious drugs would be far higher than it is.

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

4.112 While a heroin user is highly likely to have been a cannabis user, the same does not hold the other way around: cannabis users are not highly likely to become heroin users. In our view, the conclusion reached by the Runciman Report on this remains valid – namely that, as concluded by the Advisory Committee on Drug Dependence[130] some 50 years ago, convincing evidence that cannabis use in itself leads to use of more serious drugs has yet to emerge.

4.113 With respect to increased exposure to other drugs through cannabis dealers, this is plausible. As the WHO suggested, engagement of those who use cannabis in what is, by definition in the UK given the status of non-medical cannabis, an illegal subculture, increases opportunity and encouragement to try other illicit drugs.[131] That said, not all cannabis dealers will offer other drugs, and those who source their cannabis online may be less likely to face active encouragement to try other substances.

4.114 In terms of cannabis activating some pharmacological driver towards harder drugs, this notion has largely been discounted.[132] We consider, though, it is not unreasonable to assume that users of non-medical cannabis who enjoy its psychoactive effects are perhaps more likely to be willing to try other mood-altering drugs than those who do not choose to try cannabis, or who dislike its effects. So rather than any inherent property of cannabis, it may be that factors associated with a willingness to use cannabis may also be associated with a willingness to use other drugs.[133]

4.115 What is somewhat clearer in terms of pharmacological impact is the existence of an association, in some users, between cannabis use and psychiatric disorders (although, as we discuss in chapter 8, the nature of this association is complex). And there is some evidence to suggest presence of a psychiatric disorder may increase the risk of progression in drug use from less risky to more risky substances.

4.116 The same also seems to be true for intense use of an individual drug.[134] But while heavy use of cannabis and the presence of psychiatric disorder may increase the likelihood of subsequent use of other drugs, the presence of one or both factors by no means guarantees an individual will do so.

4.117 Alongside individual factors, social elements also likely play a role in any progression from cannabis use, including the influence of friends (and dealers offering additional drugs) and other factors associated with problematic drug use, such as poverty and unemployment.[135] While true that cannabis use does tend to

[130] The Wootton Report Table of Contents (druglibrary.net) para.51, section 4. *Accessed 29th November 2023.*
[131] World Health Organization (1997). *Cannabis: a health perspective and research agenda*. Geneva, World Health Organization.
[132] See for example Institute of Medicine (1999). *Marijuana and medicine: assessing the science base*. Washington D.C., National Academy Press. Available at First, Do No Harm: Consequences of Marijuana Use and Abuse - Marijuana and Medicine - NCBI Bookshelf (nih.gov) chapter 3. *Accessed 29th November 2023.*
[133] Ibid.
[134] Ibid.
[135] See footnote #129.

precede that of other illicit drugs, this may simply reflect the fact that opportunities to access cannabis present themselves earlier in life (as with alcohol and tobacco) than do opportunities to access more harmful drugs such as heroin.[136]

4.118 Overall, we are not convinced that cannabis use itself increases the chance of progression to use of other illicit drugs. We do consider it likely, however, that sourcing cannabis from dealers raises the chance of exposure both to opportunities to purchase those drugs and to sell drugs (the 'supply gateway'.)[137] This is a facet of the illegal status of cannabis rather than the drug itself and one which, arguably, a legally regulated model would diminish – at least for those who transition to a legal market.

4.119 As several experts put it to us, cannabis use is in effect a gateway to criminalisation (and possibly to becoming engaged in dealing drugs),[138] rather than a gateway to other drugs. Although that said, as evidence from international jurisdictions suggests, the existence of a legal market does not necessarily mean people who use cannabis eschew the illegal.

4.120 Moreover, the culture of co-consumption in the UK means that, for some, their first exposure to tobacco is via smoking cannabis.[139,140] Cannabis can therefore in some instances present a gateway to tobacco, and, while not all will continue to smoke tobacco independently, a number almost certainly will.

4.121 Under a different legal framework for non-medical cannabis, very substantial public health campaigns would be required to dissuade particularly first-time cannabis users from smoking cannabis in conjunction with tobacco. Indeed, for any future users barred from the legal tobacco market because of their age (see para.4.106), they would be in the reverse position to now, whereby they would be able legally to purchase cannabis but not tobacco.

[136] Morral, A.R., McCaffrey, D.F. & Paddock, S.M. (2002). *Research Brief – Using Marijuana May Not Raise the Risk of Using Harder Drugs*. RAND Drug Policy Centre. Available at Using Marijuana May Not Raise the Risk of Using Harder Drugs | RAND *Accessed 29th November 2023.*
[137] Bryan, M., Del Bono, E. & Pudney, S. (2013). *Licensing and Regulation of the Cannabis Market in England & Wales: Towards a Cost–Benefit Analysis*. The Beckley Foundation and the Institute for Social and Economic Research, University of Essex.
[138] Ibid.
[139] Walsh, H. (2023). Unpublished PhD findings shared with the London Drugs Commission.
[140] See footnote #75. *Accessed 24th July 2024.*

5. THE UK CANNABIS MARKET

In this chapter we set out our understanding of the market for non-medical cannabis in London and the UK (for details of the legal medical cannabis sector, see chapter 11). This includes demand, price, availability of and access to the drug, as well as common sources.

We have explored the operation of supply chains, including the role of organised crime and so-called 'county lines', focusing particularly on the involvement of children and young people. Efforts to tackle supply chains are ongoing and we set out recent statistics showing the scale of endeavours by both law enforcement and Border Force.

The chapter concludes with brief consideration of the economic case for legalising non-medical cannabis: who might benefit and to what extent, the nature of associated uncertainties and the interplay between illicit and licit markets.

Cannabis demand and availability

5.1 Demand for non-medical cannabis in the UK is high. In England & Wales alone, recent figures indicate sales equate to around 240 tonnes per annum, with approximately 2.6 million users and a total value of £2.4 billion.[141]

5.2 That said, the market is shrinking. Levels of reported use across England & Wales are falling (more markedly so in London; see chapter 4), and overall sales have dropped by one-third over the past 20 years. While estimates vary, in 2003/04 around 360 tonnes of cannabis were sold in England & Wales, valued at £900 million[142] (though later revisions put the value at over £1.4 billion).[143]

5.3 By 2010, sales had fallen to an estimated 216 tonnes[144] – although at between £1.1[145] and £1.4 billion,[146] the market value did not decline to the same extent. The reason for this is thought to lie in the fact that, by 2010, a majority of the market comprised higher-strength product (commonly known as 'skunk', which contains higher levels of THC – see chapter 4 and para.5.7). As it commands a higher

[141] Unpublished data shared with the London Drugs Commission by the National Crime Agency.
[142] Pudney, S., Badillo, C., Bryan, M., Burton, J., Conti, G. & Iacovou, M. (2006) Estimating the size of the UK illicit drug market. In *Measuring different aspects of problem drug use: methodological developments (2nd edition)*. Home Office.
[143] Vincent, I., Mills, H. & Blyth, P. (2013) The scale of the illicit drugs market. (Annex 2 in *Understanding organised crime: estimating the scale and the social and economic costs.* Research Report 73. Mills, H., Skodbo, S. & Blyth, P. Home Office. Crown Copyright. Available at Understanding organised crime: estimating the scale and the social and economic costs (publishing.service.gov.uk))
[144] Bryan, M., Del Bono, E. & Pudney, S. (2013). *Licensing and Regulation of the Cannabis Market in England & Wales: Towards a Cost–Benefit Analysis*. The Beckley Foundation and the Institute for Social and Economic Research, University of Essex.
[145] See footnote #143.
[146] See footnote #144.

price, this meant that, while overall demand fell, the value of the market remained buoyant.[147]

5.4 During 2016/17, (at least) 255 tonnes of non-medical cannabis were estimated to have been consumed across the entire of the UK, with an estimated value of £2.6 billion.[148] If consumption in England & Wales only was 216 tonnes in 2010, 255 tonnes across the UK some years later suggests demand stabilised somewhat, falling only slightly in ensuing years to the current 240 tonnes (at a value of £2.4 billion) reported above for England & Wales.

5.5 The illicit market for non-medical cannabis thus remains both buoyant and substantial, despite some falls in levels of use. This has understandably led to significant and continued debate as to the value of that market were use of non-medical cannabis to be legal.

5.6 As we describe in chapter 4, despite its illegality non-medical cannabis is widely available across the country. London is no exception. Prices vary according to the type of product (herbal, resin, edible etc) and strength, as well as geographical region, but we heard that herbal cannabis currently retails in the capital for an average of £10 per gram (with reductions for bulk purchase).

5.7 Unlike cannabis of previous decades, strains that now dominate the market are substantially more potent. These come under the umbrella term of 'skunk' and were described to us as having flooded the market. Relatively easily to cultivate in indoor environments, there are countless variants available at different price points. One of the more expensive, it was put to us, is known as 'Cali', short for California Skunk. We heard this can fetch up to £20 or more a gram in London, and, as its name suggests, it originates in California.[149] Like all varieties of skunk, and again as the term suggests, it has a particularly pungent aroma.

5.8 *'It's everywhere'* was a common refrain across our witnesses – many of whom lived or worked in London. It is ubiquitous across boroughs; it was put to us that increasing numbers of young people are involved both in growing and supplying cannabis (and using). While an active choice for some, for others it is a coerced activity.

5.9 As we set out elsewhere, we heard public dealing of cannabis in London is commonplace and statistics, albeit national rather than specific to the capital, bear this out. In 2021, half (52%) of children aged 11–15 who had taken drugs reported buying or being given cannabis in the street, in a park or other outdoor area,[150]

[147] See Snowdon, C. (2018). *Joint Venture: Estimating the Size and Potential of the UK Cannabis Market*. IEA Discussion Paper No.90. Available at iea.org.uk
[148] Ibid.
[149] Although some Cali product is imported into the UK, much of it is grown here from imported seeds or is misbranded as Cali when it is in fact a different strain.
[150] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Table 9.12. *Accessed 1st December 2023.*

and we have no reason to believe the situation is different in London, where during 2022/23, 6.2% of 16–59-year-olds reported using the drug.[151]

Sourcing cannabis

5.10 Testimony to its widespread use is the perceived ease of sourcing cannabis – indeed, it was put to us by many witnesses that those who wish to use it know exactly where and how to get it. Again, statistics bear this out. While the proportion of children claiming accessing cannabis is easy has fallen from one-third in the past 20 years, around a quarter (26%) continue to report such, and this rises to around half of 15-year-olds.[152]

5.11 Among young people and adults aged 16–59, during the year to March 2023 almost two-fifths (38%) reported it being easy to source illegal drugs of any kind within 24 hours, rising to over 44% of those aged 20–29. Less than 30% reported it would be difficult or impossible.[153]

5.12 Consumers purchase primarily from known sources. Over half (57%) of 16–59-year-olds who bought illegal drugs in the year to March 2023 sourced their most recent purchase from a family member, friend, neighbour, colleague or other acquaintance, and just over 12% from a known dealer. In comparison, around 10% reported purchasing from a stranger or a dealer not known to them personally. Just over 1% purchased via the internet (excluding social media sites), with a further 1% using the dark web.[154]

5.13 Similarly, around two-thirds of children aged under 16 who reported trying cannabis in 2021 got it from a friend or sibling on the first occasion, and around one-fifth from a dealer.[155] Just over one in ten purchased cannabis from someone they knew of but did not know personally, but none reported buying from a stranger.

5.14 While internet-based cannabis purchases are less common overall than in-person routes,[156] in 2021, 16% of children in England aged 11–15 reported making at least one purchase of (unspecified) illegal drugs via the internet.[157] While based on a survey with a small sub-sample, and purchases were not necessarily cannabis,

---

[151] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 3.07. *Accessed 15th January 2024.*
[152] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Table 9.17. *Accessed 1st December 2023.*
[153] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 5.04. *Accessed 16th January 2024.*
[154] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 5.01. *Accessed 16th January 2024.*
[155] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital, Table 9.4. *Accessed 14th November 2023.*
[156] See also European Monitoring Centre for Drugs and Drug Addiction & Europol (2023). *EU Drug Market: Cannabis — Retail markets*. Available at EU Drug Market: Cannabis — Retail markets | www.emcdda.europa.eu *Accessed 13th May 2024.*
[157] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Table 9.21. *Accessed 1st December 2023.*

our enquiries suggest that in 2023 its purchase is increasingly likely to be made online (although products may not always be delivered, meaning buyers collect and sometimes pay in person).

5.15 Online outlets selling cannabis (some also offer other drugs including powder cocaine and ecstasy) are proliferating. Online purchasing offers a level of convenience and safety as it removes, at least when goods are posted rather than collected, any risks associated with meeting sellers offline (although arguably it creates new risks associated with a user's details being recorded in a database and is open to interception by authorities).

5.16 Legitimate businesses may offer supplementary cannabis services – we heard, for example, about a dog-walking app being used as a means of enabling ordering and delivery. A checkout code indicates cannabis rather than a dog-walking service is requested, and the product is paid for and delivered to the home.

5.17 Alongside word of mouth, online sales are facilitated chiefly though social media, with Instagram and particularly Snapchat dominant in the UK. Both platforms have a relatively young user base. Around one-quarter of Instagram users in the UK are aged between 18 and 24,[158] and almost half (48%) of Snapchat users are under 24, with almost one-fifth (18%) aged 12–17.[159] Snapchat's 'Quick Add' function, which suggests users who may be known to an individual or in whom they may be interested, allows cannabis sellers to connect with and offer products to hundreds of people at once.

5.18 Research in 2019[160] found a quarter of young people aged 16–24 had seen illicit drugs advertised for sale on social media (predominantly Snapchat and Instagram), with cannabis the most common. Sellers (not always UK-based) will often highlight a link to a closed Telegram account, acceptance to which affords access to what in some cases can be tens or even hundreds of different strains and types of cannabis, set out in 'weed menus'. Notably, there are no age limits – proof of identification, social media platform profile and/or ability to pay is usually sufficient.

5.19 Products are posted (routinely via Royal Mail) and some sellers permit collection if a purchaser agrees to various conditions. The functionality of social media platforms and closed groups not only allows sophisticated, user-friendly mechanisms for purchase, it also permits those who in past decades would be known as 'dealers' to effectively become 'pushers': sellers can 'push out' details of products they have in stock and advertise forthcoming items and strains.

5.20 The legality of non-medical cannabis elsewhere and the largely unfettered nature of the internet means people in the UK can access an inordinate number of

[158] UK Instagram users by age group 2023 | Statista *Accessed 4th December 2023.*
[159] UK data watchdog issues Snapchat enforcement notice over AI chatbot | Snapchat | The Guardian *Accessed 4th December 2023.*
[160] McCulloch, L. & Furlong, S. (2019). *DM for Details: Selling Drugs in the Age of Social Media*. Volteface. Volteface--Social-Media-report-DM-for-Details.pdf *Accessed 6th December 2023.*

legitimate websites registered in parts of the world where the drug is legal, which are selling perfectly legitimate products.

5.21 While illegal for sellers to ship to the UK,[161] there is nothing to stop individuals based in the UK seeking out websites and gaining a huge amount of information about different strains, tastes and effects, and how to approach growing cannabis. All of this serves further to normalise the drug across our society and affects market dynamics. The different elements of cannabis (smell, taste, look, effects) are important and those who use it often seek new strains: knowing they are available elsewhere likely creates demand in the UK market.

The supply chain and the role of county lines

5.22 Somewhat at odds with the law prohibiting production, supply and possession of non-medical cannabis, cannabis seeds are widely available in the UK through online and offline outlets. While sellers stipulate they are for collectable or souvenir purposes only because to germinate them is illegal, inevitably many purchasers will aim to do just that. Certainly, the large number of small-scale seizures of cannabis plants suggests, as noted in the Black Review, that many individuals and small groups are cultivating the drug.[162]

5.23 On a larger scale, supply chains for cannabis consumed in London and across the UK are both domestic and international in nature, and often controlled by organised crime groups (OCGs, i.e. groups of people working together to plan and conduct criminal behaviour on a continuing basis).

5.24 Cultivation happens across the country although, where growers struggle to produce enough cannabis, or sufficient varieties at scale, we heard they may import product to meet demand for well-known, high-profile strains. Often produced in the US, these are regularly promoted by cannabis influencers and other well-known celebrity users of the drug.

5.25 The National Crime Agency (NCA, the UK's national specialist function with respect to tackling serious and organised crime) confirmed to us that cannabis is imported to the UK via three main routes: bulk shipments arrive via unaccompanied air and sea freight containers (destined for warehouses or large garages, often on remote industrial estates), products are posted to individual purchasers through standard international postal providers, and air passengers bring in tens of kilos at a time in checked baggage.

5.26 Whether imported or grown in the UK, we heard that bulk cannabis is sold primarily to national wholesalers who sell to local operators in cities and regions around the country. They sell to dealers, who in turn sell the drug to end users

[161] And in the US, while non-medical cannabis remains illegal at the federal level it similarly remains illegal to ship products using the US Postal Service or private carriers, domestically or internationally.
[162] Black, C. (2020). Review of Drugs – evidence relating to drug use, supply and effects, including current trends and future risks PowerPoint Presentation (publishing.service.gov.uk) *Accessed 4th December 2023.*

including regular customers and, as we heard happens regularly in parts of London, street-level strangers.

5.27 So called 'county lines' have become a significant part of the drug supply chain, with cannabis no exception. These are used to move drugs around the country, typically from major cities into smaller towns and rural areas – meaning the majority of activity originates in London, followed by Merseyside, the West Midlands and Greater Manchester. The term 'lines' refers to the networks of mobile phone lines used to run supply operations. It was put to us that these are an incredibly cost-effective method of drug distribution, generating more income in one day than the annual budget of the Metropolitan Police Service (MPS) ringfenced to combat the activity.

5.28 Children and young people, particularly those from deprived backgrounds where families struggle to make ends meet, are at heightened risk of being drawn into county lines. As described to us by those who work with young people, involvement offers tantalising opportunities to make a lot of money very quickly and cannabis, we were told, is the most common gateway into this world.

5.29 It was put to us that as cannabis is a cheap drug that is widely accepted – even normalised – among young people, OCGs and local gangs will target young people, often those living in deprived areas and/or suffering troubled, chaotic home lives. They offer cannabis 'to try' and in accepting, not only is a drug debt unwittingly created, but young people become exposed to sought-after trappings of wealth associated with the drugs trade, namely expensive clothes, trainers, jewellery and cars. Such material gains are reportedly often evident to those working with children and young people, in education and wider youth settings.

5.30 A gang will demand 'payment' for the cannabis, with young recipients offered the chance to work off their 'debt' through supplying drugs. This can mean they are expected to travel some distance from home and where family life is chaotic or neglectful, it may be less likely that the alarm will be raised following their disappearance.

5.31 The Black Review discusses the emergence of the hugely exploitative county lines model in depth.[163] It examines why young people from deprived backgrounds or troubled homes are particularly vulnerable to being targeted – although it points out that children from seemingly stable families with no prior police or care service contact are not immune from being approached.

5.32 Factors to which the Black Review points chime with evidence we heard from those working with young Londoners. Both sources emphasised that cuts to youth services, alongside parental absence or inadequate parenting, school exclusion, living in poverty, family breakdown and, for some, entering the care system, leave

[163] Black, C. (2020). Review of Drugs: Executive Summary. Department of Health and Social Care and Home Office, Crown Copyright. Microsoft Word - SummaryPhaseOne+foreword200219 (publishing.service.gov.uk) *Accessed 6th December 2023.*

many increasingly vulnerable to county lines exploitation. Ongoing consequences of the Covid-19 pandemic have likely exacerbated or compounded many of these issues.

5.33 Involvement in a county line offers opportunity to make what in some cases is a substantial amount of money, particularly to those raised and living in poverty. It can provide a chance to own things that would never otherwise be affordable. We heard from those working in London's education sector about young people suddenly arriving in school wearing or possessing expensive items, often having developed a certain 'swagger' – visible signs of involvement in county lines activity.

5.34 We heard it is common for a handful of young people in mainstream education, at least in some parts of London, to be arrested several times over the course of a year due to cannabis use and/or selling. Moreover, students in alternative education provision, who struggle with learning and behaviour in mainstream school, tend to be disproportionately involved with the criminal justice system (CJS). It was put to us that a substantial driver of that involvement is use, possession and dealing of cannabis.

5.35 For some, involvement in county lines activity causes them to start carrying a weapon, and it is this which often initiates contact with the CJS. Ostensibly to protect against the risk of being targeted by other actors in the drug trade, including those working in conflicting lines who bring cannabis and other drugs into the local area, it is also one of the principal ways in which drug-related violence manifests.[164]

Breaking the supply chain

5.36 It was put to us that main routes of cannabis importation (air and sea freight, air passenger luggage and postal packages) have all seen substantial increases in traffic over the past three years.[165] The US and Canada are the main countries of export, possibly due to over-production of cannabis seen there in recent years (see chapter 7). In previous years, other countries such as Morocco tended to dominate the imported cannabis market.

5.37 Indeed, the NCA recently reported that during the first eight months of 2024, 378 people were arrested in connection with cannabis smuggling by air passengers.[166] The vast majority were arrested in relation to cannabis originating in Canada and the US, and now also Thailand. Around 15 tonnes of cannabis were detected and seized at UK airports in the same period. This is around three times more than in the whole of 2023, when approximately five tonnes of cannabis were seized and 136 people arrested, and more than seven times the two tonnes seized in 2022.

[164] See Black, C. (2020). Review of Drugs – evidence relating to drug use, supply and effects, including current trends and future risks PowerPoint Presentation (publishing.service.gov.uk) Slides 54, 58. *Accessed 4th December 2023.*

[165] Unpublished data shared with the London Drugs Commission by the National Crime Agency.

[166] See It's not worth the risk – jail warning for passengers flying to the UK after increase in cannabis arrests - National Crime Agency *Accessed 28th August 2024.*

5.38 Wider domestic and import data similarly point to increases in the amount of cannabis being traded. The total quantity of herbal cannabis seized by the police and Border Force in England & Wales during the year ending March 2023 represented a rise of 96% on the previous year, i.e. from 35,436 kilograms (kgs) in the year to March 2022 to 69,302 kgs (the rise from 2020/21 to 2021/22 was over 100%, from 17,155 to 35,436 kgs).[167]

5.39 Amounts of seized cannabis resin rose even more dramatically, from 611 kgs to 1,467 kgs – a rise of 140%, though the number of seized cannabis plants fell by 34% (from 785,955 to 515,884 plants).[168]

5.40 The number of seizures made by police and Border Force (as opposed to quantity) of herbal cannabis and resin also rose between 2021/22 and 2022/23, by 4% and 60% respectively. Seizures of plants fell 3%. This means overall the number of seizures of any form of cannabis rose by 7% (from 131,668 in the year to March 22 to 140,370 in the year to March 2023). In comparison, between 2020/21 and 2021/22, overall cannabis seizures fell by 16%.[169]

5.41 While it is difficult to know whether year-on-year changes represent Border Force and police (de-)prioritisation of related activity, the amounts that continue to be seized suggest supply chains remain resilient.

5.42 Seizures of illicit Synthetic Cannabinoid Receptor Agonists (SCRAs, which fall under the definition of proscribed compounds in the MDA and as such are prohibited through the Misuse of Drugs Regulations 2001; see chapter 8),[170] however, fell.

5.43 In the year ending March 2023, a total of 637 seizures were made by Border Force and police forces in England & Wales, a fall of 63% from 1,731 seizures the previous year[171] (compared with a decrease of 24% between 2020/21, when 2,271 seizures were made, and 2021/22).[172]

[167] Seizures of drugs in England and Wales, financial year ending 2023 - GOV.UK (www.gov.uk) Data tables: Summary Table 2. *Accessed 24th May 2024.*
[168] Ibid.
[169] Seizures of drugs in England and Wales, financial year ending 2023 - GOV.UK (www.gov.uk) Data tables: Summary Table 1. *Accessed 24th May 2024.*
[170] Synthetic Cannabinoid Receptor Agonists (SCRAs) are classified as Class B drugs under the Misuse of Drugs Act 1971 (amended).
[171] Seizures of drugs in England and Wales, financial year ending 2023 - GOV.UK (www.gov.uk) Data tables: Appendix Table 1. *Accessed 24th May 2024.*
[172] Seizures of drugs in England and Wales, financial year ending 2022 - GOV.UK (www.gov.uk) Data tables: Appendix Table 1. *Accessed 24th May 2024.*

5.44 The quantity of doses of synthetic cannabinoids seized by Border Force and police, however, rose by 64% from 2,198 in 2021/22 to 3,597 in 2022/23.[173] (compared to a dramatic previous fall from 15,139 in 2020/21).[174]

5.45 Due to the very high strength of SCRAs (they can be very many times more potent than THC), they can be shipped or posted in smaller quantities that are more difficult to detect. Falls in the numbers of seizures may not, therefore, accurately reflect the extent of use or market penetration – although statistics suggest their use to be lower than use of herbal cannabis.[175] We consider SCRAs and their potential for harm in more detail in chapter 8.

The role of organised crime

5.46 As noted by the Black Review and as we heard from law enforcement, OCGs are heavily involved in drug activity across the UK. As of December 2022, it was put to us by the NCA that over half (57%) of all active OCGs were linked to such activity, and just under one-fifth (18%) were directly involved in cannabis cultivation. This creates a significant challenge for law enforcement at local and national level.

5.47 At least half of OCGs involved in cannabis are thought to be poly-criminal, and violence is associated with around one-fifth of those. Many involve firearms so present a substantial threat of very serious harm – although OCGs involved primarily or solely in wholesale supply and retail of cannabis are typically less violent than those supplying crack/powder cocaine and heroin.[176] Where the ethnicity of those involved is known, British and Albanian nationals dominate.

5.48 Modern Slavery and Human Trafficking (MSHT), often involving violence, is a particular concern associated with OCG-run cannabis operations. This involves trafficking vulnerable people – typically but not exclusively from Vietnam, as well as Albania and other parts of the Western Balkans – into the UK to work in large cultivation sites. During the year ending March 2023, 20% of all those referred to the National Referral Mechanism[177] as potential victims of criminal exploitation (5,647 individuals in total) came from Albania and Vietnam (902 and 229 respectively). Almost all were males aged over 18.[178]

5.49 While many might intuitively expect that legally regulating production and sale of non-medical cannabis would eliminate the illegal market and thus the involvement of organised crime, this is not in fact the case. As we show in chapter 7, legal

[173] Seizures of drugs in England and Wales, financial year ending 2023 - GOV.UK (www.gov.uk) Data tables: Appendix Table 2. *Accessed 24th May 2024.*
[174] Seizures of drugs in England and Wales, financial year ending 2022 - GOV.UK (www.gov.uk) Data tables: Appendix Table 2. *Accessed 24th May 2024.*
[175] Drug misuse in England and Wales - Appendix table - Office for National Statistics (ons.gov.uk) Table 4.01. *Accessed 10th May 2024.*
[176] See Black, C. (2020). Review of Drugs – evidence relating to drug use, supply and effects, including current trends and future risks PowerPoint Presentation (publishing.service.gov.uk) Slide 11. *Accessed 4th December 2023.*
[177] The National Referral Mechanism is a framework for identifying and referring potential victims of modern slavery and ensuring they receive appropriate support.
[178] Data provided to the LDC by the National Crime Agency.

regulation does not eradicate demand for illicit cannabis, meaning the illicit market continues to play a role – albeit to varying degrees in different jurisdictions.

5.50 It was put to us that, for example, at least 50 gangs continue to be involved in what remains of the Canadian illicit cannabis market post-regulation. They seek principally to meet demand for cannabis among those below the minimum age limit for legal purchase, and desires for high-strength, cheaper product than that which is now available legally.

5.51 This suggests that a more permissive approach to non-medical cannabis in the UK would be unlikely to cause OCGs to withdraw from its production, distribution and sale. While it seems reasonable to assume that over time the illicit market would become less profitable, which might deter OCG involvement, at the same time we heard that perceived risks associated with cannabis activity would also likely fall. This could well counter any drop in profitability.

The economic possibilities of a legally regulated non-medical cannabis market

5.52 A for-profit legal regime for non-medical cannabis has long been advocated by stakeholders across a wide range of UK sectors and we heard from many who called passionately for its introduction. A key plank of the case lies in forecasts about the potential for a legal market to raise significant amounts of tax revenue. This, it is argued, can be ploughed back into public coffers to support, for example, drug-related health, treatment and education services.

5.53 Canada and some US states that have legalised cannabis via for-profit models have explicitly made such reinvestment a part of their approach. Undoubtably this has led to significant increases in public services funding – particularly healthcare. For example, close to 60% of $1 billion cannabis-related tax revenue projected to be raised in Washington state in 2021–23 was earmarked for healthcare services.[179]

5.54 Simply increasing funding, however, does not necessarily improve health services and outcomes. The importance of infrastructure and governance should not be underestimated, as illustrated in Oregon where non-medical cannabis has been legal since 2014. Assessment of the state's wider move in 2020 to decriminalise possession of all controlled drugs[180] found the approach to provision of treatment services (the principal recipient of cannabis-related revenue)[181] remained siloed

[179] Figures sourced from Washington State Office of Financial Management and cited in How $1 billion in pot taxes gets spent in Washington state | Cascade PBS News (crosscut.com) *Accessed 10th May 2024.*
[180] This decision was overturned in early 2024. Repeal of Measure 110, which decriminalised possession of small amounts of all controlled drugs, is due to take effect in September 2024. Cannabis will remain legal.
[181] See Figure 7, Oregon Liquor and Cannabis Commission (2023). *Oregon Needs to Modernize Cannabis Laws to Help Grow the State's Economy and to Ensure Equitable Opportunities and Benefits for all Communities*. Report 2023-15: Oregon Audits Division. Oregon Liquor and Cannabis Commission Oregon Needs to Modernize Cannabis Laws to Help Grow the State's Economy and to Ensure Equitable Opportunities and Benefits for all Communities *Accessed 10th May 2024.*

and fragmented.[182] Lack of infrastructure to distribute funds, alongside challenges to scaling up posed by the Covid-19 pandemic, have not helped.

5.55 On the face of it, considering the level of demand for non-medical cannabis and its estimated market value in England & Wales, the attractiveness of the economic argument for legalisation is evident. Our examination of associated consequences of for-profit models, however, leads us to believe the situation is less straightforward than the basic premise suggests, notwithstanding impressive sales revenue figures.

5.56 As we note in chapter 7, there is little doubt that a legally regulated, for-profit market in non-medical cannabis generates economic opportunities for investors and governments alike. But those opportunities seem often to have been overestimated and the hotly anticipated 'green rush' has largely, in our view at least, so far failed to materialise to any great extent.

5.57 While it has likely made a relatively small number of cultivators, investors, sellers and influencers very wealthy, widespread profitability seems to be more limited and we are not convinced that, so far, there is reliable and consistent evidence of net fiscal benefit.

5.58 As we demonstrate in chapter 7, understanding the costs and benefits of different models of legalisation is complex. The interplay and trade-offs between taxation, regulation, revenue, public health and the illegal market are challenging to unpick. This is the case for jurisdictions that have implemented a legal market and where hard data is emerging: it is inevitably even more so for the UK, where possibilities and calculations remain assumption-dependent.

5.59 The potential for a legally regulated market to generate economic gain cannot be considered in isolation from its potential to generate parallel costs. Whether overall the former offset the latter to elicit net gain is a question that, in our view, is too early to answer.

5.60 There is certainly, for example, emerging indication of adverse consequences to public health, but their extent and severity remain as yet unclear. More broadly, it seems reasonable to suggest that potential frictions between economic and other aims of legal regulation (such as protecting public health) are likely to be significant.

5.61 Set taxes or prices too high and the illegal market likely continues to flourish. Set them too low and public health objectives are at risk through potential for higher levels of use, which is, of course, fundamental to any for-profit model: increased demand means increased profit.

---

[182] Oregon Health Authority (2023). *Too Early to Tell: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program Has Yet to Be Determined*. Report 2023-03: Oregon Audits Division. Oregon Health Authority: Too Early to Tell: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program has Yet to Be Determined *Accessed 10th May 2024.*

5.62 So far, the international picture remains mixed and, to our mind, inconclusive. Billions of dollars have been generated through sales of legal non-medical cannabis and reductions in CJS system costs allied with hitherto criminal offences. But whether associated rises in use ultimately drive up public health costs (monetised and non-monetised) to an extent that outweighs those benefits remains to be seen.

Estimating the economic return of a legal cannabis market in the UK

5.63 The most recent estimate of which we are aware put the potential tax revenue from cannabis products in the UK, were legal regulation in place, at £690 million per annum. This is based on 2018 prices, tax at 30% plus VAT and an illegal market value of £2.6 billion.[183] Together with direct and indirect taxes on those working in the legal industry, that analysis estimated total annual tax revenues would exceed £1 billion. The same analysis estimated parallel savings to the NHS and other public services, principally the CJS, of at least £300 million per annum. Analysis elsewhere estimates savings to be even higher.[184]

5.64 Clearly, and notwithstanding the caveats that accompany them, these figures are considerable. They, are, however, based by necessity on a series of assumptions. In our view, and with the luxury of more recent evidence, including that drawn from several jurisdictions that have now been operating legal regulation for some years, we consider those assumptions somewhat optimistic.

5.65 One of the most crucial relates to transition from illegal to legal markets. The evidence with which we have been presented suggests this has been neither swift nor wholesale in any jurisdiction that has implemented legalisation – and certainly nowhere near the 95% assumed in the UK market analysis. While that is not to say the UK could not achieve a greater level of movement, a 95% switch seems, to us, unlikely.

5.66 Similarly, evidence put to us suggests assumptions regarding levels of THC and legal availability might also be overly favourable. We agree both are important with respect to diminishing the illegal market. But from what we heard, it is only really when legal outlets proliferate, with long opening hours, that they offer a consumer-friendly alternative to the swift, often doorstep delivery of illegally sourced cannabis. Not only do legal markets struggle to sustain those levels of service, but the public tend not to welcome high streets dominated by cannabis retail shops that are open all hours.

5.67 Capping THC levels in legal products seems to us to be important. Not only are the health risks associated with cannabis consumption exacerbated with increased potency (see chapter 8), evidence from Canada suggests that following legalisation, there has been some shift towards consumption of higher strength

[183] See footnote #147.
[184] Ramanauskas, B. (2018). *Potential savings from the legalisation of cannabis*. Taxpayers' Alliance. Available at Cannabis_Legalisation.pdf (d3n8a8pro7vhmx.cloudfront.net) *Accessed 13th May 2024*.

cannabis products. Parallel increases in cannabis-related healthcare presentations have also been reported.[185]

5.68 Caps on THC are adopted to varying extents by all jurisdictions that have legalised non-medical cannabis. But the 15% cap proposed in the UK market analysis from 2018 is, we think, unlikely to be sufficient to encourage substantial numbers of users to switch to legal products: we heard time and again about increasing demand for higher-strength cannabis.

5.69 What the cap should be, i.e. where the right balance lies between facilitating market transition and protecting public health, is not clear. What is clear, however, is the recommendation from the Canadian Review of the first five years of non-medical cannabis legalisation that tax regimes should effectively discourage consumption of higher-strength products.[186]

5.70 More is beginning to be known about the ways in which legal cannabis markets operate, with evidence emerging from Canada and elsewhere of the nature of impacts on, among other things, public health and criminal justice systems. Monetised and non-monetised costs and benefits in these sectors must be considered, alongside the considerable revenues raised through taxes, to understand how they offset or complement net economic gain.

5.71 The economic case for legalising use of non-medical cannabis in the UK should be reconsidered in light of this evidence and the latest data on health consequences (positive and adverse) of consumption, which more accurately reflect the realities of the strength of modern-day cannabis.

5.72 **The government should commission an updated assessment of costs and benefits that could be realised through a legal market for non-medical cannabis. This needs to be a net benefit assessment and include potential for additional public health and other costs associated with different models of legalisation** (R2). It should also consider non-monetisable aspects, including benefits derived (or perceived to be derived) by different groups of people who consume cannabis.[187]

5.73 We recognise the shortcomings and frustrations inherent in a 'more research is needed' recommendation. But effects of factors including advertising and marketing strictures, number and location of retail outlets, permitted THC levels and tax structures, as well as the set-up and running costs of regulatory and enforcement regimes, are critical considerations.

5.74 From the evidence we have considered, we have been unable to identify any jurisdiction in which the overall economic position following legalisation of non-medical cannabis has been improved wholesale. That is to say, while it unarguably and relatively quickly raises tax revenue, and some savings are realised similarly

[185] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca p.3.
[186] Ibid, recommendation 27, p.12.
[187] See footnote #144.

quickly to policing once cannabis-related activities are no longer illegal, initial net benefit may not be sustained in the longer term.

6. PUBLIC ATTITUDES

Public attitudes towards non-medical cannabis can play a role in the approach adopted by different jurisdictions, and the issue has long drawn heated debate. Indeed, public opinion arguably influenced to some degree the UK governments decision in 2018 to legalise cannabis-based products for medicinal use (CBPMs, see chapter 11), and similarly helped drive the political decision to legalise non-medical cannabis in Canada (chapter 7).

In this chapter, we draw on publicly available data from the UK/Great Britain and London, as well as results from our bespoke research (all cited quotes are drawn from here)[188] and survey findings (Appendices C and D) to explore public feeling about issues we have considered throughout our inquiries.

The nationwide perspective

6.1 Overall, the public increasingly favour more liberal approaches to cannabis. Surveys show that over half support decriminalisation (possession of small quantities of cannabis is no longer criminal) or legalisation (cannabis may be legally produced, supplied and purchased), with the latter often more popular. Recent YouGov data, for example, showed 32% of those polled backed legalisation compared with 24% in favour of decriminalisation.[189]

6.2 When asked simply whether they would support or oppose cannabis legalisation, around half the public in recent years have supported the measure.[190],[191] Indeed, one survey reported more support for legalisation of cannabis (49%) than tobacco (40%, although 27% opposed the measure against 22% for tobacco).[192] And while support tends to be highest among younger age groups, half of those aged over 40 are also in favour.[193]

6.3 That said, around one-third remain in favour of prohibition of some kind, and YouGov's tracker suggests support has in fact increased, rising from 30% in 2019 to 40% in 2021, falling back slightly to stabilise since at around 37% (May 2024.[194] Whether driven by active desire for prohibition, however, or from a (real or perceived) rise in cannabis being traded and consumed openly in public spaces – which as we heard attracts substantial concern – is difficult to say.

---

[188] See footnote #11.
[189] Criminalisation of soft drugs e.g. cannabis (yougov.co.uk) *Accessed 1st August 2024.*
[190] See (2023) https://yougov.co.uk/topics/health/survey-results/daily/2023/04/20/8d0a4/1; (2021) https://yougov.co.uk/topics/politics/survey-results/daily/2021/04/06/fcf4a/3; (2019) YouGov | What the world thinks *Accessed 17th August 2023.*
[191] VI-28 Corbyn, Anti-Social Laughing Gas and Do we need Radical Policies? | Omnisis Table 28. *Accessed 17th August 2023.*
[192] 220810+APPG+polling+results+Great+Britain.pdf (squarespace.com) *Accessed 17th August 2023*
[193] See footnote #191.
[194] See footnote #189. *Accessed 1st August 2024.*

6.4 Nevertheless, a more liberal approach would likely find favour among around half the public, meaning it is perhaps unsurprising that faith in current UK drug policy is low. Over one-third (38%) consider it unsuccessful in reducing the supply and use of harmful drugs, compared to one-fifth who think it a success.[195]

6.5 In terms of harm, many of those we heard from, particularly among the health sector, emphasised that use of cannabis is not without risk (whether related to health or, where illegal, criminal sanction). The only guaranteed safe way to consume the drug is not to consume it at all. Similarly, the public tend not to view it as risk-free – although other substances, including alcohol, tobacco and Class A drugs, are considered to pose greater health and societal harm.[196,197,198]

6.6 In local communities, cannabis use and dealing are perceived as commonplace. Almost two-thirds (65%) considered the supply and use of cannabis to be widespread in their area[199] (after tobacco at 76% and alcohol at 68%), which suggests criminalisation is little barrier to access and use, at least in some parts of the country, is ubiquitous.

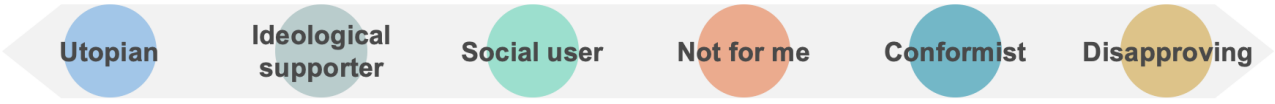
The London perspective

Prohibition and alternatives

6.7 Overall, a majority of Londoners support a more liberal approach. Around six in ten are in favour,[200,201] with fewer directly opposed to legalisation compared to the public nationwide (25% of Londoners compared to 32% nationally).[202]

6.8 That said, the nature of support does vary, and our research identified six distinct 'mindsets', ranging from those open to cannabis use and legalisation to those mostly against both:

Figure 4: Cannabis mindsets among Londoners*



*For detailed descriptions, see Thinks Insight & Strategy (2023). *Lived experiences of cannabis among Londoners*. MOPAC

[195] See footnote #192. *Accessed 16th August 2023.*
[196] See footnote #191. *Accessed 17th August 2023.*
[197] See: How harmful is cannibus to people who regularly use it? (yougov.co.uk); How harmful is cocaine to people who regularly use it? (yougov.co.uk); How harmful is ecstacy to people who regularly take it? (yougov.co.uk); How harmful is tobacco to people who regularly use it? (yougov.co.uk); How harmful is alcohol to people who regularly drink it? (yougov.co.uk) *Accessed 2nd August 2024.*
[198] See footnote #192. *Accessed 17th August 2023.*
[199] Ibid.
[200] See footnote #189. *Accessed 17th August 2023.*
[201] See Appendix D.
[202] See footnote #191. *Accessed 17th August 2023.*

6.9 Irrespective of mindset, though, the possibility of a five-year custodial sentence on conviction of cannabis possession felt overly harsh (and was surprising to many). More widely, surveys suggest around half of Londoners (and 42% of the public nationwide) believe cannabis laws should be less tough.[203]

6.10 While Londoners largely understand cannabis is an illegal Class B drug, many in our research assumed there would be few if any consequences if caught consuming or carrying small amounts. This is based partly on seeing cannabis openly supplied and consumed with no perceived police response. A number of participants were also surprised to learn it is illegal to use cannabis at home, with a broad view that such use is not – and should not be – policed.

6.11 Across mindsets, and among respondents to our online survey (N=153, Appendix C), there was a perception that the current legal system is failing. And for many, attempts by police to uphold cannabis laws are seen to be inconsistent, a poor use of resource and frequently resulting in unfair outcomes, particularly for those from ethnic minority (excluding white minority) backgrounds.

6.12 We explore issues related to policing practice and disproportionality in chapter 10, but the public sense of unfairness being baked into the legal and enforcement system is important. This holds regardless of attitudes towards cannabis per se and the nature of personal experiences of cannabis policing (which vary from amicable to acrimonious).

6.13 Police use of Stop & Search (S&S) showcases this perceived unfairness. Many want an end to the practice with respect to suspicion of cannabis possession for personal use, which is largely felt to be inappropriately and disproportionately applied to black Londoners. A majority of those responding to our online survey felt it was ineffective.

6.14 Flagrant consumption in parks and other public areas, and overt sale of cannabis within communities, is considered a more appropriate focus for enforcement of the law. Accordingly, dislike of cannabis consumption in public spaces was a common theme and people openly using the drug and impacting upon the personal space of others was raised with us throughout the course of our inquiries.

6.15 Indeed, when asked about police activity to control cannabis use in the local community as part of our inquiries, almost half of Londoners asked felt they should do more. One-third agreed what they do now is about right, and around one-fifth considered they should do less (see Appendix D).

6.16 The smell produced when cannabis is smoked (usually with tobacco as is common in the UK and Europe, unlike in the US where it tends to be smoked with no supplement) can be pervasive and intrusive. Consequently, it prompts complaint,

[203] See for example Do you think the current cannabis laws should be tougher, less tough, or are about right? | Daily Question (yougov.co.uk) *accessed 18th August 2023.*

particularly when consumed in spaces frequented by children (e.g. parks, high streets).

6.17 There is frustration with the way cannabis is dealt with in law. Its illegality drives an expectation of enforcement for some (regardless of whether they agree with the law) but at the moment there is a sense that no one wins. Those who use cannabis face criminalisation (with risk seen to be unfairly shouldered by black Londoners), and those who do not, or who object to its use in public spaces, feel the law is not being upheld in their interests:

'You can smell cannabis smoke even if you go for a small walk. On top of that, police reluctance to do nothing about it – pretty much like vehicle crime. They just ignore it.'

6.18 For others, the perceived failures of prohibition outweigh any desire for an upholding of the law:

'With over a third of 16–25 [-year-olds] having tried cannabis in their life, it seems that policing the supply and demand of the drug has failed.'

'The illegality of cannabis production, sale and possession has done nothing to inhibit the potential harms.'

'Criminalising people over the drug wastes tax, ruins lives and incarcerates people, as well as reducing the labour force.'

6.19 Decriminalisation of personal use was largely supported by participants in our research. Some considered it to be the de facto position – though with concerns regarding how, when and to whom the law is applied. And while several would not wish production and supply to also become legal, they recognised the challenges inherent in a model where personal use is permitted but enabling activities are not.

6.20 Having considered evidence and heard from experts in jurisdictions that have gone beyond decriminalisation and fully legalised non-medical cannabis, it is clear that frameworks grapple with a range of issues and trade-offs. Many of these were identified by Londoners in our research, including:

- The protection of young people from harmful substances in general (including alcohol, e-cigarettes/vapes and tobacco, as well as cannabis).
- Age and marketing restrictions.
- Need for quality-assured products to be sold by trained and qualified staff.
- Desire for a mixed economy to facilitate small business participation and support transition for dealers to reduce risk of displacement to other illicit markets.
- Risk of increasing the number of users.
- Balancing individual freedoms or rights of those who choose to use cannabis against those of non-users.

- How to manage the risk of those who use cannabis working or driving while intoxicated.
- How to ensure the (likely inevitable) remnants of the illegal market do not simply undercut prices of legal products.

6.21 The potential for a legal market to end – at least to some extent – involvement of criminal gangs in cannabis supply, and to deliver safer, quality-assured products, was acknowledged. However, there was also distrust of corporate entities and a dislike of for-profit models of regulation, seen by some to pose a risk of harm through financial incentives to increase sales and therefore probably the numbers of people who use cannabis. That said, there was also recognition of the potential for tax revenue and reinvestment of profit into communities.

Awareness of the impacts of cannabis

6.22 Most Londoners in our research considered cannabis use, especially in one's home, to be acceptable – as long as no harm is done to others. The risk to oneself was thought minimal – or at least no worse than smoking cigarettes or consuming alcohol.

6.23 That said, more Londoners believed cannabis to be the substance most damaging to a person's health and wider society (13%) than the national average (8%),[204] suggesting broad support in the capital for a more liberal approach is tempered by some degree of concern about impact of the drug itself.

6.24 And while our research participants who used cannabis cited positive consequences including relaxation, sociability and pain relief, they acknowledged negative effects such as hallucinations, paranoia and a sense of feeling unwell (though tended to attribute such to a 'bad batch' or irresponsible use). They did not, however, see it as down to legal strictures to help people avoid such effects, rather it was an individual's responsibility to manage (through weaker strains, abstaining or using when in the right frame of mind).

6.25 Respondents to our online survey (Appendix C) considered the top drivers of non-medical cannabis use to be relaxation, the management of stress and anxiety, and pain relief. Relatively few cited the desire to get 'stoned' (high), or to be sociable. Taken together with findings from our qualitative research and evidence from witnesses, the adjective 'recreational' to describe use of non-medical cannabis seems for some to be misleading, suggesting a level of active enjoyment that may not always be the case.

6.26 This is borne out in evidence we heard from young people and those working with young Londoners in a range of sectors. The view that cannabis use was driven in many cases by a desire to manage distress resulting from traumatic or otherwise adverse life experiences rooted in childhood and the present day (including as a

[204] See footnote #192. *Accessed 18th August 2023.*

result of anxieties stemming from the Covid-19 pandemic) was relatively widely held.

6.27 The risk of use cited most frequently by respondents to our online survey was damage to the lungs, with over half (59%) reporting this to be a common harm (although associated with co-consumption of tobacco rather than perception of any inherent harm posed by combustion of the drug itself). A criminal record was the second most cited harm (47%), followed by paranoia (cited by 28% of respondents).

6.28 We discuss the impact of cannabis on physical and mental health in chapter 8, including its effects on young people. While our survey suggested high public awareness about the risks to children (70% cited those aged under 16 as vulnerable) there was less awareness of vulnerabilities of young adults. This is concerning for two reasons. Firstly, because of the risks posed by cannabis use to brain development, a process that continues until a person reaches their mid-twenties. And secondly, the fact that cannabis use is particularly prevalent among 16–24-year-olds (see chapter 4).

6.29 More hearteningly, over half (52%) of respondents identified those with a family history of mental illness (including psychosis) to be particularly vulnerable to risks of cannabis, and 43% felt those with a current mental illness to be similarly at risk.

6.30 Given evidence of the impacts and who may be more at risk of harmful effects, in our view there is scope for greater education about cannabis use. While numbers seem to be falling (see chapter 4), very many people still choose to consume the drug and we heard throughout our enquiries how easily available it is. Better education is a theme to which we return throughout this report and is the focus of chapter 12.

6.31 We heard, too, of public desire for more information. In the absence of accessible, credible and objective evidence, views and decisions tend to rely on anecdote and personal judgement. Helping those who choose to use non-medical cannabis regardless of its il(legal) status do so with less risk to health seems to us to be sensible.

7. INTERNATIONAL APPROACHES TO CANNABIS REGULATION

In exploring the UK's approach, we sought evidence from jurisdictions around the world who have adopted, or are in the process of adopting, alternatives to prohibition. Our enquiries were not exhaustive, and we acknowledge there are several countries where non-medical cannabis is decriminalised or legally regulated but with whom we did not engage (e.g. South Africa, Thailand, the Czech Republic).

That said, we heard from experts hailing from several US states, Australia, Canada, Catalonia, Denmark, Germany, Luxembourg, Malta, Mexico, Portugal, Switzerland and Uruguay. These experts occupied roles within policing and criminal justice, health, policy, not-for-profit and other third sector organisations, academia and government. We have also considered the positions in the Netherlands, Spain and New Zealand.

This chapter is in two parts: the first describes regulatory models in place in those countries considered, the second considers evidence of effects on public health, crime and policing and economic considerations. Due to earlier adoption of non-prohibitive approaches, the majority of evidence originates in the US and Canada.

While jurisdictions differ in precise drivers of regulation, grappling as they are with specific challenges brought by different domestic contexts, broadly speaking they aim to:

- Protect public health and safety through provision of quality-assured products and education regarding the risks and effects of cannabis consumption.
- Combat the illicit market through transitioning purchases to a legal market, ensuring state and citizens, not criminal enterprises, benefit from profits.
- Combat cannabis use particularly among young people.
- Address disproportionate harms caused by the war on drugs, whereby people of colour are more likely to be arrested, charged and convicted of cannabis offences.

It is clear to us, however, that, even where non-medical cannabis has been legally regulated for some years, robust evidence of the extent to which these aims have been met is limited. We find it hard, therefore, to disagree with the conclusion of the International Narcotics Control Board in its Annual Report 2022 that:

> '*It is difficult to assess the impact of the ongoing legalization initiatives on society and individuals. In many States, the time since these laws have come into effect is too short to produce valid data and to judge the full effects of legalization. The consequences do not appear immediately after enactment or implementation of the relevant law and regulations… The impact of legalization on public health,*

public safety and the economy is difficult to measure and varies according to the different legalization model."[205]

7a: Alternatives to prohibition in regulating non-medical cannabis

Details were accurate at time of writing. Positions with respect to use, purchase and supply of non-medical cannabis may have since changed. We consider the frameworks adopted in the US and Canada first because we consider them to represent the most extensive alternatives to wholesale prohibition. Uruguay, the first country in the world to legalise use of non-medical cannabis, follows, and we then explore the positions of various European countries. The section concludes by describing the situation in Australia, New Zealand and finally Mexico.

The US

7.1 Cannabis in the US is illegal at federal level. This means it remains prohibited by the Controlled Substances Act and is, at time of writing, classed as a Schedule 1 narcotic. However, the Biden Administration initiated investigation of rescheduling the drug in 2022. The Health & Human Services Department duly recommended it be moved to Schedule 3 in 2023, and the Drug Enforcement Administration concurred with that recommendation the following year.

7.2 This means that, while remaining illegal for non-medical use at federal level, cannabis will sit alongside other substances seen as posing a low to moderate risk of abuse and harm with some potential for medicinal purpose, such as ketamine and anabolic steroids. It will no longer be classed alongside those substances considered to pose a much higher risk with no medicinal value, including ecstasy, LSD and heroin. (Although note that while the US considers heroin to hold no medical value, the UK position differs. Here, it may be prescribed under the generic name diamorphine for use as a powerful painkiller to treat acute or chronic pain, including during terminal illness).

7.3 The move follows the Presidential pardon issued in 2022 to all Americans convicted at the federal level of possessing small amounts of cannabis. While this had little immediate impact as no individual was serving a custodial sentence at the federal level solely for possession of cannabis (most such convictions occur at state level), it was also intended to support those with prior convictions for possession to secure employment, housing and education opportunities.

7.4 Despite federal prohibition, many states have made their own laws in relation to both medical and non-medical cannabis – although anyone involved in the industry is technically engaging in illegal activity under federal law, which can make traditional methods of banking and investment (and interstate commerce) difficult. Sales are regulated and taxed at state level and provisions regarding public

[205] unis.unvienna.org/unis/uploads/documents/2023-INCB/INCB_annual_report-English.pdf pp.17–18. *Accessed 5th October 2023.*

consumption, the amount that adults (over 21) can possess, and permissions to grow plants at home vary from state to state.

7.5 As at November 2023, 38 states, four territories and Washington D.C. had passed laws allowing cannabis to be used for medical purposes and 24 states, three territories and Washington D.C. permitted non-medical use (although not all permit commercial sales), as shown in Table 1. (Note sales do not begin until sometime after legislation for use is passed). States where non-medical use remains illegal all share at least one border with a state where its' use is now legal.

Table 1: Legal regulation of non-medical cannabis in the US[206]

Date of legalisation*	US State/territory
2023	Delaware, Minnesota, Ohio, US Virgin Islands
2022	Missouri, Maryland, Rhode Island
2021	Connecticut, New York, New Mexico, Virginia**
2020	Arizona, New Jersey, Montana
2019	Guam, Illinois
2018	Michigan, Northern Mariana Islands, Vermont
2017	-
2016	California, Maine, Massachusetts, Nevada
2015	-
2014	Alaska, Oregon, Washington D.C.**
2013	-
2012	Colorado, Washington (state)

* Date when legislation approved. Date legislation takes practical effect follows in due course.
** [207]

7.6 In US states where cannabis is legalised, the 'for-profit', or commercialised model dominates. This means entities that have rights to cultivate, process, distribute and sell products do so in a manner which maximises profits, not necessarily public health or safety. While the practice is restricted in some states, many industry players operate on a 'seed-to-sale' basis whereby all associated processes are vertically integrated within one company.

7.7 Levels of taxation, along with mechanisms of licensing and regulation, are set by individual states and differ accordingly. Most, if not all, stipulate how much of the revenue raised through cannabis taxes goes back into drug treatment, healthcare, education and research and for many there is overt intent to focus on communities most harmed by the 'war on drugs' (usually communities of colour). Several states were suggested as good models of such reinvestment programmes, including California, Illinois and New York, all of which include specific programmes and

[206] As at time of writing, based on State Medical Cannabis Laws (ncsl.org), Table 1. *Accessed 8th August 2024.*
[207] In Virginia, a bill allowing legal recreational sales to commence in 2025 has passed but remains vetoed by the state Governor. Limited home grow, possession, and gifting is permitted. In Washington D.C., while the measure technically allows for commercial sales of cannabis by licensed retailers, Congressional opposition means no regulatory system has been implemented to allow for this. Limited home grow and gifting of up to one ounce is permitted.

policies funded at grass-roots levels to support community-wide, community-led development.

7.8 States also differ with respect to public use of cannabis. In some, such as Washington state and Colorado, this remains a civil offence punishable by a fine or some form of community service order. This can help limit exposure of non-users in public spaces to the distinctive smell of smoked or vaped cannabis – which is an important consideration for us. Our enquiries have highlighted widespread dislike of public consumption of cannabis in London and the issue is recognised by the public and local government leaders as a concern across the capital.

7.9 Making public consumption a civil offence, however, is not without challenge. It effectively discriminates against those unable to consume the drug at home for a range of reasons, including because to do so would infringe private or social rented housing policy. This can further exacerbate discrimination against communities of colour, who are more likely to live in rented housing and who have already been particularly harmed by the war on drugs through disproportionate criminalisation.

7.10 This is principally why New York, for example, which legalised cannabis for non-medical purposes in 2021 (first shops operational from late 2022), permits the smoking of cannabis wherever smoking cigarettes is permitted. While this means, for example, it cannot be consumed in vehicles, restaurant patios and public parks, early indications suggest the approach is also not without difficulty. We heard anecdotally that the smell of cannabis is pervasive across large areas of New York City and, indeed, the issue was highlighted in media coverage of the 2023 US Open tennis championship, where several players complained of a smell of cannabis on the court.[208]

7.11 Free speech laws in the US mean commercial advertising of cannabis, like tobacco, is permitted in all states, although some have limited what products may be marketed, where and how. That said, we heard anecdotally of a proliferation of advertising in some states, particularly on large billboards alongside highways (in California, for example).

7.12 Many states also place limits on product packaging, not permitting, for example, edibles to be sold in shapes and wrapping that might appeal to children or otherwise be confused with standard food products. It was put to us that such rules are frequently violated, however, due to lack of clear enforcement and sufficient civil penalties for businesses who choose to violate these laws.

7.13 We heard about the crucial importance of having licensing and regulatory frameworks not only agreed but in place and operational from the moment legal regulation is passed into statute, with clear guidance to support applicants. California, which was the earliest adopter of legalised medical cannabis in 1996,

[208] Weed at the U.S. Open? Some Players Swear They Can Smell It – The New York Times (nytimes.com) *Accessed 6th October 2023.*

failed to introduce a regulatory framework until almost 20 years later in 2015, when it became apparent that a vote on legal regulation for non-medical cannabis was inevitable.

7.14 It was put to us that this effectively created a chaotic and piecemeal approach to cannabis regulation whether for medical or non-medical use, and that 'birthing' a marketplace and subsequently trying to wrap a regulatory framework around it had made it more difficult to achieve associated legislative aims.

7.15 Learning from California's experiences, the states that followed in legalising medical and/or non-medical cannabis have adopted a more proactive approach, attempting to ensure frameworks and licensing regimes were designed and agreed before being implemented.

7.16 Having such plans agreed on paper, however, is not the same as having systems fully operational and properly resourced. Several witnesses commented that despite a well-considered system in New York, with social equity principles at its heart (see part 7b of this chapter), insufficient thought and resource was committed to its roll out and subsequent operation.

7.17 This meant that, when non-medical cannabis became legal, the responsible office was overwhelmed, and applicants seeking a licence to cultivate, distribute and/or sell cannabis have reportedly struggled to access and navigate the system. This is particularly challenging for those whom the system is designed to prioritise – notably people from communities most harmed by the war on drugs of recent decades.

7.18 We heard, too, that delays in implementation of the regulatory framework have allowed, particularly in New York City, illicit operators to gain a firm foothold in the emerging non-medical marketplace.

Canada

7.19 In 2016, the Canadian government acknowledged its prohibitive approach to non-medical cannabis had failed, highlighting that thousands of citizens had sustained criminal records for (non-violent) cannabis offences, cannabis use among young people was among the highest worldwide and organized crime was reaping billions of dollars in profits from cannabis sales.

7.20 The government was thus persuaded to pursue legal regulation for non-medical use, following legalisation of medical use in 2001. Legal regulation had been a campaign issue prior to the election of the government, and enjoyed high levels of support – certainly a majority of the public felt cannabis possession should not be subject to harsh criminal sanctions.

7.21 A specialist Task Force[209] considered the most effective means of meeting the government's desire to address the social and health harms associated with cannabis, and its findings informed the Cannabis Act of 2018. Canada became the second country in the world after Uruguay (see below) to legalise non-medical cannabis for adults.

7.22 In line with recommendations from the Task Force, and given experiences in the US, efforts were made to ensure capacity for a legal cannabis industry was developed in key areas prior to the start of the regulatory regime (including laboratory testing, licensing and inspection). The government also committed $46 million for cannabis education and awareness, and its legislation required an evaluation be conducted after three years to determine whether and how legal regulation is meeting its objectives.[210] This review was recently completed[211] and its considerations are highly relevant to our work. They include:

i. Health and consumption habits of young people.
ii. Impact of the cultivation of cannabis plants in a housing context.
iii. Economic, social and environmental impacts.
iv. Access to regulated, lower-risk, legal cannabis products.
v. Deterrence of criminal activity and displacement of the illicit market.
vi. Impact on access to medical cannabis.
vii. Impacts on Indigenous peoples, minority communities and women – including whether they face greater barriers to participation in the legal industry.

7.23 Today, non-medical cannabis is permitted in all ten Canadian provinces and its three territories. While the federal government controls production licences (as of 31st March 2023, it had issued 913 – a ninefold rise from the 100 licensed at the point of legalisation), retail is the responsibility of each province/territory. Some chose a state-owned model that follows the way alcohol is regulated in many areas (i.e. state monopolies for distributors and retailers); the remainder operate commercial models.

7.24 Despite the number of production licences (913), and original intent to prioritise smaller producers, the market has become somewhat monopolised by a handful of large companies: according to the Competition Bureau of Canada, the six largest cannabis producers have an overall industry market share in excess of 40%.[212]

7.25 Prices are variable by province/territory (as in the US). In 2019, legal cannabis was cheapest in Quebec ($7.88 per gram) and most expensive in New Brunswick ($11.36 per gram), which at the same time also hosted the cheapest illegally sourced cannabis at $4.90 per gram (followed by Quebec at $5.08 per gram).[213]

---

[209] A Framework for the Legalization and Regulation of Cannabis in Canada - Canada.ca
[210] S.151(1)(2) of the Act Cannabis Act (justice.gc.ca)
[211] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca
[212] Competition Bureau submission to Health Canada and the Expert Panel to support the *Cannabis Act* legislative review. Available at Planting the seeds for competition (canada.ca)
[213] Average price of cannabis, by province, 2019 (statcan.gc.ca) *Accessed 9th October 2023.*

7.26 The Cannabis Act sets out restrictions on production, sales and marketing, with responsibilities shared across federal and provincial governments. The latter, for example, set minimum age limits for purchase (if higher than the federal minimum age of 18), maximum amounts permissible to possess in public or share with others (up to a federal maximum of 30 grams for both) and how many plants (up to a maximum of four) can be grown per residence.

7.27 While cannabis edibles and concentrates have been legal since 2019, not all provincial governments adopted the permission wholesale. Quebec, for example, has explicitly limited the type of edible products available throughout the province, banning sweets, confectionery, desserts and cannabis-infused chocolates. As a result, the types of edible products currently available in the Quebec market include beef jerky, fruit-based bites, dried figs, infused beets and beverages.

Uruguay

7.28 In 2013, Uruguay became the first country in the world to legalise adult-use cannabis, principally to combat violent crime associated with the illegal drug trade and deal with rising pressures on the criminal justice system, alongside a desire to improve public health through access to quality-assured product. Notably, personal possession of all drugs had been decriminalised since 1974, and there was relatively widespread social acceptance of cannabis use,[214] although this did not necessarily translate into majority support among the public for its legal regulation.

7.24 The country adopted a non-profit, state-run model. This means the government controls prices, which products can be sold (and their potency), who can purchase and how much they may purchase. It also issues multi-purpose licences for cultivation, processing and packaging of unbranded cannabis and for distribution to pharmacies (five companies are currently licensed).[215] Retail sales are permitted through for-profit pharmacies, although within the parameters set by the government's price controls.[216]

7.25 Consumers have three options for accessing legal cannabis, all of which require registration with the government via the *Instituto de Regulación y Control del Cannabis* (Institute for the Regulation and Control of Cannabis). They cannot combine sources, so must decide which one of the routes they wish to use:

i. Home grow, where up to six (female) plants may be grown for personal use. Sales are prohibited – if surplus is produced, the grower must call the regulator to collect it, or otherwise throw it away.

[214] Magson, J. (2014). *Drugs, Crime and Decriminalisation: Assessing the Impact of Drug Decriminalisation Policies on the Efficiency and Integrity of the Criminal Justice System*. Winston Churchill Memorial Trust.
[215] Seddon, T. & Floodgate, W. (2020) *Regulating Cannabis: A Global Review and Future Directions*. Palgrave Macmillan.
[216] Pardal, M., Kilmer, B., d'Auria, S., Strabel, T., Galimberti, S., Hoorens, S., Decorte, T. & Senator, B. (2023). *Alternatives to profit-maximising commercial models of cannabis supply for non-medical use*. RAND Corporation.

ii. Join a not-for-profit cannabis social club[217] (CSC – see section on Spain and Catalonia) where members cultivate cannabis collectively for their own consumption with no profit motivation.[218] Membership is capped at 45 members with a 40-gram monthly consumption limit per member.

iii. Purchase one of six types of dried flower (edibles, oils etc are not permitted) from a pharmacy, with purchases limited to 40 grams per month or 10 grams per week. THC levels in pharmacy products are lower than those in home-grown cannabis and in that available in CSCs, and prices are capped at $1.82 per gram.

7.26 Indoor smoking of cannabis is prohibited in all places where tobacco smoking is banned, and it is not permitted on school or hospital premises. Driving following consumption is banned.

7.27 We were told that the number of registered cannabis users in Uruguay represents an estimated one-third of all those in the country who use the drug. It was put to us that the requirement to register with the government is likely to deter many given levels of public mistrust, although those who have done so consume quality-assured product. This is likely to be less potent (and therefore less risky) than that available from the illegal market (though they may of course dual-purchase from both legal and illegal markets).

Portugal

7.28 In 2001 Portugal decriminalised possession of all drugs for personal use in an attempt to stem rising drug use and associated health and social issues, arguing that criminal punishment does not deter people from using illicit drugs. Possession of relatively small quantities of cannabis for personal use is therefore dealt with as an administrative rather than a criminal offence. Possession of larger quantities, however, and involvement in sale, distribution or production of cannabis, remain activities that are dealt with under criminal law.

7.29 In parallel, Portugal invested in welfare, social support and treatment services (partly through repurposing parts of criminal justice budgets), which were seen as vital elements of a public health approach to drug use. In line with this, 'Dissuasion Commissions' (DCs), established as de facto replacements for criminal courts where possession of drugs is concerned, were set up under the Ministry of Health rather than Justice.

7.30 DCs were created in each of Portugal's 18 Districts and on both its islands, and typically comprise a legal expert, health professional and social worker. Those appearing before them (following police referral) undergo a risk assessment that explores reasons for drug use alongside a range of health and socio-economic

[217] Clubs are tightly regulated and must first obtain approval to run as a non-profit organisation, then register with the Ministry of Education and Culture, and finally with *the Instituto de Regulación y Control del Cannabis*.
[218] Queirolo, R., Boidi M.F. & Cruz, J.M. (2016) Cannabis clubs in Uruguay: The challenges of regulation. *International Journal of Drug Policy*, (34), pp.41–8.

factors. Conclusions from that assessment inform the DC's decision regarding whether to issue any sanction(s) and what it/they should be.

7.31 As the name suggests, DCs aim to discourage drug use and they have several administrative penalties at their disposal, including fines,[219] community work, regular reporting to the commission, withholding of social benefits and group therapy. They may also refer a person to treatment and can execute further sanctions following non-compliance with any condition imposed, including referral to the criminal court. We heard, however, that non-compliance is low – in part because sanctions are negotiated to ensure they take the form of something that works with an individual's personal capabilities and capacities.

7.32 The majority of referrals to DCs are due to cannabis possession (we were told they make up around 80% in Lisbon). Most do not, however, demonstrate problematic use[220] and thus attract no, or minimal, sanction. Proceedings are commonly suspended,[221] with less than 10% routed into significant intervention. Referral to drug treatment or addiction services tends to be reserved for those with current or previous symptoms of psychosis, although the aim is reduction of, or abstinence from, cannabis use. Signposting to employment centres is common as many risk assessments identify long-term unemployment as a factor in cannabis use.

Spain & Catalonia

7.33 While production, importation and sale of non-medical cannabis are criminal offences, possession and home cultivation for personal use are decriminalised, up to a certain limit (typically around 100 grams, or 3.5 oz). Any plant visible from a public space, however, is not permitted and can lead to a fine of between €601 and €30,000, as can public possession or consumption of cannabis.[222]

7.34 Law enforcement is prolific in this regard: in 2020, Spain recorded around four in ten (n=258,379) of all sanctions across Europe for cannabis use or possession,[223] although past-year prevalence of adult use was higher in both France and the Czech Republic.[224]

---

[219] The law stipulates that a financial penalty cannot be levied to a drug-dependent person due to a risk that it may lead to further offences to obtain the money. For non-dependent users, amounts levied can be increased with any successive appearance before the DC.

[220] Up to 90% of individual cases in 2018 were reported as not demonstrating problematic use; see https://transformdrugs.org/assets/files/PDFs/Drug-decriminalisation-in-Portugal-setting-the-record-straight.pdf and footnote 26: SICAD (2020). Statistical Bulletin 2018: Illicit Substances. p.7. http://www.sicad.pt/BK/EstatisticaInvestigacao/ Documents/2020/sinopses/SinopseEstatistica18_ substanciasIlicitas_EN.pdf

[221] Eastwood, N., Fox, E. & Rosmarin, A. (2016). *A Quiet Revolution: Drug Decriminalisation Across the Globe*. Release. pp.28–9.

[222] Spain, Country Drug Report 2019 | www.emcdda.europa.eu *Accessed 10th October 2023.*

[223] Statistical Bulletin 2022 — drug law offences | www.emcdda.europa.eu *Accessed 10th October 2023.*

[224] Cannabis use in Europe 2020 | Statista *Accessed 10th October 2023.*

7.35 The introduction of administrative sanctions for public use of cannabis was partly what led to emergence of the not-for-profit Cannabis Social Club (CSC),[225] as users protested against perceived interference in their private lives.[226] The first CSC emerged in 2001 in Barcelona (Catalonia), and they have since proliferated across the region and Spain as a whole (and are central to Uruguay's not-for-profit model of legal regulation). It is not clear how many there are in total, but in 2017 estimates ranged from ~800 to over 1,000,[227] with several hundred in Barcelona alone. It was put to us that numbers have since increased, with the total number somewhere between 1,500 and 2,000.

7.36 Existing in something of a legal grey space, the model took advantage of a loophole created by a Supreme Court jurisprudence that '*distinguished between possession for personal consumption and possession for distribution*' and permitted '*shared consumption among those dependent on drugs'.*[228]

7.37 This meant no criminal offence was deemed to have occurred where drugs were purchased for immediate consumption among a closed group of users and no profit was made from their distribution.[229]

7.38 However, a subsequent Supreme Court judgment concluded CSC activity creates a risk of distribution to, and use of, cannabis by non-members, and thus clubs should be considered criminal endeavours.[230] A statement in 2015 set this out: *'…organised, institutionalised and persistent cultivation and distribution of cannabis among an association* [i.e. CSCs] *open to new members is considered drug trafficking'.*[231]

7.39 This left clubs in a precarious position. While not a police priority (indeed, it was put to us that some feel clubs reduce public consumption and dealing), they remain at risk of closure and the owners risk prosecution.

7.40 A number of regions have attempted to introduce their own regulatory frameworks to legitimise clubs, but so far all have been declared unconstitutional by the national government. The Basque Country is the exception, although while it is the

[225] The history behind the CSC model, its operation and impacts are too complex to cover here in detail but are set out in many sources, including: Marks, A. (2019). Defining 'Personal Consumption' in Drug Legislation and Spanish Cannabis Clubs. *International and Comparative Law Quarterly (68)*, 193–223: Pardal, M., Decorte, T., Bone, M., Parés, Ò. & Johansson, J. (2020). Mapping Cannabis Social Clubs in Europe. *European Journal of Criminology,* pp.*1–24*. doi.org/10.1177/1477370820941392: M. Pardal, Ed. (2022). *The Cannabis Social Club.* Routledge.
[226] See Sánchez, C. & Collins, M. (2018). *Better to Ask Forgiveness Than Permission: Spain's Sub-national Approach to Drug Policy*. Policy Brief 12, Global Drug Policy Observatory, Swansea University.
[227] Decorte, T., Pardal, M., Queirolo, R., Boidi, M.F., Avilés & Franquero, O.P. (2017). Regulating Cannabis Social Clubs: A comparative analysis of legal and self-regulatory practices in Spain, Belgium and Uruguay. *International Journal of Drug Policy*, (43) pp.44–56.
[228] Franquero, O.P. & Bouso Saiz, J.C. (2015). *Innovation Born of Necessity: Pioneering Drug Policy in Catalonia*. Open Society Foundations.
[229] This has its origins in the 1980s when the system was overwhelmed with heroin users purchasing small amounts for peer distribution. The law meant they were charged with trafficking, resulting in very many people being given prison sentences.
[230] See footnote #226.
[231] Spain, Country Drug Report 2019 | www.emcdda.europa.eu *Accessed 10th October 2023.*

only region whose regulations have not been suspended by the Constitutional Court the law has not been developed further, leaving the legal position in limbo.

7.41 In keeping with their origins, CSCs are largely non-profit associations, whose members are adult users of cannabis. An existing member must verify any prospective member as a cannabis consumer, to help ensure clubs do not encourage people to begin taking the drug. Membership fees cover cultivation and operating costs, with revenue reinvested into the club. Clubs provide information on the CBD, THC and terpenes specific to strains offered, and daily limits on individual consumption help growers know how much cannabis to cultivate. These also reduce the chance of product being diverted for sale through the illegal market.

7.42 Clubs provide space for members to relax and consume cannabis with other members, although not all do so, preferring to consume at home (small amounts are permitted for off-site consumption). Many also provide opportunities to listen to music and watch sport or other entertainment and may offer a range of (non-alcoholic) drinks and snacks, adopting more of a café environment. Consumption of other types of drugs is prohibited and any member caught attempting to do so is ejected – although it was put to us that this is not a common occurrence.

7.43 Many clubs employ harm reduction strategies,[232] with staff trained to provide advice on safer methods of consumption (e.g. vaping rather than smoking) and less potent strains, and to offer general information about cannabis and risks of use. Seen as trusted, credible voices, where they detect signs of problematic consumption staff are encouraged to signpost a member into treatment services.

7.44 In recent years, however, the original ethos and model of the CSC has been somewhat reinterpreted, with some now much bigger than originally intended. Many are aimed at tourists, with touts used to approach visitors in key tourist areas (particularly in Barcelona) to encourage them to sign up.

7.45 A majority of these larger clubs are thought to be run by organised crime groups (OCGs), which often control large cultivation sites and sell the product through a CSC. Because criminal players are much larger than locally based operators, they can better afford to take the risks of operating without legal cover.

7.46 This development is shifting the dynamic: clubs run by criminal enterprises are remaining open at the expense of smaller non-profit associations. It was put to us that the Supreme Court judgment several years ago that effectively prevented formal regulation of CSCs (although a number of Cannabis Social Club Federations provide guidance and codes of practice to members) has helped facilitate the entry of organised crime into the market.

[232] See for example RdRCannabis, which in partnership with the Health Department of Catalonia seeks to support and complement risk and harm reduction endeavours undertaken by clubs. Home - rdrcannabis.cat *Accessed 2nd August 2024.*

7.47 More widely, the original non-profit ethos of CSCs has been adopted by recently introduced legislation in Malta and is a core part of endeavours in Germany and Switzerland to introduce limited forms of legal regulation for non-medical cannabis.

Malta

7.48 Malta de-penalised cannabis possession in 2015, meaning individuals caught by police with small amounts of the drug (up to 3.5 grams) are diverted to the Commissioner for Justice and given a fine instead of facing criminal consequences. The country legalised the medical use of cannabis in 2018.

7.49 In 2021, it partially decriminalised cannabis for personal use and became the first country in Europe to legally regulate a limited number of activities related to collective cultivation and distribution of the drug, though in a much more limited fashion than Canada and the US. It was emphasised to us that the change centres on individual rights and public health, allowing those who consume cannabis to do so more safely without fear of prosecution or exposure to adulterated and synthetic cannabis.

7.50 Cannabis has not been legalised wholesale. The legislation permits use and possession, with a limited framework for cultivation – so is more akin to a 'decriminalisation plus' model. From the age of 18, adults may carry up to seven grams of cannabis in public, grow up to four plants per household (if they remain out of sight to third parties), store up to 50 grams of dried cannabis flowers at home and consume the drug in a private setting. Public consumption, however, remains illegal and carries a fine.

7.51 Notably the model does not explicitly seek to shrink the illegal cannabis market from the outset, acknowledging that it will take time for legal regulation to grow and consolidate sufficiently to meet demand. In order to sustain focus on public health and harm reduction, the approach is not-for-profit because, as it was put to us, for-profit models are diametrically opposed to public health. The alcohol and tobacco industries were cited as examples that gain from increases in both the number of users and high-risk use – in contravention to notions of public health.

7.52 As befits its non-profit approach, Malta does not permit marketing or advertising of cannabis, and there is no traditional retail market. Those unable or unwilling to pursue home grow can join a non-profit (collectively owned) Cannabis Harm Reduction Association (CHRA). These offer several services, among them access to cannabis flowers. They are modelled on core principles of the peer-led CSCs established in Spain, although consumption is not currently permitted on site and staff must engage in harm-reduction activity (such as encouraging users to adopt less risky methods of consumption). Each association will cultivate, process and distribute cannabis among its own membership base.

7.53 CHRAs must register with and be licensed to operate by the newly created regulator, the Authority for the Responsible Use of Cannabis (ARUC). They must have a minimum of two founders, both aged 18 or over and resident in Malta for at

least five consecutive years. Cultivation must be undertaken away from the CHRA, which is then used as the distribution mechanism.

7.54 Clubs are permitted a maximum of 500 members, in part to discourage larger corporate operators and retain the ethos of ensuring safer ways for those who choose to do so to consume cannabis. As of time of writing, applications had been made by a mix of associations, some seeking a licence for around 100 members, with others planning for up to 500. The ARUC currently charges €1,000 for a licence that accommodates up to 50 members, €13,000 for a licence that accommodates up to 250 members, and €26,000 for a licence that permits up to 500 members.

7.55 We understood that ARUC does not expect to grant licences to all applicants. Plans will be carefully scrutinised and those deemed not to be genuinely not-for-profit, or which do not set out clear harm-reduction strategies, will fail. Similarly, applicants are subject to rigorous checks including criminal and financial histories, and funds flowing into and out of associations will be regulated, with wages expected to be in line with average market rates.

7.56 ARUC neither fixes prices for cannabis nor levies taxes, in an attempt to allow CHRAs to compete with the illegal market more easily. Nor have they placed a cap on the number of licences they will issue, on the basis that the more there are, the greater the capability to provide a safer way for users to consume cannabis. Members will be permitted a maximum of 50 grams per month and the intention is that, in time, the quality and assured nature of the product available through CHRAs or home grow will encourage a permanent shift from illegal sources.

7.57 Some criticism has been levelled at the decision to bring in a form of legal regulation, notably from Malta's National Addictions Advisory Board, which is concerned about the potential for motor vehicle accidents resulting from cannabis intoxicated drivers. However, and as we discuss elsewhere, this issue is complex as there is currently no reliable technology or other form of test to distinguish cannabis as present in the bloodstream (which could be a consequence of consumption several days or even weeks previously) from cannabis intoxication, which evidence suggests impairs motor skills and judgement.

7.58 Expungement of criminal convictions sustained for cannabis possession is permitted under the new law, acknowledging that those previously convicted of such should not continue to suffer the consequences of behaviour no longer considered criminal. The process however is not without complication, and is not automatic: it must be undertaken via court decree, meaning applicants require legal support to navigate the requirements. This leaves open the possibility that expungement will only ever be an option for those who can afford to engage with the demands of the process.

Luxembourg

7.59 Luxembourg is embarking on a two-stage journey towards a fully regulated market for non-medical cannabis, following a commitment in 2018 by the former coalition government and the legalisation of cannabis for medical use that year. The commitment recognised that demand for cannabis across Luxembourg is not abating, with increasing numbers of both users and high consumption users, particularly among the youth population.

7.60 Moreover, there was growing concern about risks associated with the consumption of illicit cannabis of unknown quality and constitution. The cautious view of the former government was that on balance, some form of regulated market would not risk more harm than prohibition, and that public health would, in the longer-term, benefit.

7.61 A concept paper set out the plan in detail[233] and from July 2023, as per stage one of implementation, it became legal for a household to grow up to four cannabis plants and for cannabis to be consumed within the home. Criminal proceedings remain in place with respect to possession, transport or purchase of cannabis, though the new legislation reduces the range of fines available. Public consumption of cannabis remains illegal.

7.62 Implementation of stage two depends on the political will and priorities of the new coalition government, which following elections in October 2023 has been in place since November of that year. Public health considerations lie at the heart of this second stage, including safeguarding consumer health more effectively via access to quality assured cannabis, diverting people from adulterated or synthetic products procured via the illegal market. Over time, the wider strategy hopes, too, to reduce organised crime through shifting cannabis purchases from the illegal to the legally regulated market.

7.63 Under the plans, vendors would be trained to signpost customers to CBD-dominant strains first, thus encouraging purchase of lower-potency products, and to introduce alternative methods of consumption that do not involve co-consumption of tobacco (e.g. vaping). Legal regulation also aims to reduce the stigma surrounding cannabis use, which architects of the policy believe is limiting treatment-seeking behaviour among those who develop associated problems.

7.64 The approach draws heavily on that adopted in Canada, in particular the model developed in Quebec. Here, legal retail of cannabis is limited to state-owned outlets, meaning the provincial government retains control over pricing as well as the number and location of stores. If it proceeds, Luxembourg plans to open 14 cannabis retail outlets across the country, which would similarly be state-owned and -run. Seeking to maximise profit is thought to undermine public health aims,

[233] See Non-medical use - Health Portal - Luxembourg (public.lu) and Report of the "Cannabis for Non-Medical Purposes" Working Group: *Pilot Project for Legal Access to Cannabis for Non-Medical Purpose*. (2023). Ministry of Health, Ministry of Justice (Luxembourg). *Accessed 11th October 2023.*

so will not be a priority. Instead, outlets will focus on promoting safer use of cannabis and signposting treatment services where necessary.

7.65 Production and distribution will not be state-owned, but fee-based licences will be issued to private cultivators and operators. There is currently no intention to cap the THC content in flower-based products on the basis, we were told, of research which purportedly found no evidence that such a cap would support public health aims. It was put to us that people choosing to use cannabis would simply consume twice as much in order to achieve the desired effect (known as 'compensatory smoking' in the tobacco field) and that it would increase the risk of consumers shifting to the illicit market.

7.66 The position in Luxembourg underlines the importance of agreement regarding the primary purpose of any legally regulated market. Raising taxes is not a priority in the model; likewise in Malta, because financial aims arguably undermine their principal aims of improving public health. This is obviously the case with any industry selling a product with potential to damage health: rising consumption can raise health risks in tandem with profits – as is the case, of course, with alcohol, tobacco and sugar. It is easy to see, therefore, how tension between health and economic considerations within government makes for a challenging legislative process.

7.67 With this in mind, Luxembourg's strategy decouples health outcomes from cannabis sales. It recognises that commitments to use sales-generated revenue to support treatment services, for example, automatically create a vested interest in increasing sales of what is, after all, a drug with potential to lead to addiction and other health problems for some who choose to consume it.

7.68 Education is a key plank of the strategy and in partnership with the National Addiction Prevention Centre, the Ministry of Education has developed a range of materials related to cannabis use. The intention is for these to be delivered uniformly across schools to all year groups from around age 12 upwards. Messaging will include the potential for cannabis to lead to addiction and associated risks, and how to use cannabis in a less risky fashion should young people choose to do so.

7.69 Wider public campaigns are also planned, focusing on how to engage in lower-risk consumption of cannabis (including consuming without tobacco). Expectations regarding public cut-through and impact are however low to moderate, in recognition of the fact that there is relatively limited evidence of such campaigns affecting significant behaviour change.

Germany

7.70 In its 2021 coalition agreement the German government set out its intention to pass a Cannabis Act, creating a legally regulated retail market for non-medical cannabis which, it intended, would be available in shops nationwide. Drivers included the desire to, as elsewhere, curb the illegal cannabis market, protect

consumers from adulterated product and improve public health outcomes, and reduce drug-related crime.

7.71 However, the proposals risked breaching both UN international drug control treaties and EU regulations (which currently do not allow commercial production and retailing of cannabis for non-medical use). The latter were a particular concern given the risk of direct political consequences as well as the possibility of serious sanctions and tensions with Germany's EU neighbours.

7.72 As a result, the country scaled back its original plan, proceeding with a more restricted two-phase strategy that was passed by parliament in early 2024. The approach was informed by a government-sponsored systematic literature review of impacts of legal regulation elsewhere (predominantly the US and Canada),[234] on which we draw later in this chapter.

7.73 From 1st April 2024, phase one decriminalised non-medical cannabis possession and domestic cultivation. German residents aged 18 and over are now permitted to possess up to 25g of cannabis in public and store up to 50g at home. They may consume the drug in public (though it is illegal to do so near premises including schools, playgrounds and sports grounds) and each household can grow up to three cannabis plants for personal consumption.

7.74 Alternatively, users may register with a non-profit association to procure cannabis. Operational from July 2024, each association, or club, is permitted a maximum of 500 members. Cannabis consumption on the premises is prohibited (similar to the Maltese approach) and all running costs are covered by membership fees.

7.75 Phase two will pilot a time limited 'experiment' where specialist shops in participating cities and municipalities will be licensed for retail sales of non-medical cannabis (similar to Switzerland, see below). Evaluation will consider how public health, youth protection and the illegal market are impacted, as well as how supply chains cope and might scale up for any future roll-out nationwide.

7.76 As an experiment with an associated research strategy rather than a formal change in the law, the expectation is that the plan will not breach EU regulations. This has, however, yet to be tested and at time of writing there remains no further detail or timescale for phase two of the country's approach.

7.77 Medical doctors and the police are reportedly largely opposed to the reforms. As, too, are the political opposition who have committed to scrapping the law if they win power in the next general election in 2025, which serves to highlight how politically controversial the issue of cannabis legalisation remains.

[234] Manthey, J., Hayer, T., Jacobsen. B., Kalke, J., Klinger S., Rehm, J. … & Zobel, F. (2023). *Technical Report – Effects of legalizing cannabis*. ECaLe_Technical_Report.pdf (bundesgesundheitsministerium.de). As a systematic review, this represents a methodologically robust assessment of available literature, encompassing only those studies which met stringent inclusion criteria. Studies we reference that are sourced from this paper we therefore considered to be robust and reliable.

Switzerland

7.78 Cannabis for (limited) medical use has been legal in Switzerland since 2022 with a doctor's prescription (before then, it was possible to obtain but patients were required to apply to the Federal Office of Public Health). The new law allows for easier access with a doctor's prescription, although the use of medical cannabis is not typically covered by compulsory health insurance unless in exceptional cases [235].

7.79 While it remains illegal at the federal level, under a recently launched pilot programme participating cantons may provide non-medical cannabis through regulated, non-profit pharmacies, Drug Information Centres' and social clubs (which allow consumption on site). Participating cantons include Basel, Bern, Geneva, Lausanne and Zurich, each of which is permitted to register a maximum of 5,000 participants who must meet a set of specific criteria[236].

7.80 Participants must prove themselves to be existing cannabis users, Swiss citizens, able to speak the principal language of the canton, and must undergo a range of health tests and questions before entering the pilot and at regular points throughout its term. ID cards are required to purchase cannabis and to demonstrate if stopped by law enforcement that the holder is legally permitted to possess the drug, making them immune from criminal sanction. These measures are intended to ensure scientific rigour and safeguard participant heath[237].

7.81 Irrespective of the canton, all cannabis available through the pilots will be produced organically in Switzerland by pre-approved cultivators. Available in dried flower, edible and hash form, THC levels are capped at 20% for dried flower and 10mg per unit of edibles. Sale prices are set to reflect the current rate in the illegal market. All products must be sold in separate units of five grams with neutral, childproof packaging containing health warnings. Public consumption is prohibited, and violating this rule could result in a person having their cannabis confiscated[238].

7.82 The different cantons will lead independent evaluations of their project, conducted in partnership with universities (Basel's pilot, for example, is known as Weed Care, and in Zurich it is the ZüriCan project). Each will examine the impact of regulated cannabis sales on consumption patterns and the health of users over the lifetime of the pilot[239].

The Netherlands

7.83 One of the most well-known examples of de-penalisation of cannabis for personal possession and consumption, the current iteration of Dutch policy dates back to

[235] https://practiceguides.chambers.com/practice-guides/medical-cannabis-cannabinoid-regulation-2024/switzerland
[236] https://www.bag.admin.ch/bag/en/home/gesund-leben/sucht-und-gesundheit/cannabis/pilotprojekte/faqs.html
[237] Ibid.
[238] See footnote #235.
[239] https://cannactiva.com/en/cannabis-in-switzerland/

the 1970s when the first coffee shops selling small amounts of cannabis for consumption on- and off-premise were established and tolerated.[240]

7.84 A principal driver was the notion of 'separation of markets'. It was thought that, by separating cannabis from other 'harder' drugs such as cocaine and heroin, limited access to the former could be facilitated in such a way that does not expose a user to other, riskier drugs that might be offered by an illegal source.[241] The subsequent amendment to the relevant legislation in 1976 did not technically decriminalise cannabis, but rather implemented written guidelines that instructed prosecutors to consider prosecution of sale and possession of small amounts of cannabis as their lowest priority.[242]

7.85 Following this, in 1977 further legislative changes gave localities across the Netherlands the power to decide whether to prosecute small-scale sales of cannabis, effectively introducing a policy of de-penalisation. This relates to the Dutch concept of *gedogen*, which '*refers to activities that are not legal, but are not treated as illegal unless they cause other harms*'.[243] It also reflects the values placed by the Dutch on individual freedoms.[244]

7.86 The coffee shop phenomenon that emerged in the 1970s expanded throughout the 1980s, leading the government to issue official guidelines for regulation in the early 1990s. Referred to as the 'AHOJ-G' criteria and enacted in 1994, these included limits on both the daily amount that can be sold to individuals and on advertising, which can amount to no more than very low-profile signposting of the coffee shop. Neither alcohol nor harder drugs can be sold or held on the premises (though up to 500 grams of cannabis is permitted) and cannabis sales are prohibited to under-age patrons.[245]

7.87 Failure to comply with regulations led to the closure of many coffee shops from 1997 onwards and further restrictions followed in an attempt to address ensuing concerns about public disturbances related to some shops, as well as the emergence of cannabis tourism. While these restrictions did not, in the main, last very long, as a consequence of regulations more broadly the number of coffee shops has continued to reduce over time and at the time of writing stands at c.570 across the Netherlands.[246]

7.88 The de-penalisation approach, or 'toleration policy', highlights the 'back door problem', whereby Dutch coffee shops selling cannabis are exempt from prosecution for the sale of small quantities (the front door), but still liable to

[240] See footnote #215.
[241] Grund, J-P. & Breeksema, J. (2013) *Coffee Shops and Compromise: Separated Illicit Drug Markets in the Netherlands*. Open Society Foundations.
[242] Stevens, A. (2010) *Drugs, Crime and Public Health: The Political Economy of Drug Policy*. Taylor and Francis Group.
[243] Ibid.
[244] See footnote #241.
[245] Ibid.
[246] Background and design of the controlled cannabis supply chain experiment | Drugs | Government.nl *Accessed 12th October 2023.*

criminal prosecution for the purchase of large quantities to facilitate those sales (the back door).[247] This legal uncertainty is one of the principal challenges of the model, and indeed was identified by many participants in our own research[248] when asked to consider the advantages and disadvantages of a range of approaches to cannabis regulation. The fact that consumers cannot be certain as to the provenance and constitution of the cannabis they purchase is a further difficulty.

7.89 The government has recently come under increasing pressure to address these, and other problems caused by the toleration policy. As a result, they are preparing to launch a four-year experiment[249] in ten regions, to explore the impacts of formally decriminalising cultivation, permitting provision (and regulation) of a quality-controlled supply of cannabis to coffee shops. Growers and coffee shops across participating regions will agree on the strains of cannabis to be provided, and within the framework of the experiment it will no longer be a criminal offence to grow, distribute or sell cannabis.

7.90 Independent researchers have been appointed to monitor and evaluate the impact of the experiment, focusing on public order, crime and public health. While the government acknowledge there may be some economic benefits resulting from the trial, they stress these are not the focus. Key aims are to shrink the illegal market and improve public health, with coffee shop staff trained to provide information about the risks of cannabis and ways to reduce them. Staff will refer customers to sources of further information as well as support and treatment if they see signs of problematic use and shops must display a range of material setting out the risks of cannabis use.

Denmark

7.91 The Danish model for dealing with non-medical cannabis use is one of prohibition, although those found in possession of the drug for personal use are mostly fined rather than arrested. If they show signs of dependency or limited financial means, the police have discretion to issue a caution or divert into treatment.

7.92 The approach was strengthened in the early 2000s, when fine levels were raised and the policing of low-level drug crime intensified, in an attempt to reinforce the deterrence approach and signal zero tolerance to drug use more widely. Surveys assessing consumption and treatment, however, suggest little effect with respect to cannabis.

7.93 It was suggested to us that, as in other jurisdictions, those from marginalised and ethnic minority communities (which, of course, often overlap) are over-policed. That said, in some districts the police are purportedly becoming increasingly resistant to the zero-tolerance approach and are making more of their discretion

[247] Ibid.
[248] See footnote #11.
[249] Controlled cannabis supply chain experiment | Drugs | Government.nl *Accessed 12th October 2023.*

to divert people into treatment. The aim of this approach is ultimately to stop drug use, motivated by the fact police often encounter the same people using cannabis time and again. Which not only suggests the financial penalty approach has limited effect at best, it requires significant police resource to manage.

7.94 Medical cannabis was legalised in Denmark in 2018, so prescription-based cannabis is now possible. As in the UK, however (see chapter 11), there are ongoing issues with implementation, with some doctors reluctant to prescribe and THC in medical cannabis capped at a low level. This means the illegal market continues to thrive – even for those able to access a prescription, it was put to us that the cannabis permitted may not always be of sufficient strength to address symptoms (particularly with respect to pain).

7.95 Denmark is similar in many ways to other countries where non-medical use remains criminalised to some extent. But the country is also notable for its Freetown Christiania district. A commune comprising 15 local areas and situated in Copenhagen's Christianshavn district, it dates back to the countercultural movement of the late 1960s and early 1970s. Legally recognised by the Danish government in 1989, it is very much a community-led enterprise with matters including finances, business operations, construction, and social and public services discussed and agreed at local level.

7.96 An open, illegal cannabis trade has historically been a central element of the district's culture and community. The drug has long been widely sold and used within Christiania and, until around two decades ago, the trade was supplied by small-scale dealers and sales managed through pop-up stalls situated predominantly on Pusher Street. Those involved were largely residents and/or employees of the community (although the district has always attracted a substantial tourist presence). While the police did on occasion raid Pusher Street and its environs, they largely left it alone.

7.97 However, two decades or so ago organised crime gangs, whose members were neither resident in nor employed by Christiania, began to take over the trade, leading to a hardened police approach. Small-scale participants in the trade were largely forced out, unable to afford to take the necessary risks to remain involved. In 2016 two police officers and a civilian were shot and seriously injured by a Danish citizen known to be involved in cannabis sales, which led Christiania residents to remove the cannabis stalls in Pusher Street.

7.98 The stalls ultimately returned, accompanied by regular police raids. But a fatal shooting in 2023, thought to be linked to the criminal cannabis enterprise, prompted residents to call for an end to the district's illegal cannabis trade. A press release issued by Christiania called for it to be replaced by a state-regulated legal market, seen as a more effective way of dealing with the violence through lessening the grip of organised crime over trade of illegal cannabis.

7.99 No such regulation has emerged. Indeed, quite the opposite, demonstrating that cannabis policies globally are not all moving in one direction, namely from

prohibition to liberalisation. In an attempt to end the organised cannabis trade in Christiania, a legal change in early 2024 designated the area an 'enhanced penalty zone'. Those caught in possession of cannabis within the designated area face increased fines for first time offences and imprisonment for subsequent offences. While this is considered likely to reduce the cannabis trade in Christiania, experts have voiced concerns that it will merely relocate to other parts of Copenhagen.

7.100 In terms of the district more widely, it is seeking to lose its former reputation and association. Based on collaborative agreement between Christiania residents, the police and the municipality of Copenhagen, in April 2024 the infamous 'Pusher Street' was dug up with the intention of turning it into a recreational area comprising playgrounds, gardens and creative art shops.

Australia

7.101 Non-medical cannabis is prohibited in Australian federal law, although in practice a majority of states and territories operate a cautioning scheme for minor cannabis and most other minor drug offences. Two, however, have in place some type of de jure (i.e. in law) decriminalisation, namely South Australia and the Northern Territory. Decriminalisation was also in place throughout the Australian Capital Territory (ACT) until 2020, when a limited legalisation scheme was introduced:

i. *ACT*: Possession of all illegal drugs for personal use has been decriminalised (effective since October 2023, and since 1993 for cannabis). However, since 31st January 2020 it has been legal for people over the age of 18 to possess, grow, and use small amounts of cannabis at home, in line with specified limits, namely: up to 50 grams of dry, or 150 grams of fresh, cannabis, and up to 2 plants per person and not more than 4 per household. Those who exceed the limits incur a Simple Cannabis Offence – a civil penalty (i.e.: fine). Using cannabis in a public place, growing it hydroponically or where it is accessible to the public, storing it where children can access it, and using it where children could be affected by cannabis smoke, remain illegal.

ii. *South Australia*: Since 1987, police have issued a Cannabis Expiation Notice (CEN) for minor cannabis possession and cultivation offences. Over time the scheme has been tightened so that at present it is limited to those caught possessing up to 100 grams of cannabis, or 20 grams of resin, or cultivating no more than one plant for personal use.[250]. A fine of up to AU$400 must be paid within 28 days, after which no record is made. If the individual fails to pay, they receive a reminder, which attracts an additional fee. If they still do not pay, they are referred to court, leading to an enforcement fee, automatic criminal conviction and enforcement of the outstanding fine(s).

iii. *Northern Territory*: Cannabis has been decriminalised since 1996[251] and possession of up to 50 grams of cannabis, 1 gram of hash oil, 10 grams of

[250] See footnote #221.
[251] Ibid.

hash or 2 non-hydroponic cannabis plants results in an infringement notice requiring payment of a fine of up to AU$200. Failure to pay results in a debt owed to the state but there is no criminal conviction or formal record.

7.102 While medical cannabis (including herbal cannabis flower) has been legal across the country since 2018, the position in some states and territories with respect to non-medical cannabis has shifted around following changes in government.

7.103 Thus, under the Gallop Labor Government, Western Australia introduced a 'prohibition with civil penalties' scheme in 2004. This meant personal possession (of not more than 30 grams of cannabis or a used smoking implement, or cultivation of not more than 2 non-hydroponic plants) was not legal but if apprehended, citizens were issued with an infringement notice. If they cleared this by paying a fine or completing an approved education session, they would not receive a criminal record. This resulted in many thousands of people avoiding criminal penalties and the adverse consequences for employment, housing and travel that follow criminal conviction.

7.104 The reform was, however, formally repealed in 2011 as part of a 'tough on crime' approach adopted by the then Liberal state government, despite no evidence of a rise in cannabis use. Police may now issue a 'Cannabis Intervention Requirement' (CIR) to anyone found in possession of small amounts of the drug for the first time, but this is at their discretion and users may still end up being prosecuted through the criminal courts. Anyone caught on a subsequent occasion having once been issued with a CIR is automatically prosecuted.

7.105 This recriminalisation took place despite widespread public support, which has been growing steadily since the 1980s, for some form of legal regulation of non-medical cannabis – particularly among young people. Latest data at time of writing showed 78% of Australians supported the removal of criminal penalties for cannabis (an increase from 74% in 2016) and over 40% agreed it should be legalised (up from 35% in 2016).[252] The groundswell of public support for legal regulation remains difficult, however, for politicians who agree. Often labelled 'Soft on Drugs', they can become easy targets for the media and opposition parties, as indeed they are in other parts of the world.

7.106 It was put to us that decriminalisation of possession both reduces the costs of law enforcement (around 76,000 arrests were made in 2019–20 for cannabis possession across Australia)[253] and helps address what can be very severe social consequences for those convicted of a minor cannabis-related offence (as we discuss elsewhere).

7.107 However, because cannabis production and supply remain criminal where possession is decriminalised, users must continue to access the illegal market

[252] See tables 9.15 and 9.23: National Drug Strategy Household Survey 2019, Data - Australian Institute of Health and Welfare (aihw.gov.au) *Accessed 16th October 2023.*
[253] Australian Crime Commission (2021). *Illicit Drug Data Report 2019–20*.

(where unable or unwilling to grow plants at home if this is also decriminalised) with all the risks inherent in doing so. Moreover, decriminalisation does little to address the stigma associated with using what remains an illegal drug, which, it was suggested to us by experts across jurisdictions, does nothing to encourage problematic users to seek help (where drug treatment services exist).

New Zealand

7.108 Cannabis for non-medical use is prohibited in New Zealand. All associated activities remain illegal and the maximum sentence for personal possession is 3 months' imprisonment (though this is rare) or a $500 fine. However, in 2019 the country passed into law a Misuse of Drugs Amendment which gave police greater discretion in terms of arresting and prosecuting those found in possession of illicit drugs.

7.109 The amendment encouraged a health-centred approach, with prosecution reserved for more serious cases where the police considered it to be in the public interest. In practice though, at least for possession of cannabis, police have been increasingly exercising discretion not to prosecute for several years, with associated charges falling quite considerably as a result.

7.110 Cannabis for medical purposes has been legal since 2018 and in 2020, the Misuse of Drugs (Medicinal Cannabis) Regulations 2019 came into force. This enabled implementation of the Medicinal Cannabis Scheme, intended to improve hitherto very limited access to medicinal cannabis products. In practice, however, many argue the Scheme has had little impact with those who find the drug alleviates symptoms of ill health still struggling with access.

7.111 In the same year (2020), in a public referendum held during the general election, New Zealand's voters narrowly rejected a Bill which would have legalised non-medical cannabis for commercial (but regulated) production and distribution, as well as home-growing. Just over half (50.7%) voted against the proposal, with 48.4% in support.

Mexico

7.112 There has been long-standing desire for drug policy reform in Mexico, where from 1920 until recently cannabis was illegal for any purpose. A turning point came in the mid-2000s following various government crackdowns on OCGs trafficking drugs; many thousands of Mexicans were imprisoned following convictions for drug possession, in particular cannabis.

7.113 This led to the establishment of thresholds for possession of certain substances, including cannabis, without danger of prosecution. In 2011, a series of reforms followed that placed human rights at the centre of Mexico's constitution. These made laws compatible with human rights treaties to which Mexico was a signatory, cementing human rights into the country's international obligations. The scene was set for renewed emphasis on drug policy reform and the judiciary were effectively

permitted to accept that such reform was not out of line with human rights and international treaties designed to protect them.

7.114 These reforms paved the way for several cases to be brought to the Supreme Court challenging laws on use of non-medical cannabis. In 2015, the Court ruled that prohibiting people from growing cannabis for personal consumption was unconstitutional as it '…*violated the human right to the free development of one's personality'*,[254] and this was followed by four further cases in which similar rulings were passed, the fifth of which took place in 2018.

7.115 During this period (in 2017), the government also passed a bill permitting use of medical cannabis, although this is limited to pharmaceutical derivatives only, which are imported into the country. The barriers to import can be substantial, meaning products are expensive.

7.116 Under Mexican law, it was necessary for the Supreme Court to rule in five consecutive cases that the law on non-medical cannabis was unconstitutional, in order for legal jurisprudence to be reached. Having done so, the Supreme Court cannot, however, then rewrite the law to enable non-medical cannabis to be fully legally regulated; this must be done by Congress. The necessary bill was drafted and by March 2021 had passed in both parliamentary chambers (Senate of the Republic and the Chamber of Deputies) – but is not yet enacted in full due to ongoing disagreement on several articles.

7.117 This has created something of a halfway house. As a result of the Federal Congress's inability to regulate, the Supreme Court issued a general declaration of unconstitutionality regarding the administrative prohibition system surrounding non-medical cannabis. To operationalise this in the absence of a law in statute, those aged 18 and over may apply for a free-of-charge permit to cultivate and consume their own cannabis. This includes permission to carry up to 28 grams of cannabis (without a permit, over five grams is a criminal offence). As with tobacco, smoking cannabis in public and in front of children is banned.

7.118 If a permit holder is stopped by police, they must articulate their protection in law and show their permit. While not necessarily sufficient to avoid arrest, the permit will protect its holder from subsequent criminal prosecution. Until, however, the court ruling is signed into federal law and a legal structure allowing cultivation, supply and sale of non-medical cannabis is created, cultivation beyond home grow, and transportation of amounts over 28 grams, remain illegal.

7.119 Those unable or unwilling to grow cannabis or apply for a permit remain unable to legally access and consume non-medical cannabis, and those incarcerated for cannabis offences (many of whom have remained unsentenced for many years in

[254] Article 22 in the Universal Declaration of Human Rights Article states that: *'Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.'*

one of the largest prison populations in the world)[255] continue in limbo with no path to release.

7.120 Differences between criteria attached to permits issued at different times creates a confusing landscape and has effectively created different laws for different people. Permits issued more recently, for example, stipulate the maximum number of plants that an individual can grow, whereas earlier permits did not.

7.121 It was put to us that without a change in the law police will continue to arrest people for possession of cannabis, although following the court ruling some judges are increasingly dropping cases and routing people away from incarceration on the grounds that it is unconstitutional. But because the law technically permits it, others continue to imprison people for cannabis possession.

7.122 As we heard elsewhere, people from particular communities are disproportionately more likely to end up being arrested, charged and incarcerated – namely young men from poor households. And it was put to us that women in Mexico can be liable to particularly harsh treatment, attracting more serious charges and lengthier custodial sentences.

7.123 We also heard that since the Supreme Court ruling, several large Canadian cannabis growers have been pressing to access the Mexican market, anticipating the time when the law is fully enacted. As relatively experienced operators (Canada regulated non-medical cannabis in 2018) they are well placed to set up quickly, meet market entry criteria and comply with regulations. This provides them with a significant advantage as it risks undermining the position of local Mexican growers – often operating in entrenched poverty, they are forced to sell their product to criminal gangs who distribute it domestically and internationally.

7.124 One aim of proposed legal regulation is to address the increased harms caused by a security-focused strategy aimed at ending Mexico's 'war on drugs'. In the mid-2000s increased fighting between rival drug gangs for control of territory and markets, including shipment routes, brought widespread and increasing use of the military in response.

7.125 The strategy has arguably failed to stem the violence. Homicide rates rose[256] (despite a slight fall in recent years, over 360,000 people have been killed since 2006)[257] and over 100,000 Mexicans are currently registered in the interior ministry's official database as 'disappeared': the vast majority, mostly thought to be victims of organised crime, have disappeared since inception of the military-based strategy. Moreover, the number of OCGs dedicated to drugs has increased very substantially, from a handful of big cartels to, we were told, over 300.

[255] Mexico was ninth at the time of writing, with 220,866 people in custody – Incarceration Rates by Country 2023 (worldpopulationreview.com) *Accessed 18th October 2023.*
[256] See Mexico Murder/Homicide Rate 1990-2023 | MacroTrends *Accessed 18th October 2023.*
[257] https://www.cfr.org/backgrounder/mexicos-long-war-drugs-crime-and-cartels *Accessed 30th July 2024.*

7.126 While legal regulation is by no means expected to end the violence any time soon, it is hoped it will, as and when it comes, decrease the resources to which criminal organisations have access. This means they would be less able to effect harm and it should be easier for law enforcement to target and shut them down.

In summary

7.127 Clearly the global position with respect to legal frameworks governing non-medical cannabis is changing rapidly. The contents of this report are accurate at time of writing, but will inevitably become out of date as more countries seek alternatives to prohibition and evidence continues to emerge on the impact of doing so.

7.128 While we set out evidence of those impacts to date in the next part of this chapter, it is important that the Mayor and UK government remain appraised of future developments in order to further review the position in this country when appropriate. **We recommend, therefore, that changing international practice and associated outcomes, including those related to public health, levels of wider crime, size of the illegal market, burdens on criminal justice systems and economic considerations, be monitored, ideally by an independent body that reports into either City Hall or central government or both** (R3).

7b: The impact of alternatives to prohibition

The UNODC focuses on eight impacts of legal regulation (see Figure 5). All are broadly encompassed within our principal considerations, namely public health, crime and policing, and economic implications. After a brief introduction to contextual factors, in this second half of chapter 7 we explore what the evidence shows so far, considering:

- *Public health*: including what happens to the prevalence of cannabis use and methods of consumption, parallel use of alcohol and tobacco, and rates of mental health disorder, poisonings, suicide and self-harm. Evidence on cannabis-related road traffic incidents and use of the drug in pregnancy concludes this section.
- *Crime and policing:* we cover what happens to volumes of arrests and charges for cannabis-related offences, the impact on law enforcement (principally police) expenditure and how expungement of criminal convictions for cannabis offences has operated. We also look at what happens to crime levels – including organised crime activities – and implications for the illicit cannabis market.
- *Economics of legalisation:* here, we look at tax revenues, employment and the price of cannabis. Economic impacts vary as a function partly of the type of legalisation model, and we touch on this. We also look at the licit/illicit market interplay and the role of social equity – an explicit driver of regulatory change in some jurisdictions.
- *Other considerations:* we close this chapter by looking briefly at how perceptions of cannabis use and associated risks change following legalisation, the role of public messaging, and concerns about public consumption of cannabis.

Figure 5: Understanding the impacts of cannabis legalisation

Source: United Nations Office on Drugs and Crime: WDR 2022_Booklet 3 (unodc.org)

Interpreting the evidence base

7.129 Evaluation of regulatory change is both complex and in its infancy.[258] The first markets for non-medical cannabis have existed for a little over ten years and plans for consistent, independent evaluation were not always in place from the outset.

7.130 In addition, public policy that depends to a large extent on behaviour change to meet its objectives requires time to take effect (in the case of cannabis regulation this includes behaviour of users and law enforcement). Behavioural patterns do not change overnight, so expectations about the extent to which consequences can be reliably determined just a few years post-implementation must be realistic.

7.131 Disentangling trends in cannabis consumption driven by regulatory changes from those related to the Covid-19 pandemic (some studies suggest consumption may have increased in response to changed daily routines and related stress) will also take time.

7.132 Moreover, much of the evidence on the nature and extent of impacts lacks clear consensus. And as noted by the UNODC, different regulatory models operate in different social, legal and economic contexts, which mean trends in indicators monitored following policy change may be, to some extent at least, independent from the change itself and therefore not evidence of genuine cause and effect.

7.133 Added to which is the fact that, reflecting both the complexity of the issues and the relative infancy of evaluation of legal regulation, there are, so far, few methodologically robust, wholly independent studies affording conclusions that offer little room for interpretation.

7.134 For example, one review exploring the impact of legalisation on health screened 6,253 relevant studies, of which 136 were eligible for review.[259] Of those, only 13 met the inclusion criteria for analysis. While these included data from a substantial number of participants (N=333,550), all were conducted in North America, meaning findings cannot be extrapolated wholesale to other contexts where different cultures and policy regimes will inevitably play a role in outcomes.

7.135 We also note that most studies evaluating the impact of non-prohibitive models of regulation focus on full (commercial) legal regulation, particularly in the US. There are even fewer examinations of the impact of decriminalisation policies, for example, despite the fact that these are currently (globally) more common and widespread than legal regulation.

[258] Key issues summarised in: WDR22_Booklet_3.pdf (unodc.org) p.30. *Accessed 24th October 2023.*
[259] Manthey, J., Jacobson, B., Hayer, T., Kalke, J., López-Pelayo, Pons-Cabrera, M.T., Verthein, U. & Rosenkrantz, M. (2023). The impact of legal cannabis availability on cannabis use and health outcomes: A systematic review. *International Journal of Drug Policy*, *116*. doi:10.1016/j.drugpo.2023.104039

7.136 All this being the case, we do, however, consider there to be some important early indications that we have understood from both the views put to us and wider data and research, which we set out in the remainder of this chapter.

Public Health

7.137 Changes in indicators of health harms are a crucial part of considering whether prohibition of non-medical cannabis is more or less harmful overall than alternative approaches. We have therefore explored whether adverse consequences for mental and physical health which can result from cannabis use (see chapter 8) rise in jurisdictions where it is legally permitted.

7.138 We acknowledge once again the comparative newness of legislative changes. Health indicators will likely be affected by prevalence of cannabis use that broadly rises following relaxation in laws governing non-medical cannabis. But it will take time for the extent of any associated health consequences to become fully apparent.

7.139 We are mindful, too, that, even where a legal cannabis industry has been in place for several years, it continues to adapt to meet demand and comply with regulatory frameworks. This means a steady-state scenario is unlikely to emerge for some time, and arguably, where it is beginning to do so, namely in early-adopting US states, it will still be some while before longer-term trends are clear.

7.140 Moreover, industry efforts to lobby for relaxations on limits designed to reduce health harms (for example, advertising, THC caps and levels of tax),[260][261] may bring as yet unknown further consequences for public health that complicate the picture.

7.141 And alongside rising global trends in cannabis use there have been parallel rises in related health problems. These pre-date regulatory changes, meaning that, while several reviews point to increases in adverse health outcomes post- legalisation, the extent to which these are a direct effect is not yet wholly clear.

Prevalence and frequency of cannabis use

7.142 Whether legal regulation leads to a rise in cannabis use, particularly among the young given evidence of the adverse impact of use of the drug on brain maturation and cognitive function (see chapter 8), is a critical consideration.

7.143 As above, attributing any rise to regulatory change is challenging because prevalence has been rising globally for some time, often for some years before non-medical use was introduced.[262] In US states where it is permitted and those where it is not, as well as those where medical cannabis only is allowed, overall

[260] Hall, W., Stjepanović, D., Dawson, D. & Leung, J. (2023). The implementation and public health impacts of cannabis legalization in Canada: a systematic review. *Addiction*. doi:10.1111/add.16274
[261] See footnote #259.
[262] See for example footnote #215, pp.62–3.

prevalence rose between 2018 and 2021. Past-year use was higher in states where non-medical use is legal, but not substantially so (36% in 2021 compared with 33% in illegal states).[263]

7.144 The UNODC, however, has concluded that, notwithstanding historical trends, legal regulation in the US, Canada and Uruguay has increased cannabis use (at least among adults),[264] with similar conclusions reached by other studies and reviews.[265][266][267] Recent research has reported an average increase in frequency of use in the US of around 20% or more following legalisation of non-medical cannabis.[268]

7.145 While much evidence relies on self-report data, which tend to be confounded by the fact that people are more willing to disclose cannabis use once it is legal (meaning regulation does not change use, simply the likelihood of reporting it), several studies are based on comparative analysis of data from regions that have and have not introduced the measure. These are supported by a handful of (mainly US-based) wastewater analysis and workplace drug tests, which corroborate findings on prevalence.[269]

7.146 Further evidence of a link between legalisation and increased use comes from Canadian sales data, which shows spending on legal non-medical cannabis has steadily increased since introduction of the Cannabis Act in 2018 – see Table 2:

Table 2: Canadian retail sales of adult-use non-medical cannabis, 2018–2023

Month ending December	Sales ($billion)
2018	0.16
2019	1.2
2020	2.6
2021	3.8
2022	4.5
2023	5.1

[263] Hammond, D., Corsetti, D., Goodman, S., Iraniparast, M., Danh Hong, D. & Burkhalter, R. on behalf of the ICPS Research Team. (2022). *International Cannabis Policy Study – United States 2021 Summary*. Sept 2022.
[264] See WDR 2022_Booklet 3 (unodc.org) *Accessed 20th October 2023*.
[265] See footnote #234.
[266] See for example Lalam, N., Weinberger, D., Alimi, D., Obradovic, I. & Gandilhon, M. (2017). *Executive summary of the Cannalex study results*.
[267] See footnote #260.
[268] See Zellers, S.M., Ross, J.M., Saunders, G.R.B., Ellingson, J.M., Anderson, J.E., Corley, R.P. … & Vrieze, S. (2023). Impacts of recreational cannabis legalization on cannabis use: a longitudinal discordant twin study. *Addiction, 118*(1), pp.110–118. doi.org/10.1111/add.16016. See also Pessar, S.C., Smart, R., Naimi, T., Lira, M., Blanchette, J., Boustead, A. & Pacula, R.L. (2024). The association between state cannabis policies and cannabis use among adults and youth, United States, 2002–2019. *Addiction*. doi.org/10.1111/add.16663
[269] Hollingsworth, A., Wing, C. & Bradford, A.C. (2022). Comparative Effects of Recreational and Medical Marijuana Laws on Drug Use among Adults and Adolescents. *The Journal of Law and Economics, 65*(3), 515–54: Burgard, D.A., Williams, J., Westerman, D., Rushing, R., Carpenter, R., LaRock, A. … & Banta-Green, C.J. (2019). Using wastewater-based analysis to monitor the effects of legalized retail sales on cannabis consumption in Washington State, USA. *Addiction*, *114*(9), pp.1582–90. Both cited in ECaLe_Technical_Report.pdf (bundesgesundheitsministerium.de).

Source: Statistics Canada 2023[270]

7.147 As in the US, cannabis use in Canada had been increasing pre-legal regulation.[271] But legal sales data, combined with the fact that these outpaced decreasing sales in the illegal market, equates to a net rise in estimated overall spend on the drug (combining non-medical, medical and illegal sales) of around 40% between 2018 and 2022.[272]

7.148 In addition, the growth in reported use noted by the Expert Review Panel responsible for the legislative review of the Cannabis Act 2018[273] is marked. Almost seven million Canadians (22% of those aged 15 and over) reported past-year use of cannabis in 2020–2021.[274] This is an increase of over two million people, or 56%, compared with data from pre-legalisation in 2017.[275] Similarly, the International Cannabis Policy Study (ICPS)[276] reported prevalence of past-year use in 2018 among Canadians aged 16–65 to be 28%, rising to 35% in 2022. Monthly and daily/near daily consumption followed a similar pattern (19% to 25% and 9% to 12% respectively).

7.149 Whether cannabis use specifically among young people changes following legal regulation is unclear. While some reviews report there is little evidence that frequency of use among existing young users is affected,[277] analyses report mixed findings with respect to overall prevalence. It is, however, still early days. As pointed out by authors of the review undertaken for the German government, youth use is likely to change over time as cannabis becomes more normalised among adults following legal regulation (as has been the case for cigarettes and alcohol). Inevitably this will take time.

7.150 We heard from several witnesses that levels of use have remained largely stable among young people in the US and Canada, and several academic reviews agree[278] (with similar evidence from Uruguay).[279] Indeed, one recent study found no evidence that legalisation was associated with encouraging cannabis use among a large national sample of young people (aged around 16) across the US.[280]

---

[270] Statistics Canada. Table 20-10-0056-01 Monthly retail trade sales by province and territory (x 1,000). doi.org/10.25318/2010005601-eng *Accessed 15th April 2024.*
[271] Health Canada. Canadian Alcohol and Drugs Survey (CADS): summary of results for 2019. Canadian Alcohol and Drugs Survey (CADS): summary of results for 2019 - Canada.ca. *Accessed 20th October 2023.*
[272] See footnote #234, p.50.
[273] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca
[274] Statistics Canada, Canadian Community Health Survey 2021. (2022). Table 13-10-0096-01 Health characteristics, annual estimates https://doi.org/10.25318/1310009601-eng *Accessed 20th October 2023.*
[275] Health Canada. (2018). Canadian Tobacco, Alcohol and Drugs Survey (CTADS): summary of results for 2017. Canadian Tobacco Alcohol and Drugs (CTADS) Survey: 2017 summary - Canada.ca *Accessed 20th October 2023.*
[276] Hammond, D., Corsetti, D., Fataar, F., Iraniparast, M., Danh H.D. & Burkhalter, R. (2023). *International Cannabis Policy Study – Canada 2022 Summary*.
[277] See footnotes #234, p.37 and #258. *Accessed 24th October 2023*.
[278] See for example footnote #260.
[279] Rivera-Aguirre, A., Castillo-Carniglia, A., Laqueur H.S., Rudolph, K.E., Martins, S.S. & Cerdá, M. (2021). Does recreational cannabis legalization change cannabis use patterns? Evidence from secondary school students in Uruguay. *Addiction* (117), pp.2866–77.
[280] Anderson, D.M., Fe, H.T., Liang, Y. & Sabia, J.J. (2024). Recreational Marijuana Laws and Teen Marijuana Use. *JAMA Psychiatry*, pp.1993–2021. doi:10.1001/jamapsychiatry.2024.0698

7.151 Several other studies report a rise in prevalence of cannabis use, with still others suggesting it has fallen following legalisation. Concentrating on those with longer follow-up periods, however, it seems likely that in the longer-term youth use rises.[281] Some of this is probably due to non-users initiating consumption – certainly, there are some data from the US and Canada which suggest legalisation increases the likelihood of this happening.[282]

7.152 The same is true for adults, i.e. at least some of the rise in prevalence is probably driven by previous non-users entering now legal markets,[283][284] possibly no longer deterred by the risk of criminal sanction. Where overt marketing, wide product ranges and a high density of retail outlets are permitted, it seems intuitive that the likelihood of non-users trying cannabis is heightened, even if use is not sustained. We discuss implications of different elements of commercialisation later in this chapter.

7.153 Among young people (aged both up to and over 18), at least in Canada, use has almost certainly risen post-legalisation.[285] While difficult to causally attribute given prior rising trends, the rate of increase among young adults aged 20–24, between the months preceding and subsequent to legal regulation, was greater than among other age groups.[286] Notably, while use of cannabis at least once in the preceding year was highest among those aged 26–35 (47%), over one-third (34%) of those aged 16–25 reported doing so.

7.154 We must also have regard to an important health-related side effect of any rise in prevalence of cannabis. Namely, that where the drug is co-consumed with tobacco, use of the latter likely rises. As the primary method of cannabis consumption in the UK, this would represent a very unwelcome consequence of a move away from prohibition of the drug for non-medical use.

7.155 If increased prevalence were driven by use of cannabis without tobacco (whether smoked in isolation, vaped or consumed via edibles) this might be less of a concern: evidence from Canada suggests this is feasible (see para.7.160) but it is difficult to know whether the pattern would replicate in the UK, where co-consumption is so dominant.

---

[281] See footnote #234, p.35.
[282] Ibid, pp.35–6.
[283] Gunadi, C., Zhu, B & Shi, Y. (2022). Recreational cannabis legalization and transitions in cannabis use: findings from a nationally representative longitudinal cohort in the United States. *Addiction*, 117(10), pp.2651–9: Hollingsworth, A., Wing, C. & Bradford, A.C. (2022). Comparative Effects of Recreational and Medical Marijuana Laws on Drug Use among Adults and Adolescents. *The Journal of Law and Economics, 65(3)*, pp.515–54. Cited in ECaLe_Technical_Report.pdf (bundesgesundheitsministerium.de).
[284] See footnote #259.
[285] See footnote #234, p.51 for data on those aged over 18. For data on 12–18 year olds, see Imtiaz, S., Nigatu, Y.T., Sanches, M., Ali, F., Boak, A., Douglas, L. … & Elton-Marshall, T. (2024). Effects of cannabis legalisation on patterns of cannabis consumption among adolescents in Ontario, Canada (2001–2019). *Drug Alcohol Rev, 43*(3), pp.764–774. doi.org/10.1111/dar.13786. Legalisation was not associated with increased cannabis initiation during the first year, but was associated with an increased likelihood of any cannabis use, daily use and cannabis dependence.
[286] Health Canada. Canadian Alcohol and Drugs Survey (CADS): summary of results for 2019. Available at Canadian Alcohol and Drugs Survey (CADS): summary of results for 2019 - Canada.ca. *Accessed 20th October 2023.*

7.156 Associated, too, with any rise in prevalence of cannabis use is the risk of a consequent rise in problematic use, which might increase the prevalence of symptoms of poor mental or physical health.

7.157 In terms of less punitive approaches to non-medical cannabis that fall short of legal regulation, namely decriminalisation or de-penalisation, and their impact on cannabis use, it is again difficult to disentangle effects from prior trends. One recent review, however, drawn from studies in Australia, the Czech Republic, Denmark, Germany, Jamaica, the Netherlands, Portugal, the UK and the US, found no strong evidence for a link between reduced sanctions for drug possession and increased drug use.[287]

7.158 And one European review reported an increase in cannabis use (as well as in potency and treatment rates) across most countries and age groups, irrespective of the legal framework in place. While reported daily use among past-month users was highest in Portugal, followed by Luxembourg and Spain – in all three, possession of cannabis is effectively decriminalised – overall past-month use rates were higher in several other countries where it is not, including France.[288]

Cannabis products and methods of consumption

7.159 Legal regulation typically diversifies the range of cannabis products available. While some jurisdictions such as Uruguay and Malta have acted to limit this, others permit sales of a wide variety of products with equally wide variation in levels of THC. More potent products, particularly dabs and other forms of concentrate that can be up to 90% THC, have become available in many markets[289] and, it was put to us, demand increases to match. This is perhaps inevitable as more users are exposed to such products, but is nonetheless of concern given the generally accepted increased risk to health of consuming very high-strength cannabis.

7.160 While dried cannabis flower remains the most popular, use is falling against rising use of other products. The Canadian ICPS[290] reported falls among users of both flower and hash (81% consumed flower in 2018, down to 68% in 2022, with hash falling from 25% to 21%), with rises in use of all other product types including edibles, vapes and tinctures. Perhaps unsurprisingly given the fall in use of flower, the Legislative Review of the Canadian Cannabis Act reported a decline in smoking of cannabis between 2018 and 2022 (from 89% to 70% among past-year

[287] Stevens, A., Hughes, C.A., Hulme, S. & Cassidy, R. (2022). De-penalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *European Journal of Criminology*, (19), pp.29–54.
[288] Manthey, J., Freeman, T.P., Kilian, C., López-Pelayo, H. & Rehm, J. (2021). Public health monitoring of cannabis use in Europe: prevalence of use, cannabis potency, and treatment rates. *The Lancet Regional Health – Europe*. doi.org/10.1016/j.lanepe.2021.100227
[289] See for example footnote #260.
[290] See footnote #276.

users), with a concurrent rise in consumption of edibles (41% to 53%) and vape pens (16% to 33%).[291]

7.161 Consumption patterns across Canadian provinces and territories vary little with respect to different products, with the exception of Québec, where consumers are less likely to report using edibles, vape oils, topicals and concentrates. Notably, Québec remains the only province to cap THC at 30% and to implement restrictions on edibles and vape oils, and has fewer stores per capita than other regions, as shown in Table 3.

Table 3: Cannabis retail stores across Canadian regions, September 2022

Sales regulatory model	Region	Cannabis stores per 100,000 population
Public	Nova Scotia	5.11
	New Brunswick	3.73
	Prince Edward Island	2.75
	Québec	1.24
Private	Alberta	20.38
	Yukon	16.41
	Northwest Territories	16.29
	Saskatchewan	15.46
	Manitoba	14.12
	Ontario	12.10
	British Columbia	10.13
	Newfoundland & Labrador	8.96
	Nunavut	3.56
	Canada (all regions)	10.6

Source: Myran et al. (2023)[292]

7.162 Table 3 shows clear differences in access to cannabis outlets between Canadian jurisdictions operating private retail models and those with public, or state-run, models. The former had on average 6.98 times more stores per capita than public systems (13.19 vs. 1.83 stores per 100,000 individuals aged 15+ years). Not surprisingly, therefore, neighbourhoods in private retail regions are closer to their nearest cannabis store (2.55 mins drive vs. 5.63 min).

7.163 Regions operating private retail models also, however, experienced eight times more permanent store closures than those with public models (7.8% vs. 0.6%) – although they sold on average 1.82 times more ($13.53 vs. $7.43 CAD per individual aged 15+ years) before doing so.

[291] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.22.
[292] Myran, D.T., Friesen, E.L., Dickson, S., Konikoff, L., Arora, G. & Tanuseputro, P. (2023). Access to legal cannabis market in Canada over the four years following non-medical cannabis legalisation. *Drug and Alcohol Review, 42*(5), pp.1114–9. doi.org/10.1111/dar.13650

7.164 We consider the economic consequences and sustainability of legal regulation in more detail later in this chapter but, importantly, evidence suggests that greater retail availability is associated with increases in both use[293] and related healthcare visits.[294]

Cannabis as replacement for alcohol and tobacco

7.165 Levels of consumption of alcohol and tobacco continue to cause alarm among public health officials across the world, and there is some suggestion that, once legally available, non-medical cannabis can help stem use of both through substitution.

7.166 This depends, however, on cannabis being consumed without tobacco. As we set out previously, the dominance of co-consumption in the UK means there may be more risk of tobacco use in fact rising following any change to the legal framework governing non-medical cannabis than is the case in jurisdictions where cannabis tends to be smoked in isolation. Unless, that is, tobacco-smoking behaviour could be shifted.

7.167 Use of tobacco overall is declining: the WHO reported 1.30 billion global users in 2020, down from 1.32 billion in 2015, and estimates a further fall to 1.27 billion by 2025.[295] Legal regulation of non-medical cannabis coincides: between 2002/03 and 2019/20, falls in tobacco use were observed in US states both with and without access to legal non-medical cannabis.[296]

7.168 Alcohol consumption, however, remained stable over the same period regardless of the legal status of non-medical cannabis. While cannabis use rose across US states, it began to do so several years earlier where non-medical use was legalised, and there is some indication that binge drinking was also slightly higher in those states. The UNODC conclude that, while there is no evidence that legalisation of non-medical cannabis impacts on alcohol sales, there is a positive association between regular cannabis and alcohol use in US and Canada.[297]

7.169 More recently in Canada, sales of both alcohol and non-medical cannabis have been steadily rising following legal regulation of the latter.[298] It was also suggested to us that players in the alcohol and tobacco industries, here and elsewhere, are increasingly seeking to enter the legal cannabis market, perceiving future opportunities in light of risk of declining sales (despite there being little evidence of

[293] Young-Wolff, K., Pacula, R.L. & Silver, L.D. (2022). California Cannabis Markets – Why Industry-Friendly Regulation Is Not Good Public Health. *JAMA Health* Forum, *3*(7) doi:10.1001/jamahealthforum.2022.2018
[294] See footnote #292.
[295] See 9789240039322-eng.pdf (who.int) *Accessed 24th October 2023.*
[296] See footnote #264. *Accessed 24th October 2023.*
[297] Ibid. *Accessed 24th October 2023.*
[298] See chart 6, Research to Insights: Cannabis in Canada (statcan.gc.ca) *Accessed 25th October 2023.*

this so far). This also, of course, opens up the future possibility of the infusion of cannabis products with alcohol or tobacco.[299]

Psychiatric disorders and Cannabis Use Disorder (CUD)[300]

7.170 Evidence on whether legalisation of cannabis for non-medical purposes directly increases the prevalence of mental health disorders, at least in the short term, is so far mixed. As with other measures of impact, research often fails to account for the fact that cannabis-related hospital admissions were increasing in many places before regulatory change.

7.171 That said, experts largely agree the lack of clear evidence of a causal relationship between legally available non-medical cannabis and increasing rates of mental health disorder overall does not preclude the emergence of such over the longer term. In our view, and that of many health experts, an increasing body of evidence suggests some relationship between access to legal cannabis and increased rates of both psychosis and Cannabis Use Disorder (CUD) – although there may well be other factors involved.

7.172 There has been a modest rise overall in the number of adults and young people across the US and Canada showing symptoms of, or being admitted to hospital with, signs of CUD.[301][302] Rises in US jurisdictions permitting non-medical cannabis tend, however, to be greater than in those which have not.[303]

7.173 It is possible of course that, rather than a genuine increase, such rises simply reflect a greater willingness to self-disclose symptoms post-legal regulation. Several experts from whom we heard were, however, sceptical of this suggestion and, on balance, we consider that the possibility of legalisation leading to a rise in CUD cannot be ruled out.

7.174 Indeed, in one US state where non-medical cannabis use is legal, around one-fifth of a recent sample of healthcare patients who reported using the drug showed signs of CUD. Moreover, moderate to severe symptoms were more prevalent among those reporting non-medical use, either alone or alongside medical use cannabis.[304] Which suggests use of the drug for medical purposes is also not

[299] Kilmer B. (2019). How will cannabis legalization affect health, safety, and social equity outcomes? It largely depends on the 14 Ps. *The American Journal of Drug and Alcohol Abuse, 45*(6). doi:10.1080/00952990.2019.1611841

[300] Cannabis dependence, also known as cannabis use disorder, refers to a problematic pattern of cannabis use characterised by the development of tolerance, withdrawal symptoms upon cessation, unsuccessful attempts to cut down or control use, and continued use despite negative consequences. American Psychiatric Association, DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™* (5th ed.). American Psychiatric Publishing, Inc. doi.org/10.1176/appi.books.9780890425596

[301] See footnote #234, p.70.

[302] See footnote #260.

[303] See for example Cerdá, M., Mauro, C., Hamilton, A., Levy, N.S., Santaella-Tenorio, J., Hasin, D. …. & Martins, S.S. (2020). Association between recreational marijuana legalization in the United States and changes in marijuana use and cannabis use disorder from 2008 to 2016. *JAMA Psychiatry*, *77*, pp.165–71.

[304] Lapham, G.T., Matson, T.E., Bobb, J.F., Luce, C., Oliver, M.M., Hamilton, L.K. & Bradley, K.A. (2024). Prevalence of Cannabis Use Disorder and Reasons for Use Among Adults in a US State Where Recreational Cannabis Use Is Legal. *JAMA Network Open, 6*(8). doi:10.1001/jamanetworkopen.2023.28934

without risk – although whether that risk is outweighed by benefits in terms of alleviating other symptoms of ill health is unclear.

7.175 This is supported by diagnoses of CUD among US veteran populations. While rates increased overall between 2005 and 2019, the rise was slightly higher both in states that had legalised cannabis for medical use only and those where non-medical use was also permitted (although the role of other factors could not be ruled out).[305]

7.176 In terms of psychiatric disorders and the impact of legalisation (for medical or non-medical use), the picture is more mixed. Some US data suggest state cannabis policies have not been associated with a statistically significant increase overall in rates of psychosis-related health outcomes, or in prescribed anti-psychotic medication, although there is some indication of a rise among particular groups.[306]

7.177 Conversely, in Colorado, one of the first US states to legalise non-medical cannabis, the prevalence of mental health conditions in emergency department visits has been shown to be higher among those reporting cannabis exposure than those without.[307] Direct causality, however, remains elusive as other factors alongside legalisation remain possible drivers.

7.178 Canadian evidence so far is relatively limited, with no conclusive evidence that non-medical cannabis legalisation is responsible for significant rises in visits to emergency departments involving symptoms of psychosis or schizophrenia. While presentations have been rising, the trend pre-dates legalisation in 2018 (tripling between 2006 and 2016). [308] Which once again serves to highlight the difficulty in extrapolating precise impacts of regulatory change.

7.179 What seems clearer, however, is a link between commercial expansion of the legal cannabis industry and increased risk of mental health disorder. Health administration records from several Canadian provinces showed emergency department visits for cannabis-induced psychosis rose following implementation of

[305] Hasin, D.S., Wall, M.M., Choi, C.J., Alschuler, D.M., Malte, C., Olfson, M. & Saxon, A.J. (2023). State Cannabis Legalization and Cannabis Use Disorder in the US Veterans Health Administration, 2005 to 2019. *JAMA Psychiatry, 80*(4), pp.380–8. doi:10.1001/jamapsychiatry.2023.0019

[306] Elser, H., Humphreys, K., Kiang M.V., Mehta, S., Yoon, J.H., Faustman, W.O. & Matthay, E.C. (2023). *State Cannabis Legalization and Psychosis-Related Health Care Utilization*. doi:10.1001/jamanetworkopen.2022.52689 *Accessed 26th October 2023.*

[307] Hall, K.E., Monte, A.A., Chang, T., Fox, J., Breivik, C., Vigil, D.I. … & James, K.A. (2018). Mental Health–related Emergency Department Visits Associated With Cannabis in Colorado. *Academic Emergency Medicine, 25*(5), pp.477–608. doi.org/10.1111/acem.1339

[308] Callaghan, R.C., Sanches, M., Murray, R.M., Konefal, S., Maloney-Hall, B. & Kish, S.J. (2022). Associations Between Canada's Cannabis Legalization and Emergency Department Presentations for Transient Cannabis-Induced Psychosis and Schizophrenia Conditions: Ontario and Alberta, 2015–2019. *The Canadian Journal of Psychiatry, 67*(8), pp.616–25. doi:10.1177/07067437211070650

full commercialisation of non-medical cannabis.[309,310] In contrast, no such rise was observed during the initial period of legalisation, when restrictions were in place on the number of stores and range of cannabis products permitted.

7.180 Moreover, the number of retail outlets per capita and proximity to a retailer has been associated with higher use of health services for the treatment of psychosis in both Canada[311] (specifically Ontario) and Colorado.[312] Which suggests the burden of psychosis on mental health services may rise in line with greater numbers of cannabis outlets, particularly in areas where populations are at higher risk of onset of cannabis use and/or a greater predisposition to psychosis.

7.181 As a result, the Canadian Legislative Review panel recommended health warning messages that pertain to cannabis-related mental health risks, including psychosis and schizophrenia, should be (re)instated across cannabis products.[313]

7.182 We have not only considered fully legalised settings. Following decriminalisation of all drugs in 2001 and a corresponding rise in (reported) cannabis consumption, Portugal saw a substantial rise in hospitalisations for psychotic disorders. Between 2000 and 2015, the number of hospitalisations for psychotic disorders or schizophrenia associated with cannabis use increased by around 30 times (although how much of this was due to increased propensity to seek help following decriminalisation is unclear), and the proportion of cases with a secondary diagnosis of cannabis use or dependence rose from 0.87% to 10.6%.[314]

7.183 That said, the impact of the policy on overall use of cannabis is debatable.[315] Evidence is mixed but does not indicate any dramatic effect either way – as above (para.7.158), Portugal does not appear to have become a particular outlier in comparison with other European nations.

7.184 Cannabis strength is also relevant to consideration of psychotic disorders and CUD as higher potency is linked to increased risk of both.[316] As legally regulated

---

[309] Myran, D.T., Pugliese, M., Roberts, R.L., Solmi, M., Perlman, C.M., Fiedorowicz, J. … & Anderson, K.K. (2023). Association between non-medical cannabis legalization and emergency department visits for cannabis-induced psychosis. *Molecular Psychiatry*. doi.org/10.1038/s41380-023-02185-x

[310] Myran, D.T., Gaudreault, A., Konikoff, L., Talarico, R. & Pacula, R. L. (2023). Changes in Cannabis-Attributable Hospitalizations Following Nonmedical Cannabis Legalization in Canada. *JAMA Netw Open, 6* (10). doi:10.1001/jamanetworkopen

[311] Wootten, J.C., Rodrigues, R., Gilliland, J., Carter, B., Shariff, S.Z., Zhong, S. … & Anderson, K.K. (2023). The effect of non-medical cannabis retailer proximity on use of mental health services for psychotic disorders in Ontario, Canada. *International Journal of Social Psychiatry,* pp.1–11. doi:10.1177/00207640231206053

[312] Wang, G.S., Buttorff, C., Wilks, A., Schwam, D., Tung, G. & Pacula, R.L. (2022). Impact of cannabis legalization on healthcare utilization for psychosis and schizophrenia in Colorado. *Int J Drug Policy*. doi:10.1016/j.drugpo.2022.103685

[313] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca p.33, recommendation 9. *Accessed 17th April 2024.*

[314] Gonçalves-Pinho, M., Bragança, M. & Freitas, A. (2020). Psychotic disorders hospitalizations associated with cannabis abuse or dependence: a nationwide big data analysis. *International Journal of Methods in Psychiatric Research*. doi.org/10.1002/mpr.1813

[315] See discussion in footnote #218, p.29.

[316] Petrilli, K., Ofori, S., Hines, L., Taylor, G., Adams, S. & Freeman, T.P. (2022). Association of cannabis potency with mental ill health and addiction: a systematic review. *The Lancet Psychiatry Review, 9(9)*, pp.736–50. doi.org/10.1016/S2215-0366(22)00161-4 *Accessed 26th October 2023.*

markets emerge, expand and seek to meet demand for product variety, potency is likely to be of increasing concern to those seeking to minimise adverse consequences for public health. As one witness put it to us, cannabis in the 1980s was generally no higher than 5% THC. Cannabis in the 2020s, however, averages around 20% THC, with daily use also more likely.

7.185 With more people using cannabis than pre-legal regulation, and very high-strength products available in many markets, the expectation among several of those we heard from is that mental health problems associated with cannabis use will increase over the next generation. We heard too that the extent of cannabis use among patients in psychosis clinics is very high, and demand for such services is thought likely to increase.

Poisonings

7.186 Cannabis-related poisonings have increased following legal regulation. Related calls by adults and young adults to US poison centres rose following retail sales beginning in nine states (by 77% and 61% respectively) and emergency department data in several US states (including Colorado and California)[317] and Canadian provinces/territories[318] shows this followed through to admissions.

7.187 Poisonings, some of which have resulted in hospitalisation, have also risen among children.[319,320,321] This is thought to be largely down to unintentional ingestion of cannabis edibles in the home,[322] and data from Canada suggests the more commercial the approach to regulation and the greater the variety of products permitted to be sold, the greater the rise in accidental intoxication.

7.188 The rise in Canada is notable given strict regulations in place aimed to minimise childhood poisonings, including a maximum of ten mg THC per package of edibles (which is ten times less than some US states permit), plain and child-resistant packaging, and education campaigns to raise awareness of how to store edibles safely at home.[323]

7.189 It was put to us that the nature of edibles, however clear the labelling around dose and strength, means they can lend themselves to over-consumption. We heard how one serving size could equate to, for example, one or two gummies out of a larger pack, or one-tenth of a cookie. Arguably, expecting a user to restrict consumption to such a small proportion of available product, particularly when the

[317] See footnote #264. *Accessed 30th October 2023.*
[318] See footnote #234, pp.27, 39.
[319] Ibid, p.39.
[320] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca
[321] Myran, D.T., Tanesuptro, P., Auger, N., Konikoff, L., Talarico, R. & Finkelstein, Y. (2023). Pediatric hospitalizations for unintentional cannabis poisonings and all-cause poisonings associated with edible cannabis product legalization and sales in Canada. *JAMA Health Forum*. doi:10.1001/jamahealthforum.2022.5041
[322] See footnote #234.
[323] Myran, D.T., Tanuseputro, P., Auger, N., Konikoff, L., Talarico, R. & Finkelstein Y. (2022). Edible cannabis legalization and unintentional poisonings in children. *New England Journal of Medicine: Research, 387*, pp.757–9.

effects take some time to materialise (certainly longer than when cannabis is smoked or vaped), is to misunderstand human behaviour.

7.190 Access to legal, quality-assured cannabis may, however, at least reduce use of synthetic cannabinoids, thought to pose a greater danger to health (see chapter 8) than botanical cannabis. There is some limited evidence of a fall in emergency admissions caused by synthetics,[324] but the extent to which this offsets rises in legal cannabis-related poisonings and other adverse health consequences is unclear.

7.191 And quality assurance is dependent on quality of the testing process. In Canada this is overseen by the state, but in the US the system is more fragmented. While federal prohibition remains in place, national services to oversee and deliver testing have not been possible, leading to inconsistency within and across states that permit non-medical cannabis. We heard that in California, for example, cannabis producers choose who assures their products, which has led to some degree of gaming and a lack of clarity over relative equivalence of cannabis from different producers.

Suicide and self-harm

7.192 So far, evidence of association between self-harm and cannabis consumption is limited. And while mental health disorders, particularly depression, can raise the risk of suicide, and depression can be associated with cannabis use (especially more frequent use),[325] it is difficult to unpick the relationship. Whether poor mental health is a cause or result of cannabis use is a complex question.

7.193 This means conclusions as to whether legal regulation of cannabis causes suicide rates to rise are difficult to reach. And the relatively few robust studies that have explored the issue have reported mixed findings. The evidence review commissioned by the German government (see para.7.72) found little evidence of regulation increasing self-harm (including non-suicidal and suicidal attempts) among adults, although reported a tentative suggestion of association with a rise among men aged between 21 and 39 years in the US.[326]

7.194 While the UNODC has reported higher suicide rates in US states that allow non-medical cannabis compared with those where it remains illegal,[327] the quality of studies in this area more broadly has been characterised as low.[328]

---

[324] Klein, T.A., Dilley, J.A., Graves, J.M. & Liebelt, E.L. (2022). Synthetic cannabinoid poisonings and access to the legal cannabis market: findings form US national poison centre data 2016–2019. *Clinical Toxicology, 60(9),* pp.1024–8. doi:10.1080/15563650.2022.2099887

[325] See footnote #264. *Accessed 30th October 2023.*

[326] Matthay, E.C., Kiang, M.V., Elser, H., Schmidt, L. & Humphreys, K. (2021). Evaluation of State Cannabis Laws and Rates of Self-harm and Assault. *JAMA Network Open*. doi:10.1001/jamanetworkopen.2021.1955

[327] See footnote #264. *Accessed 30th October 2023.*

[328] Shamabadi, A., Ahmadzade, A., Pirahesh, K., Hasanzadeh, A. & Asadigandomani, H. (2023). Suicidality risk after using cannabis and cannabinoids: An umbrella review. *Dialogues Clin Neurosci. 25*(1), pp.50–63. doi:10.1080/19585969.2023.2231466

7.195 For example, toxicology reports from Colorado have shown a rise in the proportion of suicides testing positive for cannabis following legal regulation.[329] Figures had been rising pre-regulation but rose more rapidly after the change took effect – although conclusions are not clear-cut as they are based on cases where toxicology data was available rather than all suicides. As there may be bias in those cases where testing was undertaken, it is unclear whether the rise reflects a real increase or is an artefact of the base data.

Driving

7.196 Evidence is similarly inconclusive with respect to the role of cannabis in vehicle crashes (with and without fatalities). One of the challenges is in isolating the effect of cannabis on driving: if a driver has cannabis present in his or her bloodstream, this may not indicate intoxication to an extent that impairs driving (with respect to motor skills, reaction times, cognitive and spatial judgement etc). We heard from several experts about the need for technology to support law enforcement in this regard, as the inability to accurately detect intoxication means it is difficult to enforce prohibitions related to cannabis consumption and driving.

7.197 Moreover, cannabis remains detectable in the human body for up to 30 days (though this depends on a range of factors including THC levels, frequency of use and physiological characteristics such as body fat and metabolism). Detection in a driver's bloodstream following an accident does not automatically mean consumption played a causal role.

7.198 Reviews have reached different conclusions with respect to the role of legal regulation of non-medical cannabis on motor vehicle crashes and fatalities. The UNODC found little difference in cannabis-related traffic fatalities between US states that have and those that have not legalised non-medical cannabis.[330] More specifically, evaluation in Colorado and Washington found limited evidence that fatalities rose significantly following regulation[331] (despite rises in the number of accidents where the driver tested positive for cannabis, again this trend was apparent pre-regulation).

7.199 In Canada's British Columbia, however, the prevalence of moderately injured drivers with a THC level of at least the legal limit (i.e. 2 nanograms per millilitre) more than doubled following legal regulation in 2018[332] (although this may be due at least in part to increasingly accurate recording instruments). And wider reviews have reached similar conclusions, namely that legalisation is associated with increased prevalence of THC in drivers involved in motor vehicle crashes.[333]

---

[329] Rocky Mountain HIDTA Investigative Support Center (2021). *The Legalization of Marijuana in Colorado: The Impact. Volume 8*. RMHIDTA-Marijuana-Report-2021.pdf (dfaf.org) *Accessed 30th October 2023.*
[330] See footnote #264. *Accessed 30th October 2023.*
[331] Hansen, B., Miller, K. & Weber, C. (2019). Early evidence on recreational marijuana legalization and traffic fatalities. *Economic Inquiry, 58(2)*, pp.547–68.
[332] Brubacher, J.R., Chan, H., Erdelyi, S., Staples, J.A., Asbridge, M. & Mann, R.E. (2022). Cannabis Legalization and Detection of Tetrahydrocannabinol in Injured Drivers. *New England Journal of Medicine, 386*, pp.148–56. doi.org/10.1056/nejmsa2109371
[333] See for example footnote #234, pp.29–32.

7.200 Research among law enforcement officers in the US state of Washington reported a firm belief that following legal regulation, there are many more cannabis-impaired drivers on the road.[334] They too noted they were inadequately equipped to detect cannabis impairment and thus enforce related laws.

7.201 On balance it seems reasonable to us that following legal regulation, a rise in the number of drivers found with THC present in their bloodstream is likely, resulting from probable rises in both the numbers of drivers who use cannabis and in increased testing. Among those drivers, some will have sufficient THC present to impair driving, increasing the risk of accident. But whether the actual number of such impaired drivers increases as a direct result of legal regulation so far remains unclear.

Cannabis use during pregnancy

7.202 The impact of cannabis during pregnancy on child outcomes (including low birth weight and neurocognitive functioning) is unclear, largely due to methodological limitations of studies such as the failure to control for tobacco exposure. That said, given THC is capable of crossing the placenta, and is present in the milk of cannabis-using breastfeeding mothers, health experts advise against its use if trying to get pregnant, while pregnant and during breastfeeding.

7.203 The overall trend of increased cannabis use post-legal regulation has also been observed in pregnant women. Data from the US Pregnancy Risk Assessment Monitoring System suggests residing in a state with legalised non-medical use of cannabis is associated with higher prevalence of cannabis use prior to, during and after pregnancy.[335]

7.204 A rise in the number of pregnant women presenting at Ontario emergency departments following cannabis use has also been reported.[336] While based on small samples and limited to one province, this suggests a similar pattern to the US may be emerging in Canada. It may also point to the impact of commercialisation – an earlier Ontario study that took place less than two years post-legal regulation (i.e. before market expansion in the province) reported no change in cannabis use among pregnant women.[337]

---

[334] Stanton Sr, D.L., Makin, D., Stohr, M., Lovrich, N.P., Willits, D. & Snyder, J. (2022). Law enforcement perceptions of cannabis legalization effects on policing: Challenges of major policy change implementation at the street level. *Contemporary Drug Problems*, *49*(1), pp.20–45.

[335] Taylor, D.L., Bell, J.F., Adams, S.L. & Drake, C. (2021). Factors Associated With Cannabis Use During the Reproductive Cycle: A Retrospective Cross-Sectional Study of Women in States With Recreational and Medical Cannabis Legalization. *Maternal and Child Health, 25*, pp.1491–1500. doi.org/10.1007/s10995-021-03197-1

[336] Myran, D. T., Roberts, R., Pugliese, M., Corsi, D., Walker, M., El-Chaâr, D., Tanuseputro, P. & Simpson, A. (2023). Acute care related to cannabis use during pregnancy after the legalization of nonmedical cannabis in Ontario. *Canadian Medical Association Journal, 195*(20). doi.org/10.1503/cmaj.230045

[337] Drabkin, M., Pudwell, J. & Smith, G.N. (2022). Before and After Legalization: Cannabis Use Among Pregnant Patients at a Tertiary Care Centre in Ontario. *Journal of Obstetrics and Gynaecology Canada, 44*(7), pp.808–12. doi.org/10.1016/j.jogc.2022.03.014

7.205 While we acknowledge there has been no evidence of a rise in adverse birth outcomes in the US or Canada,[338] the lack of clear evidence of the effects of using cannabis in pregnancy and the difficulties inherent in reliably testing in this area means a cautious approach is warranted with respect to any use at all of cannabis in pregnancy.

7.206 Post-legal regulation, dispensaries in some jurisdictions have in fact recommended cannabis-based products to pregnant women (primarily to treat nausea).[339] Given the general agreement among health professionals that cannabis should be avoided by pregnant women, this suggests a need for greater education among both women of child-bearing age and cannabis retailers.

Crime and policing

7.207 Arguably the most dramatic impact of any framework that at the very least decriminalises use of non-medical cannabis has been with respect to the criminal justice system (CJS). Arrests for cannabis possession fall substantially, as we heard from very many of the experts we have spoken with, and observed in available statistics.

7.208 This is an important outcome. A criminal record, no matter how minor the offence, can limit an individual's prospects (albeit to varying degrees depending on individual jurisdictional policy). It can hamper employment and restrict travel opportunities, render social housing inaccessible and in some cases threaten access to children. Those given a custodial sentence are at particular risk of suffering mental and physical ill health and of losing protective ties with family and friends.

7.209 But the chances of incurring such a conviction for a cannabis-related offence do not fall equally. We found or heard evidence of racial disproportionality in cannabis policing in most if not all the jurisdictions we examined – both before regulatory change and after. We return to this issue when we briefly consider social equity drivers of legal regulation later in this chapter.

Arrests and charges

7.210 Not surprisingly, jurisdictions that have decriminalised or de-penalised cannabis possession see falls in arrests,[340] though the position is not without complication. South Australia, for example, which operates a de jure decriminalisation approach to cannabis possession (see para.7.101ii), initially saw more people ending up with a criminal conviction – as a result of unpaid fines issued where they were found in possession of more than the legal limit.[341]

---

[338] See report in footnote #234, p.41.
[339] Dickson, B., Mansfield, C., Guiahi, M., Allshouse, A.A., Borgelt, L.M., Sheeder, J., Silver, R.M. & Metz, T.D. (2018). Recommendations From Cannabis Dispensaries About First-Trimester Cannabis Use. *Obstetrics and Gynecology, 131*(6), pp.1031–8. doi:10.1097/AOG.0000000000002619
[340] See footnote #264.
[341] See footnote #221.

7.211 Subsequent government action (namely permitting fine payment by instalments, substituting community service for payment and clarifying fine requirements) did lead to a substantial fall in convictions for cannabis possession – but the example serves as a cautionary tale in terms of unintended consequences of policy change.

7.212 More positively, there is very clear evidence that adverse social impacts of a criminal conviction for cannabis possession far outweigh those resulting from a civil sanction,[342] so the reduction in the former that South Australia ultimately achieved is compelling evidence for the approach.

7.213 Jurisdictions going further and fully legalising non-medical cannabis have seen additional reductions in arrests (including, unsurprisingly, for production, trafficking and importation, distribution and sales).

7.214 While previously falling trends (due largely to reduced law enforcement attention rather than any fall in use of cannabis) mean the extent to which falls in cannabis-related arrests are due to regulatory change is unclear, any reduction is to be welcomed given the widely acknowledged harm caused to those convicted of even minor offences.

7.215 By way of example, in two of the earliest adopters of legal regulation in the US – Colorado and Washington states – cannabis-related arrests fell substantially after implementation in 2012. Seven years after Colorado's regulatory change, the total number had fallen by 68% (possession arrests dropped by 71% and sales by 56%),[343] and in Washington cannabis offences fell by 38% by 2018.[344] Elsewhere it is a similar picture. In Oregon, for example, arrest rates decreased from 35 per 100,000 adults in 2011 to three per 100,000 in 2016,[345] and in Uruguay, too, legal regulation has been associated with a reduction in cannabis possession offences.[346]

7.216 A comparable effect has been observed in US states that decriminalised possession (before later implementing legal regulation). Overall, the change in Massachusetts, Connecticut, Rhode Island, Vermont and Maryland resulted in large decreases (around 75%) in cannabis possession arrests among both youth and adults.[347]

---

[342] Lenton, S., Humeniuk, R., Heale, P. & Christie, P. (2000). Infringement versus conviction: the social impact of a minor cannabis offence in South Australia and Western Australia. *Drug and Alcohol Review 19*(3), pp.257–64.
[343] Impacts of Marijuana Legalization in Colorado: A Report Pursuant to C.R.S. 24-33.4-516 (July 2021) (state.co.us) *Accessed 1st November 2023.*
[344] See footnote #334.
[345] Marijuana Consequences - Oregon 2019 *Accessed 1st November 2023.*
[346] Cited in Barata, P.C., Ferreira, F. & Oliveira, C. (2022). Non-medical cannabis use: International policies and outcomes overview. An outline for Portugal. *Trends in Psychiatry and Psychotherapy*. doi.org/10.47626/2237-6089-2021-0239
[347] Grucza, R.A., Vuolo, M., Krauss, M.J., Plunk. A.D., Agrawal, A., Chaloupka, F.J. & Bierut, L.J. (2018). Cannabis decriminalization: A study of recent policy change in five U.S. states. *International Journal of Drug Policy, 59,* pp.67–75. doi:10.1016/j.drugpo.2018.06.016

7.217 And in Canada, legal regulation of cannabis in 2018 seems to have further intensified the pre-existing falling trend in related charges, particularly possession offences; see Table 4:

Table 4: Cannabis-related charges in Canada, 2017 and 2022

Offence	Charges		% change
	2017	2022	
Possession	13,715	624	↓ 95
Trafficking	3,973	825	↓ 79
Import/export	30	18	↓ 40
Production	837	248	↓ 70

Source: Adapted from Table 2: Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca

7.218 These falls apply to Canadian adults and young people, suggesting that legal regulation met at least one of the original aims of the policy, namely, to protect youth. Not surprisingly, however, falls are less substantial for those below the age minimum for consumption of legally regulated cannabis in US states[348] and Canada,[349] for whom possession remains a criminal offence.

7.219 Moreover, and somewhat concerningly, Canadian data from 2015–2019 suggest that, where young people are charged with cannabis possession post-legal regulation, they are dealt with more harshly than previously.[350] Legal regulation for adults has perhaps led to renewed police attention on enforcing the law for youths.

7.220 And while absolute numbers and rates have fallen for all racial groups following adoption of legal regulation or decriminalisation, racial disproportionality persists in remaining cannabis-related arrests and charges. We discuss this in chapter 10 with respect to interactions with the police and the wider CJS in the UK but, globally, people of colour are more likely than white people to be stopped and searched by police on suspicion of a cannabis offence, and more likely to be subsequently proceeded against.

7.221 Given they are broadly no more likely to be users of cannabis than white people (see chapter 4), a certain degree of racial bias within justice systems, particularly within policing, is widely agreed to be largely responsible for this over-representation.

7.222 It was put to us that in Canada legal regulation of non-medical cannabis has resulted in little difference in policing practices. People of colour remain more likely to experience interaction with the police, but for something other than cannabis possession. It is difficult to support this assertion with statistics because Canadian data are not broken down by race, but provincial figures cited in the review of the

[348] See footnote #264.
[349] Impact of Cannabis Legalization on Youth Contact with the Criminal Justice System (ccsa.ca)
[350] Ibid.

Cannabis Act[351] showed black and Indigenous Canadians continue to be over-represented in the justice system with respect to cannabis offences, relative to other ethnicities.

7.223 In the US, arrest statistics tell a similar story, namely that white Americans remain less likely to be arrested for cannabis-related offences than Americans of colour. In Colorado, for example, the greatest fall in the number of cannabis related arrests between 2012 and 2019 was observed for those from a white background (72%), followed by black (63%) and Hispanic (55%). Arrest rates show the extent to which racial disparity remains even more starkly: 76 per 100,000 white individuals, 107 per 100,000 Hispanics and 160 per 100,000 black individuals in the state in 2019.[352] Similar patterns have been observed elsewhere.[353,354]

7.224 In Australia, it is a comparable story. With the exception of Tasmania, the three states that have introduced some form of de jure decriminalisation or de-penalisation recorded the lowest number of arrests for cannabis offences during 2020–21, and the Australian Capital Territory, which decriminalised possession in 2020, issued zero Simple Cannabis Offence Notices.[355] But racially disproportionate policing has not been eliminated, particularly so, it was put to us, where police retain discretion over whether to apply a civil or criminal sanction.

7.225 In New South Wales, for example, the use, supply and possession of cannabis remain illegal but first-time offenders caught with less than 15 grams may be issued with a caution instead of being prosecuted – at police discretion. But substantial racial disparity exists in who is cautioned instead of prosecuted: among eligible Aboriginal offenders, 40% were issued a caution, compared to 74% of eligible non-Aboriginal offenders.[356]

7.226 And we heard from experts across jurisdictions about the very significant harms caused to communities of colour as a result of over-policing of cannabis and subsequent over-representation in the justice system. While legal regulation of cannabis does much to reduce the volume of people caught up in the justice system, racial bias evidently remains with respect to those who continue to be arrested and charged.

Law enforcement expenditure

7.227 One of the arguments in favour of a legally regulated market for non-medical cannabis is that it frees up law enforcement to focus on bigger, more serious criminal enterprise. But this has largely not been the case so far, as far as we can tell.

---

[351] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.72.
[352] Impacts of Marijuana Legalization in Colorado: A Report Pursuant to C.R.S. 24-33.4-516 (July 2021) (state.co.us) *Accessed 3rd November 2023.*
[353] For a brief summary see Garius, L. & Ali, A. (2022) *Regulating Right, Repairing Wrongs: Exploring Equity and Social Justice Initiatives within UK Cannabis Reform*. London: Release.
[354] Marijuana Consequences - Oregon 2019
[355] cannabis_iddr_2020-21_forweb.pdf (acic.gov.au) *Accessed 9th November 2023.*
[356] Why are Aboriginal adults less likely to receive cannabis cautions? (nsw.gov.au) *Accessed 9th November 2023.*

7.228 Data from US states that have adopted legal regulation show no clear change in expenditure relative to national trends.[357] Indeed, law enforcement officers in Washington state reported an increase in time spent on cannabis-related matters since regulatory change in 2012, including identifying and dealing with illegal cannabis growers, i.e. those who fail to comply with licensing and regulatory requirements.[358]

7.229 That said, they welcomed the reduction in demand for resources previously directed at arresting, prosecuting and in some cases incarcerating low-level cannabis consumers. But rather than a reduction in overall cannabis-related law enforcement, there seems simply to have been a shift in focus.

7.230 In Portugal, where all drugs have been decriminalised for over 20 years, processing individuals for possession through Dissuasion Commissions has, it was put to us, demonstrably reduced costs and simplified procedures relative to equivalent court processes – though it is unclear whether police resources have similarly reduced. Findings from one study[359] support the view that court costs, as well as prison expenditure related to drug offending, have indeed fallen, although police costs appear on average to have seen little change. (Note this is based on a series of assumptions because data on drug-related police costs were largely unavailable).

Expungement of cannabis-related criminal convictions

7.231 Most if not all experts agree that criminalisation of drug possession has not only failed to stem drug use, it has led to a great many people sustaining criminal convictions, which can not only stigmatise but cause long-standing problems in terms of participation in and access to wider society and services. Moreover, the act of arrest itself can be extremely distressing and, as we discuss in chapter 10, have a detrimental impact not only on the arrestee but on how they and others view the police and engage with them in the future.

7.232 In recent years, the UN, the WHO and the International Narcotics Control Board (INCB) have all acknowledged that criminalisation of drug possession is largely disproportionate to the behaviour and can deter help-seeking among those in need of treatment. Their collective position is beginning to lead to a global shift in how drug possession is viewed, and in 2019 the Chief Executives Board of the UN, representing 31 UN agencies, adopted a common position that endorses decriminalisation of drug possession and use.[360] We have had regard to this in

[357] Dills, A. Goffard, S., Miron, J. & Partin, Erin. (2021). *The Effect of State Marijuana Legalizations: 2021 Update*. Cato Institute, Policy Analysis No. 908. https://ssrn.com/abstract=3780276 *Accessed 2nd November 2023.*
[358] See footnote #334.
[359] Gonçalves, R, Lourenço, A. & Nogueira da Silva, S. (2015). A social cost perspective in the wake of the Portuguese strategy for the fight against drugs. *International Journal of Drug Policy, 26*(2), pp.199–209. doi.org/10.1016/j.drugpo.2014.08.017
[360] CEB-2018-2-SoD.pdf (unsceb.org) *Accessed 3rd November 2023.*

making our recommendation in chapter 10 regarding the treatment of cannabis possession in England & Wales.

7.233 Legal regulation has been used to try to redress some of the adverse consequences resulting from the criminalisation of cannabis possession: pardons, and/or expungements of convictions, are a key element of regulatory change in some jurisdictions.

7.234 In the US, mass pardons have been issued, officially 'forgiving' those convicted of what is now considered legal behaviour in many states. Most notably, President Biden declared in 2022 that all US citizens with a federal record solely for cannabis possession would be pardoned. This has since been applied to around 6,500 citizens.[361] At state level, similar action has been taken where non-medical cannabis is now permitted, pardoning residents of low-level possession offences.

7.235 Pardons are not, however, equivalent to expungement, which effectively seals a conviction from view or otherwise deletes it from the record. In some states, the expungement process is automatic, meaning the conviction is automatically struck from the record, or otherwise made permanently unavailable for access. Elsewhere, the onus is on the individual to apply, which not surprisingly tends to limit take-up.

7.236 In Canada, expungement has not so far been automatic and the opportunity has not been taken up as widely as expected. The process is reportedly cumbersome and, while now free for applicants, remains difficult to access and requires documentation that some may not have. Moreover, those perhaps most in need of expungement, due to a variety of compounding social challenges and deprivation from which they are already more likely to suffer, are often the least able to access the process (including First Nations, Inuit and Métis peoples, black and other minority ethnic Canadians).[362]

7.237 Even where records are expunged, they may not be deleted in their entirety, meaning some US authorities, for example, remain able to view a record even where a Canadian agency can no longer do so. Opportunities for travel or emigration, for example, may therefore remain limited for those with prior convictions for minor cannabis activity previously considered illegal. So, while the intention behind pardons and expungements is positive, procedural challenges means that intent has yet, for many, to be realised.

Crime

7.238 As we discuss in our consideration of economic impacts, legal markets for non-medical cannabis do not eradicate illegal markets. Demand for cheaper product remains, as does demand among those unable to purchase legal cannabis

[361] News Advisory: Updated Analysis Relating to Executive Action to Pardon Federal Convictions for Simple Possession of Marijuana (ussc.gov) *Accessed 3rd November 2023.*
[362] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.9.

(namely those under the minimum age). This means the market for illegal cannabis remains and associated opportunities for organised crime continue. Indeed, Uruguay saw a rise in homicides connected with disputes between cannabis dealers following implementation of its legal model in 2013 – though more positively, authorities have estimated a fivefold reduction in their activities more generally.[363]

7.239 Whether regulating non-medical cannabis reduces organised crime to any great extent is unclear and, based on what we have heard, seems unlikely. While we are not aware of any independent study that has examined the matter, we heard there is little anecdotal evidence of legalisation having materially changed the extent of organised crime or its operations in the US or Canada. Indeed, according to UK intelligence assessments, almost one-third of organised crime gangs operating in Canada remain involved in the production and distribution of illicit cannabis.

7.240 The police themselves report little impact on organised crime activity and, where a substantial illegal market in cannabis remains despite legalisation, organised crime continues to be heavily involved. And while Spain, for example, continues to operate a prohibitive model, unofficial tolerance of Cannabis Social Clubs without the oversight and regulation brought by legalised models has effectively increased involvement of organised crime (see para.7.45).

7.241 And it was put to us that, while organised crime continues to play a role in illegal cannabis markets, both online and offline, law enforcement functions are largely under-resourced to tackle the issue. This in turn increases the challenge of reducing illicit market share in favour of legal markets.

7.242 On more localised criminal activity, evidence is mixed. Some US states show a rise in property crime following legalisation, others report no impact – although where related to cannabis dispensaries, the increase may be driven by the fact that cannabis currently remains illegal at the federal level.[364]

7.243 Retailers are thus dependent on cash as they cannot use banking mechanisms to process their activities, meaning premises can be an attractive target for burglary (which sometimes involves violence). Possibly for this reason, there has been no evidence of a similar rise in Canada or Uruguay, where proceeds can be banked in the usual manner.

7.244 More broadly though, we could find no evidence of any clear association between regulatory change and rates of violent or other types of crime in any jurisdiction that has legalised non-medical cannabis.

7.245 One facet of legal regulation at the US state level, and which may in due course become an issue on the European mainland as and when individual countries

[363] Cited in Barata, P. C., Ferreira, F. & Oliveira, C. (2022). Non-medical cannabis use: International policies and outcomes overview. An outline for Portugal. *Trends in Psychiatry and Psychotherapy*. doi:10.47626/2237-6089-2021-0239

[364] See for example footnote #264.

legalise non-medical cannabis, is cross-border transference of legal cannabis to states or countries in which it is prohibited but which share a land border.

7.246 This is not only an issue for shared borders. As we discuss in consideration of the economics of legal non-medical cannabis, over-production can fuel trafficking to countries where it remains illegal. UK law enforcement suggested that since regulatory changes, Canada and the US (and more recently Thailand) have become source countries of cannabis entering the UK, displacing countries like Morocco, which previously featured more heavily.

The economics of legal regulation

7.247 The economics of different regulatory models for non-medical cannabis are complex and the interplay between regulation, taxation, revenue, public health and the illegal market even more so. And while there is no doubt that a legally regulated, for-profit market generates economic opportunities for investors and governments, the anticipated so-called 'green rush' may not have been the panacea originally hoped for.

7.248 Creating a model that shrinks the illegal market, reduces criminalisation and therefore police enforcement and associated (predominantly racial) disparities, but does not unduly threaten public health by making cannabis consumption as commonplace as coffee drinking, is fraught with complexity and trade-offs.

7.249 Grasping the net economic position is complicated by the emergence of benefits and costs at varying paces. Monetised benefits, specifically rises in tax revenue and falls in the number of prosecutions for what had been criminal offences, can be seen relatively quickly (where data collections are in place).

7.250 But shifts from illegal to legal markets take longer to emerge, reliant as they are on consumer behaviour change which does not happen overnight. Understanding the extent and long-term sustainability of such shifts takes time. The same is true for impacts on public health. While likely to be a mixed picture of benefits and costs (given cannabis may have some therapeutic effects in addition to heightening the risk of adverse consequences), they likely do not emerge for some time.

7.251 As a result, and despite the number of jurisdictions that now have some form of legalised model in place for non-medical cannabis, we find it difficult to reach clear conclusions as to whether, overall, the benefits of legalising use of non-medical cannabis outweigh the costs. It is, we think, simply too early to tell – and reliable answers will be forthcoming in due course only where data collection practices permit.

7.252 Considering the evidence available so far, it seems to us that no jurisdiction has achieved the ideal balance between costs and benefits. There is an inherent friction between economic and other aims of legal regulation. If taxes and/or prices are set too high, the illegal market continues to flourish and investment in the legal market can be disincentivised. Set them too low and user entry to the legal market

is more effectively facilitated, threatening public health objectives through encouraging take-up and higher levels of use. And where taxes are set as a function of price, lower prices mean lower tax revenue – unless there is a parallel increase in consumption.[365]

7.253 Any for-profit commercial model is incentivised to increase consumption to maximise revenue, enticing non-users of cannabis into the market and encouraging higher consumption among users. It was put to us that 20% of cannabis users consume about 80% of cannabis,[366] meaning the health implications for a minority of users of increased access to cheaper and more varied products in a legally regulated market are likely to be significant.

7.254 As one recent review noted, lower prices and reduced profit margins have a significant impact on the nature of the market. It becomes harder for smaller businesses to compete, meaning that, over time, larger corporations will almost inevitably end up controlling much of the market.[367] Not only is this likely to be at odds with aims of social equity, a key driver of legalisation in several jurisdictions as we cover below, it may disincentivise some users from transitioning from illegal to legal markets due to preferences for, and loyalty to, smaller craft growers who cannot afford to enter, or to remain in, the latter.

7.255 Overall, the longer-term picture is unknown. While it is certainly the case that billions of dollars have been generated through legal non-medical cannabis, as we illustrate in the next section, it is unclear whether associated rises in prevalence of use will in the longer-term lead to increased public health-related costs (monetised and non-monetised) that outweigh those economic benefits.

Revenue, taxes and costs

7.256 The picture with respect to the overall value of the for-profit market is complex and mixed. While sales of legal non-medical cannabis have raised billions, discernible impact on overall gross domestic product (GDP) so far seems uncertain. States that had implemented legal sales by early 2021 had not, at that time, shown marked increases in GDP compared with the national average.[368]

7.257 As yet, there has been little impact on employment rates (though there is some variation by state)[369] – with the exception of the agricultural sector in early adopters of the legal non-medical market, namely Colorado, Washington, California and Oregon.[370] With most US states moving to legal regulation only

[365] See footnote #299.
[366] See discussion of Pareto's Law in Kilmer B. (2019). How will cannabis legalization affect health, safety, and social equity outcomes? It largely depends on the 14 Ps. *The American Journal of Drug and Alcohol Abuse, 45*(6). doi:10.1080/00952990.2019.1611841
[367] Pardal, M., Kilmer, B., d'Auria, S., Strabel, T., Galimberti, S., Hoorens, S., Decorte, T. & Senator, B. (2023). *Alternatives to profit-maximising commercial models of cannabis supply for non-medical use*. RAND Corporation.
[368] See footnote #357. *Accessed 2nd November 2023.*
[369] Ibid.
[370] Dave, D.M., Liang, Y., Muratori, C. & Sabia, J.J. (2022). *The Effects of Recreational Marijuana Legalization on Employment and Earnings*. National Bureau of Economic Research Working Paper, 30813.

within the past five years, it is too early for more significant workforce impacts to show.

7.258 Demand forecasts for non-medical cannabis may have been overly optimistic. Over-production in the US and Canada has flooded the market with surplus product and several cultivators have closed, with resultant job losses – which may help explain the relatively minimal impact on job markets.

7.259 The extent to which that surplus makes its way into illegal markets is unclear but, as we discuss (see para.7.246), a certain amount seems likely to be doing so. Similarly, what happens to surplus produced by home growers is also unclear (as is the amount of such surplus), but it is likely to impact on users transitioning to the legal market. Some, too, is likely to find its way to the illegal market for distribution domestically and overseas.

7.260 All that said, state revenues have undoubtably risen following legalisation of non-medical cannabis (though as we have noted, the extent to which these are offset by associated increases in public expenditure elsewhere, most notably in healthcare, is, as far as we can tell, so far unclear). And the market continues to be valuable.

7.261 The general pattern, perhaps unsurprisingly, is for initial growth as measured by tax revenue to slow down some years after legalisation, as seen among early adopters such as Washington state and Colorado. Peaks in 2021,[371] likely driven by increased use of cannabis during the Covid-19 pandemic, have tended to be followed by some drop-off in more established markets, although they remain relatively buoyant.

7.262 The extent of future growth, however, is difficult to predict – certainly in the US. As the number of states legalising non-medical cannabis continues to rise, revenues in states with more established markets may be affected in various ways. There is evidence, for example, that sales by dispensaries along state borders fall substantially once neighbouring states introduce legal regulation.[372]

7.263 Moreover, it is difficult to accurately compare revenue raised through cannabis sales because the precise level and nature of sales and excise taxes vary between jurisdictions, as do licensing and other fees. Not all US states, for example, impose a general sales tax in addition to excise taxes, and few so far impose taxes related to potency (i.e. levels of THC). While a potency-based measure could help nudge consumers towards lower-strength products,[373] it also risks nudging them towards the illicit market.

---

[371] See examples in How much revenue do states make from marijuana taxes? (usafacts.org). *Accessed 2nd May 2024.*

[372] Hansen, B., Miller, K. & Weber, C. (2020). Federalism, Partial Prohibition, and Cross-Border Sales: Evidence from Recreational Marijuana. *National Bureau of Economic Research, Working Paper 23762*. http://www.nber.org/papers/w23762 *Accessed 5th November 2023.*

[373] See footnote #299.

7.264 The regulatory model in place, restrictions around usage and product availability, and the level of government control on pricing all act to place different burdens on producers, retailers and consumers (the UNODC sets outs details for each US and Canadian state/territory, and Uruguay.)[374]

7.265 Levels of taxes are important, however, not just because of overall cost to the consumer and revenue raised for public coffers, but because they are thought to offer one way of moderating public consumption. Higher taxes mean higher overall costs, which in turn should drive down demand for cannabis products.

7.266 At least, so the theory goes. Despite taxes in the earliest adopters of non-medical cannabis legalisation in the US, Washington state and Colorado, being markedly different (37% compared with around 18%),[375] latest data show little difference in the overall value of cannabis sales. In 2023, Washington reported sales valued at $1.2 billion,[376] with Colorado's figures totalling around $1.3 billion.[377]

7.267 Tax revenue, however, was significantly higher in Washington ($465million,[378] compared with $274 million in Colorado.)[379] While it is not clear how sales break down (types of product, average value of sales, numbers of purchasers etc), the fact that cannabis products are now reportedly less expensive in Washington than Colorado[380] suggests retailers are not passing on the cost of taxes to consumers.

7.268 Which highlights the importance of the interplay between tax and retail price, and the challenge of using tax as a strategy to protect public health. Canada's recent review found similar, reporting cannabis licence holders to be largely bearing taxation costs rather than passing them on to consumers,[381] which in the longer term may threaten their sustained presence in the market.

7.269 More generally, however, whatever the level of taxation, there seems little doubt that legalisation of non-medical cannabis allows governments/governing bodies to collect considerable additional revenue.[382] Even accounting for declines seen post-pandemic, both Colorado and Washington collected more from state cannabis taxes than from state alcohol and cigarette taxes in 2022.[383]

7.270 Which suggests the value of the cannabis market not only seems here to stay (albeit subject to fluctuation) but may prove more lucrative in terms of so-called 'sin taxes' than its predecessors. While perhaps reflecting some shift in consumer

---

[374] See footnote #264.
[375] How much revenue do states make from marijuana taxes? (usafacts.org). *Accessed 2nd May 2024.*
[376] Washington State: $465 Million in Marijuana Taxes Made in FY 2023, Over 5,000 Approved Products (themarijuanaherald.com) *Accessed 2nd May 2024.*
[377] Marijuana Sales Reports | Department of Revenue (colorado.gov) *Accessed 2nd May 2024.*
[378] See footnote #376. *Accessed 2nd May 2024*
[379] Marijuana Tax Reports | Department of Revenue (colorado.gov) *Accessed 2nd May 2024.*
[380] Adlin, B. (2020). *Where's the Cheapest Cannabis? A State-by-State Comparison*. Leafly. Available at https://www.leafly.com/news/strains-products/wheres-the-cheapest-cost-cannabis-a-state-by-state-comparison
[381] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca p.49.
[382] How do state and local cannabis (marijuana) taxes work? | Tax Policy Center *Accessed 2nd May 2024.*
[383] Auxier, R. & Airi, N. (2022). *The Pros and Cons of Cannabis Taxes*. Tax Policy Centre, Urban Institute & Brookings Institution. Pros and Cons of Cannabis Taxes_0.pdf (urban.org) *Accessed 2nd May 2024.*

behaviour from one product to another, and certainly tobacco consumption is falling, there is little evidence that legalisation of non-medical cannabis has much impact on alcohol sales (see para.7.168).

7.271 US states that have more recently entered the market also report increasing tax revenue. California, for example, registered steadily rising figures quarter on quarter since 2018.[384] There, too, revenue peaked in 2021 with $1.5 billion raised (from $5.1 billion of sales). While it fell in 2022 to just over $1.1 billion, there are early signs of stabilisation, with tax revenue in 2023 equating to just under $1.1 billion.[385]

7.272 While we have been unable to source comparative figures for the world's first country to legalise non-medical cannabis, Uruguay, which of course adopted a very different model to those taking hold in the US, in Canada the value of the emerging legal cannabis market is similarly not insignificant.

7.273 In 2022, more than C$5 billion ($3.7 billion) was spent on non-medical cannabis,[386] and 2021–2022 saw over C$1.5 billion ($1.1 billion) raised in taxes and other duties[387] (although the proportion attributable to non-medical rather than medical is unclear). This rose to C$1.9 billion ($1.4 billion) in 2022–2023, and, between legalisation taking effect in 2018 and the end of 2021, the sector created an estimated 150,000 jobs.[388]

7.274 Despite this, however, the picture is not entirely rosy in Canada's burgeoning non-medical cannabis market. While dwarfed by costs associated with the alcohol and tobacco industries (which accounted for over 62% of the C$49 billion ($36 billion) in economic costs associated with substance use), those related to cannabis use in 2020 still amounted to C$2.4 billion ($1.8 billion). These included costs connected with lost productivity, healthcare and criminal justice.[389]

7.275 While criminal justice costs fell by around 3% between 2019 and 2020 (driven by fewer incidents, charges and admissions for cannabis possession), healthcare costs rose from C$360 million to C$381 million ($264 to $279 million), and lost productivity from C$468 million to C$491 million ($343 to $360 million).[390] Costs had been increasing for some years before the Cannabis Act 2018, so it is difficult to directly associate continued rises directly with legalisation, but those related particularly to healthcare rose more sharply than had been seen for some time.

---

[384] Cannabis Tax Revenues, Grid View *Accessed 2nd May 2024.*
[385] Ibid. *Accessed 2nd May 2024.*
[386] Statistics Canada. (2023). Table 36-10-0124-01: Detailed household final consumption expenditure, Canada, quarterly (x 1,000,000). https://doi.org/10.25318/3610012401-eng *Accessed 6th November 2023.*
[387] Statistics Canada. Table 10-10-0165-01 Net income of cannabis authorities and government revenue from the sale of cannabis (x 1,000) doi.org/10.25318/1010016501-eng *Accessed 2nd May 2024.*
[388] Deloitte and Ontario Cannabis Store. (2021). *An industry makes its mark: The economic and social impact of Canada's cannabis sector*. An industry makes its mark - The economic and social impact of Canada's cannabis sector (deloitte.com) *Accessed 6th November 2023.*
[389] Canadian Substance Use Costs and Harms Scientific Working Group. (2023). Canadian Substance Use Costs and Harms, 2007–2020. Canadian Institute for Substance Use Research & the Canadian Centre on Substance Use and Addiction. Canadian Substance Use Costs and Harms 2007–2020 (csuch.ca) *Accessed 6th November 2023.*
[390] Ibid.

7.276 And we heard Canada is struggling to maintain the initial success of its non-medical cannabis sector. Despite early issues meaning supply struggled to match demand, several years on the country is seeing oversupply and challenges achieving profitability. In many provinces/territories, a proliferation of cultivators and dispensaries has meant substantial competition in a sector arguably still in its infancy – the lack of caps on retail licences has meant a flooding of the marketplace in many areas, in a similar fashion to parts of the US.

7.277 Since 2018, several producers have reportedly exited the Canadian market. Among those remaining in 2023, around half owed excise duties and over 12% of regulatory fees (c.C$7.6 million) remained unpaid.[391] Perhaps indicative of the gap between demand forecasting and reality, almost 200 licensed cultivators reported no production during 2022 and a further 599 licensed retailers reported no sales.

7.278 Despite the intention for a mixed economy comprising larger and smaller players, enabling hitherto illegal or 'legacy' craft growers such as those cultivating the renowned British Columbia (BC) Bud to enter the legal market, the sector is increasingly dominated by corporate players. Costs of entry are high and economies of scale mean larger, corporate producers are of more interest to distributors (where not part of a vertically integrated model.)[392] Craft growers produce too little to be a maximally economically viable option and, we heard, struggle to meet the costs of taxation and regulatory compliance.

7.279 The recent Legislative Review makes a number of recommendations with respect to the administrative burden of legal compliance, the excise tax model (including proposing that higher-potency products attract larger duties) and distribution processes, while also cautioning that changes should not compromise public health and public safety objectives of the legislation. This illustrates the fundamental challenge of balancing economic success with other considerations.[393]

7.280 Further market consolidation, it was suggested to us, risks increasing prices and reducing product diversity. We heard that where small growers have been forced to exit the sector, in some cases following bankruptcy, they may well have returned to the illegal market – taking their customers with them – which in turn will threaten some of the gains made in shifting custom from illegal to legal markets (see below).

7.281 Regardless, interest in the cannabis sector is growing, including from the alcohol and tobacco industries[394] – at least in the US. This means the influence of large corporations, with their power to shape regulatory frameworks to their own benefit, represents a further threat to the interests of and engagement from smaller businesses and artisanal cannabis producers.

---

[391] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.55.
[392] i.e. An individual company has direct ownership of all elements of its operation, from seed (cultivation) to sale.
[393] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca pp.12–13.
[394] See footnote #264.

7.282 There is also arguably tension between the interests of those who use cannabis and those of public administration. Users want variety in brands and products, and many are loyal towards smaller, craft growers, who can be renowned for long-standing skill and expertise in growing particular strains of cannabis, like BC Bud. However, overseeing and regulating a mixed market comprising a number of large corporate entities alongside very many smaller elements is a complex administrative challenge.

7.283 As was put to us by several experts, large producers, distributors and retailers have more to lose through non-compliance with licencing and other regulatory requirements. They are thus more likely to invest in and demonstrate high levels of compliance and it is likely to be easier for governing bodies to oversee a handful of large operators than to manage compliance across a much greater number of micro/small/medium-sized enterprises.

7.284 And as we heard, levels of taxation have led many in the industry to claim it is prohibitively difficult to compete with prices in the illegal market. Taxes and fees, and in Canada the suite of regulations regarding advertising, product packaging and labelling, have been blamed for claimed issues with profitability and sustainability.[395]

7.285 Perhaps more worryingly, those regulations restricting labelling and promotions have reportedly, and presumably inadvertently, led cannabis consumers to fixate on THC content (which must be clearly shown) as a marker of quality, or value. Meaning, as the Canadian Review[396] found, more consumers are purchasing higher-potency products – which, given the link between consumption of stronger cannabis and adverse mental health consequences, is troubling from a public health perspective.

Price

7.286 Where the illegal market remains the only source of non-medical cannabis, price tends to remain relatively fixed. The significant risks associated with producing, distributing and selling cannabis due to consequences of being caught, and the need to ensure product security, resist illegal competitors and potentially retaliate against takeover, means prices must reflect those risks, even if demand rises.

7.287 That said, while prices of illegal cannabis can and do shift up and down, they will almost always remain lower than prices in legal markets, where the two exist side by side. The impact of taxes and regulatory compliance costs in the latter will almost always outweigh risk-related pricing in their illegal counterparts.

7.288 There are, however, two almost universal inevitabilities of a legally regulated market for non-medical cannabis: a fall in price (though an initial spike is common)

[395] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.59.
[396] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca p.50.

and product diversification. The risks inherent in illegal markets are largely eliminated in legal supply chains, and participants can overtly take advantage of economies of scale, which translate into lower marginal costs and reduced retail prices. Cultivators, for example, can purchase huge plots of land to grow large quantities of cannabis, with no fear of penalty and no costs associated with clandestine operation.

7.289 Since passage of the Cannabis Act in 2018, prices in Canada have fallen across both legal and illegal markets to an all-time low. On average (notwithstanding provincial variation), the cost of one gram of legal dried flower fell by 43% from C$10.70 in 2019 to C$6.12 in 2020, with illegal prices dropping 36% from C$7.22 to C$4.62.[397]

7.290 In the US, prices vary significantly by state, reflecting factors including the newness of the market, levels of competition and tax structures. But across states with legal non-medical cannabis, retail prices fell by around 20% between 2021 and 2022, and by even more in mature markets such as Colorado and Oregon.[398] Indeed, in Colorado the wholesale price of a pound of cannabis flower fell from $1,876 in 2014 to $649 in 2023, and in Oregon the average cost per gram dropped from $10.50 in 2016 to $4.17 by 2022.[399]

7.291 Overall, the price per gram of non-medical dried flower averaged $8.99 across US legal markets in 2021, compared with $8.48 for the same from illegal sources. And average prices across US legal markets (inclusive of product sourced from legal and illegal sources) was lower than in states where it remained illegal: $8.75 compared with $9.94.[400]

7.292 Prices may also vary as a result of level of harm. In a handful of jurisdictions, cannabis intended to be co-consumed with tobacco and/or containing high levels of THC, is more expensive. While consistent with attempts to safeguard public health, this strategy likely risks pushing those seeking higher-potency products towards the illegal market and probable cheaper product.

Impact of different commercialised models

7.293 Legal regulation of non-medical cannabis use is not a binary yes/no choice. There are different models and, where a commercial marketplace is introduced, a range of policy choices to be made in terms of, for example: under what conditions (if any), products may be advertised and marketed; what products are permitted for sale, in what packaging with what labelling; whether the number of retail stores is capped (according to location and/or population density); whether potency and prices are capped; whether retail is state or privately controlled, and whether public campaigns are implemented with respect to safer use of cannabis.

---

[397] See footnote #276.
[398] Cannabis Industry Statistics for 2023 (flowhub.com) *Accessed 6th November 2023.*
[399] Cited in Kilmer, B. & Pérez-Dávila, S. (2023). Nine Insights from 10 Years of Legal Cannabis for Nonmedical Purposes. *Clinical Therapeutics, 45*(6), pp.496–505. Elsevier Inc.
[400] See footnote #263.

7.294 As we set out in part a) of this chapter, different jurisdictions have implemented a range of approaches and it is important to consider their relative impact on outcomes of interest. While the evidence is so far too limited to reach conclusive views, we heard about some emerging indications.

7.295 Academic assessment of early US policies concluded the models that are most effective in reducing, or limiting, excessive cannabis use in adults and young people (where desired) are those which target business practices rather than consumers. This means using, for example, tax levers and limitations on retail operations and advertising to help control use, rather than relying on possession limits and associated penalties.[401]

7.296 With respect to adverse health consequences, evidence – albeit limited so far – suggests greater access to cannabis stores is associated with increases in both use and related healthcare visits. Limits on retail outlet densities and locations have been proposed as one of several measures to safeguard public health while the evidence base regarding impacts on health indicators builds (others include labelling and packaging requirements, potency and price controls, public health messaging about safer use, and investments in mental health services).[402]

7.297 That said, restricting the number of outlets may simply help sustain the illegal market, or at least limit transition to new legal markets. Canadian research found provinces with fewer stores had more illegal compared to legal sales, but overall prevalence of use was similar to that in provinces with more stores.[403]

7.298 Comparison of Canadian provinces and territories sheds some tentative light on links between aspects of commercialisation and cannabis use. Québec, for example, has fewer retail outlets per capita than any other province/territory (see Table 3), a limit of 30% THC on products and additional restrictions on edibles and vapes. Consumers are less likely to report use of edibles, vape oils, topical cannabis products and solid concentrates than elsewhere in the country,[404] and prevalence rates in Québec are below both the national average and those recorded in other provinces/territories.

7.299 However, a less commercialised model and lower levels of reported use do not equate to an obsolete illegal market: it remains unclear to what extent the approach has shrunk in Québec as compared to provinces that adopted a more commercialised model. It is possible that Québec contains a disproportionate amount of Canada's total remaining illegal market, but it is not clear how legal and illegal market shares break down across different provinces.

---

[401] Blanchette, J.G., Pacula, R.L, Smart, R., Lira, M.C., Boustead, A.E., Caulkins, J.P. … & Naimi, T.S. (2022). Rating the comparative efficacy of state-level cannabis policies on recreational cannabis markets in the United States. *International Journal of Drug Policy, 106*. doi:10.1016/j.drugpo.2022.103744

[402] See footnote #326.

[403] Armstrong, M.J. (2021). Relationships Between Increases in Canadian Cannabis Stores, Sales and Prevalence. *Drug and Alcohol Dependence*. doi:10.1016/j.drugalcdep.2021.109071

[404] See footnote #276.

7.300 As different approaches become more embedded, data and research should increasingly begin to paint a clearer picture of the interplay between varying conditions of commercialisation and outcomes. We explore the impact of legalisation on illegal markets in the next section.

Impacts on the illegal cannabis market

7.301 As we have set out, the illegal market does not disappear in the face of a legally regulated market. It adapts and survives – indeed, both Canada and the US (as well as the UK) retain illegal markets in tobacco and alcohol despite their legality. Alternatives to non-medical cannabis prohibition will never completely eradicate the illegal market: a (convenient) legal supply is a necessary but not sufficient condition for its reduction.[405]

7.302 Legalisation does, however, shrink the illegal market to some degree, albeit not overnight. In 2022, several years on from enactment of its Cannabis Act in 2018, almost C$8 billion was spent on cannabis in Canada overall: at C$5.1 billion, the majority was in the legal market and, while a further C$2.4 billion was spent in the illegal market (the remainder went into the medical sector), this was about half the estimated spend of C$4.9 billion on illegally sourced cannabis in 2017.[406]

7.303 Findings from the ICPS[407] also suggest legal sales now dominate the non-medical sector in Canada. Past-year consumers reportedly purchased 82% of their cannabis from legal outlets (online and offline) – a substantial increase from 61% in 2019. Purchases from family or friends and dealers declined to 41% and 15% respectively (from 61% and 36% in 2018) – although we note the risk of over-reporting legal purchases due to wariness about admitting illegal market sources within a legal structure.

7.304 The market for illegal cannabis in the US is similarly shrinking as users increasingly report purchasing exclusively from licenced retailers, with corroboration from (albeit so far limited) wastewater analysis. In Washington, for example, legal sales grew much faster than THC levels measured in wastewater, suggesting some displacement from the illegal market rather than an overall rise in sales.[408]

7.305 While very limited, evidence from Uruguay suggests that, while legal regulation has equally elicited shift from the illegal market, legal market share remains well

[405] Goodman S., Wadsworth, E. & Hammond, D. (2022). Reasons for Purchasing Cannabis From Illegal Sources in Legal Markets: Findings Among Cannabis Consumers in Canada and U.S. States, 2019–2020. *Journal of Studies on Alcohol and Drugs, 83* (3), pp.392–401.
[406] Statistics Canada (2023). Table 36-10-0124-01: Detailed household final consumption expenditure, Canada, quarterly (x 1,000,000). doi.org/10.25318/3610012401-eng *Accessed 6th November 2023.*
[407] See footnote #276.
[408] Burgard, D.A., Williams, J., Westerman, D., Rushing, R., Carpenter, R., LaRock, A. … & Banta-Green. C.J. (2019). Using wastewater-based analysis to monitor the effects of legalized retail sales on cannabis consumption in Washington State, USA. *Addiction*, *114*(9), pp.1582–90.

below 50% and there has been a considerable move to the grey market (i.e. legally sourced but illegally distributed cannabis).[409]

7.306 Low retail prices set by government have done little to reduce illegal market share (and therefore operations of organised crime and drug-related gangs), principally because price is relevant mainly for lower-income users who are often not registered with the government and therefore ineligible, under Uruguay's model, for legal access.[410]

7.307 More positively, reported use of adulterated cannabis in Uruguay has fallen since legal regulation in 2013. That said, this is less likely to be the case among poorer, more marginalised communities given their lower likelihood of registration, which acts as the gateway to legal access to quality-assured product. Uruguay's model does not, it seems, reach or affect everyone in the same way.

7.308 Irrespective of jurisdiction, however, the main drivers for illegal purchases remain price, convenience and quality, and, for some, a desire to remain anonymous, which suggests stigma associated with cannabis use remains, to some extent, in a legal market.

7.309 And as above, difficulties faced by craft growers in sustaining a presence in the legal market can discourage user transition from the illegal market. Many reportedly prefer to support independent, non-corporate producers with whom they often have a long-standing relationship. Loyalty, and a desire to benefit those who have spent years fighting against prohibition rather than 'corporate cannabis', transcends desire to shift to the legal market – particularly in Canada.

7.310 Moreover, it was suggested to us that loyalty is likely to be felt particularly strongly among more frequent cannabis users, in part because illegal dealers allow large bulk purchase. This means that, at the individual level, economies of scale are possible in the illegal market in a way the legal market will often not permit.

7.311 So while reduced to varying degrees, the illegal market continues to exist and indeed, as it was put to us, thrive in some states despite legal regulation. This is partly because of higher prices of legal product relative to illegal (due to production and regulation costs, as well as taxation) but also issues of accessibility.

7.312 California, for example, is a vast state with large areas that are effectively legal cannabis deserts. Illegal cannabis is easier to access – and there are plenty of opportunities to do so. Unlicenced farms reportedly proliferate across the state and produce huge amounts of cannabis, impacting legal wholesale prices and livelihoods of legitimate cultivators. They are also allegedly causing environmental damage, forcing labourers to work in dangerous conditions and, due to the need

[409] Queirolo, R., Álvarez, E., Sotto, B. & Cruz, J.M. (2022). How High-Frequency Users Embraced Cannabis Regulation in Uruguay. *Journal of Drug Issues, 53*(4). doi.org/10.1177/00220426221134902
[410] See footnote #234, pp.55–7.

to protect grows from rivals, are introducing armed guards and exacerbating cannabis-related violence.[411]

7.313 Their continued existence underlines the view among law enforcement that the illegal market continues to flourish despite access to licensed cannabis products. In 2019, Washington state legislature allocated $3 million to the Washington State Patrol to address the persistence of the illegal market and associated involvement of organised crime[412] – indication that, several years on from legalisation, there remain significant problems despite hopes that implementation would render them much diminished.

7.314 Reduced criminal penalties associated with illegal cannabis activity following legal regulation, alongside a reduced focus among some law enforcement, inevitably lower perceived risk. It is therefore hard to see criminal enterprises ever completely eschewing involvement, especially as opportunities to set up illegal retail outlets (offline and online) that mirror legal counterparts seemingly abound.

7.315 This is problematic for users, many of whom struggle to distinguish legal from illegal[413] product despite official guidance[414] (and risk buying adulterated product as a result). It also causes difficulties for law enforcement, who struggle to identify and shut down illegal outlets (especially given reduced focus on illegal cannabis activity following legalisation). New unlicensed outlets continue to open on a regular basis – in Los Angeles County, for example, in the state of California, one study reported that almost half of such stores open in 2020 were not recorded as existing in 2019.[415]

7.316 And despite seed-to-sale tracking systems, intended to prevent diversion of legal product to the illegal market, there is evidence of market leakage. In 2022, 25% of cannabis purchased from an illegal or unauthorised source in Canada was originally made for legal sale, which is not perhaps surprising given reports of surplus product.[416]

7.317 Overall, the degree to which legal regulation shrinks the illegal market is dependent on several factors. Switching is more likely where legal markets are cheaper, highly competitive and less regulated, allowing wide choice – particularly with respect to higher-potency products. This scenario, however, is also likely to drive up the number of hitherto non-users seeking to try cannabis.

7.318 In effect, the more regulated the legal market, the more slowly the illegal market will reduce. While higher prices and inconvenience of legal sources of cannabis

---

[411] Reality of legal weed in California: Illegal grows, deaths - Los Angeles Times (latimes.com) *Accessed 7th November 2023.*
[412] See footnote #334.
[413] See footnote #276.
[414] See for example Reduce your risk: Choose legal cannabis - Canada.ca *Accessed 7th November 2023.*
[415] Firth, C.L., Warren, K.M., Perez, L., Kilmer, B., Shih, R.A., Tucker, J.S. ... & Pedersen, E.R. (2022). Licensed and unlicensed cannabis outlets in Los Angeles County: the potential implications of location for social equity. *Journal of Cannabis Research, 4*(18). doi.org/10.1186/s42238-022-00120-5
[416] See footnote #276.

are common barriers to legal transition,[417] when legal markets expand sufficiently to address those difficulties, use of the drug and related health problems are likely to increase.[418]

7.319 Which demonstrates the tension at the heart of setting policy objectives in this area: reducing the illegal market is arguably, at least to some extent, incompatible with safeguarding public health. Diminishing market share captured by dealers and organised crime is positive but, at the same time, seemingly somewhat of a mixed blessing.

Social equity

7.320 Principles of social equity are an important part of the global movement to legalise production, supply, sale and use of non-medical cannabis. That said, for cultural and historical reasons they hold more importance in some jurisdictions than others.

7.321 They have been a particular focus in the US, where harms caused by cannabis prohibition are felt particularly unevenly. Rates of arrest and incarceration for simple cannabis possession, as we set out above, have been many times higher among black citizens than white, reflecting the extent to which the so-called 'war on drugs' has been felt most keenly by communities of colour.

7.322 While not an explicit aim of Canada's Cannabis Act, its recent Review reported calls for an expansion of its objectives to include measures to improve equity. Recommendations duly included reconsidering the regulatory fee structures applicable to 'equity-deserving groups' and working to ensure those eligible for support to enter the legal market are aware of what is available.[419]

7.323 Broadly speaking, social equity approaches proactively support actors in the illegal cannabis industry to transition into legal markets. At their heart are intentions for profits to be realised first and foremost by those most harmed by the war on drugs (as opposed to corporate endeavours), with a variety of models in place to try and prioritise entry to markets for qualifying applicants.

7.324 Some US states, for example, license one equity then one non-equity applicant for production, supply and retail licences. Others prioritise equity applicants for a certain period of time before opening out the process to others. Elsewhere, a lottery model guides the awarding of licences. The process is often complemented by commitments to reinvest a proportion of revenue generated by the legal non-medical industry into communities disproportionately harmed by prohibition.

7.325 However, it was put to us that intent behind equity programmes has not been matched by resource, meaning that, while good in theory, in practice – so far at

[417] See footnote #405.
[418] See footnote #234.
[419] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca pp.51–4, recommendations 30, 31, 33, 34, 35. *Accessed 18th April 2024.*

least – they have not been as effective as hoped. Inadequate resource has been compounded by operational challenges: we heard processes can be too easy to game or circumvent, and eligibility criteria can inadvertently act as barriers to those they seek to encourage.

7.326 Wider structural inequalities in the US also mean business knowledge and access to capital funding is lacking among communities eligible for equity programmes. And access to alternative banking (allowing legal cannabis businesses to operate in spite of the industry remaining illegal at federal level) has hampered sustained entry to the market among marginalised communities.

7.327 The need for longer-term resources and funding has also, it was suggested, been underestimated. This has meant that, once corporate players are permitted to enter the market, equity applicants must compete against long-standing businesses who often have a legit footprint in the medical cannabis market. Their existing infrastructure affords easy transition to, and dominance of, the non-medical sector.

7.328 Legal frameworks that prohibit smoking or vaping of cannabis in public have also served to entrench rather than improve social inequities. Those who own their own homes or whose rental agreements permit smoking, or who otherwise have access to private outside space, are lawfully able to consume at home. But those whose living conditions do not permit this but whose consumption preference is smoking or vaping can struggle to find space to do so without risking a penalty (such as a civil fine).

7.329 Because those from more deprived or disadvantaged socio-economic backgrounds are less likely to own their home, and people of colour are more likely to come from such backgrounds, public bans on cannabis consumption arguably generate discriminatory effects in contravention of wider social equity objectives that legal regulation has sought to meet.

7.330 There is no simple solution. New York City has sought to address the issue by permitting cannabis to be smoked wherever tobacco is permitted (see para.7.10). This is not, however, ideal from the perspective particularly of those who do not consume cannabis: we discuss throughout our report the challenges faced by local lawmakers and officials in London in addressing disquiet about public cannabis consumption.

7.331 Progress is also slow in improving diversity within the sector. As put to us, those who were over-represented in prohibitive frameworks in terms of harms are under-represented in legal markets in terms of opportunities. White men continue to dominate the US and Canadian[420] industries, particularly in senior positions: in

[420] See for example Deloitte and Ontario Cannabis Store. (2021). *An industry makes its mark: The economic and social impact of Canada's cannabis sector*. An industry makes its mark - The economic and social impact of Canada's cannabis sector (deloitte.com) *Accessed 10th November 2023.*

2020, they comprised 73% of executives and directors across legal cannabis producers and parent companies in Canada.[421]

Other considerations

Perceived risk and education regarding cannabis use

7.332 Level of perceived risk is important as the less risky an individual considers cannabis to be, unsurprisingly the more likely they are to use it.[422] But evidence is mixed regarding the effect of legal regulation on risk perception, both within and across jurisdictions.

7.333 According to one large study, it has had little impact in US states and Canada.[423] Elsewhere, however, evidence suggests perceptions of risk are generally below the national average in US states where non-medical cannabis is permitted (although the overall trend is one of declining perceived risk),[424] whereas in Canada the reverse seems to be the case. Here, there is some evidence that perceptions of risk and addiction potential resulting from cannabis use rose following legalisation, with a similar trend emerging in Uruguay.[425]

7.334 One explanation for national differences may lie in levels of commercialisation: US states have largely allowed models that permit advertising and marketing, with few restrictions on packaging. Canada, however, set more stringent regulations at federal level so states have less flexibility in terms of commercial possibility, and Uruguay opted for a much more limited model overall.

7.335 Public campaigns warning of risks of non-medical cannabis use may also play a role. Uruguayan authorities produced a range of materials that launched following regulation in 2013, and Canada too invested in public education following passage of the Cannabis Act 2018, as have several US states. Campaigns have sought to raise awareness of health and safety risks associated with cannabis, prevent problematic use, including with respect to driving under the influence of cannabis, and promote informed choices.

7.336 We heard how legalisation has certainly facilitated more informed public conversations about safer consumption. Greater awareness of how different forms of the drug exert effects, with better understanding of potency (and how it is

---

[421] See Maghsoudi, N., Rammohan, I., Bowra, A., Sniderman, R., Tanguay, J., Bouck, Z. … & Owusu-Bempah, A. (2020). *How Diverse is Canada's Legal Cannabis Industry? Examining Race and Gender of its Executives and Directors*. Centre on Drug Policy Evaluation. How-Diverse-is-Canada's-Legal-Cannabis-Industry_CDPE-UofT-Policy-Brief_Final.pdf *Accessed 10th November 2023.*

[422] Schleimer, J.P., Rivera-Aguirre, A.E., Castillo-Carniglia, A., Laqueur, H.S., Rudolph, K.E., Suárez, H. …. & Cerdá, M. (2019). Investigating how perceived risk and availability of marijuana relate to marijuana use among adolescents in Argentina, Chile and Uruguay over time. *Drug and Alcohol Dependence, 201*, pp.115–126.

[423] Lemos, M.K., Taylor, E., Wadsworth, E., Reid, J.L., Hammond, D. & East, K. (2023). Perceptions of cannabis use risk to mental health among youth in Canada, England and the United States from 2017 to 2021. *Drug and Alcohol Dependence, 250*. doi.org/10.1016/j.drugalcdep.2023.110904

[424] See footnote #357.

[425] See footnote #264. *Accessed 8th November 2023.*

measured) and risks of adulteration associated with illegal product, are arguably positive in terms of encouraging safer use and informed choices.

7.337 That said, it was put to us that more could be done, certainly in Canada, where message cut-through seems to be falling (unlike in the US, where it reportedly increased slightly between 2018 and 2021).[426] While numbers vary, overall the proportion of Canadians recalling a cannabis education campaign or public health message fell between 2019 and 2022[427,428] – although it is unclear whether this reflects genuine reduction in message cut-through or in the frequency of campaigns.

7.338 The review of the Cannabis Act highlighted frustration with the pace of progress on public campaigns (and aligned research activity). Moreover, it found better attenuation of messages to meet needs of different groups was warranted, and suggested health warnings be tailored to product format (generic messages about smoking should not be applied to edible products, for example).[429]

7.339 Cannabis literacy more widely, it was put to us, is not yet sufficiently widespread among Canadian families, education providers, law enforcement or health professionals. The Review found certain risks (for example, cannabis-related psychosis) and specific populations (including those with a family or personal history of mental health disorders) have received inadequate attention in terms of education and awareness. It makes a range of associated recommendations in this space.[430]

7.340 We heard that messages focusing on less harmful ways of consuming cannabis are valuable, akin to those around (e-)cigarette and alcohol consumption, and messenger as well as content is key. As the Covid-19 pandemic highlighted, credible, trusted voices are crucial – perhaps including people with experience of using cannabis rather than physicians or government. Pharmacists too could play a role given their presence within communities (we explore this within the UK context in chapter 9).

7.341 In legalised settings, supporting people who use cannabis to identify legal and illegal sources of the drug – offline and online – is also important. The latter particularly so for communities with no nearby dispensary who are more likely to purchase online. Cannabis bought remotely means there is little or no opportunity to enquire about products, effects and strength (unlike in retail stores where staff, known as 'budtenders', can advise) – highlighting the importance of ensuring an educated customer.

---

[426] See footnote #263.
[427] Health Canada. (2023). The Canadian Cannabis Survey 2022 and 2019. https://epe.lac-bac.gc.ca/100/200/301/pwgsc-tpsgc/por-ef/health/2022/124-21-e/index.html and https://epe.lac-bac.gc.ca/100/200/301/pwgsc-tpsgc/por-ef/health/2019/130-18-e/index.html
[428] See footnote #276.
[429] See Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca and Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca
[430] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca p.28.

7.342 Driving under the influence of cannabis was highlighted by several of those we heard from, with some desire for deterrence campaigns similar to those designed to prevent drink driving. These are largely accepted to be relatively successful, perhaps in part because of the risk of police stops. That said, the challenge of distinguishing intoxicating levels of cannabis (as distinct from mere presence) remains.

7.343 Public education strategies alone, however, are unlikely to achieve harm reduction objectives, particularly where these depend on behaviour change. Specific programmes focusing on drivers of cannabis use, mental health and wider skills development are important and require adequate investment and ongoing funding. We discuss education about cannabis use in more detail in chapters 8, 9 and 12.

7.344 Most of those from whom we heard accepted that the non-medical cannabis industry is still nascent, and that expectations for more substantial shifts in attitudes, practice and resources after, for example, only five years since Canada passed its Cannabis Act in 2018 following 100 years of prohibition, were overly optimistic.

7.345 On the other hand, regulatory changes were widely recognised to have brought welcome opportunities for more open, informed conversations about cannabis use. Along with associated education and awareness raising which legalisation has facilitated – albeit fairly limited thus far – such opportunities were accepted as important components of legislative aims to improve public health.

Use of cannabis in public

7.346 Following legal regulation, we heard that people tend to feel more comfortable using cannabis in public. That said, a certain stigma remains, meaning some feel self-conscious among a prevailing view, at least in some places, that consumption should happen in private.

7.347 While we heard it is not generally the norm for cannabis to be smoked in public spaces in Canada, and byelaws enacted in many provinces and territories in an effort to counter public concerns about odour mean it is illegal to do so (as in many US states), there remains a strong likelihood, particularly in some areas, of encountering the smell of cannabis. And even where a person smokes cannabis in their home, if they do so in gardens or on balconies, in reality the smell is likely to drift – particularly in built-up areas and high-density housing.

7.348 It was put to us that smell of cannabis (and tobacco) smoke, risk of passive inhaling and anxieties related to children witnessing cannabis being smoked are the primary concerns with public consumption in jurisdictions that permit its use. Whether these rise following legalisation, however, is unclear. Certainly, concerns exist in London despite continued prohibition of non-medical cannabis, as we heard many times from elected leaders and other senior officials, as well as members of the public. Concerns around public dealing, however – a worry for many Londoners – seem to diminish following legal regulation (although it was put

to us that some hotspots remain, which is not surprising given the persistence of the illegal market).

7.349 It was also suggested that legal regulation tends to shift cannabis use down the public, political and media agenda more broadly. In Canada, for example, it was put to us that concerns around alcohol and hard (illicit) drugs now take primacy, with cannabis largely considered a relatively non-controversial issue.

8. THE EFFECTS OF NON-MEDICAL CANNABIS ON PHYSICAL AND MENTAL HEALTH

While the biological mechanisms through which cannabis exerts its effects are beyond the scope of our inquiry, we have considered the nature and extent of those effects. Isolating the precise causal effects of cannabis (beyond immediate impacts) is challenged by methodological and other limitations of research, but nonetheless an increasing body of evidence points to some risk of harm, particularly in certain circumstances.

In this chapter, we summarise our understanding of the evidence and explore health-related harms as well as potential therapeutic benefits of non-medical cannabis. We look at the impact of the drug on the body and brain, particularly its relationship with serious psychiatric disorders and potential for dependency and addiction. We then consider the extent to which cannabis is implicated in wider injury and death, as well as associations with physical diseases.

As cannabis is typically co-consumed in this country with tobacco, we examine related concerns. Use, too, of cannabidiol (CBD), a non-psychoactive component of cannabis contained in products designed for the wellness market, also merited consideration. We briefly explore the risks of synthetic cannabinoid receptor agonists (SCRAs) as well as the relationship between cannabis potency and health.

We conclude by reflecting on public messaging and education, considering opportunities to inform and help those who choose to use the drug do so with less risk.

The starting point

8.1 Despite the use of cannabis going back millennia, findings from the vast evidence base investigating its effects on the human body and mind remain largely mixed. While in some areas the evidence seems to be converging, there is no universally held view among the medical community with respect to the precise nature or extent of either harmful or beneficial effects of cannabis on physical and mental health. Inconsistencies are in part due to the heterogeneity of populations assessed, the aims of research and the different patterns and preparations of cannabis studied.

8.2 Most agree cannabis is not a harmless drug, irrespective of whether they are in favour of relaxing the legal framework governing its use for non-medical purposes. Views differ, however, on the relative risk of harm versus pleasurable or beneficial effects, who is at most risk of harm, to what degree and in what circumstances.

8.3 Whether cannabis plays a causal role in the onset of specific mental health conditions, including psychosis as well as anxiety and depression, is the subject of

some debate. Most research, however, supports the notion of some association, particularly in the case of psychosis and, too, schizophrenia, and that risks are greatest among those who commence use at an early age, those who use heavily and frequently, and those with co-morbid mental health conditions.

8.4 We recognise upfront some of the limitations of study in this area because they have a bearing on the strength or surety of conclusions we feel able to draw in some respects. While the quality and strength of evidence is improving all the time, key challenges facing health-related research, particularly in some areas, have included:

- *Inconsistent and relatively small, or unrepresentative, sample sizes*, meaning it is difficult to generalise research findings in some areas to wider populations. Increased use of systematic reviews, meta-analyses and cross-border population studies are helping to address this.
- *Risk of bias*, which can result from sample selections being drawn too narrowly, or from partiality in funders of research exploring the effects of cannabis use.
- *Lack of adequate control groups or access to information on all potential confounding factors*, meaning, in some areas, clear evidence of causality between cannabis use and observed effects is difficult to establish conclusively.
- *Lack of standardised procedures or measures* making it difficult to compare findings across studies to build up a reliable picture of effects (this includes the lack of a standard 'unit' of THC, the main psychoactive component of cannabis).[431]
- *Failure to account for confounding factors,* particularly use of alcohol, tobacco and/or other drugs as well as variations in personal vulnerability. This means in some cases physical or mental health markers following cannabis use cannot easily be isolated from effects of other substances or pre-existing conditions.
- *Changes in potency*, meaning cannabis available today tends to be stronger (higher in THC, lower in CBD) than ten or even five years ago. Findings from studies undertaken some time ago may hold up less well in the current context.
- *Knowledge of the impact of edible cannabis and vaping remains under-developed* as the majority of studies have historically focused on the relationship between smoking the drug (often with tobacco) and symptoms of ill health. Those who use cannabis are now increasingly adopting other methods of consumption.

8.5 Despite these limitations, however, recent studies and reviews have reached well-supported conclusions regarding a number of health risks associated with

[431] Freeman, T. P. & Lorenzetti, V. (2020). Standard THC units: a proposal to standardize dose across all cannabis products and methods of administration. *Addiction*, *115*(7), pp.1207–16.

cannabis use.[432] These chime with much of the evidence put to us directly from experts working in academic and policy settings as well as frontline health delivery services.

8.6 It is, though, important to consider those risks in the broader context as a substantial proportion of (adult) users of the world's most widely consumed illicit drug suffer no adverse health consequences – even where use is regular.[433]

8.7 The sheer number of total users means in volume terms, though, many will experience some transient or longer-lasting ill effects (of the estimated 193 million users worldwide, at least 10% are thought to be affected by cannabis use disorder (CUD),[434] for example, and the figure could be higher, see para.4.72). But the overall risk of adverse impact is somewhat smaller than, say, among those who use opiates, or alcohol. Over one-fifth (23%) of adults in England aged over 16 report drinking more than the recommended maximum units per week.[435]

8.8 In 2021, 9,641 deaths in the UK were recorded as due to alcohol-specific causes,[436] whereas cannabis-related fatal poisonings equated to less than 1% (n=32) of drug-poisoning deaths in England & Wales in 2022. The risk of death due to cannabis toxicity is reportedly negligible.[437] That said, cannabis use is implicated in other fatal outcomes (resulting, for example, from cardiac failure, suicide, non-intentional self-inflicted injury and road traffic collisions), which we discuss in subsequent sections.

8.9 And the principal risk posed by cannabis use is of course not death but rather, as we set out in this chapter, development or exacerbation of a severe mental health disorder, or other life-worsening conditions such as increased anxiety. Not only can these cause huge distress to an individual and their loved ones but such disorders place significant pressure on heavily oversubscribed treatment services. They also risk wider costs to society through, for example, incapacity to work or participate fully in wider life.

8.10 So, while cannabis use unquestionably raises some health risks, as we have commented elsewhere so too does consumption of other perfectly legal substances, notably alcohol and nicotine (tobacco), but also caffeine, sugar and

---

[432] Solmi, M., De Toffol, M., Yeob Kim, J., Je Choi, M., Stubbs, B., Thompson, T. … & Dragioti, E. (2023). Balancing risks and benefits of cannabis use: umbrella review of meta-analyses of randomised controlled trials and observational studies. *The BMJ, 2023; 382:e072348.* doi.org/10.1136/bmj-2022-072348 *Accessed 12th February 2024.*

[433] Fergusson, D.M., Boden, J.M. & Horwood, L.J. (2015). Psychosocial sequelae of cannabis use and implications for policy: findings from the Christchurch Health and Development Study. *Soc Psychiatry Psychiatr Epidemiol, 50*, pp.1317–26. doi:10.1007/s00127-015-1070-x *Accessed 11th March 2024.*

[434] Connor, J.P., Stjepanović, D., Le Foll, B., Hoch, E., Budney, A.J. & Hall, W.D. (2021). Cannabis use and cannabis use disorder. *Nature Reviews Disease Primers 7*(16). doi.org/10.1038/s41572-021-00247-4 *Accessed 11th March 2024.*

[435] Health Survey for England 2019: Adults' health-related behaviours data tables, Table 10. Health Survey for England, 2019: Data tables - NHS England Digital

[436] Alcohol-specific deaths in the UK - Office for National Statistics (ons.gov.uk)

[437] Rock, K.L., Englund, A., Morley, S., Rice, K. & Copeland, C.S. (2022). Can cannabis kill? Characteristics of deaths following cannabis use in England (1998–2020). *Journal of Psychopharmacology, 36*(12). doi.org/10.1177/02698811221115760

fat. All have addictive properties and, if consumed to excess, risk harmful consequences for physical and mental health.

8.11 As we explore in this chapter in relation to cannabis, some people are at greater risk of health harms than others (because of genetics, pre-existing mental health conditions or other lifestyle factors). Education and honest conversations between health services and the patients they serve may, however, help individuals make more informed choices and moderate those risks. Arguably, in much the same way that public health information is offered regarding consumption of alcohol, cigarettes and processed foods, the same could be offered for cannabis.

Impacts of cannabis use on the human brain and body

8.12 Just because cannabis is a plant does not mean it contains no harmful properties – indeed, plant extracts are used not only in medicines but also poisons. And it is perfectly possible to develop an addiction to cannabis, although the chances are slightly lower than for alcohol and substantially lower than for opioids or psychostimulants.[438]

8.13 As the Runciman Report points out, when cannabis is compared to other illicit drugs, as well as alcohol and tobacco, using the main criteria of harm (mortality, morbidity, toxicity, addictiveness and relationship with crime), it is less damaging to individuals and wider society.[439] Certainly, the majority of experts who contributed to our inquiries considered the health risks from tobacco to be greater than those linked to cannabis. That said, we note these criteria do not include mental health morbidity, a significant consideration with respect to cannabis use.

8.14 Consideration of such relative harms partly underpinned the Runciman conclusion that cannabis is wrongly designated a Class B drug. We have had significant regard to this in our considerations, over two decades later, about the most appropriate legal framework to govern its non-medical use.

8.15 In the following sections we summarise our understanding of evidence on health-related consequences associated with cannabis. We consider first what are widely thought of as detrimental, or harmful, effects, then touch on potential therapeutic benefits (covered in more detail in chapter 11 on medical cannabis).

8.16 But before doing so, we must first acknowledge the perspective put forward by those frontline experts who participated in our inquiries from health, criminal justice and educational settings. While almost universally among those witnesses there was little active support for maintenance of the criminalisation of use of non-medical cannabis (widely accepted to cause significant harms), this tended not to equate to support for outright legalisation.

---

[438] Curran, H.V., Lawn, W. & Freeman, T.P. (2023). Cannabis and Addiction. In D.C. D'Souza, D. Castle & R. Murray (Eds.), *Marijuana and Madness.* (pp.299–310). Cambridge University Press.

[439] *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (2000). The Police Foundation. Police Doc. (police-foundation.org.uk) chapter 7, para.21. *Accessed 12th February 2024.*

8.17 We recognise many of those we heard from occupy roles that mean they spend their days with patients struggling with drug addiction and abuse, or offenders for whom drugs form part of a wider range of needs. They likely have less exposure to the very much greater number of people whose use of cannabis does not become problematic. However, in considering our position with respect to legalisation, we must have regard to implications for those struggling with cannabis use. Because the user population is so large, the number who go on to develop significant health-related harms can arguably be relatively high.

8.18 Whether these harms (as distinct from harms associated with criminalisation; see chapter 10) would be exacerbated or moderated through an alternative legal framework is very difficult to predict. On the one hand, legalising use of non-medical cannabis might encourage help-seeking behaviours among those at risk of, or suffering from, adverse consequences. On the other, it might increase the number of users in need of such help.

Brain structure and cognitive function

8.19 The effect of cannabis on the brain has received much attention. While the picture is mixed, there is a degree of convergence on the suggestion that acute effects (transient and seen during the period of intoxication)[440] can include memory impairment and behavioural inhibition, which can in turn increase impulsivity. The extent of such effects is likely to be moderated by the strength of cannabis consumed (strains high in THC and low in CBD are widely accepted to cause greater memory loss) and acute impacts on judgement, cognition and motor skills are relevant particularly for consideration of driving, studying and operation of machinery.

8.20 Longer-term, heavy use may impact more significantly on brain structure and composition, with changes to, or reduction in, some cognitive functions including learning, memory (both working and episodic) and decision-making. This is of particular note because the human brain continues to develop and mature until a person reaches their mid-twenties. As use of (non-medical) cannabis is particularly common among young people (see chapter 4), this raises obvious concerns about the potential for alterations to the process of brain development and maturation of neural pathways.

8.21 The earlier in life a person begins using cannabis regularly, the greater the risk of dependence, the more significant the impact on development of the endocannabinoid system and brain development, and the greater the risk of poorer cognitive outcomes.

8.22 The role of other factors, including adverse childhood experiences and mental health disorders (which are associated with earlier onset of use and can

[440] Curran, H.V., Freeman, T.P., Mokrysz, C., Lewis, D.A., Morgan, C.J.A. & Parsons, L.H. (2016). Keep off the grass? Cannabis, cognition and addiction. *Nature Reviews – Neuroscience, 17*, pp.293–306. Macmillan Publishers Limited.

independently affect brain structure) is not always clear, but at least one large birth cohort study[441] has reported a greater decline in neuropsychological functioning when cannabis use began in adolescence. More persistent use was also associated with greater decline.

8.23 This so-called neurotoxic effect of cannabis on the adolescent brain is accepted by the majority of experts regardless of their position on legalising non-medical cannabis use. Most if not all of those we heard from agreed that use among young people should not be supported, and one recent review of 101 meta-analyses concluded that adolescents and young adults should avoid using it.[442]

8.24 The possibility of reverse causation cannot be entirely discounted, at least in some cases. This means that pre-existing conditions, patterns of mental ill health or genetic predispositions may pre-date or even drive cannabis use in some cases, rather than be a consequence of it. Even where not the case, isolating causal effects of cannabis use from other factors implicated in the emergence of poor mental health (significant life stressors, trauma etc) means conclusively determining causality remains a challenge (though less so in the case of psychosis, which we discuss further in this chapter).

8.25 There is some evidence to suggest, for example, that young people with poor cognitive performance are more likely to become regular cannabis users, and poorer cognition and education outcomes have been reported to pre-date the onset of cannabis use among some. That said, its use, particularly where heavy and frequent, is likely to further exacerbate those poor outcomes.

8.26 Sustained abstinence from cannabis following regular, heavy use may, however, lead to cognitive recovery (although not among adolescent-onset cannabis users, or at least not complete recovery)[443] and, where present, improvement of psychotic symptoms. Which suggests detrimental effects on brain function may not always be long-lasting or indeed permanent.

8.27 The fact that cannabis use is, as was put to us, very common among the Child and Adolescent Mental Health Services (CAMHS)[444] caseload reinforces our position on the need for balanced education about the effects of cannabis use, which we summarise at the end of this chapter and cover, too, in chapter 12. Whether legal for non-medical purposes or not, realistically young people do and will continue to use cannabis.

8.28 The view that, rather than seeking to stop them using cannabis completely, they should be encouraged to desist from use for as long as possible and be educated

[441] Meir, H., Caspi, A., Ambler, A., Harrington, H., Houts, R., Keefe, R.S.E. … & Moffit, T.E. (2012). Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proceedings of the National Academy of Sciences* (PNAS). doi.org/10.1073/pnas.1206820109
[442] See footnote #432.
[443] See footnote # 441.
[444] The NHS services that assess and treat children and young people with emotional, behavioural or mental health difficulties.

about means of safer consumption, was echoed time and again across our witnesses. This should, as we discuss in chapter 12, begin very much earlier than at present, if there is to be hope of lessening the chances of children and young people turning to cannabis as a solution to the pressures and harms of current and future life challenges, including the inequalities faced by many.

8.29 As the aforementioned review of meta-analyses concluded, negative effects on academic or wider scholastic performance are to be '*reasonably expected*', particularly where use commences at an early age and is heavy. The risk of underachievement and any number of well-documented consequences associated with poor school outcomes are heightened.

8.30 We note the challenge presented by the timing of the natural process of brain maturation set against the legal minimum purchase age for cannabis in jurisdictions where non-medical use has been legalised. In some this is 18 years, in others 21 – but even in cases of the latter, brain development is not complete by the time would-be users reach the minimum purchase age.

8.31 Prohibiting people from buying cannabis products until they reach 25 or 26 is clearly neither practicable nor credible, given parallel age limits for alcohol and tobacco purchase. Given many young people in the UK are no doubt well aware that cannabis is legal for non-medical use elsewhere in the world, this makes the need for clear and balanced information about the risks that substantial consumption may pose to their brain maturation even more critical.

Mental health

8.32 The debate around whether cannabis use directly causes mental health problems is particularly polarised. That said, evidence at least with respect to its role as a risk factor in development of psychosis and schizophrenia is now relatively well established, particularly where there is existing predisposition to develop those illnesses.

8.33 The nature of the association between other forms of mental illness and cannabis use is less clear and debate continues to rage in medical and academic circles, as well as among those who feel strongly that the drug should remain illegal or, conversely, subject to regulation and legally available through choice.

8.34 Knowledge should be substantially furthered in coming years as the largest scientific study of its kind into the effects of cannabis on mental health bears fruit. The 'Cannabis & Me' study, launched in 2023 by King's College London, will explore why a minority of those who use the drug experience paranoia and/or full-blown clinical psychosis. It aims to examine whether and how biological make-up (DNA) interacts with socio-economic and other factors to modify effects of the drug, and how this may change across different strains and potency.

8.35 We consider different disorders separately because evidence varies accordingly, but acknowledge upfront an important conclusion from the previously referred

review of meta-analyses. Namely that those prone to, or who have a mental health disorder, should refrain from using cannabis. Risk of adverse reaction to its main psychoactive component, THC, which is more dominant in cannabis strains of recent years, is considerably heightened. And conversely, relative levels of CBD – whose properties, some evidence suggests, may alleviate or mitigate wider symptoms of poor mental health – have diminished.

Psychosis and schizophrenia

8.36 A person suffering from psychosis has lost at least some contact with reality, and neutral events or stimuli can become intensely meaningful. They can experience changes in perceptions, hearing and seeing things which other people cannot see or hear (hallucinations). They may hold unshakeable beliefs against evidence to the contrary, which are not supported by their social or cultural background (delusions). Such beliefs can seem bizarre or paranoid in nature: sufferers can often, for example, believe they are the target of conspiracy. A sufferer may also present with disorganised thinking and speech[445].

8.37 A person diagnosed with schizophrenia, a mental health condition affecting thought processes, emotions and behaviour, can experience symptoms of psychosis – but not all those experiencing psychosis have schizophrenia.

8.38 While multiple factors are widely recognised to be involved in the onset of both psychosis and schizophrenia, and cannabis use is neither necessary nor sufficient to cause either[446], evidence increasingly shows an association between development of the illnesses and use of the drug[447]. Incidence rates are higher and age of onset lower where cannabis use, particularly heavy use, is reportedly more prevalent[448].

8.39 More specifically, evidence is converging around the notion of risk thresholds[449]. In other words, frequent, heavy use of high potency cannabis[450], when no disorder has already occurred, can raise the risk of onset - particularly in those with a hitherto dormant genetic predisposition[451].

---

[445] Overview - Psychosis - NHS (www.nhs.uk) *Accessed 9th February 2024.*
[446] D'Souza, D.C., Di Forti, M., Ganesh, S., George, T.P., Hall, W., Hjorthøj, C. & Spinazzola, E. (2022). Consensus paper of the WFSBP task force on cannabis, cannabinoids and psychosis. *The World Journal of Biological Psychiatry, 23*(10), pp.719–42. doi.org/10.1080/15622975.2022.2038797
[447] See footnote #433.
[448] Pow, J.L., Donald, C., Di Forti, M. Roberts, T., Weiss, H.A., Ayinde, O. & Hutchinson, G. (2023). Cannabis use and psychotic disorders in diverse settings in the Global South: findings from INTREPID II. *Psychological Medicine*, pp.1–8. doi.org/10.1017/S0033291723000399
[449] Robinson, T., Ali, M. U., Easterbrook, B., Hall, W., Jutras-Aswad, D. & Fischer, B. (2023). Risk-thresholds for the association between frequency of cannabis use and the development of psychosis: a systematic review and meta-analysis. *Psychological Medicine, 53*(9), pp.3858–68. doi:10.1017/S0033291722000502
[450] Marconi, A., Di Forti, M., Lewis, C. M., Murray, R. M. & Vassos, E. (2016). Meta-analysis of the association between the level of cannabis use and risk of psychosis. *Schizophrenia Bulletin*, *42*(5), pp.1262–9. doi.org/10.1093/schbul/sbw003
[451] Patel, S., Khan, S., M, S. & Hamid, P. (2020). The Association Between Cannabis Use and Schizophrenia: Causative or Curative? A Systematic Review. *Cureus, 21;12*(7). doi:10.7759/cureus.9309

8.40 Adults and adolescents who use cannabis are likely to be at greater risk of developing psychosis and/or schizophrenia in such circumstances than non-users, or those who use lower-strength product less regularly.[452][453] Indeed, meta-analyses suggest that the odds of frequent users of cannabis developing a psychotic disorder specifically are four times greater compared to non-users (cannabis users overall have twice the odds).[454]

8.41 Among those diagnosed with a psychotic disorder or schizophrenia, cannabis use is likely to exacerbate symptoms,[455] worsen clinical outcomes and raise the chance of relapse and hospitalisation – even among patients responding well to antipsychotic medication.[456,457]

8.42 It remains difficult to pin down the precise impact of cannabis use as distinct from unknown predisposition to schizophrenia or psychosis – here too, the possibility of reverse causality cannot conclusively be ruled out. Nevertheless, longitudinal studies show that after statistically controlling for those who began using cannabis to ameliorate psychological distress and sub-clinical psychotic symptoms, and those with a family history of psychosis, heavy cannabis use – particularly if started in adolescence – increases the risk of psychosis.

8.43 While it seems likely the relationship operates in both directions, evidence suggests the pathway from cannabis use to development of psychotic symptoms is stronger than that from development of symptoms to use of cannabis.[458]

8.44 The fact that evidence suggests regular (daily or near daily) users of cannabis are more likely than non-users to be diagnosed with schizophrenia or psychosis[459] is clearly cause for concern. Regardless of the direction of association, there is a raised likelihood of adverse consequence from cannabis use for those at heightened risk or suffering from either disorder. Indeed, we heard the extent of cannabis use among patients under the care of mental health services treating psychosis is very high, in some cases up to 80%.

8.45 Furthermore, it was put to us that, if high-potency cannabis strains (THC=>10%) were no longer available, 30% of cases of first-episode psychosis in south London could be prevented (and 50% in Amsterdam, where cannabis possession is

---

[452] See footnote #432.
[453] Petrilli, K., Shelan, O., Hines, L., Taylor, G., Adams, S. & Freeman T. (2022). Association of cannabis potency with mental ill health and addiction: a systematic review. *The Lancet Psychiatry Review, 9*(9), pp.736–50. doi.org/10.1016/S2215-0366(22)00161-4.
[454] See footnote #450.
[455] Hamilton, I. (2017). Cannabis, psychosis and schizophrenia: unravelling a complex interaction. *Addiction, 112*(9), pp.1653–7. doi:10.1111/add.13826
[456] See footnote #432.
[457] See footnote #453.
[458] See footnote #433.
[459] See summary in Wang, G.S., Buttorff, C., Wilks, A., Schwam, D., Tung, G. & Pacula, R.L. (2022). Impact of cannabis legalization on healthcare utilization for psychosis and schizophrenia in Colorado. *Int J Drug Policy*. doi:10.1016/j.drugpo.2022.103685

effectively de-penalised, see chapter 7).[460] This has obvious and powerful implications for London's oversubscribed psychiatric services (the city has a higher incidence rate for psychosis than elsewhere):[461] removal of one-third of the caseload would significantly lessen the pressure.

8.46 While common among psychiatric populations, forensic psychiatric services reported very high rates of cannabis use among offenders – in excess of 90% (see chapter 10). Practitioners here were similarly agreed on a clear link between psychosis and cannabis – particularly with use of high-potency products.

8.47 Research has also attempted to quantify the extent of the burden of cannabis use with respect to schizophrenia: one estimate suggests around 14% of people with the disorder might never have developed the condition had they not begun to use the drug.[462] While less stark than the association with psychosis, it seems incontrovertible that regular use particularly of high-potency cannabis likely increases the burden on public health services.

8.48 We recognise most cannabis users do not develop psychosis or disorders such as schizophrenia, and many of those diagnosed with such conditions have never used cannabis.[463] But several health experts told us they expect to see a rise in the number of users presenting psychotic symptoms over the next decade or so, due to increasingly potent products now being the norm rather than the exception.[464]

8.49 While difficult to predict the extent of any rise until research has opportunity to investigate the link over the longer term in large samples of people who use modern-day cannabis, it is likely to be felt unequally across different regions of the country.

8.50 Differences in exposure to risk factors for psychosis and schizophrenia, including socio-economic factors (measured by, for example, levels of owner-occupied housing) and elevated risk among some groups, particularly young people, migrant populations and men from black ethnic backgrounds[465,466] mean large urban areas tend to show higher rates of both disorders. This is particularly evident in London.[467]

---

[460] Di Forti, M., Quattrone, D., Freeman, T.P., Tripoli, G., Gayer-Anderson, C., Quigley, H. … & the EU-GEI WP2 Group. (2019). The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): a multicentre case-control study. *Lancet Psychiatry, 6*, pp.427–36. doi.org/10.1016/S2215-0366(19)30048-3

[461] Ibid.

[462] Medical Research Foundation | Spreading the word about harmful 'skunk'. *Accessed 27th March 2024*.

[463] See footnote #440.

[464] See also Freeman, T.P. & Winstock, A.R. (2015). Examining the profile of high-potency cannabis and its association with severity of cannabis dependence. *Psychol Med, 45*(15), pp.3181–9. doi:10.1017/S0033291715001178

[465] See for example Psychosis data report (publishing.service.gov.uk)

[466] Bebbington, P., Rai, D., Strydom, A., Brugha, T., McManus, S. & Morgan, Z. (2016). Psychotic Disorder. Chapter 5 – Adult Psychiatric Morbidity Survey 2014. adult_psychiatric_study_ch5_web.pdf (digital.nhs.uk)

[467] Jongsma, H.E., Gayer-Anderson, C., Lasalvia, A., Quattrone, D., Mulè, A., Szöke, A. … & Kirkbride, J.B. (2018). Treated Incidence of Psychotic Disorders in the Multinational EU-GEI Study. *JAMA Psychiatry, 75*(1), pp.36–46. doi:10.1001/jamapsychiatry.2017.3554

8.51 And of course, the risk of developing CUD among those who use cannabis more generally is somewhat higher than the likely risk of developing either psychosis or schizophrenia as a result of use of the drug.

8.52 Underpinning views from experts, we heard powerful testimonies from patients at London's Cannabis Clinic for Patients with Psychosis (CCP, see chapter 9), who were, or who had been, users of high-strength cannabis. We heard how vital the clinic has become for its patients, who are routed into the service primarily through community-based psychosis teams or following time in a psychosis ward, and how valuable its support and tools are to reduce dependence on cannabis.

8.53 These testimonies highlighted how much of a role the wider environment can play in a patient's decision to use cannabis. Similar to drivers among non-psychotic users, use is often precipitated by a desire to avoid dealing with a particular issue(s), feelings or life circumstances. It was described by one patient, for whom extreme paranoia had featured among his symptoms, as *'a form of socialising with no one there'*. The importance of wider wraparound services in helping psychotic cannabis users address needs related to other areas of their lives was highlighted to us several times.

8.54 The role of wider life inequalities featured in much of the evidence put to us. While consumed across socio-economic groups, high levels of cannabis use are particularly common among young people, especially males,[468] (which perhaps goes some way to explaining why young men tend to be over-represented in psychiatric and drug-dependent populations). They are often living in poverty with poor family support, a past engagement with the criminal justice system, low educational attainment and a history of school exclusion. And as was put to us, the latter is likely to be a precipitant as much as a consequence of cannabis use.

8.55 We discuss these issues throughout our report and note the challenges in determining whether cannabis use is a driver or a consequence of wider inequalities. Irrespective of that relationship, however, is the fact that cannabis use is widely considered to risk worsening social inequalities still further.

8.56 It was also suggested, however, that more is known about poor than middle class people who use drugs. Much research and therefore evidence tends to be gathered from patients involved in treatment services. Lengthy wait times and a lack of local NHS services drive those who can afford to do so to private healthcare, meaning associated data about their characteristics and drug use are less accessible. This means data about the poor may come to dominate in health and drug statistics and research.

[468] See for example European Monitoring Centre for Drugs and Drug Addiction (2023). *Cannabis – the current situation in Europe (European Drug Report 2023)*. *Available at* European Drug Report 2023: Trends and Developments | www.emcdda.europa.eu

8.57 Built-in data bias may also be at least partly responsible for the observed gender imbalance: young men are over-represented in psychiatric populations compared to young women, but they are also more likely to be caught up in the criminal justice system (CJS) and excluded or suspended from school.[469] It is thus perhaps easier for clinicians and researchers to explore drivers and consequences of drug use, alongside contextual factors, for men, as they are more likely to come to the attention of authorities more generally.

Mood disorders (depression and bipolar disorder) and anxiety

8.58 Evidence with respect to association between use of cannabis and mood disorders is mixed. Several studies report a link particularly, again, between regular use of high-potency cannabis and depression (although research elsewhere reports no such association).[470] The same is true for bipolar disorder, where continued use is associated with recurrence of manic episodes and reduced response to treatment.

8.59 Consumption of higher-potency cannabis may be particularly associated with the development of anxiety disorders. Certainly, for some users THC can heighten feelings of anxiety while intoxicated. Dependence on cannabis (see below) has also been linked with symptoms of anxiety and depression,[471] although we note some sufferers report cannabis to be helpful in reducing these.

8.60 The possibility of reverse causation once again cannot be discounted. As with other conditions, symptoms of depression, bipolar disorder or anxiety might cause a person to initiate (and in some cases become dependent on) cannabis use, at least in part by way of self-medication (as we discuss elsewhere).

Cannabis dependence, addiction and Cannabis Use Disorder

8.61 Cannabis dependence is defined in the International Classification of Diseases (ICD)[472] as a disorder of regulation of cannabis use arising from repeated or continuous use of cannabis, characterised by a strong drive to use the drug. This is manifested by impaired ability to control use, increasing priority given to use over other activities, and persistent use despite harm or negative consequences.

8.62 Tolerance and withdrawal symptoms following cessation or reduction are physiological indicators of dependence, with mental dependence indicated by a strong desire to use cannabis, which can become a conditioned response to an event or feeling (triggers). It is possible to be dependent on cannabis without being addicted.

---

[469] Suspensions and permanent exclusions in England, Autumn term 2022/23 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk) *Accessed 21st February 2024.*
[470] See footnote #453.
[471] See discussion in Curran, H.V., Lawn, W. & Freeman, T.P. (2023). Cannabis and Addiction. In D.C. D'Souza, D. Castle & R. Murray (Eds.), *Marijuana and Madness.* (pp.299–310). Cambridge University Press.
[472] World Health Organization (2018). *International classification of diseases for mortality and morbidity statistics (11th Revision)*. World Health Organization.

8.63 While often used interchangeably with dependence, addiction is a separate concern and refers principally to behavioural changes in a user. The main priority of a person addicted to cannabis (or any substance) becomes the use of cannabis come what may, irrespective of any harm caused to themselves or others in the process. Addiction to cannabis is likely to mean a user is dependent on the drug.

8.64 CUD arguably combines elements of both addiction and dependence. It is defined by the Diagnostic and Statistical Manual of Mental Disorders as '*a problematic pattern of cannabis use characterized by the development of tolerance, withdrawal symptoms upon cessation, unsuccessful attempts to cut down or control use, and continued use despite negative consequences*.'[473]

8.65 Despite a common belief among those who use it that cannabis neither leads to dependence nor incurs withdrawal symptoms, that these definitions are included in the principal guides to mental disorders used across the world suggests otherwise. Estimates of the prevalence of CUD worldwide vary but evidence suggests at least around 10% of global users[474] would meet the criteria for the disorder.

8.66 And this figure may well be higher, likely because of the increasing dominance of high-potency cannabis:[475] one review reported double that prevalence with an average of over 20% of users across several studies showing symptoms of CUD. As with other mental health disorders, risk increased with early onset and frequent use.[476]

8.67 Moreover, risk is not confined to non-medical use. The disorder is reported among medical users too (although there are challenges in reliably distinguishing this group from those who also, or solely, use cannabis for non-medical purposes). One recent review found up to 25% reported symptoms, most commonly withdrawal and tolerance.[477]

8.68 While debatable whether such symptoms should be specified for CUD when they are not applied in DSM-5 criteria of, for example, Opiate Use Disorder,[478] the fact remains that cannabis is seemingly not without risk even when used to alleviate symptoms of poor physical and/or mental health.

---

[473] American Psychiatric Association, DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™* (5th ed.). American Psychiatric Publishing, Inc. doi.org/10.1176/appi.books.9780890425596
[474] See footnote #434.
[475] See discussion in Hall, W. & Hoch, E. (2023). Minimizing double standards in assessing the adverse and beneficial effects of cannabis. *Addiction, 118*(9), pp.1606–8. doi.org/10.1111/add.16267
[476] Leung, J., Chan, G.C.K., Hides, H. & Hall, W.D. (2020). What is the prevalence and risk of cannabis use disorders among people who use cannabis? a systematic review and meta-analysis. *Addictive Behaviours, 109*. doi.org/10.1016/j.addbeh.2020.106479
[477] Dawson, D., Stjepanović, D., Lorenzetti, V., Cheung, C., Hall, W. & Leung, J. (2024). The prevalence of cannabis use disorders in people who use medicinal cannabis: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 257*. Elsevier.
[478] Ibid.

8.69 Cannabis use in jurisdictions where it is legal for non-medical purposes may be driving up overall reported prevalence of CUD – although whether due to increased numbers of those using the drug or more frequent use by existing users is unknown. A recent report from Washington state in the US, where non-medical cannabis has been legal since 2012, found just over one-fifth of primary care patients who were also cannabis users – including those who used it only for medical purposes – showed signs of CUD.

8.70 While symptoms were reported among medical and non-medical users, moderate to severe symptoms were particularly prevalent among those reporting non-medical use (alone or alongside medical use).[479] This group were also more likely than medical users to report use of cannabis in hazardous circumstances, uncontrolled escalation of use, cravings and interference with wider obligations.

8.71 In the UK, clinicians told us around 25,000 people a year present in clinics with symptoms of cannabis addiction – or around 1% of those in England & Wales who report using the drug (see chapter 4). This represents a fraction of those who might potentially be experiencing CUD – the global prevalence rates above suggest they could number at least 250,000 and possibly be as many as half a million users of cannabis.

8.72 While individual and public health burdens associated with CUD may well be lower than those associated with use of, for example, heroin or other opioids, they are certainly not nothing. Given that frequent use of high-potency cannabis[480] heightens the risk of developing symptoms (as with psychosis, schizophrenia and other disorders), the fact that this now dominates the market suggests there is potential for the burden posed by CUD to rise.

8.73 Environmental factors, including living alone and negative life events such as a major financial crisis or parental death, can also raise the risk of cannabis addiction. Personality traits including impulsivity, novelty-seeking and behavioural inhibition (common in those with ADHD) have equally been associated with more problematic cannabis use.

8.74 And as we have discussed, earlier onset of cannabis use increases risk. One estimate suggests those aged under 18 are three times more likely to become addicted compared to people over 18: there is some evidence that adolescents may be more resilient to cannabis effects, which might contribute to escalated use and thus increased risk of dependence and addiction.[481]

[479] Lapham, G.T., Matson, T.E., Bobb, J.F., Luce, C., Oliver, M.M. … & Bradley, K.A. (2024). Prevalence of Cannabis Use Disorder and Reasons for Use Among Adults in a US State Where Recreational Cannabis Use Is Legal. *JAMA Network Open, 6*(8). doi:10.1001/jamanetworkopen.2023.28934

[480] See footnote #464.

[481] See discussion of risk factors in Curran, H.V., Lawn, W. & Freeman, T.P. (2023). Cannabis and Addiction. In D.C. D'Souza, D. Castle & R. Murray (Eds.), *Marijuana and Madness.* (pp.299–310). Cambridge University Press.

8.75 Indeed, recent research[482] found an increased risk of CUD symptoms in adolescents aged 16–17 who currently use cannabis regularly, compared with adults aged 26–29 who use the drug similarly. This risk persisted over the course of the year-long study (though symptoms reduced over time in both groups).

Injury and death

8.76 Evidence of a link between cannabis and self-harm or suicide/suicidal ideation is conflicting. Several studies show an association, but others suggest this is explained by factors including use of other drugs and diagnoses of poor mental health (including depression and psychosis). Of the 32 drug-related poisonings recorded in England & Wales during 2022 in which cannabis was mentioned on the death certificate, only one was recorded as suicide[483] (the remainder were classified as non-suicides).

8.77 While some evidence from other jurisdictions suggests suicide rates rise following legalisation of non-medical cannabis (see chapter 7), it is difficult to unpick whether these are 'real' rises or simply a result of improved or more comprehensive toxicology testing. More broadly, and certainly compared to alcohol dependence, any direct association between cannabis use and suicide seems likely to be small.[484]

8.78 But given that risk of suicide ideation is particularly pronounced in those who begin consuming cannabis in adolescence, as well as heavy users,[485] and as it seems likely these factors (especially where cannabis is high-potency) can raise the risk of addiction as well as psychosis, we think a cautious approach is warranted. The possibility of a causative link between cannabis use and suicide ideation should not be ruled out until more robust evidence can cast a more conclusive light.

8.79 There is also evidence that cannabis consumption during pregnancy may adversely affect offspring,[486] though we note once again that findings are mixed and largely unable to account for confounding factors such as concurrent tobacco use. Use is likely motivated in some cases by a desire to treat pregnancy-related nausea but, as we acknowledge in chapter 7, there is general agreement among most health professionals that cannabis should be avoided by pregnant women. Such a cautionary approach seems sensible in the absence of clear evidence that it does not cause prenatal harm.

---

[482] Lees, R., Lawn, W., Petrilli, K., Brown, A., Trinci, K., Borissova, A. … & Freeman, T.P. (2024). Persistent increased severity of cannabis use disorder symptoms in adolescents compared to adults: a one-year longitudinal study. *Eur Arch Psychiatry Clin Neurosci*. doi.org/10.1007/s00406-024-01806-y

[483] Using the ICD-10 code for suicide. Deaths related to drug poisoning, England and Wales, 2022 (2023): Table 3. Deaths related to drug poisoning, England and Wales - Office for National Statistics (ons.gov.uk) And Table 'Deaths related to drug poisoning by selected substances, England and Wales 1993–2022'. Deaths related to drug poisoning by selected substances, England and Wales - Office for National Statistics (ons.gov.uk) *Accessed 2nd September 2024.*

[484] See for example Inskip, H.M., Harris, E.C. & Barraclough, B. (1998). Lifetime risk of suicide for affective disorder, alcoholism and schizophrenia. *The British Journal of Psychiatry: the Journal of Mental Science*, 172, pp.35–7. doi:10.1192/bjp.172.1.35

[485] See footnote #432.

[486] Ibid.

8.80 The acknowledged stigma associated with cannabis use means, however, the subject may not arise when pregnant women are seen by their GP and other health services, so opportunities to flag the risks are missed.

8.81 Driving following cannabis consumption likely raises the risk of both fatal and non-fatal road traffic accidents,[487][488] though it is difficult to isolate precise effects because cannabis presence in the bloodstream does not necessarily equate to intoxication sufficient to impair driving (due to the length of time it remains detectable, see chapter 7). The drug is also often consumed alongside alcohol which confounds isolation of effects. That said, when regular users smoked cannabis before partaking in a simulated driving experiment, performance remained impaired for four to five hours[489].

8.82 Consumption – particularly of higher-potency cannabis – affects cognition and can loosen behavioural inhibition, at least in the short term and particularly with parallel alcohol consumption. We therefore consider the conclusion drawn in the recent review of meta-analyses that cannabis should be avoided before and while driving (i.e. while impaired, as per DVLA guidance for medical cannabis users)[490] to be intuitive and sensible.

Cancer, respiratory and cardiovascular diseases

8.83 As far as we are aware, there is little conclusive evidence of a causal relationship between cannabis and a range of cancers. Evidence is strongest for an association between chronic use and testicular cancer but the nature of that association remains unclear. Studies are confounded by the impact of parallel tobacco use (either mixed with cannabis or in separate cigarettes), particularly so with respect to lung and other cancers that are widely accepted to be causally linked to tobacco.

8.84 The confounding effects of tobacco also beset attempts to determine the nature of any association between cannabis use and respiratory diseases (such as chronic bronchitis and chronic obstructive pulmonary disease, COPD). Frequent use has been associated with respiratory problems[491] but separating such effects from those caused by tobacco remains a significant challenge, meaning evidence regarding the impact of cannabis remains inconclusive.

---

[487] See footnote #437.

[488] See for example Asbridge, A., Hayden, J.A. & Cartwright, J.L. (2012). Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis. *The BMJ*. doi.org/10.1136/bmj.e536

[489] Marcotte, T.D, Umlauf, A., Grelotti, D.J., Sones, E.G., Sobolesky, P.M., Smith, B.E. & Fitzgerald, R.L. (2022). Driving Performance and Cannabis Users' Perception of Safety: A Randomized Clinical Trial. *JAMA Psychiatry, 79*(3), pp.201–9. doi:10.1001/jamapsychiatry.2021.4037

[490] Grollman, C., Pinto, C., Ismail, F. & Roberts, E. (2021). *Medical cannabis and road safety. A research report for the Department for Transport.* NatCen Social Research. Medical cannabis and road safety - GOV.UK (www.gov.uk) *Accessed 15th February 2024.*

[491] As cited in McManus, S., Bebbington, P., Jenkins, R. & Brugha, T. (Eds.) (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. *Note: this survey runs every seven years, the next iteration is currently in preparation.*

8.85 Current wisdom seems to be that, while smoking cannabis without tobacco is not without harm, and is associated with heightened rates of symptoms of chronic bronchitis,[492] it does not increase the risk of COPD, or of lung or airway cancers (at least where consumption is light to moderate). Evidence suggests the risks of pulmonary complications from cannabis smoking – even regularly and heavily – are far outweighed by those resulting from smoking tobacco.[493]

8.86 With respect to cardiovascular disease, there is increasing evidence of an association between cannabis use and adverse outcomes. A recent large US study, which in controlling for tobacco use and other demographic factors addressed many of the methodological limitations of earlier research, found use of the drug to be associated with increased risk of heart attack and stroke, with more frequent use raising the odds of these outcomes.[494]

8.87 Notably, similar increases in risk were also found in cannabis users who do not smoke tobacco, meaning that, while there may be little evidence of risk to pulmonary functions among this group, they may nevertheless be at increased risk of other serious disease.

8.88 Research drawing on UK Biobank data[495] suggests similar. Those who smoke cannabis more than once a month were significantly more likely than those who do so less frequently or not at all to suffer a heart attack. This finding remained once some other relevant factors (such as age, sex and body mass index) were controlled for.[496] Crucially, however, the analysis did not control for tobacco use, which of course is also a risk factor for cardiovascular disease. Moreover, reliance on Biobank data means findings cannot be considered representative of the UK population more generally.[497]

8.89 Further suggestion of a causal link, though, comes from analysis of 3,455 deaths reported to England's National Programme on Substance Abuse Deaths (NPSAD) between 1998 and 2020, in which post-mortems detected the presence of cannabinoids.[498]

8.90 Cardiac failure immediately following cannabis use was recorded in 9 of the 14 cases where cannabis itself (as opposed to alongside other drugs and/or alcohol)

---

[492] See discussion in Ware, M. (2013) Cannabis and the Lung: No More Smoking Gun? *Annals of the American Thoracic Society, 10*(3), p.248. doi.org/10.1513/AnnalsATS.201302-034ED

[493] Tashkin, D.P. (2013). Effects of Marijuana Smoking on the Lung. *Annals of the American Thoracic Society, 10*(3),pp.239–47. doi.org/10.1513/AnnalsATS.201212-127FR

[494] Jeffers, A.M., Glantz, S., Byers, A.L. & Keyhani, S. (2024). Association of Cannabis Use With Cardiovascular Outcomes Among US Adults. *Journal of the American Heart Association, 13*(5). doi.org/10.1161/JAHA.123.030178

[495] A biomedical database and research resource containing genetic and health information from half a million UK participants. UK Biobank - UK Biobank

[496] Wei, T., Chandy, M., Nishiga, M., Zhang, A., Kumar, K.K., Thomas, D. ... & Wu, J.C. (2022). Cannabinoid receptor 1 antagonist genistein attenuates marijuana-induced vascular inflammation. *Cell, 185*, pp.1676–93, Elsevier Inc. doi.org/10.1016/j.cell.2022.04.005

[497] See Keyes, K.M. & Westreich, D. (2019). UK Biobank, big data, and the consequences of non-representativeness. *The Lancet Correspondence*, 393(10178), p.1297. doi.org/10.1016/S0140-6736(18)33067-8

[498] See footnote #430.

was considered the underlying cause of death. Death following use of cannabis alone was rare (136 cases, or 4% of the total 3,455) with traumatic injury the most common underlying cause in such instances (the vast majority of which resulted from self-inflicted injuries or a road traffic collision).

8.91 We consider the evidence so far suggests a need to pay close attention to the incidence of both cardiovascular disease and road traffic accidents in jurisdictions where cannabis for non-medical purposes is legal, particularly given indications that THC increases inflammation of blood vessels, which can be an important antecedent of a heart attack.[499]

8.92 Those at greater risk more generally of cardiovascular disease would, we think, be wise to consider desisting from using cannabis – once again, this points to a need for better education about the health risks of the drug.

8.93 However, the focus on smoking cannabis or, where other forms of consumption are considered, a failure to distinguish effects according to mechanism of consumption, means a better understanding of the cardiovascular impact of cannabis ingested in other ways (via edible products or vaping, for example) remains a gap.

Co-consumption with tobacco

8.94 One of the most potentially harmful and possibly under-appreciated effects of cannabis is the 'reverse gateway': by smoking tobacco together with cannabis, individuals risk becoming addicted to nicotine, especially where they were not previously smokers. Consuming cannabis in this way is the most common form of administration across the UK and Europe, in contrast to the US and Canada, where if the drug is smoked, it tends to be without tobacco.

8.95 Those jurisdictions which have moved to legalising non-medical cannabis also, of course, offer a variety of other means of consuming the drug that do not involve tobacco, most notably edibles and vapes. While inhalation of a vaporised liquid extracted from cannabis is not without risk, particularly to respiratory health (and the consequences of long-term vaping remain unknown), it does at least allow the effects of cannabis to be experienced without parallel exposure to tobacco-related harms.

8.96 Availability of legal, regulated and quality-tested cannabis for consumption without tobacco is one benefit of a legally regulated framework. Edibles and vapes allegedly containing THC are accessible via the illegal market in the UK (primarily via the internet, as we discuss in para.8.148 with respect to cannabis foodstuffs more widely). As we have raised elsewhere, however, and touch on in this chapter with respect to SCRAs, there are no guarantees of composition or potency and no comeback for users against suppliers of adulterated goods.

[499] Marijuana and heart health: What you need to know - Harvard Health *Accessed 22nd February 2024.*

8.97 We heard of some (albeit limited) evidence that consideration of the consequences of cannabis use among the public tend to focus on potential health benefits rather than risks, even when consumed with tobacco. This is possibly at least in part a result of narratives emerging from the expanding wellness industry, in which cannabis-derived products based around CBD extracts from the cannabis plant are a significant and growing element (see para.8.136).

8.98 Any optimism bias, albeit one rooted in confusion of health benefits potentially conferred by CBD with consequences of consuming THC, likely increases chances of both initial uptake and continued use. This reinforces the need for better, more comprehensive education about cannabis, highlighting that co-consumption with tobacco almost certainly outweighs the potential for any positive health effects resulting from parallel consumption of CBD.

Therapeutic effects

8.99 We have focused up until now on the adverse risks to health of cannabis use, particularly heavy and sustained use of high-potency cannabis, which, compared with what was commonly available in the last century, is now the norm.

8.100 There are, however, several potential benefits of cannabis and cannabinoids, but these have received relatively little research attention compared with that given to their harms. Cannabis is used for a range of pleasurable psychological and social effects that are highly valued by users,[500] as well as for medicinal, or therapeutic, purposes, which we discuss in more detail in chapter 11.

8.101 We note that evidence of the therapeutic effect of cannabis with respect to severe, rare forms of epilepsy, vomiting or nausea caused by chemotherapy, and muscle stiffness and spasms related to multiple sclerosis (MS), is considered sufficiently strong that licensed cannabis-based medicines to treat those conditions are available on NHS prescription.

8.102 Symptoms associated with a much wider range of conditions, such as Alzheimer's disease, Crohn's disease, glaucoma, endometriosis, pain and nausea as well as a range of mental health conditions including anxiety, depression and PTSD, are considered by many to also be treatable with cannabis-based medicines, although there are as yet no licensed products to do so. Those we spoke to who prescribe and dispense such unlicensed cannabis-based products for medicinal use (CBPMs) were optimistic about their capacity to improve quality of life for users – although clinical evidence of the precise nature and extent of effects is in its infancy.

8.103 There is some (albeit limited) support for the use of cannabis to improve mental health from elsewhere, including US research[501] that noted falls in mental health

[500] See footnote #440.

[501] Ortega, A. (2023). The highs and the lows: Recreational marijuana laws and mental health treatment. *Health Economics, 32*(10), pp.2173–2919. doi.org/10.1002/hec.4726

treatment admissions across states that had legalised non-medical cannabis by 2019. The authors suggest this might be explained by individuals who would otherwise seek treatment turning to cannabis instead, alleviating symptoms sufficiently to deter them from health services.

8.104 Given, however, that evidence remains unable to reach a conclusive position on the causal nature of the effect of cannabis on mental health overall, the use of (unlicensed) CBPMs is not currently endorsed by the National Institute for Health and Care Excellence (NICE) or the Royal College of Physicians (RCP). This means they remain unlicensed and as such are very difficult indeed to secure through the NHS: the vast majority of prescriptions are dispensed through private (paid-for) healthcare (see chapter 11).

8.105 We are aware, too, that many cannabis users enjoy the feeling of being high or 'stoned', the sense of relaxation that the drug can induce, and its often facilitative effects on wider social interactions. While by no means the case for all those who use cannabis, many report positive effects on creativity and associated activities, with enhanced enjoyment of music, art or film. Like any drug, including alcohol and tobacco, it can make those who use it feel good.

Synthetic cannabinoid receptor agonists (SCRAs)

8.106 Consideration of SCRAs falls outside the scope of our inquiries. However, several witnesses felt they represented a much greater risk to health than that posed by natural cannabis. Classed as a 'novel psychoactive substance', SCRAs are, as the name suggests, synthetic chemicals that stimulate the cannabinoid receptors in the body and mimic the effects of natural psychoactive THC found in herbal cannabis.

8.107 First created in the 1980s to enhance understanding of the endocannabinoid system and explore therapeutic potential of drugs that interact with it,[502] they were not at the time covered by the Misuse of Drugs Act 1971 (MDA), so began to be commercialised a decade or so later, appearing for sale in the UK as 'legal highs'.

8.108 Typically comprising an herbal mixture, paper or clothing infused or sprayed with SCRA and designed to be smoked (although other methods of consumption included vaping and ingestion of pills or powders), they came to be known under the umbrella term of 'spice', although Spice was originally a brand name along with several others including Black Mamba, Annihilation, Crazy Monkey and K2.

8.109 While mimicking the effects of THC, SCRAs are much more potent than natural cannabis: some variants can be up to several hundred times stronger. While cannabis only partially stimulates cannabinoid receptors, SCRAs are capable of fully stimulating them.

[502] Advisory Council on the Misuse of Drugs (2020). *Synthetic cannabinoid receptor agonists (SCRA): An updated harms assessment and a review of classification and scheduling under the Misuse of Drugs Act 1971 and its Regulations.* ACMD Synthetic cannabinoid receptor agonists (SCRA) report (publishing.service.gov.uk)

8.110 The range of adverse effects of SCRAs (the causal relationship is much less contested than for natural cannabis) is extensive. They include loss of consciousness (though arguably this is for some, see para.8.115, a desired effect), raised heart rate and blood pressure, nausea and vomiting, seizures and psychosis. Behavioural effects include aggression and violence.

8.111 Cardiac dysrhythmias, cardiac arrest, heart attacks, stroke and acute kidney failure have also been reported,[503] and in extreme cases SCRAs can kill. Synthetic cannabinoids were listed on the death certificate in 48 fatal drug-related poisonings in 2022 (cannabis was mentioned in 32),[504] though this is probably an underestimate as SCRAs may not be routinely tested for.[505]

8.112 The relative risk of health-related harms posed by SCRAs compared with natural cannabis has been quantified through pursual of emergency medical treatment. The risk associated with use of the former was 30 times higher than that associated with the latter. Moreover, significantly more symptoms were reported by those seeking treatment for synthetic cannabinoid use than for cannabis.[506]

8.113 Longer-term effects linked with use of SCRAs include mood disorders, anxiety, depression and suicidal thoughts. More recent evidence suggests they can adversely impact memory and cognition, with tolerance, swift dependence and withdrawal effects also associated with use.[507'508]

8.114 All SCRAs became illegal to sell, make, import and export under the Psychoactive Substances Act (PSA) 2016, although possession (unless a person was in prison) remained legal. However, following amendment to the MDA that same year, most known SCRAs, including those commonly found in Spice, became Class B drugs classified under that legislation, meaning possession became illegal.

8.115 While use of SCRAs has declined among the general population, it remains prevalent particularly among the homeless and those in prisons. This is likely driven by the strength of effect (often allowing a user to lose consciousness for several hours), lower costs relative to other illicit drugs and low likelihood of detection via drug testing.

8.116 Legislation now specifies and outlaws the vast majority of SCRAs, although as manufactured, synthetic (or semi-synthetic) compounds they are subject to

---

[503] Ibid.
[504] Deaths related to drug poisoning by selected substances, England and Wales, 2022 (2023). Table 'Number of drug-related poisonings where new psychoactive substances were mentioned on the death certificate, England and Wales, deaths registered between 1993 and 2022'. Deaths related to drug poisoning by selected substances, England and Wales - Office for National Statistics (ons.gov.uk) *Accessed 2nd September 2024.*
[505] See footnote #502.
[506] Winstock, A., Lynskey, M., Borschmann, R. & Waldron, J. (2015). Risk of seeking emergency medical treatment following consumption of cannabis or synthetic cannabinoids in a large global sample. *Journal of Psychopharmacology 29*(6), pp.698–703. doi:10.1177/0269881115574493
[507] See footnote #502.
[508] Spice-info-sheetv1.3-Interactive-national.pdf (drugwise.org.uk) *Accessed 19th February 2024.*

constant evolution, meaning it is difficult for the law to keep pace. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has, for example, recently pointed to the emergence of hexahydrocannabinol (HHC) and two related substances known as HHC acetate and hexahydrocannabiphorol, which are semi-synthetic compounds synthesised from cannabis.[509]

8.117 While the effects of HHC in humans have not yet been formally studied, animal studies show it activates the same cannabinoid receptors as THC. This means it has psychoactive properties which, while reportedly less intense than those associated with delta-9-THC in herbal cannabis, as the EMCDDA notes means it may have potential for abuse and dependence in humans.

8.118 As well as being sprayed or mixed into herbal (low-THC) cannabis, resin and edibles, HHC is also available in vape pens and cartridges. Not currently a specified controlled drug in the UK or EU (it remains under monitoring by the EMCDDA), in the UK its psychoactive properties mean that under the PSA it is technically illegal to produce, sell or supply HHC products. Possession for personal use, however, is not criminalised (although remains illegal in prison).

8.119 This means the legal risk associated with use is lower than that associated with cannabis. That said, if caught in possession, UK police are liable to consider it cannabis until forensic tests prove otherwise. Moreover, HHC-based flowers/bud and edible products can easily be purchased from online marketplaces selling CBD products, marketed as 'non-psychoactive' or 'THC-free' but very similar in look to illicit cannabis. In our view, there is something of a legal grey status when it comes to the status of HHC.

8.120 And the similarity to illicit cannabis of products containing HHC means there is a risk, as with prohibited SCRAs, that it may be mis-sold, or used to further adulterate cannabis and CBD products and produce effects that users are not expecting.

8.121 This is a growing challenge with herbal cannabis and related CBD- and THC-based products, in particular vapes, as reported by the UK's nationwide drug testing facility. The Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS)[510] service reported almost 40% of liquids tested during 2023 that were purchased in the belief they were cannabis, CBD or THC e-liquids for use in vapes in fact contained one or more SCRAs.

8.122 Inadvertent consumption of SCRAs is a concern. Arguably it is potentially also, at least in part, one of the consequences of prohibiting use of cannabis for non-medical use, because users cannot be confident in what they are purchasing. What looks and smells like cannabis (or derivatives), sold in packages which look

[509] European Monitoring Centre for Drugs and Drug Addiction (2023). *TECHNICAL REPORT Hexahydrocannabinol (HHC) and related substances*. Luxembourg: Publications Office of the European Union. Hexahydrocannabinol (HHC) and related substances | www.emcdda.europa.eu *Accessed 20th February 2024.*
[510] WEDINOS - Welsh Emerging Drugs & Identification of Novel Substances Project

to all intents and purposes like those which house legitimate product from jurisdictions where non-medical cannabis is legal[511], is not necessarily cannabis.

8.123 Testing services like the WEDINOS are an important part of furthering understanding about how cannabis is adulterated. As a postal submission service, though, it is not designed to provide would-be users with near real-time information about the make-up of cannabis (or any other illicit drug) they intend to consume. We were therefore pleased to note the recent expansion of a user-centred drug testing service run by The Loop, which is now live in Bristol.[512]

8.124 This builds on the service already provided by the organisation at festivals, where confiscated drugs or those left in amnesty bins are tested and, if found to be stronger than usual, contaminated or sold as something they are not, a warning is issued to festival-goers. The Bristol service focuses on enabling would-be users to make an informed decision whether to take a drug they have purchased: they leave a sample of the product and return around an hour later to receive the results.

8.125 Crucially, a health consultation is offered along with the results, providing opportunity to discuss drug use and risks. Focused on dependent, frequent and problematic drug use, the service aims to reduce consumption of adulterated and contaminated drugs and thus reduce the risk of poisoning and overdose, while signposting users to support services.

8.126 Understandably, due to limited capacity and high risk of harm, the service is focused on Class A drugs. It is also currently limited to Bristol, although we understand the introduction of a similar service in London is being explored. **The Mayor of London should expedite considerations to introduce a drug testing service in London, which includes the capability to test cannabis, as soon as practicable** (R4).

Cannabis potency

8.127 The proportion of THC relative to CBD is what determines the strength, or potency, of cannabis. As noted at the beginning of this chapter, the lack of a standard 'unit' of THC means it is not yet possible to understand what a 'safer' dose of cannabis might amount to.

8.128 The lack of what constitutes a 'standard dose', as well as an appropriate definition of 'high potency', has implications for public health messaging and education about cannabis use more widely, as alluded to in the Legislative Review of Canada's Cannabis Act and associated recommendation.[513]

---

[511] Empty packaging, printed with known names, images and brands of cannabis strains, are available online and offline.
[512] What We Do — The Loop (wearetheloop.org)
[513] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca pp.31–5, recommendation 14. *Accessed 26th March 2024.*

8.129 Strength of alcoholic beverages, in contrast, is measured in standard units of alcohol. This permits different types of alcoholic drink to be compared so users know, for example, that one large glass of wine (250ml) equates to around three units, approximately equal to three single measures of spirits (25ml each) or one pint (568ml) of strong lager. The measurement of one standard alcoholic unit has enabled development of safer consumption guidelines and permits a person's consumption to be objectively counted. This is not currently possible with cannabis.

8.130 Severe intoxication could result from consumption of just one joint if the cannabis is very high in THC, or from several joints if potency is lower. One person who consumes two joints in 24 hours might consume far more THC than another who consumes 6 edible gummies: there is simply no way of measuring this, meaning assessing consumption and any associated treatment needs is difficult.

8.131 We were pleased to hear about work currently underway in the UK to develop a standard measure of one unit of THC, which would apply irrespective of method of administration and product (i.e. across cannabis flower/bud, resin, concentrated extracts and dabs, vape oils and edibles). This could in future support education and guidance about the number of units, or milligrams, of THC, which is generally sufficient for an intoxicating effect but poses less risk of adverse side effects.

8.132 While cannabis for non-medical use remains illegal, however, the concept of units of THC remains to some extent academic. Dealers are unlikely to label their goods in the way of alcoholic drinks, indicating the number of THC units per serving/entire product. Indeed, even if they wished to, they would have little way of knowing what the correct number was.

8.133 The likely behavioural response of users is also unknown: would knowing how many units of THC units were contained in a cannabis product mean they would moderate consumption? Or would it drive risk-taking and competitiveness? This is a concern perhaps particularly relevant for young people. It would be helpful to better understand these issues. **The Home Office (HO) and Department for Health & Social Care (DHSC) should consider commissioning independent research to explore how those who use cannabis view potency and do or do not adapt their consumption accordingly** (R5).

Cannabidiol (CBD) based edible products

8.134 While not within our terms of reference, our inquiries inevitably touched on the relatively recent emergence of a legal (under the MDA) market for cannabis-derived extracts as the basis of a vast array of goods for human consumption.

8.135 As we discuss in chapter 2, cannabis has long been cultivated for hemp (i.e. those plants which contain tiny amounts of THC so are not considered to have psychoactive properties). Hemp cultivation, principally for oilseed and fibres, has long been a legal practice.

8.136 More recently, however, a market for edible and non-edible products (such as body creams and lotions) based on CBD has emerged. Sold predominantly as health supplements and other wellbeing products, their history, particularly that of edible consumables, in terms of authorisation and licencing is somewhat chequered.

8.137 Over tens of thousands of different edible products containing varying amounts of CBD have entered the market since the mid–late 2000s. Their status as 'edible' remained unchallenged until a European assessment in 2019 deemed them to be 'new' products, which therefore required authorisation for manufacture, sale and consumption.

8.138 This led the UK's Food Standards Agency (FSA, the UK regulator responsible for authorising new foods as safe for consumption) to take steps to ensure the industry was compliant with standards set for the novel foods market in this country. (EU Exit meant the agency was taking over relevant authorising processes from the European Commission.) As they had little or no history of consumption before May 1997, when the EU brought in its original laws defining 'novel foods', FSA authorisation was required for CBD edible products to remain on the market in the UK. In 2021, the FSA permitted the industry to retrospectively apply for permissions to sell products that had been available for sale prior to February 2020.

8.139 The FSA told us around 90 applications for authorisation are currently being considered, covering many hundreds of different companies and listing many thousands of edible products, including gummies, chocolates and baked goods as well as coffee, tea and other soft drinks. Listed products remain legal while authorisation is pending.

8.140 Where retrospective authorisation is refused, the product will be deemed as non-compliant, meaning it must be removed from sale. Any products developed since 2021 must apply for FSA authorisation before entering the market.

8.141 While there is no cap on permitted quantities of CBD in edible products, recent reviews concluded that long-term use could risk liver, thyroid and other health problems. This led the FSA, towards the end of 2023, to update its guidance[514] on CBD intake from food and recommend an acceptable daily intake (ADI), i.e. 10mg (around four or five drops of 5% CBD oil).

8.142 As this is a recommendation only, any products that contain more than the suggested daily limit can remain on sale. Consumers will, however, need to pay attention to labelling and serving size to ensure they are aware of how much CBD they are consuming. Any future authorisations granted will place legal limits on quantities of CBD in edible products.

[514] Cannabidiol (CBD) | Food Standards Agency *Accessed 20th February 2024.*

8.143 Arguably this is no different to consumption of other foodstuffs that, when consumed in quantity, pose a risk of adverse health effects (notably sugar, caffeine and alcohol): consumers here may make their own decisions with respect to what and how much they consume.

8.144 There is a question, however, in terms of the interplay with consumption of illegal cannabis that also contains THC. People consuming cannabis alongside 'CBD-only' products, even where use of the latter does not exceed the recommended daily limit, will clearly be ingesting more CBD than may be safe in the long term. **The Department for Education, in partnership with the DHSC, HO and FSA, should consider the issue of consumption of legal CBD alongside illegal cannabis further, with thought given to how educational materials regarding cannabis use might raise awareness of the potential risks of CBD consumption** (R6).

8.145 FSA-authorised products must comply with limits on permitted levels of THC (specifically delta-9-THC), which must be sufficiently low so as not to induce a psychoactive 'high' and thus contravene the MDA. Following advice from the Advisory Council on the Misuse of Drugs (ACMD), forthcoming legislation intends to cap the total amount of THC in one single serving of a CBD edible product to 50 micrograms (mcg).

8.146 Widely available in larger retailers including supermarkets, as well as health shops and pharmacies, CBD 'infused' products are, like it or not, rapidly becoming normalised within wider food and drink choices (and other non-edible product ranges) and are swiftly growing in popularity. Indeed, Trip, a CBD-infused drink sold in major retail outlets, became the UK's fastest growing soft drinks brand in 2023.[515]

8.147 Availability in outlets associated with health and wellbeing is likely to further strengthen any association in the mind of the public between cannabis and health benefits. Indeed, young people are increasingly turning to infused drinks as an alternative to alcohol: a lucrative market is developing that, as was put to us, is of huge interest to both the alcohol and tobacco industries. Seeing declining revenue from future purchasing generations, they are seeking to diversity their interests.

8.148 Widespread availability of CBD-derived products within a wider landscape in which edibles containing more than trace amounts of THC remain illegal is, in our view, confusing. Moreover, it is perfectly possible to order edibles containing significant amounts of THC through online outlets. As they are likely shipped from jurisdictions where they are legal, with payment usually required via digital currency (e.g. bitcoin), there is nothing on sale sites to suggest such products are in fact illegal in the UK.

8.149 Once again, we return to education, which has seemingly not kept up with the reality of a rapidly expanding marketplace for cannabis and cannabis-derived

[515] CBD brand Trip becomes 'fastest-growing' soft drink in the UK | News | The Grocer *Accessed 22nd February 2024.*

products. Attention of policy makers and health service providers with respect to illegal drug use tends, it was put to us, to be directed towards synthetic opioids,[516] chemsex,[517] overdose prevention and needle-sharing prevention – as we heard is also the case with forensic (offender) populations.

8.150 In a world of limited resource, focusing on drug use that risks the most immediate harm and, in some cases, death, is understandable. But cannabis use is not risk-free, particularly in today's world of wider choice in method of consumption and higher-potency products.

8.151 Providing neither education to explain risks and encourage safer use among those who choose to use it anyway (as many do), nor accessible treatment and support services (as we cover in chapter 9), may well serve simply, over time, to increase the number of users suffering harm. Who begin as ill-informed and end up ill-served by services inadequately equipped to prioritise their needs.

Education about the risks of cannabis and health

8.152 As we set out in this chapter, there are a range of medical or otherwise therapeutic uses for the cannabis plant, as well as several pleasurable benefits afforded by the drug, and we do not disregard the importance of these.

8.153 We also recognise that, despite the risks (related not just to health but to procuring and using an illegal substance), non-medical use of cannabis is plainly not going away despite continued prohibition, 'just say no' public messaging and criminalisation of those involved in production, supply and possession.

8.154 It is important to acknowledge this. Without accepting the reality of use, opportunities for meaningful, credible policy and education strategies with potential to reduce the risk of health-related harms are lost. We recognise the challenge inherent in discussing safer or more responsible consumption of what remains an illegal drug – but the reality of widespread cannabis use cannot be ignored.

8.155 We discuss the matter in more detail (as it relates to children and young people specifically) in chapter 12 but believe public policy and education practices should support those who choose to use cannabis, as well as would-be users, to make informed choices, similar to campaigns focusing on the health risks associated with alcohol and tobacco. Key messages include:

- Heavy, regular consumption from an early age can affect brain development and cognitive function at a crucial time in a young person's life. This can substantially harm their prospects for education and employment in addition to the success of interpersonal relationships.

[516] Following advice from the ACMD, the UK government banned 11 synthetic opioids in 2023.
[517] Sexual activity, mostly between men, undertaken while under the influence of illegal stimulant drugs such as methamphetamine or mephedrone.

- For some, particularly those with genetic predisposition to serious mental or physical health disorders or who already suffer such, cannabis acts similarly to an allergen. They are, simply put, allergic and cannot use or enjoy it in the same way others are able to – the risks are too great and are greatest if someone is already acutely unwell.
- Cannabis may in some cases limit rather than create opportunities to achieve, find employment, build and maintain relationships, or to find and enjoy activities that do not revolve around use of the drug.
- The drug does not universally aid imagination, flair and creativity (indeed, we heard how some CCP patients reported such abilities to be significantly heightened once they stopped using cannabis).
- Different types of cannabis, levels of potency and methods of consumption deliver different levels of intoxication and pose different health risks, similar in some respects to alcohol and the differences between beer, wine and spirits.
- Smoking cannabis produces toxicants that are harmful to health (recognised in Canada and legalising US states through higher taxes on combusted forms of cannabis). This is compounded by co-consumption with tobacco, which also undermines attempts to quit either substance.

8.156 A focus on safer use strategies and the benefits of reducing use are likely to be more successful in effecting behaviour change than messages urging complete desistance. Outright health warnings may have less impact, particularly on those who are already regular users.[518]

8.157 Which highlights the importance of timing. Harm-reduction messaging should ideally target young people and other groups at heightened risk before the opportunity to use cannabis emerges, with a focus on the importance of delaying onset. It should be in place before use risks becoming regular and sustained.

8.158 It is important, however, to be realistic about the extent of behaviour change and priorities of cannabis users. It was pointed out to us that many heavy users, despite being fully aware of the harms of smoking cannabis (either alone or with tobacco), may well not switch to, for example, consuming edibles instead.

8.159 Principally because they value the control that smoking cannabis affords: once the desired effects are reached, or a person might begin to feel unwell, they can immediately stop smoking. Once an edible has been consumed, however, the individual must simply wait out any effects – good or bad. Because they do not take effect immediately, it is also more difficult to moderate consumption relative to desired effect.

[518] Winstock, A.R., Lynskey, M.T., Maier, L.J., Ferris, J.A. and Davies, E.L. (2021). Perceptions of cannabis health information labels among people who use cannabis in the U.S. and Canada. *Int J Drug Policy,* May; 91:102789. doi:10.1016/j.drugpo.2020.102789

9. THE HEALTH POLICY RESPONSE TO NON-MEDICAL CANNABIS USE

Our inquires did not demand a detailed exploration of drug and other treatment services that (non-medical) cannabis use might cause a person to need. Understanding possible implications for those services of any change in the legal framework governing non-medical cannabis use, however, is important.

In this chapter we set out our high-level understanding of the current drug treatment landscape in London, before considering the demand placed on the system by those with cannabis-related needs, particularly with respect to mental health. We have explored barriers to seeking help, which can include fear of judgement and criminal sanction as well as mistrust in wider authorities, and considered whether these can affect different groups in different ways.

We briefly considered the extent of the evidence base regarding 'what works' in treating symptoms of poor health related to cannabis use, and what more is needed. We go on to look at the way in which treatment services are structured across London and implications for those working in the sector – including those working with offenders presenting with drug-related needs.

Specific challenges posed by the typical separation of mental health, drug treatment and tobacco cessation services stood out and we consider the need for further join-up. This includes the potential for pharmacists to play a greater role in identifying symptoms of cannabis-related ill health and supporting help-seeking.

We conclude this chapter by briefly considering the implications of legalising non-medical cannabis for drug treatment and other health services, considering the likely rise in prevalence of use and probable accompanying rise in tobacco use.

The wider landscape

9.1 The comprehensive and highly regarded two-part review undertaken by Professor Dame Carol Black (the Black Review), which considered firstly drug supply and demand and secondly, treatment, recovery and prevention,[519] provides valuable current context. We do not wish to revisit ground so ably and thoroughly covered by that review, though note among its conclusions the judgement that provision of drug treatment and recovery services was not fit for purpose and required urgent repair.

9.2 The government's subsequent 10-year drug strategy,[520] underpinned by the findings and recommendations of the Black Review, committed to delivering a

[519] See Independent review of drugs by Professor Dame Carol Black - GOV.UK (www.gov.uk) for related reports.
[520] See From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

world-class treatment and recovery system in England. It pledged an additional £780 million to fund measures to meet that commitment.

9.3 While this investment was welcomed by the sector, we note it followed a period of several years in which treatment funding was very significantly reduced, leaving many local authorities able to offer only the bare minimum of provision. Against a backdrop of rising overall prevalence of drug use (particularly of opiates and crack cocaine) but falling numbers in treatment following shrinking of capacity, levels of unmet need rose substantially.[521] The extent to which the £780 million has served or will serve simply to return funding back to levels not seen since the mid-2000s remains to be seen.

Need for treatment among those who use cannabis

9.4 Statistics suggest around 10% of people who use cannabis worldwide will develop symptoms of Cannabis Use Disorder (CUD),[522] although the figure could be as high as 20% or more.[523] While not all those who develop symptoms of CUD (or other health issues potentially related to cannabis use) seek treatment, cannabis is the most cited problematic substance after opiates (excluding alcohol) in England.[524] This is perhaps not surprising given it is the most widely used illicit drug (see chapter 4).

9.5 During 2022/23, a total of 290,635 adults across England were undergoing some form of drug and/or alcohol treatment. Of those, 57,181 (one-fifth) cited problems related to cannabis (either alone or alongside problems with other drugs and/or alcohol). By comparison, just under half had problems with opiates, used with or without crack cocaine (n = 138,604). The most commonly cited problematic substance, however, was alcohol, cited by half (n = 145,202) of all adults in treatment.[525]

9.6 Of all those in treatment for cannabis use (n=57,181), almost two-fifths (n=22,124, 38.7%) also had problems with opiates. Almost one-third (29.7%, n=17,011) were in treatment solely for non-opiate use (including those who only used cannabis as well as those using cannabis alongside non-opiates such as crack or ecstasy). A similar number (31.6%, n=18,046) were using both cannabis and alcohol.[526]

---

[521] Black, C. (2020). *Review of Drugs – evidence relating to drug use, supply and effects, including current trends and future risks*, pp.84–5. Available at Review of drugs: phase one report - GOV.UK (www.gov.uk) *Accessed 23rd February 2024.*

[522] Connor, J.P., Stjepanović, D., Le Foll, B., Hoch, E., Budney, A.J. & Hall, W.D. (2021). Cannabis use and cannabis use disorder. *Nature Reviews Disease Primers 7*(16). doi.org/10.1038/s41572-021-00247-4 *Accessed 11th March 2024.*

[523] Leung, J., Chan, G.C.K., Hides, H. & Hall, W.D. (2020). What is the prevalence and risk of cannabis use disorders among people who use cannabis? a systematic review and meta-analysis. *Addictive Behaviours, 109*. doi.org/10.1016/j.addbeh.2020.106479

[524] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Tables 10_3 & 10_4. *Accessed 4th April 2024.*

[525] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Table 10_4. *Accessed 4th April 2024.*

[526] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Table 1_2. *Accessed 4th April 2024.*

9.7 While the number of new entrants to treatment with a primary dependence on cannabis remains lower than those for whom alcohol or opiates are the principal dependence, the figure has been slowly rising since 2018/19, with a 2% rise recorded in the last year (from 28,263 in 2021/22 to 28,845 in 2022/23). This follows a steady decline seen in years prior to 2018/19, down from an 18-year high in 2013/14 of 30,422.[527]

9.8 It is difficult to know whether this rise indicates growing numbers of problematic users, improved identification of those with symptoms, and/or increased propensity to seek help. Nevertheless, the number in treatment is likely to be a fraction of the number of people who use cannabis who may need help, given the total number of users in England & Wales is estimated to be around 2.5 million (see chapter 4) and, as above, at least 10% of those (i.e. 250,000) may have symptoms of CUD.

9.9 Compared to the 10% rise in new entrants to treatment citing problems with the next most widely used illicit drug, powder cocaine (from 21,298 in 2021/22 to 23,529 in 2022/23, see chapter 4), the 2% increase related to cannabis is arguably relatively modest.[528]

9.10 That said, it was put to us by some of those we heard from that, among young people accessing drug treatment, the proportion for whom cannabis is their primary dependence is higher than among adults. This is certainly the case for young adults – over 50% of new entrants to treatment in England in 2022/23 aged between 18 and 24 cited cannabis. Ten per cent of that age group cited opiate use (with or without crack cocaine). For those aged 25–29, 35% cited cannabis use, and 18% opiates.[529]

9.11 As with any form of substance dependence, cannabis dependence can lead to adverse consequences for other aspects of a person's life, including finances, employment and relationships. The process of trying to cut down or stop is also not straightforward and dealing with symptoms of withdrawal can pose similar challenges.

9.12 But most people dependent on alcohol or other drugs do not seek treatment. Stigma, fear of judgement and lack of awareness of the link between their substance use and other issues can be compounded by inconsistent, or inaccessible, treatment. Provision also tends to prioritise alcohol and opiates, with many of those presenting problems related to cannabis use, it was put to us, being seen instead by psychiatric services, which are often unable to address underlying issues.

---

[527] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Table 10_3. *Accessed 4th April 2024.*
[528] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Table 10_3. *Accessed 4th April 2024.*
[529] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Tables 2_2. *Accessed 4th April 2024.*

9.13 We heard too that parents can be wary of seeking help for children suffering with their mental health who also use cannabis, due to fear of recrimination related to the criminal status of the drug, as well as the stigma. Young people themselves can be particularly anxious about raising questions with health professionals because of fear of judgement.[530]

9.14 Cannabis use is not restricted to any demographic (see chapter 4). Data on characteristics of those in treatment, however, may not reflect the spread of need but rather propensities of different groups to seek help and engage with services.

9.15 One London-based service provider, for example, told us the majority of their caseload comprised middle-aged white men, and over 80% of adults in treatment in England in 2022/23 were from a white background (68% were male).[531] Treatment and harm-reduction services therefore need to be cognisant of the potential for different levels of inclination of those in need to seek help, to ensure equity of access.

9.16 Differences in propensity to seek help are likely due in part to levels of fear felt in different communities about admitting use of an illegal drug. We heard that mistrust and wariness of the police among some communities in London, resulting from a range of negative experiences (see chapter 10), can often extend to wider authority. This can include healthcare services, where similarly poor experiences, personally or second hand, might deter help seeking.

9.17 Those experiences can be compounded where service providers are not representative of communities they serve, in terms of demographics or experience of drug use. This latter speaks to the discomfort that we heard is often articulated by young people when asked to discuss cannabis use with healthcare, education or other professionals whom they perceive to have little relevant experience.

9.18 It was also put to us that sweeping funding cuts to youth services in recent years have reduced access, not only to recreational activities but to sources of trusted advice and routes into support services of all kinds, including drug treatment.

9.19 We discuss the importance of credible voices in chapter 12, but the peer mentor element of London's Cannabis Clinic for Patients with Psychosis (CCP, see para.9.46), seen by its patients as a vital part of the service, is a good example. The importance of integrating similar networks of peer-based support into drug treatment and recovery services was highlighted by the Black Review[532] and reiterated in the recent review by the Home Affairs Committee (HAC). They noted

[530] Walsh, H. (2023). Unpublished PhD findings shared with the London Drugs Commission.
[531] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Tables 1_1 and 1_6. *Accessed 4th April 2024.*
[532] Black, C. (2021). *Review of drugs part two: prevention, treatment and recovery*. Available at Independent review of drugs by Professor Dame Carol Black - GOV.UK (www.gov.uk)

the positive role played by informal, peer-run organisations that seek to promote and support recovery from drug and alcohol dependency.[533]

Treating problematic cannabis use

9.20 Evidence regarding treatment of cannabis dependence is limited compared to that for alcohol and opioids, though it suggests approaches including cognitive behavioural therapy (CBT), motivational interviewing and contingency management techniques[534] are the most effective.[535] There is no consistent approach to managing withdrawal, however, and relapse following detoxification is common. Difficulties in assessing and treating co-morbid conditions that may contribute to relapse are additional barriers to successful outcomes.

9.21 The focus on alcohol and opioids can also mean people who use cannabis perceive drug treatment services to be aimed at those who use Class A drugs and consequently feel uncomfortable attending assessments or treatment, which in turn reduces their likelihood of doing so. Services for this group can, it seems, be presented as somewhat of an 'add-on' to those aimed at people with problems related to more serious drugs: cannabis treatment does not feel to us to be a well-developed or integrated part of the wider system, especially in mental health (among child and adolescent services as well as those for adults).

9.22 For poly-drug users where cannabis use is identified (which is not a given as not all services routinely test for it), the latter risks being ignored as treating problems with more serious substances takes precedence. If a person succeeds in dealing with a heroin addiction, for example, outstanding problems with cannabis may remain unaddressed.

9.23 As one expert pointed out, dependence on heroin is treated with a drug substitute (commonly methadone or buprenorphine), but a similar approach to helping a person addicted to cannabis appears so far to be elusive. While there are largely accepted methods of reducing the risks of health harm from cannabis use (including not smoking the drug, not mixing it with tobacco or co-consuming it with alcohol, and reducing potency), evidence for the efficacy of medicinal drugs to treat cannabis dependence is less well developed.

9.24 There is some limited indication that Sativex® (a cannabis-based medicine containing THC and CBD that is licensed for use in the UK, see chapter 11) may

[533] Home Affairs Committee (2023). *Drugs: Third Report of Session 2022–23*. House of Commons, p.388. Available at Drugs - Committees - UK Parliament *Accessed 28th February 2024.*

[534] CBT helps a person recognise patterns in how they think and behave to help break out of negative cycles. Motivational interviewing helps people to identify and resolve ambivalent feelings, in order to find the internal motivation necessary to change behaviour. Contingency management provides those who are substance-dependent with rewards for both engaging in treatment and providing evidence (usually via a urine drug screen) of desisting from substance use.

[535] Winstock, A.R. & Ford, C. (2010). Assessment and management of cannabis use disorders in primary care. *The BMJ, Clinical Review*. doi.org/10.1136/bmj.c1571

help with symptoms of both withdrawal and dependence.[536] Overall, however, robust evidence of which medicinal drugs might help with cannabis withdrawal, or promote cessation or reduction in use, remains limited.[537]

9.25 A focus on opiates is understandable given limited resources and levels of harm caused not only to user health but through associated criminality (see chapter 10). Given the growing prevalence of cannabis dependence reported by clinicians, however (in isolation or as part of poly-drug addiction), **the DHSC should explore what works in cannabis treatment, for whom and under what circumstances, to support development of guidance and ultimately services to meet specific needs of this group** (R7).

9.26 This should have regard to the work of the CCP (see below) and should also consider that the common model of drug treatment, which tends to approach all illegal drugs together, may not be the most appropriate for supporting cannabis users. Other models should be tested (for example, provision of support or cessation services that include alcohol, tobacco and cannabis but not opiates). Given the dominance in London and across the UK, as elsewhere in Europe, of co-consumption of cannabis with tobacco, nicotine addiction should be central to considerations.

9.27 Aligned with this, the current guidance developed and maintained by NICE regarding interventions to address problematic use of, or dependence on, cannabis, was last reviewed in 2016.[538] Its parallel guidance related to drug misuse prevention through targeted interventions was published in 2017.[539]

9.28 Not only does neither document explicitly decouple use of cannabis from use of opioids or stimulants, the form, potency and means of access to non-medical cannabis products have changed quite considerably in the past seven or eight years. At the same time, the wellness market drawing on cannabis extracts (notably CBD, see chapter 8) has firmly established itself. All of which arguably renders the guidance somewhat out of date.

9.29 We therefore **recommend that NICE review the content of both guides covering drug misuse prevention and treatment. They should account for changes in the nature of modern-day cannabis and its use and have regard to evidence that relates specifically to the treatment of problematic use of cannabis** (R8). The process should also take account of findings emerging from any future work led by the DHSC to further understanding of what works in this space (R7).

---

[536] See for example Trigo, J.M., Lagzdins, D., Rehm, J., Selby, P., Gamaleddin, I., Fischer, B. … & Le Foll, B. (2016). Effects of fixed or self-titrated dosages of Sativex® on cannabis withdrawal and cravings. *Drug and Alcohol Dependence, 161*, pp.298–306. doi:10.1016/j.drugalcdep.2016.02.020

[537] Nielsen, S., Gowing, L., Sabioni, P. & Le Foll, B. (2019). Pharmacotherapies for cannabis dependence. *Cochrane Database of Systematic Reviews, 1* (CD008940). doi:10.1002/14651858.CD008940.pub3

[538] Overview | Drug misuse in over 16s: psychosocial interventions | Guidance | NICE *Accessed 25th July 2024*.

[539] Overview | Drug misuse prevention: targeted interventions | Guidance | NICE *Accessed 25th July 2024*.

9.30 'What works' should also consider the content of existing resources aimed specifically at those considering or already using cannabis.[540] Such material often seeks to support and inform safer use as well as provide advice to those seeking to reduce or cease their use of the drug. Aimed at cannabis consumers in general, such resources can contain evidence-based messages designed to promote understanding of levels of use and associated risks, and resonate in terms of drivers of use and effects of the drug (both positive and negative).

9.31 It was also put to us that the inability of non-medical cannabis users to be sure what they are consuming also makes attempts at harm reduction (lowering THC consumption for example) difficult. **The DHSC should consult with the medical cannabis industry to explore potential to utilise cannabis produced for prescription products, where levels of THC and CBD are strictly controlled, in treating those with problems associated with non-medical use** (R9). The use of edibles, for example, could offer a means of reducing use without co-consumption with tobacco, although they too, of course, are not without associated risks.

Cannabis treatment services in London

9.32 The commitment to increased funding set out in the government's strategy is clearly welcome and crucial to rebuilding drug treatment services across the capital. However, it will take time for entrenched issues with recruitment and retention of qualified staff to be addressed, as funding cuts over many years have inevitably led to challenges in maintaining sufficient human resources.

9.33 This in turn has meant, as elsewhere in the country, a rise in thresholds for access to London's drug treatment services. Unless cannabis users co-present with other needs, related to opiates for example, or with symptoms of severe mental health disorder, we heard they have been and remain unlikely to be prioritised by services that continue to be stretched.

9.34 The way in which those services are structured in London is complex, which further compounds challenges with access. It can be difficult for those who come into contact with people who use drugs, whether through health, education, police or the wider justice system, and who have a responsibility to refer into relevant services, to know where and how to do so. The situation is no different for an individual wishing to self-refer.

9.35 The capital's 33 local authority areas (i.e. 32 boroughs and the City of London) are individual commissioners of drug treatment services provided by a range of organisations. The NHS is one such provider (though they too commission services); others are based in the voluntary and community sector. Turning Point and Via, for example, operate in several (but not all) of London's local authorities.

9.36 Because local authorities act as individual commissioners, one provider may be governed by several different contracts across a number of boroughs. Moreover,

[540] See for example Safer Use Limits *Accessed 3rd April 2024.*

they may function as a principal provider, as sub-contractor to another provider, or both, which further complicates the system for those working within or alongside it, as well as those seeking support.

9.37 The system does permit a local authority a degree of flexibility and autonomy in the treatment services it chooses to commission, meaning in theory they can better take account of needs across the populations they serve. In practice, though, the system is likely to contribute to what was described as a postcode lottery faced by those requiring services. It also, we heard, makes economies of scale difficult because local authorities act independently from others in their role as service commissioners.

9.38 Reflecting its lesser potential for harm relative to more serious drugs (for most people who use it), as we set out above cannabis is not the principal issue of concern for the majority of those referred to London's treatment services. One provider told us that of their c.2,000 daily caseload, cannabis is the main issue for around 40 people. Many more use the drug but are referred (or self-refer) for support with other issues that they do not perceive to be related to cannabis use.

9.39 This speaks to a wider need for accurate, accessible information about the harms and dependence potential of cannabis for both consumers and their families, including the impact of use on wider aspects of life as well as health. CCP patients reported having previously received little from education, mental health or youth services about the potential effects of cannabis on mental health or its addictive qualities. This chimes with our understanding about the nature of statutory education (see chapter 12).

9.40 We heard a number of people who use cannabis first come to treatment services because of wider support on offer, including programmes focusing on Employment, Training and Education (ETE), or health and fitness. Many do not realise the challenges they face in those spheres may be due at least in part to their persistent use of cannabis.

9.41 Once identified, a service can help someone understand whether their use is problematic, what the potential harms might be, how to minimise these and how to reduce the risk of progression. For those with dependence or other issues, services can help identify the function of their cannabis use and provide support to reduce it, exploring alternative ways to achieve things that are important to the individual.

9.42 But getting someone through the door can, despite the number of people affected by drug use in London, be a challenge for providers. This means some are struggling to meet a key condition attached to additional funding, namely an uplift in the number of service users on their caseload.[541] Since 2009–10, the number of new entrants each year into drug and alcohol services has fallen by around

[541] See From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk) p.34.

10,000 (from 147,046 to 137,749 in 2022–23), reaching a low in 2017–18 of 127,307.[542]

9.43 This is puzzling, given need has not gone down – particularly so among offenders exiting prison and serving community sentences. As we heard elsewhere, a majority of offenders have drug-related needs and many are serving sentences where attending drug treatment is a mandated condition, which suggests a failure somewhere along the way to ensure users are referred into, and attend, treatment.

9.44 The widespread lack of specialist cannabis treatment across London was flagged by most health specialists we heard from. Development of a coherent, widespread and accessible response to problematic cannabis use is compounded not only by limited evidence about the most effective approach but by structural barriers within existing treatment services, including the skills and expertise of clinical staff. Once again, this tends to mean alcohol- and opiate-related issues are prioritised.

9.45 Moreover, while there are commonalities in some of the behavioural and other approaches utilised in both mental health and drug treatment, the lack of join-up between services makes a holistic approach difficult. Years of ever-reducing funding in both have, it was suggested to us, resulted in deterioration in capacity for joint working.

The Cannabis Clinic for Psychosis

9.46 London's Cannabis Clinic for Patients with Psychosis (CCP) was established in 2019 on a trial basis. Positive early evaluation[543] led the South London and Maudsley NHS Foundation Trust (SLaM), in 2022, to commission the CCP to continue to deliver clinical services. The first of its kind in the UK, the clinic provides specialist support for adults with psychosis who are seeking support related to (current or previous) cannabis use.

9.47 Its approach is one of dual diagnosis, meaning patients have both a mental health condition (psychosis) and a parallel substance use disorder (related to cannabis). Open to SLaM patients who are motivated to change their cannabis use (which could mean abstinence, a reduction in or more controlled use, or harm reduction) the clinic offers various types of support adapted to the needs of people suffering from psychosis.

9.48 These include 1:1 weekly sessions with a keyworker, psychoeducation, craving management (including help with withdrawal symptoms), relapse prevention strategies and an innovative weekly online 'Peer Group' (PEER), open to both patients and staff. This provides peer-to-peer support, access to expert guest speakers and practical tools and advice.

[542] Substance misuse treatment for adults: statistics 2022 to 2023 - GOV.UK (www.gov.uk) Tables 10_3 & 10_4. *Accessed 5th May 2024.*
[543] Cannabis Clinic for Patients with Psychosis - Maudsley Charity *Accessed 21st February 2024.*

9.49 The CCP also facilitates referrals to Nicotine Replacement Therapy (NRT) services. Given the health risks posed by co-consumption of cannabis with tobacco, this is in our view a notable benefit.

9.50 Current resources allow the clinic to see around 100 patients per year, in addition to supporting several people who are not/no longer patients but attend weekly PEER sessions. The majority are current users of cannabis (89%) and 95% of patients began using around the age of 16. Some are referred through community mental health teams that operate across the SLaM catchment area (namely Lambeth, Lewisham, Croydon and Southwark), others following admission to an in-patient psychiatric unit.

9.51 A minority reach the clinic following involvement with the police, through powers set out in sections 135 and 136 of the Mental Health Act 1983 (MHA). These enable a police officer to seek assessment and treatment for a person suffering from a mental health disorder. Sometimes, at the time of police intervention, they may be exhibiting behaviours that represent a risk of harm to themselves or to others.

9.52 CCP clinicians told us that, among their patients, managed withdrawal is vital to reduce the risk of potentially harmful or violent behaviour and, in their experience, aggression is common among cannabis users detained under the MHA.

9.53 Indeed, the widely accepted belief that cannabis universally relaxes and 'chills out' users is, it was put to us, not always the case. It is not everyone's experience and we heard that in some cases it can lower a person's threshold for aggressive behaviour. Where a psychosis patient uses cannabis, several clinicians told us their risk of violence was heightened: those who stopped using the drug or who had never used it demonstrated much lower scores on clinical assessments of violent behaviour.

9.54 Cannabis was, in the experience of a number of our witnesses, associated with a worsening of symptoms in psychosis patients, and reportedly risked an increasing sense of paranoia even among general users. While for most such users this does not reach the threshold of psychotic illness, it can nevertheless be a debilitating adverse side effect.

9.55 Abstaining from cannabis or controlling its use was considered as important as taking anti-psychotic medication in terms of managing symptoms of psychosis. This is an important part of what was described as patient–clinician 'negotiations' regarding cannabis use: most do not like taking anti-psychotics so the fact that abstinence or reduced use of cannabis could lower their dose can be a powerful lever.

9.56 It was put to us that non-compliance with anti-psychotic medication, combined with cannabis use, presents the most significant risk factor for relapse and hospital readmission: both behaviours are however potentially amenable to tailored

psychological and behavioural interventions, such as contingency management (see para.9.20).

9.57 Where CCP patients access services from an in-patient psychiatric unit and their cannabis use is actively managed down, psychotic symptoms largely subside. The challenge comes, however, after discharge. As with offenders released from prison, the risk is high of returning to previous friendship circles in which cannabis is common, and of lapsing back into use, which highlights the importance of continuation of care into the community. The role played by the CCP through its PEER group plays a vital role here.

9.58 Psychotic cannabis users outside of the SLaM catchment area are not eligible to be seen by the CCP. Neither is the service equipped to treat users presenting with non-psychotic mental health disorders, or those dependent on cannabis but who do not present acute symptoms of mental health distress (in other words, the majority of problematic cannabis users).

9.59 And while all mental health services in theory can treat acute psychosis related to cannabis use, the joint specialist mental health/drug treatment model deployed by the CCP may help reduce the chance of relapse to a greater degree.

9.60 We acknowledge there are services that cater to those cannabis users not exhibiting symptoms of mental ill health: the global Marijuana Anonymous peer-support programme, for example, has a presence in London and provides support to those wishing to stop using the drug, irrespective of any other health conditions.

9.61 There are, too, a range of general addiction services such as those provided under the auspices of the charity Humankind. Among other facilities, Humankind supports residents of Lambeth who are seeking help with recovery from drug and alcohol addiction. Like others, the organisation also offers interventions to offenders issued with drug or alcohol treatment requirements as part of a criminal justice sentence (see chapter 10). Whether such general services are optimally equipped to address issues and challenges specifically related to cannabis use is, however, unclear.

Navigating drug services alongside mental health services

9.62 Despite some overlap in treatment needs related to drug use and mental ill health, services for the latter are commissioned not by individual local authorities but through London's five Integrated Care Systems (ICS').[544] The view among health professionals and policy makers with respect to mental health provision in London, particularly for young people, was universal: similar to drug treatment, it was described as patchy, heavily oversubscribed and substantially underfunded.

[544] Partnerships that bring together providers and commissioners of NHS services across each of five areas of London with local authorities and other local partners to plan health and care services.

9.63 Given the role that poor mental health can play in driving drug use, it is difficult to disagree with suggestions that more comprehensive, accessible mental health services could reduce the risk of some sufferers turning to cannabis to try to alleviate immediate symptoms. That said, it is unclear to us how many might refrain or desist, given the range of factors involved in the decision to use cannabis (or any drug).

9.64 It feels more sensible to us to simply accept the reality of the need for dual diagnosis teams to identify, treat and manage those presenting with symptoms of mental health disorder alongside drug use disorders. This means embedding substance use specialists within mental health services.

9.65 With respect specifically to mental health for young people, we understand the creation of Mental Health Support Teams, designed to integrate mental health care across London's schools and the NHS, has been largely welcomed by the sector – but implementation is slow. Less than 50% coverage across each ICS is expected by the end of 2024, meaning what was often referred to as a postcode lottery will remain for some time in terms of access to mental health services for children and young people.

9.66 Moreover, in some boroughs, cannabis use automatically excludes a young person or adult from mental health services, even where they are using prescription-issued medical cannabis (see chapter 11) to help manage symptoms of mental ill health. In some respects this is indicative of a wider lack of service integration and poor understanding of cannabis use among parts of the sector.

9.67 Given relatively high rates of mental health disorders among those with cannabis use related disorders, failure to assess and manage the former will inevitably increase the risk of relapse where an individual tries to reduce or abstain from their cannabis use – with or without the help of treatment services.

9.68 It was put to us that treating underlying mental health conditions to reduce the risk of relapse into substance use is a well-understood narrative in psychiatry, yet the current system does not support its delivery. Indeed, it almost incentivises people who use cannabis to conceal the fact from mental health services. This means clinicians and drug workers do not always have a complete picture of a service user's history, which can threaten the appropriateness of any treatment plan and, ultimately, its success.

9.69 Experts across the sector impressed on us an increasing urgency for greater join-up between mental health services (in community and hospital settings) and drug treatment and addiction services. Greater knowledge within both about the interplay between cannabis use and symptoms of mental health would help. The model deployed by the CCP is, to our mind, an example of best practice, bringing together as it does specialists who understand both mental (ill) health and the ways in which cannabis affects bodily and brain functions.

9.70 Similarly, we heard evidence from some local authorities that primary care physicians are often unaware of a patient's cannabis use (or lack confidence to ask due to inadequate knowledge about the physiology of its effects). Stigma, and concern about access to other services, can prevent a patient from being open – which again poses implications for treatment and likelihood of successful outcomes.

9.71 We therefore **recommend a programme of work be developed to explore how physical and mental health services could better join up with treatment and addiction services, irrespective of which borough they operate within. This should consider mechanisms of delivery, commissioning practices and how to reduce inequalities in service access and be jointly led by the London Health Board and London Drugs Forum** (R10).[545] Involvement of the latter will ensure other relevant agencies are aware and have opportunity to contribute (including those within the criminal justice sector; see next section).

9.72 This programme should also play a key role in testing and piloting findings emerging from the work we recommend be led by the DHSC with respect to developing the evidence base focused on what works in treating problematic use of cannabis effectively (R7).

9.73 Of wider relevance is the fact that medical students currently receive little, if any, education on cannabis use and its effects, both adverse as well as therapeutic or medicinal. We discuss this further with respect to use of cannabis for medical purposes in chapter 11.

Treatment for offenders

9.74 As we discuss in chapter 10, drug use features heavily among offender populations and drugs, particularly synthetic cannabinoids (SCRAs, see chapter 8) are rife in prison establishments. HM Prison Service has estimated that around 60% of the prison population use SCRAs, and prisoners themselves suggest the figure is closer to 90%.[546]

9.75 We heard, too, that the performance framework for prison-based drug services is led by the number of prisoners treated in drug wings. These are wings reserved for those with more serious needs (related to opioid addiction, for example) – meaning offenders who enter prison with problems related to cannabis are less likely to be prioritised and often end up leaving custody having had no opportunity to address those issues.

9.76 Overall, we heard only around 20% of offenders and ex-offenders referred to drug treatment services in London attend, often because finding housing and employment take priority. Moreover, almost two-thirds of prison leavers fall out of

[545] The London Drugs Forum | London City Hall
[546] Cited in Abbott, M.J., Dunnett, J., Wheeler, J. & Davidson, A. (2023). The identification of synthetic cannabinoids in English prisons. Forensic Science International, p.348. doi.org/10.1016/j.forsciint.2023.111613

treatment upon release.[547] This is likely due in no small part to lack of resources, leaving community-based services unable to meet would-be clients at the prison gate on release. Previously, such engagement would help build relationships and offer opportunity to explain how treatment can support ambitions to reintegrate into society.

9.77 Failure to engage in treatment is likely to jeopardise compliance with requirements of a sentence or terms of release from custody. This is compounded by continued use of drugs and, as we heard from representatives of the Youth Justice and Probation Services, heavy use of highly potent cannabis is rife among those they supervise.

9.78 Offender managers reportedly struggle to identify the most appropriate service into which they should refer an individual whose drug-related issues relate primarily to cannabis. More broadly, and as noted by HM Inspectorate of Probation three years ago, treatment providers and probation often work in silos, which does little to help identify and source provision appropriate to meet an offender's needs. We heard no evidence that the position has changed, at least in London.

9.79 We heard too that sentencers lack confidence in the probation service to identify and refer offenders into appropriate treatment. Concerns are linked, at least in part, to consequences of the very significant structural reforms of the past decade, with the part-privatisation of the service introduced in 2014 subsequently reversed in 2019.

9.80 Sentencers, also, it was put to us, lack confidence in the capacity of drug treatment services to meet offenders' needs, due in part to aforementioned funding cuts. It will, we heard, take some time to rebuild that confidence despite the recent increase in government funding.

9.81 In London, the situation is compounded by the complex, somewhat fragmented nature of drug treatment provision and mental health services. With inadequate join-up between commissioning authorities, it is perhaps no wonder the probation service can struggle to navigate both systems, nor that those systems struggle to accommodate the needs of offenders.

9.82 A dedicated triage function to join up local treatment services with offender management might help improve confidence and provide a practical solution to match need with provision. **The ADPH, together with NHS England, those responsible for healthcare within prison and probation and local government (including ICS') should investigate creation of a 'single point of contact' advisory service** (R11)**.** This should support staff responsible for managing releases from prison and for supervision within the community, offering advice regarding substance use services available in the locale within which an offender will reside.

[547] HM Inspectorate of Probation & Care Quality Commission (2021). *A joint thematic inspection of community-based drug treatment and recovery work with people on probation*. His Majesty's Inspectorate of Probation, Manchester. A joint thematic inspection of community-based drug treatment and recovery work with people on probation (justiceinspectorates.gov.uk)

Co-use of cannabis and tobacco

9.83 Smoking cannabis combined with tobacco not only exacerbates the risk of harm, it also increases the risk of dependence and makes it harder to quit. While the offer of tobacco cessation treatment is a requirement of drug misuse services,[548] we heard the two are not well integrated.

9.84 Only 2% of substance use treatment recipients across England were offered a tobacco cessation referral in the year ending March 2021, despite over half (56%) identifying as recent smokers.[549] The CCP is an exception. Working in close collaboration with local (SLaM) in-patient and community smoking cessation providers, the clinic offers Nicotine Replacement Therapy (NRT) alongside support for reduction or cessation of cannabis use.

9.85 The situation is no better the other way around. From what we heard, referrals from tobacco cessation services into drug treatment are likely to be low – though precisely how low is unclear due to a lack of data. The illegal status of cannabis reportedly deters practitioners from asking about co-use, so data on the number of people who seek tobacco cessation services and also use cannabis is not routinely collected.

9.86 Moreover, we heard how, as elsewhere in frontline healthcare, smoking cessation advisors are poorly equipped to raise cannabis use with clients. Their lack of knowledge and often confidence means many do not broach the subject, although there is appetite to do so. A recent survey reported almost all (94%) smoking cessation respondents would welcome training on cannabis use, yet two-thirds had received none. Fewer than half of services operated a database that recorded cannabis use and not much more than one-third had any internal guidance relating to use of the drug.[550]

9.87 It is easy to see how efforts at tobacco cessation for co-users are likely to be undermined unless concurrent cannabis consumption features in the discussion. In our view, tobacco cessation practitioners should be equipped to identify and talk with their clients' about the role of cannabis consumption in tobacco cessation.

9.88 **We recommend the Association of Directors of Public Health (ADPH), in partnership with the Department for Health & Social Care (DHSC) and the Office for Health Improvement & Disparities (OHID), should consider how tobacco cessation practitioners can be supported to explore clients' cannabis use. A requirement for them to do so should in due course be built into commissioning of such services.**

[548] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017). *Drug misuse and dependence: UK guidelines on clinical management*. Public Health England.
[549] Office for Health Improvement and Disparities (2021). *Adult substance misuse treatment statistics 2020 to 2021: report*. Adult substance misuse treatment statistics 2020 to 2021: report - GOV.UK (www.gov.uk) *Accessed 28th February 2024.*
[550] Sumodhee, D., Walsh, H., Brose, L., McNeill, A., McEwen, A., & Duaso, M.J. (2024). Support Provided by Stop-Smoking Practitioners to Co-users of Tobacco and Cannabis: A Qualitative Study. *Nicotine & Tobacco Research, 26*(1), 23–30. doi:10.1093/ntr/ntad115

Assessment and recording systems should be duly adapted, with training developed on how to establish appropriate treatment plans for co-users (R12).

9.89 Pathways between drug treatment and tobacco cessation provision should be clearer for practitioners and users, and much better integrated. In actively referring psychosis patients to NRT services, as well as working with local drug and alcohol services to identify patients who might benefit from the dual diagnosis treatment it provides, the CCP offers a good example of how this can operate.

9.90 **The Office for Health Improvement & Disparities (OHID), in partnership with providers of tobacco cessation and drug treatment services, should explore the barriers to more integrated provision and how these could be overcome to better meet the needs of co-users and improve the chances of successful treatment outcome(s)** (R13).

The role of pharmacists

9.91 Pharmacists and pharmacies advise and dispense, or sell, medical and non-medical cannabis in several jurisdictions around the world. Indeed, in Uruguay, the first country to legalise non-medical cannabis for adult use, it can only be purchased through pharmacies (see chapter 7). No other retail outlets are permitted to sell the drug.

9.92 The HAC has noted the potential role of community pharmacists in supplying, distributing and administering naloxone as part of efforts to counteract opioid-related overdose.[551] Based on evidence put to us, we agree that pharmacies can occupy a unique role within communities. While other authorities can often be viewed with a degree of wariness, particularly by some communities (see para 9.16), pharmacists tend to attract relatively high levels of public trust.[552]

9.93 Pharmacies can dispense prescriptions for licensed cannabis-based medicines (Sativex®, Epidyolex® and Nabilone, see chapter 11). Since the law changed in 2018 to allow the prescribing of unlicensed cannabis-based products for medicinal purposes (CBPMs), in Great Britain pharmacies registered with the General Pharmaceutical Council (GPhC) (usually offering online/distance selling) may dispense these products too.

9.94 However, it was put to us that, as among other healthcare practitioners, there is little awareness or knowledge among the pharmaceutical profession of the cannabinoid system and the way in which cannabinoids affect the body (with the exception of those licenced to supply specialist prescriptions for CBPMs). Certainly, the subject is not routinely covered in education and training for pharmacists.

[551] See footnote #533, p.58.
[552] Maidment, I., Young, E., MacPhee., M., Booth, A., Zaman, H., Breen, J … & Wong, G. (2021). Rapid realist review of the role of community pharmacy in the public health response to COVID-19. *BMJ Open*. doi:10.1136/bmjopen-2021-050043

9.95 Moreover, while the number of NHS prescriptions for licensed cannabis-based medicines is slowly rising, overall numbers remain low (a total of 5,873 were issued in England in 2022/23).[553]. This means most pharmacists (of whom there were 64,384 registered with the GPhC in June 2024)[554] are unlikely to be very familiar with use of cannabis-based products in the medical management of ill health.

9.96 We heard, though, there is appetite for more information about the effects of cannabis and cannabis-based medicine (including unlicensed CBPMs). This is important because if, as we recommend in chapter 11, consideration is given to expanding prescribing capabilities for unlicensed CBPMS, the number of prescriptions coming to pharmacies may rise.

9.97 Our observations regarding content on the endocannabinoid system in wider medical training can equally be applied to pharmacists and other health professionals. **The GPhC should explore the feasibility of including in their syllabus content that covers the endocannabinoid system and the way in which cannabis exerts effects on the body** (R14). They should also consider R35 regarding expansion of provision of information on the use of cannabis for medical purposes (chapter 11).

9.98 Finally, public trust in pharmacies, which are often more representative of communities they serve than other public-service providers, offers a wider opportunity. They may, for example, be well placed to identify what problematic cannabis use can look like and, where appropriate, offer to coordinate with, or connect a person into, local treatment services.

9.99 This might help increase engagement with groups whom services can otherwise struggle to reach because of wider mistrust in authority. **The Mayor should consider, in partnership with the GPhC and local drug treatment services, implementing a small-scale pilot of this nature in one or more London boroughs, whereby pharmacists provide a link into services for those struggling with cannabis use** (R15).

Brief implications for drug treatment and health services of legalising non-medical cannabis

9.100 Evidence suggests that post-legalisation, the number of people choosing to use cannabis rises (see chapter 7). While difficult to conclusively disentangle contributing factors, it seems likely (and intuitive) that, without fear of criminal sanction, more people will try the drug. In the UK, this means that, unless mechanisms of consumption shifted away from co-consumption with tobacco (wider mechanisms of ingestion become available within a legally regulated model), this would be cause for concern given the indisputable health harms associated with the latter.

[553] Issued in England and dispensed in England, Wales, Scotland, Guernsey, Alderney, Jersey and the Isle of Man, based on figures provided to the LDC by the NHS Business Services Authority (NHSBSA).
[554] Registers | General Pharmaceutical Council (pharmacyregulation.org) *Accessed 23rd July 2024*.

9.101 Evidence on whether legalisation directly increases the prevalence of CUD, psychosis and other mental health disorders is more mixed. It often fails to account for the fact that rates (at least as measured by hospital admissions) were rising in many jurisdictions before regulation (see chapter 7).

9.102 It is also possible that a more permissive legal framework encourages reporting of cannabis use among those seeking help for symptoms of ill health more widely, and may increase the likelihood of those experiencing problematic cannabis use to seek help. Both phenomena would drive up the number of people recorded as presenting with cannabis-associated difficulties, but neither reflect a genuine increase in the prevalence of such difficulties.

9.103 By and large, most of those we heard from accept it is too early to tell with any certainty whether legalising non-medical cannabis drives a real increase in the number of people developing symptoms of addiction or other health-related problems (as distinct from a rise in the numbers reporting such).

9.104 Given that legalisation likely drives up the number of people who use cannabis overall, and possibly the extent of use among existing users of the drug, it is not unreasonable to expect a rise in the number who develop associated problems (particularly where use becomes more frequent). There is, however, currently no clear evidence to suggest, relative to the total number of users, that the proportion of problematic users materially increases.

9.105 All that being so, the reason for any increase in demand for drug treatment and mental health services following legalisation is in some ways immaterial from a service provision perspective. Whether due to a genuine rise in numbers of people developing problems or an artefact of increased help-seeking behaviour and better recording, or both, the bottom line is demand for support would probably go up.

9.106 Arguably, it is no bad thing if problematic cannabis users feel more able to seek help, particularly if they do so before symptoms become entrenched and more difficult and costly to treat, with less chance of success. This could represent a step forward in improving public health and is one potential benefit of removing, or at least lessening, the stigma associated with illicit cannabis use.

9.107 The extent to which that benefit would be realised, however, is unclear as there are other barriers to help-seeking behaviour that legalisation does not necessarily resolve. There are plenty of people with problematic use of alcohol and tobacco, for example, who choose not to seek support or otherwise engage with relevant services, despite neither substance being illegal.

10. CANNABIS, POLICING AND THE CRIMINAL JUSTICE SYSTEM

Data availability and the experiences of many of those we spoke to about the enforcement and consequences of cannabis laws mean we focus in parts of this chapter on London. But several of the issues we consider, particularly with respect to racial disproportionality in the criminal justice system (CJS), have relevance for communities and police forces around the UK, especially larger towns and cities with more ethnically diverse populations.

We consider the dominance of cannabis offences – particularly possession – in recorded crime, and the significance of Stop & Search (S&S) in drugs policing. We explore the nature and basis of cannabis-related S&S, including its accuracy and wider value, evidence of racially disproportionate deployment, and the experience and impact of use of the power on individuals and communities.

We briefly consider the use of strip searching, and how police deploy the discretion available to them when imposing sanctions short of arrest for cannabis offences. As part of this we discuss the role of police-led diversion schemes, before looking at how cannabis possession offences progress through the justice system, from arrest and prosecution to court sentencing.

We then consider the extent of cannabis use among those convicted of a criminal offence, and the level of demand that the illegal status of the drug places on police and justice system resources. We finish this chapter by comparing how the Misuse of Drugs Act (MDA) 1971 treats non-medical cannabis with how it would be dealt with were it subject instead to the Psychoactive Substances Act (PSA) 2016. We set out our rationale for proposing the drug be governed by the latter and discuss the likely consequences.

Note: Data sourced from the MPS Stop & Search Dashboard may have been slightly revised since extracted for this report during January – May 2024, reflecting ongoing operational updates to data collections.

Policing cannabis

10.1 The importation, exportation, production, supply and possession of non-medical cannabis, which is categorised as a Class B drug and controlled under the MDA, are criminal offences in the UK.[555]

10.2 Enforcement of the law enshrining those offences rests initially with the police. In the case of less serious offending, depending on the circumstances they have the

[555] For unlicenced dealing, production (including home cultivation) and trafficking of cannabis, an individual could face up to 14 years in prison, an unlimited fine, or both. The maximum penalty for possession of cannabis is five years in prison and/or an unlimited fine.

power to choose to apply sanctions without recourse to the criminal courts. For more serious offences, an individual is usually liable to prosecution and, if found guilty, sentenced by a magistrate or a judge.

10.3 The police therefore play a crucial role in determining who enters the criminal justice system (CJS) for cannabis offending. Stop and Search (S&S), considered a critical tool in proactively combatting drug possession and supply, is a key part of this. In this chapter we consider evidence regarding deployment and efficacy of the S&S power, as well as statistics regarding its use by the Metropolitan Police Service (MPS) and City of London Police (CoLP), who together with the British Transport Police (BTP)[556] are responsible for policing the capital.

10.4 We focus on the MPS in many aspects because they police the vast majority of the capital, namely all of its 32 boroughs. The CoLP are responsible for policing the City of London, also known as the Square Mile, and are a very considerably smaller force than the MPS (comprising around 1,000 full-time equivalent police officers compared to over 34,000 serving officers in the MPS).

Prevalence of cannabis offences

10.5 During the year ending September 2023, police across England & Wales recorded 181,810 drug-related offences, a rise of 2% on the previous year. Just under three-quarters (n=130,831) were for drug possession, the majority of which (74%, n=96,628) involved cannabis. Thus, 53% of all recorded drug offences in this period were for cannabis possession.[557]

10.6 While 9% lower than in the previous year (when 105,639 such offences were recorded), cannabis possession is a significant part of the drug-related police and wider CJS workload. This has been the case for the past 20 years. Since 2004 (when possession of controlled drugs was split into i) cannabis and ii) drugs other than cannabis), cannabis possession has been the most commonly recorded drug offence by a substantial margin.

10.7 As alluded to in the Runciman Report,[558] the dominance of cannabis (particularly possession) in crime statistics suggests its illegal status is little deterrent. The most widely used illicit drug across the world, it comprises the majority of police and Border Force drug seizures (see chapters 4 and 5). Indeed, Runciman found no indication that drugs laws in general act as a deterrent for the majority of the public. Health consequences of use reportedly play a more important role than legal controls, fear of being caught or punished, availability or price.[559]

[556] While the BTP are also responsible for policing London, and duly have the power to stop and search persons and vehicles, we have focused on the MPS and CoLP in our inquiries.
[557] Crime in England & Wales: Appendix tables - Office for National Statistics (ons.gov.uk) Year ending September 2023, Table A4a. *Accessed 6th February 2024.*
[558] *Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971* (2000). The Police Foundation. Overview, para.8.
[559] Ibid. Chapter 7, para.74.

10.8 This is no less the case in London, where we heard public dealing and consumption of cannabis are routine. Certainly, cannabis comprised the vast majority of all drug possession offences recorded in the capital during the year to March 2023 (and, at 87% for the MPS and 79% for the CoLP, it is higher than the national average of 74%).[560]

10.9 There are, however, notable differences in the prevalence of offences recorded within individual boroughs. While overall in 2022/23 the MPS recorded 29,407 cannabis possession offences[561] (a fall from 35,354 the previous year), rates per 1,000 population, as in previous years, varied considerably.

10.10 As recorded at the time of our data extraction, during the year to 2023 Richmond upon Thames saw a low of 1.12, with Barnet next lowest at 1.39. While Westminster recorded the highest rate at 13.16, this likely reflects at least in part the high numbers of tourists and other visitors to the area, rather than a particularly high rate of offending by residents of the borough. Similarly, while the CoLP recorded 38.17, this is highly likely to be driven by behaviour among those visiting rather than resident in the Square Mile (City of London).

10.11 Quite how much such statistics tell us about the true extent of the prevalence of cannabis, how much is really in circulation in London and elsewhere, and how much demand cannabis policing makes on resources is, however, to our mind debatable.

10.12 The way in which police deal with offences of cannabis possession may affect how incidents are recorded, meaning the amount of cannabis found is likely higher than statistics suggest. And while the police unquestionably spend a lot of time dealing with cannabis offences, the numbers alone do not necessarily indicate that, relative to more serious offending, the drug takes up a hugely disproportionate amount of police time overall.

10.13 Recorded crime figures are thus a function of police activity and recording as well as levels of offending. As a large proportion of cannabis possession offences are first identified via S&S, where police have a significant degree of discretion with respect to whether and who they stop, arguably at least some of the variation seen across boroughs is down to police behaviour rather than substantial geographical differences in prevalence of cannabis use.

Stop & Search: background and practice

10.14 Lord Scarman, in his inquiry into the riots of 1981 in Brixton, south London, concluded their origins lay in the breakdown of relations between police and – particularly black – communities across the borough. Against a backdrop of

[560] Figures from Police recorded crime and outcomes open data tables for year ending March 2023, table 2022_23. Outcomes open data year ending March 2023 https://www.gov.uk/government/statistics/police-recorded-crime-open-data-tables The MPS recorded 33,868 drug possession offences during the period (CoLP recorded 527), of which 29,407 were for cannabis (414 for the CoLP). *Accessed 6th February 2024.*
[561] Ibid.

deprivation, racial disadvantage and inequality, alongside rising levels of street crime, he found clear evidence of disproportionate and indiscriminate use of S&S powers by the police against black Londoners.

10.15 Over ensuing decades, S&S has continued to represent something of an ongoing sore for the police. The Lawrence inquiry,[562] led by Sir Macpherson following the murder of Stephen Lawrence in London in 1993, found racial discrimination to be a major element in issues related to S&S.

10.16 The Runciman Report, published the year after findings from the Macpherson inquiry, similarly highlighted the continuingly controversial nature of the practice.[563] And there is no doubt that, more than 20 years on from then, the tool remains contentious,[564] generating passionate views both against and in favour of its use.

10.17 Our inquiries illustrated how highly the police value the power as part of their toolkit, but we also heard from many witnesses, including former senior police officers, who argued just as strongly that it does more harm than good.

10.18 We make no comment on use of S&S conducted on grounds other than those related to drugs. But it was put to us that, at least in terms of cannabis, S&S serves, for many people, to isolate, antagonise and traumatise, as well as damage community relations – the very opposite of intent of recommendations from Scarman, Macpherson and others.

10.19 Indeed, research led by the Mayor's Office for Policing & Crime (MOPAC) found that of the one in ten Londoners surveyed who reported ever being subject to S&S, almost one-third (29%) had communicated negatively about their experience with family and friends. Just under one-quarter (24%) reported feeling negatively impacted or traumatised. Notably, black Londoners were far more likely than white Londoners to have reported such harmful consequences.[565]

10.20 The history of S&S, its current use, guidance and reforms over past decades are set out comprehensively elsewhere,[566] including by His Majesty's Inspectorate for Constabulary and Fire & Rescue Services (HMICFRS), the College of Policing (CoP) and the Independent Office for Police Conduct (IOPC), as well as countless academic experts.

---

[562] Macpherson, W. (1999). *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny*. Home Office, p.360. Available at The Stephen Lawrence Inquiry - GOV.UK (www.gov.uk)
[563] See footnote #558.
[564] See also Home Affairs Committee (2021). The Macpherson Report: Twenty-two years on. Third Report of Session 2021–22. Available at The Macpherson Report: twenty-one years on (parliament.uk)
[565] MOPAC (2023). *Public Attitude Survey: Exploring the impact of Stop and Search on Londoners, and the role of the interaction between police and public*. Slide 3 and 4. Available at https://data.london.gov.uk/download/mopac-surveys/31726cff-01ec-4246-afc5-21eca3abeecd/PAS_In%20Focus_Stop%20and%20Search%20impact.pdf *Accessed 14th August 2024.*
[566] Summarised in, for example, Nickolls, L. & Allen, G. (2022). *Police powers: stop and search.* House of Commons Library Research Briefing, No. SN03878. Available at SN03878.pdf (parliament.uk)

10.21 There is no reason to repeat that material, except to say the impact of S&S on crime is at best mixed. There is little evidence it deters offending to any significant extent (and where it does, as we go on to discuss, in our view this may well be offset by detrimental impacts).[567] The continued dominance of cannabis possession in crime statistics suggests this is no less true with respect to use of the drug. Indeed, following on from conclusions drawn elsewhere,[568] HMICFRS have in recent years called for a national debate on the policing of controlled (illegal) drugs through S&S.[569]

10.22 As the majority of S&S are, however, drug-related, and we think it a reasonable assumption that most are likely – at least on initiation – to relate to alleged suspicion of cannabis possession, our inquiries have inevitably strayed into associated issues.

10.23 The power to S&S is set out in various legislation, principally:

- *Section 1, Police and Criminal Evidence Act 1984 (PACE)*. This allows a police officer to stop and search an individual or vehicle, in a public place, when they have objective and reasonable grounds to suspect that person has been involved in a crime and/or is carrying an unlawful item such as illegal/controlled drugs, a weapon or something else that could be used to commit a crime (e.g. a crowbar), or stolen goods. It means police can detain a person who is not under arrest in order to search them or their vehicle – though they must not do so simply because a person is known to the police or has been in trouble before.

- *Section 23, Misuse of Drugs Act (MDA) 1971.* This enables police to stop and search a person or vehicle if they have reasonable grounds to suspect they are in possession of an illegal/controlled drug.

- *Sections 43* and *47A, Terrorism Act 2000*. This relates specifically to searches for evidence or articles in connection with terrorism.

10.24 The above powers are 'suspicion-based', meaning police must have a genuine suspicion they will find the object for which the power being used allows them to search before making a stop. Moreover, suspicion that an item will be found must be reasonable, based on facts, information and/or intelligence (this can include a person's behaviour as witnessed by a police officer).[570] It is these powers with which our inquiries are concerned, as they govern drug-related S&S.

---

[567] Weisburd, D., Petersen, K. & Fay, S. (2023). Does Scientific Evidence Support the Widespread Use of SQFs as a Proactive Policing Strategy? *Policing: A Journal of Policy and Practice*, 17. doi.org/10.1093/police/paac098

[568] See for example doubts expressed in the Runciman Report regarding efficacy of S&S, including regarding the extent to which dealers are arrested as a result of S&S and arrest of cannabis purchasers. See footnote #558. Chapter 5, para.34.

[569] His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2021). Disproportionate use of police powers: A spotlight on stop and search and the use of force (justiceinspectorates.gov.uk) pp.2, 6.

[570] See PACE Code A (publishing.service.gov.uk), paras. 2.2, 2.6B.

10.25 There are also a limited number of 'suspicion-less' powers, which merit mention as they are part of the wider context – particularly those set out in Section 60 of the Criminal Justice and Public Order Act (CJPOA) 1994.[571] This legislation enables officers to conduct 'no-suspicion' S&S for dangerous instruments or weapons. They may do so for a limited time within a specified area, in anticipation of violence occurring in that area or following an incident of serious violence involving a weapon.[572]

10.26 As described by HMICFRS, suspicion-based stops can be self-generated (where an officer initiates the encounter as a result of their own observations), undertaken in response to information from a third party (the public or CCTV operators, for example), or intelligence-led.

10.27 Their review of 9,304 S&S across England & Wales in 2019 showed the majority (55%) were self-generated. Over one-third (37%) were driven by third-party information and fewer than one in ten (9%) were intelligence-led. In London, over 70% of MPS-led S&S were self-generated (third behind Nottinghamshire and Merseyside) and only around 5% were intelligence-led. Slightly more CoLP-led S&S were intelligence-led (although still less than 10%) with just over 60% self-generated.[573]

10.28 The low proportion of targeted S&S in London is notable not only because both the MPS and CoLP describe it as a power which is targeted and intelligence-led[574], but because stops based on accurate, current intelligence or information are considered more likely to be effective.[575] Such stops also help to minimise inconvenience to law-abiding members of the public and to justify use of the power, both for those subjected to it and for the wider public.

10.29 The analysis by HMICFRS found S&S was used mainly for self-generated, possession only drug searches (a majority of which were likely cannabis-related). The evidential basis for the vast majority of these (80%) was considered weak. By comparison, the evidential basis was thought weak in 15% of searches made in response to third-party information, and in only 5% of intelligence-led searches. Moreover, those subject to S&S are entitled to a record of the encounter: it was suggested to us that HMICFRS also found the quality of these to be lower when a search was self-generated.

10.30 The low level of reliance on intelligence and other information in drug-related S&S means it is perhaps not surprising that so many find nothing and result in no

[571] Schedule 7 of the Terrorism Act 2000 also permits 'suspicion-less' stops, allowing police officers to examine people and goods who pass through the UK border to determine whether they may be involved or concerned in the commission, preparation or instigation of acts of terrorism.
[572] Legal basis | College of Policing *Accessed 15th January 2024*. Stops under this legislation must be authorised by a police officer of at least Inspector rank.
[573] See footnote #569, pp.33–4.
[574] See descriptions at Stop and search | Metropolitan Police and Stop and search | City of London Police *Accessed 28th August 2024.*
[575] See PACE Code A (publishing.service.gov.uk), paras. 2.4, 2.4A.

further action (NFA),[576] nor that use of the power is considered by many to be a risk to police–community relations. We consider these issues in more detail later in this chapter.

10.31 With respect to drugs, an S&S should not be conducted where a person is suspected only of having used an illegal substance, or of having been around others who have done so. Nor is it good practice for a self-generated search to be based on a single factor such as the smell of cannabis, which various guidance stipulates is insufficient justification.[577] The MPS told us this is reproduced in their local policy on cannabis related S&S.

10.32 However, evidence put to us suggested that police claims of smelling cannabis continue to drive S&S across London, including in the high-profile incident involving athletes Bianca Williams and Ricardo dos Santos in 2020. In this case, officers originally sought to stop the vehicle in which the athletes were travelling on the grounds of suspicious driving and then a failure to stop when requested.

10.33 Once stopped, officers then searched the vehicle and both individuals on suspicion of possession of drugs and weapons. The subjective nature of the grounds of S&S based on smell was laid bare when a misconduct panel found two of the officers involved had in fact lied when, in citing the grounds for the search, claimed they could smell cannabis.

10.34 While the HMICFRS analysis found the number of stops across forces that were based on cannabis smell had reduced, they too concluded the practice was still taking place. Moreover, they considered that smell on its own offered only weak grounds for an S&S, meaning a higher likelihood that nothing is found.

10.35 Where smell is not attributable to an individual (for instance when it comes from a car, area or group of people) HMICFRS considered the grounds for S&S to be even weaker, as it is even less likely a given person in that car, area or group is in possession of cannabis at that time. Without other compelling factors to justify a search, the grounds for doing so remain weak.

10.36 It seems to us that previous recommendations and guidance from HMICFRS, the IOPC, CoP and others regarding the smell of cannabis alone as a basis for S&S have failed to change practice to any meaningful degree. Similarly, while the code of practice (Code A) that governs operation of the power to S&S clearly sets out legal grounds for its deployment, it makes no reference to whether and how smell may be used.

10.37 Our view is this should no longer remain the case. We therefore recommend:

i) **All relevant guidance should explicitly set out that the smell of cannabis alone cannot ever lawfully be used to justify a stop and search.**

[576] No further action (NFA) includes a number of scenarios, including words of advice being given to the person who has been S&S, or detention under section 136 of the Mental Health Act.
[577] Legal basis | College of Policing *Accessed 9th January 2024.*

ii) A clause be inserted into PACE Code A to state the smell of cannabis alone cannot be used to lawfully justify a stop and search.

(R16).

If a person is stopped on the grounds of smell alone, civil litigation should become an option for redress.

10.38 Where police take further action following an S&S, this may not relate to the initial reason for the stop. An S&S on suspicion of cannabis possession may not yield the drug but instead, for example, may produce a weapon, for which the individual will likely be arrested. This is an important aspect of S&S practice to which we return later.

Stop and Search in London: the numbers

10.39 The MPS and City of London Police (CoLP) together account for more S&S under Section 1 of PACE (1984) each year than any other police force. During the year ending March 2023, they conducted a total of 178,936, equating to around one-third (33%) of all 542,722 S&S recorded that year in England & Wales. Unsurprisingly, the MPS were responsible for the vast majority (176,749, the CoLP force conducted 2,187).[578]

10.40 In itself this is disproportionate, given around 15% of the population of England & Wales live in London, although we recognise the capital attracts high numbers of visitors for leisure and business purposes. Forces in the north west were the second most prolific users of the power, recording 111,221 S&S overall (with the majority made by Merseyside police).[579]

10.41 While still responsible for more S&S than any other force, the number made by the MPS overall has, however, fallen over recent years. The force shared figures with us showing that between 1st August 2021 and 31st July 2024, the total number of S&S made by MPS officers fell by 39%. The number of drug-related S&S fell even more considerably, by 47% - and as a proportion of all S&S, from 63% to 56%.[580]

10.42 Suspicion of carrying drugs remains the most common reason for S&S across England & Wales, accounting for 61% (n=331,856) of all those undertaken under Section 1 of PACE (1984) and associated legislation in 2022/23. Despite the aforementioned recent falls in the number carried out by the MPS, London is no exception. As the two forces responsible for policing the capital, the MPS and CoLP undertook a combined total of 108,018 drug-related S&S in the year to March 2023, representing 60% of all S&S in London that year. The MPS were

[578] See Table SS_03, Stop and search and arrests, year ending March 2023 (second edition): https://assets.publishing.service.gov.uk/media/65ef2cd562ff4898bf87b2e3/stop-search-data-tables-summary-mar23-second-edition.ods. *Accessed 24th January 2024.*
[579] Ibid.
[580] MPS. Unpublished written submission to the London Drugs Commission.

responsible for almost all of these (i.e. 106,822, the CoLP undertook a further 1,196).[581]

10.43 The continued dominance of drugs in S&S remains at odds with the assertion made by police leaders and others that use of the power targets those suspected of carrying knives and other weapons. HMICFRS have previously suggested the focus is, in fact, drug possession, of which cannabis is by some margin the most common, and that this potentially indicates frontline policing endeavours are not effectively focused on force priorities.[582]

10.44 Moreover, while drug-related S&S's take place across all London boroughs, as with offences there is wide variability. During 2023, Richmond upon Thames and Sutton recorded the fewest (455 and 793 respectively), with the highest numbers recorded in Westminster and Tower Hamlets (6,494 and 5,596).[583] A further 9 boroughs each recorded over 3,000 stops.[584]

10.45 The variability is perhaps even more striking when considered on a per capita basis. Richmond upon Thames and Sutton saw 2.2 and 3.8 stops per 1,000 population; Westminster and Tower Hamlets recorded 26.9 and 17.[585]

10.46 That said, we must acknowledge that Westminster experiences particularly high levels of overall crime. This is likely due to the number of visitors – tourists, for example, or people gathering to protest – as well as concentration of the capital's night-time economy in the borough.[586] As a result, it is likely that proportionately more police officers are routinely deployed in Westminster, and greater levels of proactive policing such as S&S are perhaps to be expected.

10.47 Nonetheless, Home Office (HO) analysis revealed that during the year to March 2023, around 25% of all S&S in London took place in 2% of Lower layer Super Output Areas (LSOAs, small areas in which between around 1,000 and 3,000 people live).[587] Half took place in 9% of LSOAs. Alongside Westminster, parts of Croydon and Bromley also experienced very high levels of S&S.[588]

10.48 The number of S&S undertaken specifically on the grounds of cannabis as distinct from other illegal drugs is difficult to ascertain from available data. While the MPS dashboard[589] is a welcome and useful resource for exploring data at

[581] See footnote #578. *Accessed 24th January 2024.*
[582] See footnote #569, p.2.
[583] Based on analysis of 2023 data from MPS Stop and Search Dashboard Data - London Datastore *Accessed 1st May 2024.*
[584] Barking & Dagenham, Camden, Croydon, Ealing, Greenwich, Haringey, Lambeth, Newham and Southwark.
[585] Population data from 2020, available at Ethnic Groups by Borough - London Datastore *Accessed 7th February 2024.*
[586] A total of 353 offences per 1,000 population were recorded in Westminster in 2023. Kensington & Chelsea recorded the next highest at 163. Richmond upon Thames and Sutton recorded the lowest at 69 and 74 per 1,000 population respectively. Available at Stats and data | Metropolitan Police *Accessed 27th April 2024.*
[587] Census 2021 geographies - Office for National Statistics (ons.gov.uk) *Accessed 15th March 2024*.
[588] See A2 Stop and search hotspot areas, Police powers and procedures: Stop and search and arrests, England & Wales, year ending 31 March 2023 (second edition) - GOV.UK (www.gov.uk) (2024).
[589] MPS Stop and Search Monthly Report | Tableau Public

various levels, we were advised it was not possible to determine the number of drug-related S&S conducted during 2023 (in total or within each borough) that were initiated specifically on suspicion of cannabis (as opposed to other drugs).

10.49 That said, bespoke analysis by the CoLP[590] showed over half (54%, n=1,253) of all S&S conducted by the force within the Square Mile in the year to June 2023 (n=2,326) were drugs-related, of which two-thirds (65%, n=809) involved cannabis.

10.50 It is not possible to extrapolate from these figures to London more widely. The make-up of the population in the Square Mile compared to the capital as a whole is very different, comprising as it does vastly fewer residents compared to the numbers who travel into and out of the area each day for work or leisure purposes. However, they demonstrate the dominance of cannabis in drug-related S&S for the CoLP.

10.51 Together with the dominance of drug-related stops in S&S, and of cannabis possession offences in recorded drug crime, we therefore consider it reasonable to assume cannabis dominates drug-related S&S conducted by the MPS. But without more precise data, a fuller understanding of the impact particularly on police resources of cannabis remaining illegal remains out of reach.

10.52 This data gap also has implications for a fuller understanding of racial disparities in S&S (and the CJS).[591] Across England & Wales, during the year to March 2023 black people were 5.1 times more likely to be subject to S&S on suspicion of a drugs-related offence than white people. Those from an Asian background were 1.9 times more likely to be stopped and searched for drugs than white people, and those from a mixed or other background were 1.6 times more likely.[592]

10.53 Racial disparity in terms of the use of S&S is also evident in London, although we welcome recent figures which suggest it is lower in the capital than across England and Wales (see paras. 10.83-84). We also note, however, the finding reported by HMICFRS in their recent inspection of the force that officers do not always record the ethnicity of people subjected to S&S. This affected inspectors' confidence in the disproportionality data and was deemed an area for improvement.[593]

10.54 In our view, the inability to further unpick drug-related S&S statistics makes fully understanding the nature of disproportionality in this area of policing, and identifying potential solutions to what is clearly an endemic problem in London and elsewhere, more challenging. It also limits the ability to better understand the

[590] Undertaken for the London Drugs Commission, 2023.
[591] Ministry of Justice (2024). *Statistics on Ethnicity and the Criminal Justice System 2022. A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991*. Ministry of Justice: Crown Copyright.
[592] See Table 2.7, Police powers and procedures: Stop and search and arrests, England & Wales, year ending 31 March 2023 - GOV.UK (www.gov.uk) Home Office. *Accessed 2nd September 2024.*
[593] His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2024). PEEL 2023–25: Police effectiveness, efficiency and legitimacy – An inspection of the Metropolitan Police Service p.9. *Accessed 27th August 2024.*

extent and nature of any links specifically between cannabis-related offending and other types of criminality, as well as serious and organised crime.

10.55 We consider the lack of data clarifying the type of substance(s) a person is suspected of carrying when subject to a drugs-related S&S to be frustrating. In some cases, it will be obvious what an officer expects to find – where they have seen the drug or, in the case of cannabis, have smelled it. We recognise, however, this will not always be the case prior to conducting an S&S.

10.56 As such, we acknowledge the operational challenges in recording the type(s) of drug on which an S&S is based. We do, however, consider it equally important that, where a drug is found, an officer should record what they suspect it to be (e.g. cannabis, cocaine, heroin). We accept that in some cases testing will be required to permit conclusive record. As such **the Home Office, in partnership with the College of Policing and National Police Chiefs Council, should seek to update data recording systems nationwide to allow officers to routinely record** (R17)**:**

- **The suspected nature of drugs seized via S&S.**
- **The ethnicity of persons found in possession of broad drug types** (heroin, cocaine, cannabis etc)**.**
- **The outcome of an S&S** (arrest, Out of Court Disposal, diversion etc; see subsequent section) **when it results in finds of i) illegal drugs excluding cannabis, ii) those including cannabis and iii) illegal items excluding drugs. This must be linked to the ethnicity record.**

10.57 Such a move will also support forces in responding to concerns that continue to be raised by watchdogs and others that they are not doing enough to analyse the use of their search powers.[594]

<u>Stop & Search: the outcomes</u>

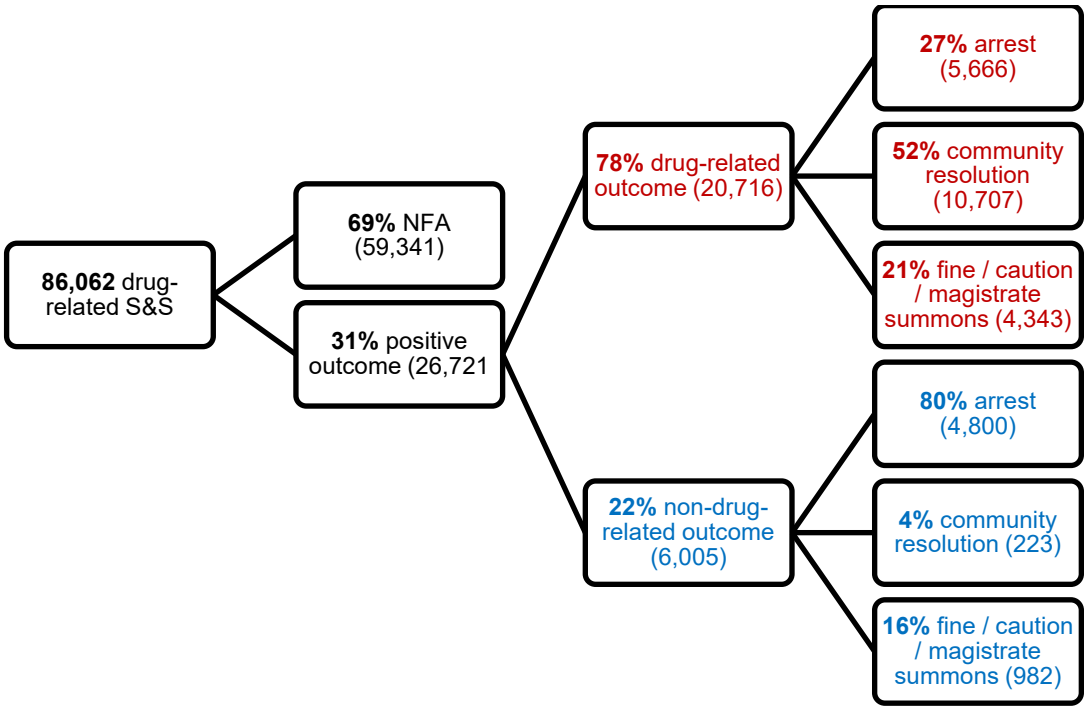
10.58 The MPS told us that around one-third of S&S end in further action, or what is known as a 'positive outcome' (such as arrest). This means around two-thirds end in NFA – in other words, most people subject to S&S are not found in possession of any illegal or stolen item, or to be perpetrating offending behaviour, at the time of the stop. This is in line with NFA rates reported by forces across England & Wales (the average in 2022/23 was 71%).[595]

10.59 The position is no different when it comes to drug-related S&S. Almost two-thirds of the 86,062 stops carried out by the MPS in 2023 (at time of data extraction) ended in NFA, with around one-third (31%, n=26,721)[596] resulting in a positive outcome. Almost four in five of those outcomes (78%, n=20,716) related to

[594] See Nickolls, L. & Allen, G. (2022). Police powers: stop and search. House of Commons Library Research Briefing, No. SN03878. Available at SN03878.pdf (parliament.uk)
[595] See Table SS_010. Stop and search outcomes summary data tables: police powers and procedures, year ending 31 March 2023 Home Office. *Accessed 24th January 2024.*
[596] MPS Stop and Search Dashboard Data - London Datastore

drugs, meaning just over one-fifth were unrelated to the original purpose of the search (22%, n=6,005), as shown in Figure 6:

Figure 6: Outcomes from MPS-led drug-related stop and searches in 2023



Source: MPS Stop and Search Dashboard Data - London Datastore

10.60 Over half of drug-related outcomes took the form of a Community Resolution (52%, n=10,707). Currently, these can be used where an offender accepts responsibility for a lower-level crime (we describe forthcoming changes with respect to such disposals later in this chapter, and in chapter 3).

10.61 A further 27% (n=5,666) ended in arrest, following which a person can be released, charged, or given a Community Resolution, fine, caution or summons. The remainder of the drug-related outcomes comprised cautions (n=121), penalty notices (fines, n=2,853) and summonses to the magistrates' court (1,369).

10.62 The remaining 22% of positive outcomes (n=6,005) followed identification of a non-drugs offence (such as carrying a weapon), or perpetration of an offence following the stop. It was put to us that the latter can and does result where a person challenges the grounds for a stop and can lead, for example, to arrest for public order or obstruction.

10.63 The vast majority (80%, n=4,800) of the 6,005 non-drug related outcomes ended in arrest. This means that, of the 86,062 drug-related S&S carried out by the MPS in 2023, almost one-quarter (24%, n=20,716) ended in a criminal justice

response for a drugs offence and a further 7% (n=6,005) in a response for a non-drugs offence.

10.64 One in eight drug-related S&S in 2023 (12%, n=10,466) therefore resulted in arrest. Drugs offences accounted for over half of these (n=5,666, 7% of all drug-related S&S), and non-drugs offences comprised the remainder (n=4,800, 6% of all drug-related S&S). We consider arrests, prosecutions and convictions later in this chapter.

10.65 As we describe earlier, police recording systems do not routinely enable the number of cannabis-related S&S to be split from the total number of drug-related S&S. Bespoke analysis by the CoLP, however, revealed that, during the year ending June 2023, 65% (n=809) of all their drug-related S&S pertained to cannabis. At 49% (n=400), the positive outcome rate for those stops was substantially higher than the England & Wales average (the rate for all S&S made by the CoLP was also higher than average, at 40%).

10.66 Of those 400 cannabis-related S&S that ended in a positive outcome, almost half (49%, n=195) resulted in arrest. A further 28% (n=112) ended in a warning, and the remainder (23%, n=93) in some other type of disposal.

10.67 Even allowing for the higher positive outcome rate recorded by the CoLP, the large majority of S&S conducted on suspicion of a drugs-related offence across London identify no criminality – drug-related or otherwise. This means tens of thousands of people are subjected to an intrusive police process when they have, on the occasion of the stop, committed no criminal offence. While we appreciate the power allows police to investigate suspicions without the need for arrest, it comes at some cost to individuals, particularly those who are law-abiding. And indeed, the process is likely to have been a negative experience for a substantial minority (see para.10.19).[597]

10.68 As above, in some cases an arrest is made despite no illegal or stolen item being found. This can be because the person is wanted for another offence, or because they become aggrieved at the S&S and end up arrested for a public order or assault offence. We agree with HMICFRS, who concluded that such outcomes have potential to cause or reinforce negative attitudes toward the police and erode trust.

10.69 Indeed, it was put to us by the oversight body that counting such outcomes as 'positive' is somewhat disingenuous because they would probably not have happened had the S&S not taken place, meaning an individual would not have risked criminalisation at all.

10.70 The MPS and CoLP told us S&S is a crucial aspect of proactive crime prevention and deterrence activity. We do not disagree (although we are not convinced there is strong evidence of either, at least with respect to cannabis offending, see

[597] See footnote #565. Slide 3.

para.10.100), and recognise the hugely complex nature of the policing landscape within which the tactic is deployed, particularly in London. As was also put to us by HMICFRS, S&S has potential to be a useful, positive element of the policing toolkit – when used well and appropriately, with officers setting out grounds in a non-threatening, polite and courteous fashion.

10.71 We recognise, too, that S&S can be a tool in the fight against violent crime, allowing police a route to finding and removing weapons from London's streets. That said, we think there is too much scope for the power to be misused in this respect, with suspicion of cannabis possession too often forming the primary mechanism.

10.72 We heard that stops might sometimes happen when an officer suspects a weapon is being carried but with no hard evidence or factual basis for the suspicion. Unable to justify on weapons grounds, the smell of cannabis may in some circumstances instead be adopted as the sole or main reason for the stop. This speaks to what has been described elsewhere as *'an often-held perception that the smell of cannabis is being used as an excuse to conduct a stop and search'*.[598]

10.73 As far as we can tell, this practice likely remains current. Indeed, our understanding of the view expressed by a very senior MPS officer was that, on occasion, S&S on the premise of suspicion of possession of cannabis may be used by the force as part of a wider strategy to identify weapons as part of tackling violence and knife crime. (A similar view was not expressed by the CoLP).

10.74 We recognise the huge challenge faced particularly by the MPS in finding and removing weapons from the streets of London, and accept the reality that, in some cases, a person suspected of carrying cannabis who might otherwise not be subject to S&S ends up being so because they are also suspected of carrying a weapon.

10.75 Undoubtably, drug-related S&S can result in finds of illegal items other than drugs. But statistics suggest these are relatively few and, ultimately, using S&S on drug-related grounds as a tactic to find and remove weapons feels to us to be against the spirit of PACE Code A and associated guidance, and an irresponsible use of an intrusive power. Research planned by MOPAC (see para.10.86-87) should shed further light on the practice, through matching the stated grounds for a stop (e.g.: drugs) to the outcome (e.g.: finding of a weapon).

10.76 We heard from the MPS about their 'Precision Stop & Search' pilot in Lambeth and Barking & Dagenham. This seeks to increase the number of weapons

[598] Pearson, G. & Rowe, M. (2020). *Police Street Powers and Criminal Justice: regulation and discretion in a time of change*. Oxford: Hart Publishing. Cited in Independent Office for Police Conduct (2022). *National stop and search learning report*. IOPC, p.14. National stop and search learning report | Independent Office for Police Conduct (IOPC) *Accessed 23rd January 2024.*

removed from the streets via a targeted, data-driven approach that focuses policing efforts on where, according to data, they can have maximum impact.

10.77 Principally designed to reduce the number of knife offences and improve public safety, it also seeks to improve the quality of S&S encounters. Focused training aims to, we were told, enhance officers' understanding of the impact of S&S and raise awareness of potential for the encounter to create lasting trauma.

10.78 We welcome the pilot but note its early stages. We consider, too, that officers dispatched to target areas may inadvertently be 'primed to see' crime, given the high-risk label attached to those areas. We think there is, therefore, some potential for this to result in less rather than more accurate S&S.

10.79 **The MPS, in partnership with the Mayor's Office for Policing & Crime (MOPAC), should ensure evaluation of the Precision S&S pilot includes recording** (R18):

- **When an officer is directed to undertake S&S using the Precision approach.**
- **Reason for S&S and, where drug-related, the type of drug suspected** (if known).
- **The type of drug found.**
- **Number of drug-related S&S that end in NFA as well as positive outcomes.**
- **Driver for each stop (self-generated, third-party information or intelligence).**
- **Views of those subject to S&S by officers receiving enhanced training, alongside views of the wider community.**

10.80 The CoLP have introduced an enhanced supervision monitoring process to bring greater consistency to policing, alongside an Inclusivity Programme. Among other things, this provides officers from the force opportunity for insight into the experiences of young black Londoners when interacting with police, particularly with respect to S&S. Where not already taking place, we encourage the CoLP to share learning from these endeavours with the MPS, to support further development of their Precision pilot.

10.81 An important outcome of visible policing like S&S can be community reassurance, particularly where obvious drug-related activity causes public concern. As we discuss elsewhere, we heard from officials and elected representatives across several London boroughs that such anxiety can be substantial. We have not, however, been presented with evidence that S&S reduces this to any meaningful extent and in some cases, among black communities in particular, it risks the opposite.

<u>Disproportionality in Stop and Search</u>

The numbers

10.82 Several of those we heard from talked powerfully about the hugely detrimental effects of being stopped and searched. While true irrespective of ethnicity, racial

disparities in the likelihood of being subject to S&S means the extent of those detrimental effects is much greater among some communities.

10.83 The racial disproportionality seen in S&S nationally (see para.10.52) is similarly evident in London. At time of writing, statistics showed that disparity rates were lower than the national average, which is to be very much welcomed and we commend the MPS and the CoLP forces for the steps they have taken to achieve this. That said, black Londoners were still 3.3 times more likely to be S&S by the MPS for any reason, and 3.1 times more likely to be subject to a drug-related S&S, than white Londoners (other ethnic minorities were 1.2 times more likely to be stopped for drugs).[599]

10.84 In the City of London, black people were 2.2 times more likely to be S&S than white people (based on London's population as a whole) although the CoLP told us the disproportionality rate was slightly lower for cannabis specific stops, at 1.8. The extent to which these figures tell us very much is, however, debatable given the unique demographics of the Square Mile and the fact that the resident population is fewer than 9,000 people.[600]

10.85 For most other boroughs across the capital, the disparity for black Londoners is stark,[601] as shown in Table 5:

Table 5: Ethnic disproportionality in drug-related stop & searches, by London borough*, 2023

	Population by ethnicity (%)				Drug-related S&S by ethnicity (%)**			
	White	Black	Asian	Other	White	Black	Asian	Other
Barking & Dagenham	45	23	25	7	51	26	21	1
Barnet	64	7	20	9	42	38	11	9
Bexley	74	11	8	7	68	23	7	1
Brent	35	12	42	11	26	46	16	11
Bromley	78	7	7	7	67	27	5	1
Camden	59	11	13	17	49	37	8	4
Croydon	57	16	20	8	35	40	10	13
Ealing	47	8	26	18	27	30	35	6
Enfield	64	17	13	7	56	31	7	4
Greenwich	54	19	21	7	50	38	9	2
Hackney	58	17	7	18	35	45	16	4
Hammersmith & Fulham	68	8	8	16	36	44	7	12
Haringey	74	13	5	8	46	41	7	5
Harrow	41	3	42	14	37	29	24	8

[599] MOPAC Action Plan Data Dashboard | London City Hall Results from Q3 2023/24. *Accessed 14th August 2024*.
[600] City of London Resident Estimates and Projections *Accessed 17th May 2024.*
[601] Based on 2020 population data, available at Ethnic Groups by Borough - London Datastore and 2023 stop and search data, available at MPS Stop and Search Dashboard Data - London Datastore *Both accessed 23rd January 2024.*

Havering	74	11	11	4	65	22	12	1
Hillingdon	49	12	31	8	34	29	32	4
Hounslow	45	13	37	4	42	25	25	5
Islington	73	7	6	14	45	38	11	6
Kensington and Chelsea	71	9	10	10	35	36	9	18
Kingston upon Thames	75	4	14	8	58	20	16	5
Lambeth	65	17	7	12	25	66	4	3
Lewisham	62	20	8	11	38	52	6	3
Merton	67	10	16	7	41	30	23	4
Newham	46	16	33	6	37	32	29	2
Redbridge	42	8	44	5	27	24	45	2
Richmond upon Thames	82	2***	7	9	56	22	12	6
Southwark	57	25	8	10	36	52	8	3
Sutton	66	8	16	10	62	23	12	2
Tower Hamlets	49	5	38	8	33	19	45	2
Waltham Forest	67	12	11	10	39	34	23	3
Wandsworth	77	8	8	8	42	40	13	5
Westminster	66	8	8	18	36	34	13	15

* Population figures from 2020, S&S figures from 2023. For counts of populations and S&S, see sources: Ethnic Groups by Borough - London Datastore and MPS Stop and Search Dashboard Data - London Datastore
** Percentages may not add up to 100% because table excludes S&S where ethnicity was not recorded.[602]
*** Suppressed in published data due to small sample sizes but calculated for purposes of this table based on total population of borough and cited figures for white, Asian and other populations.

10.86 A better understanding of what lies beneath these figures is important. We were therefore pleased to learn about a suite of MOPAC-led projects which seek to address key gaps in evidence related to S&S practice. Expected to deliver in mid-2025, these will examine what drives disproportionality and, perhaps more importantly, what levels of disproportionality should be expected (if any) given London's demographics alongside the distribution of deprivation and crime.

10.87 The work will also explore officer decision-making when identifying grounds to warrant a S&S, and how those vary (if at all) by the ethnicity of those stopped. Additionally, it will consider how cited grounds for a stop compare to outcomes for that stop. We think these projects will add considerably to understanding of S&S practice in London and look forward to seeing their findings.

10.88 There is also evidence of disparity across England & Wales in the proportion of S&S for any reason that are officer self-generated. Reportedly less likely to be effective or considered justifiable to the person searched or the wider public (see para.10.28), HMICFRS found 63% of all searches of those from a white ethnic group to be self-generated, compared with 67% of searches of black people and 77% of those from an Asian background.

[602] See also footnote #593, p.9.

10.89 For drug searches overall, a higher proportion of weak recorded grounds was found where individuals were from a black ethnic group (29%) than white (24%), with a similar pattern in possession-only searches (29% compared with 23%).[603]

10.90 While these data were not split by force, given ethnic disparities in the rate of drug-related S&S in London it is reasonable to assume a similar disparity with respect to the grounds of searches of people from different ethnic backgrounds in the capital.

10.91 The broader context of drug-related S&S is important. Between July and September 2023, black Londoners were 6.2 times more likely than those from a white background to be searched for weapons, points or blades[604]. It is worth bearing this in mind when considering the experiences of drug-related S&S among black Londoners, and wider implications.

10.92 That black Londoners are disproportionately more likely to be both victims and perpetrators of violent crime[605] was, the MPS suggested to us, at least partly responsible for the disparity rate in those S&S's led by the force. Certainly, and as Baroness Casey noted,[606] between 2020 and 2023 black people in London were 70% more likely than white people to be a recorded victim of violence against the person (including knife crime), and nearly six times more likely to be murdered. However, the majority of S&S's are drugs-related. In our view, the fact that both suspects and victims of knife, robbery and firearms offences are more likely to be black is therefore not an adequate explanation for racial disproportionality in drug-related S&S.

10.93 We recognise the very significant challenges facing the police in tackling knife crime and other weapons-related offending, and the urgent need to remove weapons from the streets. In our view, however, S&S on suspicion of drugs – principally cannabis – is not the right tactic for the MPS (or any force for that matter) to use as part of endeavours to tackle weapons-related violence.

10.94 Not only dubious in terms of legitimate use of the power, it results in what we consider to be a poor rate of return for drugs and an even lower return for weapons. Neither are the public wholly supportive of use of the power more broadly with respect to tackling knife crime – with differences by ethnic group once again apparent. White Britons are significantly more likely to consider S&S an effective measure against knife crime than those from ethnic minority backgrounds (62% against 48%).[607]

---

[603] See footnote #569, pp.35–6.
[604] MOPAC Action Plan Data Dashboard | London City Hall Results from Q3 2023/24. *Accessed 14th August 2024.*
[605] Calls for a commission on knife crime in the black community | London City Hall
[606] Baroness Casey of Blackstock, DBE CB (2023). *Final Report An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service*. BARONESS CASEY REVIEW Final Report (met.police.uk), p.312.
[607] See How do white and ethnic minority views and experiences of knife crime differ? | YouGov *Accessed 23rd August 2024.*

10.95 Moreover, there is some evidence that the rate of finding drugs following S&S of black people may be lower than it is for white people. In London, 11% of black adults surveyed who had been S&S reported a positive outcome, compared with 16% of white respondents[608]. For adults outside London, figures were 12% and 19% respectively.

10.96 Coupled with somewhat mixed evidence regarding whether black people are more likely to use cannabis than white people, and to what extent (see chapter 4 – some data suggests past-year use is higher among black people but lifetime prevalence is higher among white ethnic groups), it is not difficult to see how, as observed by Baroness Casey, the view that London's communities of colour are both over-policed and under-protected might come about.[609]

10.97 As above, we recognise S&S is an important element of proactive policing, although as far as we understand it the power is intended to be investigatory, to confirm whether a specific crime has taken place or not. While it may result in evidence of serious criminal behaviour or intent, thus prevention of crime (particularly where weapons are found) is a potential outcome, this should be a by-product of proper use of the power.

10.98 The MPS told us that, in their view, S&S confers several benefits. They cited deterrence (see para.10.70), suggesting that individuals may be less likely to carry drugs and other illegal items if they know they may be subject to a search. Where drugs are found on an individual, confiscation prevents distribution and consumption, causing some disruption to the end of the supply chain.

10.99 The MPS also suggested that S&S supports the gathering of intelligence with respect to drug-related activities, including identification of dealers and wider networks. They consider it contributes to keeping the public safe through reducing drug-related crime, and that it enables the targeting of individuals known or suspected of being involved in drug-related activities.

10.100 In our view, however, evidence which clearly demonstrates these benefits is lacking. We acknowledge that some (albeit limited) findings suggest S&S may deter offending to a small extent,[610] including that related to drugs.[611] However, we also note the unclear nature of this effect. Rather than people who use drugs and dealers genuinely desisting due to heightened perceptions of the risk of being caught, they might simply change their behaviour to make it harder for police to uncover evidence through S&S.[612]

[608] Evans, E., Olajide, P. & Clements, J. (2022). *Crime, policing and stop and search: Black perspectives in context*. Crest Advisory. Crest Advisory Stop and search report 1 (usrfiles.com) p.78.
[609] See footnote #606, p.312.
[610] See footnote #567.
[611] Tiratello, M., Quinton, P. & Bradford, B. (2018). Does Stop and Search Deter Crime? Evidence From Ten Years of London-wide Data. *The British Journal of Criminology,* 58(5), pp.1212–31. doi.org/10.1093/bjc/azx085
[612] Ibid.

10.101 As we have discussed, most drug-related S&S are undertaken on suspicion of possession and not intent to supply,[613] and the majority end in NFA. As a result, we consider any impact on wider drug supply chains is likely to be at best fairly minimal.

10.102 Moreover, the changing nature of the drugs trade may mean S&S is now less likely to uncover drugs, at least in quantities that suggest dealing or supply. As we explore in chapter 5, drugs are increasingly purchased online or via dedicated phone lines, often with doorstep delivery (by post or dealers in person). This suggests the power is at risk of becoming outdated, a mechanism of addressing a problem that manifests in a very different way in 2024 than it did even five years ago.

10.103 Overall, whether the benefits of S&S outweigh the costs is not clear to us. We consider monetised costs to police later in this chapter, but must not lose sight of non-monetised costs, most notably the risks of harm to individuals and to wider police–community relations. These are particularly pertinent to consideration of cannabis, given the majority of drug-related S&S are likely based on suspicion of related offences.

10.104 While we acknowledge the role of S&S in legitimate maintenance of law and order, it must be a constrained power. To be justifiable, use must be transparent and verifiable – which to our mind demonstrates the challenge inherent in relying on the smell of cannabis as reason for a stop.

The experience of S&S and implications

10.105 While we acknowledge the role of S&S in appropriate circumstances, we must also acknowledge that experience of the process can, as was put to us and is well documented elsewhere, be shocking, distressing, humiliating and, in some cases, very traumatic. While this is true for people of all ethnicities, it is perhaps particularly so for those from black and mixed ethnicity backgrounds.[614] Indeed, black Londoners who have been subject to S&S are less likely than those from a white background to agree police were polite, treated them with respect, and explained why they had been stopped.[615]

10.106 Where an individual perceives a search as unjustified (perhaps because it follows one or more previous searches in which nothing was found), or feels officers were disrespectful during the process or otherwise behaved unprofessionally, negative effects are likely to be heightened. Indeed, such experiences can lead to

[613] See footnote #569, p.6.
[614] See footnote #608, pp. 65 & 79.
[615] See footnote #565, Slide 4.

measurable detrimental health consequences[616][617] particularly among young people, with future attitudes towards the police also negatively affected.

10.107 Moreover, evidence suggests the experience of S&S in adolescence and young adulthood can in fact increase the likelihood of future cannabis use (as well as use of other illicit drugs, alcohol and tobacco).[618] For young black men in particular, both direct and indirect exposure to perceived racially discriminatory police interactions have been shown to increase the chance of cannabis consumption.[619]

10.108 The possibility for S&S to be counter-productive in tackling crime was raised with us several times. Use of the power – at least in London – was seen by some as serving principally to damage relationships between police and communities, leaving those with poor experiences less likely to engage with future intelligence gathering and crime investigation.[620] This is likely to be magnified where a person has been subjected to S&S multiple times, which as we heard is common particularly among young black men. Certainly, trust in the police and faith in receiving fair treatment is consistently lower among black Londoners than those from white and other ethnic minority backgrounds.[621] Poor experiences also raise the risk of wider detrimental personal consequences.

10.109 The importance of quality interactions between police and communities cannot be overstated when it comes to public trust, confidence and willingness to engage with crime investigation and public safety endeavours. One recent HO review demonstrated the crucial role this plays in public opinions of, and cooperation with, police, noting that, if they are seen to lack legitimacy or work in ways perceived as procedurally unjust, then trust and confidence falls.[622][623]

10.110 That said, even when conducted with politeness and respect the experience of an S&S remains likely to be discomforting. After being subjected multiple times to the practice, it is not hard to imagine that discomfort becoming increasingly distressing, irrespective of how politely an officer conducts the search.

10.111 With specific reference to S&S, the same HO review highlighted that negative experiences may reach beyond the individual, transmitting detrimental effects

---

[616] See footnote #567.
[617] McLeod, M.N., Heller, D., Manze, M.G., & Echeverria, S.E. (2020). Police Interactions and the Mental Health of Black Americans: A Systematic Review. *Journal of Racial and Ethnic Health Disparities*, *7*(1), pp.10–27. doi.org/10.1007/s40615-019-00629-1
[618] Jackson, D.B., Testa, A. & Boccio, C.M. (2022). Police Stops and Adolescent Substance Use: Findings From the United Kingdom Millennium Cohort Study. *Journal of Adolescent Health*, *70*(2), pp.305–12. doi.org/10.1016/j.jadohealth.2021.08.024
[619] Motley, R.O., Byansi, W., Siddiqi, R., Bills, K.L., & Salas-Wright, C.P. (2022). Perceived Racism-based police use of force and cannabis use among Black emerging adults. *Addictive Behaviors Reports*, *15*, 100430. doi.org/10.1016/j.abrep.2022.100430
[620] See also Independent Office for Police Conduct (2023). *National stop and search survey report*. October 2023. IOPC. national-stop-and-search-survey-report-oct-2023.pdf (policeconduct.gov.uk)
[621] See footnote #565, Slide 2.
[622] Hanway, P. & Hambly, O. (2023). Public perceptions of policing: A review of research and literature. Home Office. Public perceptions of policing: A review of research and literature - GOV.UK (www.gov.uk)
[623] See footnote #565.

through social connections to a much broader network. It also found evidence that socio-demographic variables, including age and ethnicity, impacted perceptions of policing. Research elsewhere supports this: both first- and second-hand negative interactions with police reportedly detrimentally affect views among black people.[624]

10.112 This has particular resonance in the capital, given that proportionally more Londoners come from a black background than elsewhere in the country (13.5%, with the West Midlands next highest at 4.5%).[625] This means greater numbers of black people in London are likely to face S&S than elsewhere, particularly because, as was suggested to us, a range of cultural as well as economic factors (including unemployment and overcrowded housing) can mean they and those from other ethnic minority communities spend more of their lives in outside spaces. Which means, of course, they are more 'available' to police officers patrolling public spaces, and so arguably represent an easier target for proactive policing tactics.

10.113 Overall, the MPS told us that almost nine in ten Londoners support the police having the power to S&S.[626] This is substantially higher than levels of support cited by independent surveys, although those too report that a majority of Londoners[627] and the public nationally are supportive – crucially, however, as long as there are reasonable grounds for suspicion and police are clear as to the reason for the stop.[628]

10.114 Given that most S&S end in NFA, the extent to which the measure is effective is at best debatable. Certainly, the large majority of respondents to our online survey[629] thought it was likely to be ineffective in helping manage or reduce any harmful effects associated specifically with the use of cannabis (see Appendix C).

10.115 Moreover, several surveys show support for S&S is notably lower among black communities. Just over half (51%) of black Londoners polled in the latest (at time of writing) MOPAC survey supported use of the power, compared with over two-thirds (71%) of both white Londoners and those from other ethnic minority groups.[630], [631] This is replicated at national level, with white Britons much more likely to support the power of the police to S&S than those from ethnic minority

[624] See research cited in Akintoye, B., Ali, A. & Stevens, A. (2022). The Ongoing Impact on the Racialised Policing of Black Communities. In I. Crome, D. Nutt & A. Stevens (Eds.), *Drug Science and British Drug Policy* (pp.198–203). Waterside Press.
[625] Regional ethnic diversity - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk) *Accessed 19th January 2024.*
[626] MPS. Unpublished written submission to the London Drugs Commission, MPS-sponsored survey of Londoners, n=7,592. Sampling criteria and sample demographics not cited meaning representativeness is unclear.
[627] MOPAC Action Plan Data Dashboard | London City Hall Results from Q3 2023/24. *Accessed 14th August 2024.*
[628] See for example Centre for Social Justice (2024). Serious Violence in London. Perceptions, Costs, and Recommendations. Centre for Social Justice. Serious Violence in London (centreforsocialjustice.org.uk). 63% of Londoners supported the power of the police to stop and search. *Accessed 23rd August 2024.*
[629] Results are not representative of Londoners' views more broadly due to the methodology employed and the small sample. Findings were not weighted.
[630] MOPAC Action Plan Data Dashboard | London City Hall Results from Q3 2023/24. *Accessed 14th August 2024*.
[631] See also footnote #628, Chart 3: 67% of white Londoners surveyed supported S&S compared with 57% of black Londoners.

backgrounds (73% compared to 53% respectively). Among black Britons, support is even lower (44%).[632]

10.116 Consistent with these figures, just over one-third (37%) of Londoners from black backgrounds feel S&S is conducted fairly, compared with 59% of Londoners from white ethnic groups and 63% from other ethnic minority groups[633] Figures such as these highlight the point that S&S is not a 'blank cheque': it depends on stops being fair, proportionate and intelligence-led.[634]

10.117 We accept S&S might play a role in wider community reassurance. But evidence put to us supports the notion that it can have the reverse effect in black communities, serving instead to entrench mistrust of the police and heighten perceptions of unjust and disproportionate policing tactics.

10.118 Indeed, the public consultation that informed the Mayor of London's 2020 Action Plan[635] reported S&S to be the most frequently raised example of disproportionate policing of black Londoners. Perceptions of unwarranted, unprofessional S&S were reportedly damaging relations between the MPS and black communities: the Action Plan set out to address these concerns and improve wider trust and confidence in the police.

10.119 Our inquiries three years later suggest there remains some way to go – although the recent assessment by HMICFRS that the MPS consistently involves communities in scrutiny of its use of S&S is welcome. Community Monitoring Groups operate across London and help hold the MPS to account[636] - but the extent to which the feedback they provide leads to associated change in practice is unclear. Certainly, groups have previously raised concerns related to the clarity of grounds provided when conducting S&S.[637] Such concerns sit against a current backdrop of continuing low levels of public trust in the MPS, particularly among women and ethnic minorities.[638]

10.120 The scrutiny body also drew attention to measures the force is taking to improve its use of S&S.[639] Inspectors highlighted a charter being developed in consultation with communities, particularly young people and those from ethnic minority groups, which will set out how police officers should interact with the community while using S&S. We are pleased this is in train and hope that in time, it will improve trust and confidence and the experience of S&S for those subjected to use of the power.

---

[632] Stop and search: how do ethnic minority Britons feel about police powers? | YouGov *Accessed 23rd August 2024.*
[633] MOPAC Action Plan Data Dashboard | London City Hall Results from Q3 2023/24. *Accessed 14th August 2024*.
[634] See footnote #608. p.94.
[635] action_plan_-_transparency_accountability_and_trust_in_policing.pdf (london.gov.uk)
[636] See footnote #593, p.10. *Accessed 27th August 2024.*
[637] See Stop and search based on the smell of cannabis (3) | London City Hall *Accessed 27th April 2024.*
[638] Pickering, S. Dorussen, H., Hansen. M.E., Reiflerd, J., Scottoe, T., Sunahara Y. & Yen, D. (2024). London, you have a problem with women: trust towards the police in England. *Policing and Society*. doi.org/10.1080/10439463.2024.2334009
[639] See footnote #593, p.12. *Accessed 27th August 2024.*

10.121 The CoLP is equally subject to challenges posed by S&S practice and public perceptions with respect to community relations. Similar to the MPS, they too operate community-led scrutiny mechanisms, and are soon to launch similar within the business communities operating in the Square Mile.

10.122 In a partnership with Amazon, the force also works with sixth-form students to improve officers' understanding of how young people view the police. They use this information to develop ways to better involve young communities and increase confidence and trust, particularly, it was put to us, with respect to S&S, which has emerged as an area of concern.

10.123 We did not consider the initiative in detail but note its identification by HMICFRS as an example of innovative practice.[640] If not in train, **MOPAC should ensure the MPS engage with the CoLP to explore the possibility of trialling a similar approach to involve and build trust among young communities** (R19).

10.124 To further explore S&S-related concerns, we asked the CoLP and the MPS about the number of complaints they received regarding use of the power, specifically when related to cannabis. While not a wholly reliable measure of the scale of public disquiet, relying as it does on a person both feeling comfortable to raise a complaint and knowing how to do so, we nonetheless consider such data an important element of understanding police–community relations.

10.125 The CoLP told us they had received three such complaints over the past ten years. The MPS provided us with a detailed report of all complaints received over the two-year period to July 2024, and we were pleased to see a fall in the number which related to S&S.

10.126 On average, for the MPS, just over 3% of all complaints made between August 2023 and July 2024 (398 out of a total of 11,675) related to S&S. Because multiple allegations may arise out of a single incident, the number of allegations made about S&S was higher, at 649 (although they too have fallen considerably from the previous year).

10.127 Unfortunately, however, the MPS do not record the purpose of a S&S about which a complaint has been made. As a result, we are not clear as to how many complaints/allegations have been made following a cannabis-related stop. Given drugs – particularly cannabis - are, by some margin, the most likely cause of an S&S, this feels to be a gap which limits development of a more detailed understanding of aforementioned police-community relations.

10.128 Moreover, black complainants are over-represented in the MPS S&S complaint statistics. They comprised 29% of those making a complaint related to the power in the year to July 2023, and the same proportion the following year.

[640] His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2021). PEEL 2021/22: Police effectiveness, efficiency and legitimacy – An inspection of the City of London Police, p.14. *Accessed 19th March 2024.*

Complainants from a white background made up 20% and 23% respectively. By comparison, black complainants made up 13% of those making a complaint about any matter in the last year (white complainants comprised 37%).

10.129 We consider it important that the MPS better understands the extent not only to which cannabis-related S&S features among all S&S complaints, but also the characteristics of individuals making those specific complaints. As a result, **we recommend MOPAC should explore how the MPS can record the specific type of S&S about which a complaint is made, and link the ethnicity of the complainant to that record** (R20). In time, this data should inform the work of external scrutiny panels (see para.10.119).

10.130 Moreover, it was also unclear to us how well the MPS understood the demand that (non-medical) cannabis-related activity places on policing in the capital. They were unable to provide sufficient insight in a number of areas, including intelligence, investigation and enforcement action. This made it difficult for us to properly understand the nature and scale of consequences associated with that demand.

10.131 The force must better understand cannabis-related demand and its associated policing response. **We recommend the MPS work with the HO and MOPAC to make better use of data concerning cannabis-related demand where these exist, and to start collating such where they currently do not. In all cases, the ethnicity of the persons reporting or being subject to police action should be recorded, and areas of demand include:**

- **Intelligence submissions linked to both public reporting and officer generation.**
- **Number of calls for service from the public linked to cannabis, as well as complaints related to local cannabis activity.**
- **Enforcement action following execution of warrants, including the number of closure orders issued.**
- **Drug driving.**
- **Volume of police seizures of cannabis.**

(R21.)

The CoLP, in partnership with the City Corporation (responsible for providing policing governance for the force) may also wish to consider whether such reporting is appropriate, although we appreciate the volume of drug-related offending dealt with by the force and the size of the resident population mean there may be less call.

The impact of being stopped and searched multiple times

10.132 It follows that, as black people are more likely to be subject to S&S, they are more likely to be S&S more than once. Over one-third (37%) of black participants in one survey reported having been S&S more than three times during their

lifetime, as had 39% of those with mixed ethnicity – compared with 24% of white participants.[641]

10.133 The experience of multiple S&S deepens what can be enduring and harmful effects, which travel down the generations. Research among black Londoners found many had been subject to numerous stops, particularly as teenagers and young adults, and primarily on the basis of nothing more than the smell of cannabis.[642] Those encounters routinely drove 'the Talk', whereby, as and when they become parents, black people who had experienced S&S or otherwise heard about the experiences of others discussed with their own children how best to approach interactions with the police.

10.134 The MPS' own review into its handling of the S&S of athletes Bianca Williams and Ricardo dos Santos, which included consultations with young black men, found searches of the same individual that consistently end in NFA to be '*extremely corrosive to the person's and wider communities' trust and confidence in policing.*'[643] It was put to us that for some Londoners the police are seen as protagonists rather than protectors.

10.135 Indeed, we heard from black Londoners who had experienced S&S many times, and from others who worked with or on behalf of black communities. We found a pervasive sense of persecution, particularly with respect to being young, black and from deprived communities, and perceptions of a distinction between the way in which Class A drug use among (predominantly white) middle-class Londoners is treated and experiences of cannabis policing: *'…the police aren't stopping people in Canary Wharf, are they?'*.

10.136 Similar views regarding differential treatment by the police with respect to ethnicity are reported elsewhere.[644] And, as we previously describe, it is clear that, despite guidance regarding use S&S on the basis of smell of cannabis alone, the experiences of very many young black people in London suggest the extent of police adherence to this is questionable.

10.137 We heard S&S was such a frequent part of daily life in one predominantly black community that *'…we know every police officer by name… and not for any good reasons. We know each other too intimately and that's problematic.'* The power was described as often being used en masse involving up to ten or more people, typically black, with the basis perceived as nothing more than an officer alleging they could smell cannabis.

10.138 The practice, certainly for many black Londoners, was described to us as one which makes them feel unsafe, in which they have no choice, and which leaves

[641] See footnote #608, p.68.
[642] See research cited in Akintoye, B., Ali, A. & Stevens, A. (2022). The Ongoing Impact on the Racialised Policing of Black Communities. In I. Crome, D. Nutt & A. Stevens (Eds.). *Drug Science and British Drug Policy* (pp.198–203). Waterside Press.
[643] Police Professional | MPS officers must justify pre-arrest handcuffing following review
[644] See for example footnote #608, pp.65, 79.

them feeling powerless. This is exacerbated in designated 'drug hotspots' where we heard many young black people are arrested for cannabis possession following S&S, rather than receiving a (permissible in some circumstances) less serious Out of Court Disposal (OOCD) – even for a first offence. We discuss use of OOCDs later in this chapter.

10.139 This practice, as described to us, effectively discriminates against children and young people growing up in those hotspots, which are likely to be the more deprived parts of London. Those affected children and young people are therefore more likely to be people of colour (see para.4.45).

10.140 As our research[645] among Londoners highlighted, the sense of disproportionate and unfair application of S&S to black Londoners is felt across ethnic groups. This underpinned a desire among some for an end to the practice with respect at least to possession of cannabis for personal use (see also chapter 6 on public attitudes towards cannabis and its legal status).

10.141 Some participants from a white background described instances where black companions had been singled out in both body and vehicle S&S's for cannabis, or had received what they felt to be a harsher punishment than that which a white person in possession of the drug would have (or had) received in a similar situation:

> *'Even though at the time [of the stop and search] myself and this other white friend were the ones holding the joints, it was my [black] boyfriend who was most aggressively spoken to, addressed, and body searched.'*

> *'Friends were driving and were stopped by a police car for no apparent reason other than they were black in a nice car. The police officers that stopped them said there was an issue with insurance and asked for car details. The officers started off aggressively and the driver reacted politely and provided all the documentation but the officer seemed unsatisfied. [The officer] asked whether anybody had been smoking cannabis because they could smell it from the car. This friend does not smoke cannabis nor has ever smoked cannabis and replied as such. The police officers vacated everyone from the car and searched the car thoroughly… They were eventually let go but this caused a lot of trauma to my friends. They were massively impacted and for a while they did not drive that car around and took public transport.'*

Source: Thinks Insight & Strategy (2023). *Lived experiences of cannabis among Londoners*. MOPAC.

10.142 We heard, too, from one white former cannabis user who had frequently purchased the drug on London's streets. Never subject to S&S himself, he

[645] See footnote #11.

described one instance when police stopped him along with several black people from whom he had just bought cannabis. He was permitted to walk away while those he was with were detained for S&S. Similarly, one young witness described seeing police S&S a white peer and find several bags of cannabis. Which they duly confiscated – before letting him go.

10.143 Such anecdotes support perceptions among London's black communities, arguably reinforced by the disparity rate, that the discretion available to police with respect to responding to cannabis possession (depending on the circumstances) is applied unequally. Data on outcomes from drug-related S&S do nothing to dispel this view – we consider these later in this chapter.

10.144 Bias – unconscious or otherwise – may be partly responsible. We also heard of perceptions that young black people are treated differently to white counterparts in response to county lines activity (see chapter 5). The former, it was suggested, are more likely to be labelled criminals, the latter victims of modern slavery and exploitation.

10.145 The use of body-worn video (BWV) offers one means to improve the way in which S&S is handled, and we welcome the fact that its use is now established within all forces in England & Wales (including the MPS and CoLP)[646] – albeit with some inconsistency.[647] It was put to us that it improves the behaviour of officers and those they S&S, although research (primarily from the US) suggests the measure tends not to affect the behaviour of either police or citizens in a clear or consistent manner.[648]

10.146 Moreover, the technology is officer-activated, meaning recording begins only when an officer turns on the device – which may not always be at the very start of an encounter. Furthermore, part of the value of BWV lies in the review of footage by police supervisors to support learning and improvement.[649] But we heard this is not as widespread as it could be, which causes us concern as there are almost certainly opportunities being missed to provide vital feedback to officers engaged in S&S.

10.147 We welcome work which we heard is underway in the MPS to assess reviews of officers' BWV for S&S, with results expected later this year: these should be passed to and discussed with MOPAC and Community Monitoring Groups as soon as practicable.

---

[646] National Police Chiefs Council (2022). *Body-Worn Video V1.0*. United Kingdon College of Policing: Body Worn Video Guidance 2014

[647] Race Disparity Unit (2022). *Inclusive Britain: government response to the Commission on Race and Ethnic Disparities. Command paper number CP 625*. Crown Copyright. Inclusive Britain: government response to the Commission on Race and Ethnic Disparities - GOV.UK (www.gov.uk)

[648] Lum, C., Koper, C.S., Wilson, D.B., Stoltz, M., Goodier, M., Eggins, E. … & Mazerolle L. (2020). Body-worn cameras' effects on police officers and citizen behavior: A systematic review. *Campbell Syst Rev, 16*(3). doi:10.1002/cl2.1112.

[649] See footnote #646.

10.148 It was also suggested to us that despite previous recommendations[650][651] and support from the National Police Chiefs Council (NPCC),[652] sharing of BWV footage with external scrutiny groups continues to be patchy. **MOPAC should mandate those charged with scrutiny of the MPS and CoLP to review a random sample of BWV of drug-related S&S at least quarterly and report any concerns to the force and MOPAC** (R22).

Strip searching

10.149 Strip searches[653] may take place in a police station or other appropriate location that is out of public view and is a suitable place in which to be partially naked.[654] While we did not explore the practice in detail, we heard how harrowing it is, particularly for young people, to be subjected to such a search. It was described as so traumatic that the end is completely unjustified by the means, and some witnesses felt it could never, in any circumstance, be considered a proportionate or appropriate response.

10.150 This view was compounded by the low rate of positive outcomes. Over half the 650 strip searches of children and young people carried out by the MPS between 2018 and 2020 resulted in no further action.[655] And the ethnic disproportionality seen in S&S more widely is also observed in strip searches, at least among children.

10.151 The well-documented case of a young black girl, known as Child Q, was something of a pivotal moment in terms of highlighting both the nature of the practice and associated ethnic disparities. Suspected of carrying cannabis, Child Q was strip searched while at school in Hackney in north-east London in 2020. In contravention of the guidance no Appropriate Adult was present. No drugs were found.

10.152 The case prompted examination of MPS practice by the IOPC and the Children's Commissioner, as well as a local child safeguarding practice review. Notably, the latter reported that *'…racism (whether deliberate or not) was likely to have been an influencing factor in the decision to undertake a strip search.'*[656]

---

[650] See footnote #647, Action 12.
[651] Independent Office for Police Conduct (2022). *National stop and search learning report*, IOPC, pp.34–5. National stop and search learning report | Independent Office for Police Conduct (IOPC) *Accessed 23rd January 2024.*
[652] See footnote #646.
[653] A strip search involves a person removing more than their outer clothing. It can involve exposure of intimate body parts.
[654] London Policing Ethics Panel (2022). *Report on conduct of searches exposing intimate parts by the Metropolitan Police Service*. London Policing Ethics Panel.
[655] Children's Commissioner (2022). *Strip search of children by the Metropolitan Police Service – new analysis by the Children's Commissioner for England.* Children's Commissioners Office. Available at Strip search of children by the Metropolitan Police Service - new analysis by the Children's Commissioner for England | Children's Commissioner for England (childrenscommissioner.gov.uk) *Accessed 22nd January 2024.*
[656] Gamble, J. QPM & McCallum, R. (2022). *Local Child Safeguarding Practice Review: Child Q*. City & Hackney Safeguarding Children Partnership (CHSCP), p.6. Child-Q-PUBLISHED-14-March-22.pdf (chscp.org.uk) *Accessed 22nd January 2024.*

10.153 Available statistics back this up. The vast majority of strip searches of 650 children aged under 18 conducted by the MPS between 2018 and 2020 were of boys (over 95%, mostly aged 16–17). Well over half (58%) were black, a further one-fifth were white and 16% were Asian.[657] Given the ethnic breakdown of 10–17-year-olds across London (in 2021, 19% were black, 44% were white, 22% were Asian), racial disparity is in our view somewhat inarguable.

10.154 More recent data published by the Children's Commissioner, however, suggests a fall in the use of strip searching of children by police across England & Wales, and we welcome the fact this was particularly notable in London.[658] Like the Children's Commissioner, we too find this reassuring.[659] In the year ending June 2023, the MPS and CoLP conducted a combined total of 66 such searches, representing 14% of all strip searches of children undertaken across England and Wales that year.

10.155 The latest report also found that while black children remain subject to a disproportionate number of strip searches, the disparity has reduced. Across England & Wales, black children are now four times more likely than white children to be strip searched rather than six times, as was previously reported. While figures are not broken down by individual police forces, we have no reason to believe the disparity is not similarly reducing in London.

10.156 Moreover, following the case of Child Q, the MPS told us they have introduced several changes to the policy and procedure regarding the most intimate form of strip searching, known as a 'More Thorough search involving Intimate Parts' (MTIP). Effective since May 2022, among other things the new guidance, we were told, raises the authorisation level for conducting an MTIP to Inspector, and local Basic Command Unit (BCU)[660] Inspectors now own all aspects of the procedures involving MTIPs of children.

10.157 While we did not have opportunity to review this new guidance, we were told the MPS aim to have in place the highest possible threshold for authorisation of an MTIP, the strongest possible safeguards for children and the highest quality administration governing the procedure. These are welcome and laudable intentions, and we hope that future assessment and inspection can demonstrate positive associated outcomes.

---

[657] See footnote #655. Note: A further 5% of children strip searched between 2018 and 2020 were marked as 'other' ethnicity and, in 2% of cases, ethnicity was not recorded.

[658] Children's Commissioner (2024). *Strip searching of children in England and Wales: First complete dataset for 2018–2023, including new data July 2022-June 2023*. Children's Commissioners Office. Strip searching of children in England and Wales: First complete dataset for 2018-2023, including new data July 2022-June 2023 (childrenscommissioner.gov.uk) *Accessed 27th August 2024.*

[659] Child strip searched every 14 hours by police in England and Wales | Children's Commissioner for England (childrenscommissioner.gov.uk) *Accessed 27th August 2024*.

[660] For policing purposes, London is divided into 12 Basic Command Units (BCUs), each lead by a BCU Commander. The boundaries of each BCU incorporate up to four individual boroughs.

Options for the police on finding cannabis for personal use during stop and search

10.158 On finding small amounts of cannabis during an S&S (i.e. not enough to constitute a supply offence, although what constitutes personal use versus supply is down to officer judgement), the police have some discretion in how they deal with the matter. Where a person admits guilt, an officer may apply an Out of Court Disposal (OOCD, some of which give rise to a criminal record), or proceed with arrest.

10.159 A Community Resolution (CR) is a type of OOCD that can be applied for a first offence, or subsequent similar offences as long as 12 months have passed since an individual was last issued with a CR. It does not appear on a criminal record – though, importantly, can be referred to in any future legal proceedings and is eligible for disclosure under an enhanced Disclosure & Barring Service (DBS) check. This means it may show up in, for example, checks conducted as part of pre-employment processes for some job roles.

10.160 Various types of CR are available, including cannabis warnings for those aged over 18 – although NPCC guidance issued some years ago means in practice these are no longer used by most forces. The simplified statutory framework for OOCDs, expected to come into force in 2025 (see chapter 3), will effectively abolish the cannabis warning.

10.161 The issuing police force is responsible for any conditions imposed as part of a CR.[661] These can include apologising or sending a letter of apology to any victim, making some form of reparation such as repairing or paying for any damage done, and/or attendance at services providing rehabilitative support for a range of issues including substance use. The latter can also be delivered via diversion schemes, which we discuss subsequently and which can also include educational courses. Failure to comply with conditions can lead to prosecution.

10.162 The police may also consider a Penalty Notice for Disorder (PND) as an alternative to a CR. These similarly attract no criminal record (though can equally be disclosed under an enhanced DBS check), and are also due to be phased out under the forthcoming simplified OOCD framework.

10.163 Where a person admits possession of cannabis but has recently been issued with a CR, or where police deem a CR inappropriate, they may under the current framework be offered a Simple or a Conditional Caution – both appear on a criminal record.

10.164 The former equates to a formal warning and has no conditions attached, the latter imposes one or more conditions similar to a CR. Simple and Conditional Cautions will in due course be replaced by the Diversionary and the Community Caution under the new framework.

[661] The MPS told us that, typically, for a drug-related CR adults would be referred to drug treatment and young people to the local Youth Offending Team to be informed about the health risks associated with drug-taking.

10.165 Where a person has already been issued with a caution for cannabis possession or similar, or the police do not consider an OOCD appropriate, they may be arrested and then charged, or released under investigation. Prosecution could follow, especially where a person is caught in possession of more cannabis than that which could reasonably be deemed for personal use.

10.166 College of Policing guidance stipulates that a person may only ever be issued with a cannabis warning once.[662] A second possession offence should (currently) result in a PND or other community resolution, and a third in arrest. However, in reality police discretion means that, where they remain in use, more than one warning might be issued, or conversely a person may proceed immediately to arrest despite theirs being a first offence.

10.167 Racial disparities in the likelihood of being S&S mean, while most will not be found in possession of drugs or anything else illegal, black Londoners who carry cannabis are more likely than their white counterparts to end up arrested for its possession, either as a result of multiple stops and progression through escalating options, or because, as it was put to us, officer discretion means they progress straight to arrest.

10.168 Where police deem there to be no public interest in prosecution, a person may instead be mandated to attend a drug-related diversionary activity, which, unlike similar mandated via an OOCD, requires no admission of guilt (an educational intervention, for example). Effectively this is a 'deferred prosecution', as if the activity is completed then no criminal record is sustained.

10.169 The case is then counted as one in which no further action (NFA) has been taken by police (i.e. it is not included as a 'positive action' in performance figures) and can be recorded in HO statistics as an 'outcome 22'. If the activity is not completed, the police will consider subsequent prosecution.[663]

10.170 The concept of outcome 22 is an important part of attempts to reduce wider disparities in outcomes. These result at least in part from the fact that people of colour are less likely to admit guilt, stemming from widespread lack of trust and confidence that they will be treated fairly by the police and justice system.

10.171 However, a refusal to accept responsibility increases the likelihood of arrest and criminal charge because OOCD disposals (with the exception of PNDs, which will be abolished under the new framework) require admission of guilt. As we heard, police often face 'no comment' throughout an interview with someone found in possession of cannabis or some other illegal item, meaning the option of an OOCD is removed.

[662] Possible justice outcomes following investigation | College of Policing *Accessed 14th March 2024.*
[663] See Microsoft Word - Outcome 22 Updated Guidance V3.5 (npcc.police.uk) *Accessed 24th January 2024.*

10.172 Given documented issues with trust, this scenario is more likely among those suspected of cannabis possession from ethnic minority (excluding white minority) backgrounds. This exacerbates racial disparities, risking criminal records and harsher outcomes, despite the fact that evidence suggests any difference in rates of use between ethnic groups is marginal if it exists at all, and certainly does not equate to the disparity seen in rates of S&S.

10.173 And a criminal record, no matter how minor the offence, can limit a person's life prospects. It might restrict employment and travel opportunities, have implications for access to social housing, and in more serious cases threaten access to children. Those given a custodial sentence on conviction are at particular risk of suffering mental and physical ill health and of losing protective ties with family and friends.

10.174 Detailed consideration of the consequences of criminalisation are beyond the scope of our inquiries, but there is a plethora of evidence on the issue.[664] With respect to cannabis, its use is particularly prevalent among adolescents and young adults (chapter 4). A related conviction and ensuing criminal record – even for a relatively minor offence – could hold a person back during a pivotal time in their later working life. This is illustrated in the Lammy Review, which suggests that selling drugs as a teenager could prevent a person from becoming a plumber or licensed taxi driver in later life.[665]

10.175 Arguably, a principal benefit of at least decriminalising possession of cannabis, if not permitting its production, sale and purchase, lies in the potential reduction in those sustaining a criminal record – a disproportionate number of whom come from ethnic minority (excluding white minority) backgrounds. And as was pointed out to us several times, a criminal record can in some cases be more harmful to an individual than use of the drug that led to it.

10.176 Given the importance of outcome 22 in permitting sanction without formal criminal record, in our view its use should be recognised as a 'positive outcome' for the police and recorded as such. In terms of S&S, an NFA outcome suggests either that nothing was found on the person stopped or, if it was, the police took no proactive measure to help that individual desist from future related offending. It seems to us this is no incentive to route someone away from the CJS in appropriate cases of cannabis-related offending.

10.177 It is important to better understand how frequently outcome 22 is used, in what circumstances, and with whom. We therefore recommend **the Home Office, in partnership with the College of Policing and National Police Chiefs Council, should ensure use of outcome 22 is recorded in such a way that allows for i) it to**

[664] Including as discussed in Black, C. (2020). *Review of Drugs: Executive Summary*. Department of Health and Social Care and Home Office, Crown Copyright. Microsoft Word - SummaryPhaseOne+foreword200219 (publishing.service.gov.uk)

[665] Lammy, D. (2017). *The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System*. Ministry of Justice, Crown Copyright. The Lammy Review (publishing.service.gov.uk) *Accessed 25th January 2024.*

be counted as a positive outcome and ii) full analysis of use across forces. This must be implemented in such a way that records do not show up in a basic or enhanced DBS check, given there is no admission of guilt (R23).

10.178 A cannabis-related outcome is not the only possible consequence from S&S. As referred to previously, there is a risk that an individual subject to an S&S may challenge the police officer. This may be heightened where a person has been subject to multiple S&S and, especially when no evidence of wrongdoing has been found, experiences a sense of increasing frustration and injustice. The nature of the encounter may thus escalate, risking arrest for a public order offence or assault, despite there not necessarily being any evidence of the drug possession that first initiated the S&S.

10.179 This is particularly so where there is a perceived lack of respect and professionalism from the officer(s). We heard how some people have been pushed and physically manhandled during an S&S, which can elicit similar in return – which of course raises the likelihood of an associated arrest.

10.180 We have some sympathy, too, with the view that being subjected to multiple S&S's – which, as discussed, is a more common experience among black than white Londoners (para.10.108) – might make a person more cautious and nervous around the police. This in itself risks being interpreted as suspicious and raises the chance of a further stop.

10.181 Risk of escalation can be further heightened by a cannabis-induced state. The sense of paranoia that consumption of the drug can cause may be exacerbated by any prior negative interactions with police, leading to confrontational behaviour. Where interpreted as aggressive and violent rather than cannabis-induced, this in turn risks a heavier-handed police response. While, encouragingly, we heard about instances where police had instead arranged for drug-related support, this was not considered to be common.

10.182 We must acknowledge the challenge for police in accurately identifying, in an uncertain situation, the cause of what may appear to be confrontation. Officers face a risk of physical assault in the course of carrying out their duties and while this does not justify unnecessarily heavy-handed responses, we recognise it may affect how behaviour is interpreted, particularly by those who are less experienced. During the year ending March 2022, 6,172 assaults were recorded against MPS officers and 81 against CoLP officers.[666]

10.183 Physical harm may also, however, be a risk of S&S for the person subjected to the power. While less likely than criminalisation, nonetheless the consequences can be severe, and we heard how the case of Jordan Walker-Brown has influenced recent attitudes to S&S among black communities. The black

[666] See Annex A: Annex: Statistics on the number of police officers assaulted in the year ending March 2022, England and Wales - GOV.UK (www.gov.uk) *Accessed 4th September 2024.*

Londoner, 23 years old at the time, was S&S by MPS officers in 2020. Found in possession of cannabis, he was arrested, charged and subsequently released.[667]

10.184 The following day, he was spotted by police and, on seeing officers leave their vehicle and approach him, he ran away. Conscious of once again carrying a small amount of cannabis (which in itself is testimony to the widely referenced failure of S&S to deter the behaviour), he was fearful of what that would mean given the prior charge.

10.185 Two of the nine officers drew Tasers (conducted energy devices that temporarily incapacitate a person). One discharged his weapon, saying he believed Mr Walker-Brown was carrying a knife. It hit him as he was jumping over a wall, causing him to fall backwards and break his back, leaving him paralysed. He believes he would not have been approached by police on either occasion had he not been a young black man.

10.186 The incident was referred to the IOPC, who concluded that the officer who discharged his Taser may have committed grievous bodily harm. The case was passed to the Crown Prosecution Service (CPS) and the officer faced trial. Despite the not guilty verdict, incidents such as these are writ large in the minds of the public, particularly among black communities, and inevitably serve to further mistrust and fear of the police.

10.187 We look at criminal justice outcomes for cannabis-related offending later in this chapter. But the importance of S&S in subsequent engagement with the CJS cannot be overestimated. The majority of recorded drug offences are for cannabis possession, and the majority of S&S are drug-related, so it is reasonable to assume that S&S is the gateway to the CJS for many of those who end up convicted of cannabis-related offending.

10.188 Given the high rate of NFA following drug-related S&S across London, we find it difficult to disagree with the suggestion that, while there are some policing gains from the practice, these are offset by the risk of negative consequences, particularly for the large majority not found to have broken the law. The disproportionate nature of S&S means black people in London and across the country, many of whom experience drug policing as the norm,[668] are more likely to suffer those consequences.

Police-led diversion schemes for cannabis possession

10.189 Diversion away from the CJS for lower-level offending is increasingly being used as understanding and evidence about the impact of criminalisation (especially of young people), costs to the system and failures of more traditional justice outcomes grows. With respect to drug offences, diversion tends to be utilised in

[667] It is not clear whether an OOCD disposal would have been an option or whether arrest and charge was the only appropriate avenue for the MPS to pursue.
[668] Akintoye, B., Ali, A. & Stevens, A. (2022). The Ongoing Impact on the Racialised Policing of Black Communities. In I. Crome, D. Nutt & A. Stevens (Eds.). *Drug Science and British Drug Policy*, p.201. Waterside Press.

response to possession for personal use, although more minor supply or cultivation offences can also be eligible.

10.190 Usually police-led and often in partnership with specialist services, diversion schemes enable those caught committing minor offences to be routed away from prosecution (whether they admit responsibility or not). Schemes in place for drug offences usually require a person to, for example, attend a health assessment and a harm-reduction or drug treatment service, or drug education provision.

10.191 The approach has its roots in US-led schemes known as Law Enforcement Assisted Diversion (LEAD), which are based on principles of harm reduction, health equity and racial justice. A growing body of evidence from the US, Canada, Australia and elsewhere, alongside emerging findings from UK schemes, suggests diversion may offer a more effective and less costly alternative to formal criminal justice disposals in terms of reducing reoffending, particularly for young people,[669] perhaps in part because they can assist with wider related needs including access to housing and employment.

10.192 It was put to us that currently, young people in London with problematic cannabis or other drug use struggle to find or access appropriate support. As a result, criminalisation following drugs possession can be the only way of triggering a referral for help – sustaining a Youth Offending Order, for example, was cited as one such route.

10.193 But support is not guaranteed due to pressure from wider demands on the health system and related services. What was described as a 'postcode lottery' across the capital with respect to availability and capacity of services exacerbates this. By the time a young person is seen, their problems can have become very acute and require more intensive support.

10.194 Or they reach the age of 18 before being seen and, because their problems may not be deemed sufficiently serious to warrant an appointment within the adult system, they fall between the cracks. The system *'…means young people are set up to fail from the start'.* Diversion schemes differ in approach and application, with some perhaps more successful in ensuring those referred are able to access the stipulated support in a timely way.

10.195 One of the earliest schemes was developed by Durham Constabulary, which set up its Checkpoint programme in 2015.[670] More recently, West Midlands police have partnered with Cranstoun, an organisation that supports adults and young people struggling with, among other things, alcohol and drugs, to implement a pre-arrest diversion model known as 'DIVERT' (originally piloted by Thames Valley Police, in conjunction with Cranstoun).

---

[669] Diversion (justiceinspectorates.gov.uk) *Accessed 25th January 2024.*

[670] See for example Weir, K., Kilili, S., Cooper, J., Crowe, A. & Routledge, G. (2021). Checkpoint: An innovative Programme to navigate people away from the cycle of reoffending – A randomised control trial evaluation. *The Police Journal: Theory, Practice and Principles*, pp.1–28. doi.org/10.1177/0032258X211018774 *Accessed 25th January 2024.*

10.196 Since 2020, West Midlands police default to diverting adults and young people caught in possession of drugs to Cranstoun, who offer assessment, advice, information and referrals to wider drug treatment if appropriate. The pathway forms a community resolution.

10.197 Early evaluation shows some encouraging results, namely:[671]

- Recorded offences for possession of drugs increased by 30%. Initially counter-intuitive, this is likely due to officers not previously recording all such offences (it is now automatic upon referral), and means more people who choose to use drugs receive some kind of positive intervention.
- While attendance is voluntary, 65% of referrals attended at least an initial assessment or harm reduction interview with a drug worker. They would previously have received no advice and may well have ended up with a criminal record, if not subject to prosecution.
- Charges for eligible offences fell by 71%, formal cautions by 80%.
- While formal criminal justice outcomes for drug possession offences fell for all groups, the drop was most marked for African-Caribbean males, from 46% to 13%. Given wider racial disparities with respect to S&S, this is particularly encouraging.

10.198 West Midlands police officers report the automatic referral takes some of the conflict out of S&S encounters, which now lead to arrest only on rare occasions. The scheme is popular with some as not only is referral straightforward, with handheld devices used to immediately divert anyone caught in possession of drugs, officers also save around 4.5 hours of processing time per individual. Others, however, reportedly feel the scheme does not represent a sufficiently legitimate outcome for criminal behaviour.

10.199 We recognise drug-related diversion schemes are not a panacea. Not all those eligible are diverted (and there may be inequities in terms of those who are compared to those who are not), and schemes require appropriate services to be funded and available locally, ideally on a multi-year basis.

10.200 As described to us by several witnesses, the fragmented nature of drug treatment and other services commissioned and provided across London (see chapter 9) mean these conditions are challenging. We heard there are several different schemes and associated funding streams in place across the capital, but lack of central ownership and governance compounds fragmentation of access and delivery.

10.201 This means existing provision lacks consistency and common entry criteria, adding to the wider postcode lottery in terms of how those caught in possession of drugs, including cannabis, may be dealt with. The situation also means there is

[671] https://www.college.police.uk/support-forces/practices/drug-diversion-following-stop-and-search-and-custody-divert-programme *Accessed 25th January 2024.*

a risk that some of those referred into services get little out of them, while in parallel adding to wider caseload pressure.

10.202 However, we are nonetheless encouraged by evidence put to us with respect to the impact of diversion schemes running outside London. A way of avoiding criminalisation but ensuring some consequence for what remains a criminal offence, diversion offers a route to support for those with problematic drug use. Given our findings with respect to gaps in statutory education about cannabis (see chapter 12), schemes potentially offer a valuable way to help users understand risks about which they may otherwise be unaware, in a non-judgemental and destigmatised setting.

10.203 While we were encouraged to learn that a majority of police forces across England & Wales have adopted some form of diversion scheme for those found in possession of illegal drugs, it is disappointing that nothing consistent is yet in place across London. While we recognise several different projects exist, we were unable to reach a clear understanding of precisely what provision they offer, particularly for those caught with small quantities of cannabis.

10.204 We heard the MPS and CoLP can refer those who are found in possession of drugs and subsequently arrested to Turning Point, a national organisation that supports those struggling with (among other things) drugs and alcohol. As we understand it, however, eligibility is dependent upon an offender's home address. The CoLP told us they can refer residents of the City of London and the borough of Hackney only, which is problematic for the force because most of those they find in possession of drugs live in other parts of the capital.

10.205 We were unclear whether the same residency limitations are in place for those found in possession of drugs by the MPS, nor whether there are any additional eligibility criteria governing referral. Whether those referred following S&S, for example, can access appropriate support quickly or whether there are lengthy waits (and what happens in the interim) was similarly not obvious to us.

10.206 We understand evaluation of a separate pilot of a deferred prosecution model (see below), led by the MPS in partnership with Turning Point in north-west London, is also currently underway. Not solely for drug offenders, low-level offenders more widely were offered a four-month, police-supervised 'contract' following apprehension, instead of being formally cautioned or charged. The MPS told us the contract imposes restorative, rehabilitative and occasionally prohibitive conditions on those taking part.

10.207 Initial analysis undertaken by the MPS[672] showed the majority of those referred for a drug-related offence were referred for possession of cannabis (some were also in possession of Class A drugs), although we are unclear what or how any residency or other eligibility criteria for the scheme operated. So far, data suggest

[672] Harber, K, (2024). Unpublished analysis from initial evaluation of the Turning Point Programme. Shared with the London Drugs Commission by the MPS.

the scheme to be associated with reductions in subsequent criminal charges among participants aged under 22. This is positive and as the evaluation progresses, we think it would be useful, given the dominance of cannabis possession offenders in the cohort, to understand more about their experiences.

10.208 Thus **MOPAC, in partnership with the MPS and Turning Point, should explore how this pilot has operated for people referred for cannabis offences, including any identified via S&S** (R24). Findings should inform preparations for roll-out of the new OOCD framework, to ensure treatment and support services across the capital are able to respond appropriately to those diverted into their provision from the CJS.

10.209 One option is to build provision into the government's Project ADDER (Addiction, Diversion, Disruption, Enforcement and Recovery).[673] Extended in 2021 firstly to the London boroughs of Hackney and Tower Hamlets and now in place (since April 2024) across the remaining 30 boroughs, this facilitates a cross-system response to drug use. It aims to get more people into treatment (and supported with, for example, housing and employment) and includes the introduction or expansion of post-arrest criminal justice diversion programmes.

10.210 Core to ADDER is the concept of (post-arrest) deferred prosecution, which means a person caught in possession of Class A or B drugs can, without admission of guilt, enter into a 'contract' whereby they agree to attend one or more sessions with a relevant service provider. Providers are usually contracted by the local authority and failure to engage means the individual is liable for subsequent prosecution.

10.211 Key to deferred prosecution is accurately recording engagement with associated conditions. This means the police must have a record of attendance so they know whether an individual has complied with diversion requirements or should be subject to prosecution.

10.212 It was put to us, however, that providers can be reluctant to disclose the necessary information because they view attendance as confidential – and their contracts may not mandate data sharing. This is, to our mind, unhelpful. **We recommend all service providers contracted to support deferred prosecution referrals should be mandated to inform the police as to whether associated conditions have been met. Alternatively, a third party should be appointed to manage the process** (R25).

10.213 We note too that, while ADDER provides a diversion mechanism for drug offenders, its focus is more serious drug use. This leads us to question whether the extent to which those diverted following cannabis-related offending will have their needs met. More specifically, whether those sanctioned for possession might end up routed into treatment services despite their levels of use posing

[673] About Project ADDER - GOV.UK (www.gov.uk) *Accessed 26th January 2024.*

little risk from a health perspective – pointing once again to the risks of poor coordination of funding and service provision.

10.214 For many such users of cannabis, a lighter-touch warning may be more appropriate – which would also lessen the risk of placing excessive burden on already limited services for those who use drugs more generally (see chapter 9).

10.215 **MOPAC should ensure ADDER evaluators collect data on characteristics of those diverted (including ethnicity), the route of referral (whether via S&S, for example) and the nature of offending (where drug-related, which drugs). The impact on provision of services for those who use drugs more widely should be monitored** (R26). Findings must inform future decisions regarding the suitability of ADDER as a diversion mechanism for those found in possession of drugs.

10.216 The lack of a consistent approach across the capital to route drug offenders away from the CJS, with or without admission of guilt, is concerning and we welcome desires across the MPS and MOPAC to ensure diversion schemes are London-wide.

10.217 We also, however, recognise the challenges inherent in drawing on stretched health-led services to meet needs resulting from criminal justice-administered sanctions – which as we note may not be suitable when services are designed to meet needs of more serious drug offenders.

10.218 We understand a separate diversionary pilot for young adults is planned in one part of the capital. This is welcome, but the exclusion of those aged over 25 is concerning given wider evidence of the positive impact of such schemes across age groups. Certainly, ADDER operates no such exclusion, and neither does the MPS pilot with Turning Point (para.10.206). We also appreciate the importance of piloting and evaluating new approaches but, arguably, diversion schemes for low-level drug offenders are not new and there is evidence of what constitutes good practice.

10.219 We **recommend MOPAC and the London Drugs Forum (LDF), together with the MPS and CoLP, should consider expanding this planned pilot for young adults across London, and across age groups. This should be in partnership with ADDER to ensure join-up and learning, and to reduce the risk of duplication** (R27).

10.220 In addition, it would be useful for the LDF to consider whether a pan-London approach to diversion would be more appropriate than the current seemingly piecemeal model that arguably forms somewhat of a postcode lottery. To this end, we **recommend MOPAC publish a list of schemes currently in place, and the LDF explore whether a city-wide model would be more effective. As a minimum the LDF, in partnership with MOPAC and the MPS, should draw up clear guidance regarding eligibility for diversion schemes** (R28). Eligibility should allow for repeat opportunities for diversion: failure to do so essentially criminalises drug

dependency, given the likelihood that in many cases this drives repeated contact with police.

10.221 We understand the model adopted by West Midlands police in partnership with Cranstoun has been considered by MOPAC and the MPS. In our view, its operation pre-arrest at street level, and the fact that it avoids the need for treatment providers to share information directly with police due to referrals being managed by a third party (i.e. Cranstoun), offer significant benefits. We strongly urge that both elements be given serious consideration as diversion provision in London is developed further.

10.222 We accept, however, that the sheer volume of drug possession offences in London, as well as the way in which health service commissioning currently operates, would inevitably challenge implementation of any such model.

10.223 We heard too about low rates of referrals from the police into diversion schemes (this is a wider issue across the CJS). Whether down to concerns about capacity of schemes, repeat offending or something else is unclear – but for any model to succeed, it requires police engagement alongside available and appropriate services into which eligible offenders may be referred. **Requiring police to specify why they choose not to refer an eligible individual to a diversion scheme would shed light on the use and efficacy of these schemes, and MOPAC should work with the MPS to ensure this happens** (R29).

10.224 The level of treatment and ancillary services required to support those diverted from the CJS is significant and provision is currently patchy. We understand additional investment has been and continues to be provided by central government to bolster drug and alcohol treatment services,[674] but it will take time for this to bear fruit.

10.225 As we discuss in chapter 9, we heard from frontline practitioners and health policy experts how the sector more broadly, never mind those parts focusing on drug-related offending, has been hollowed out after many years of underfunding. It will take time to recruit, train and retain sufficient staff to provide the necessary levels of service, and the same will apply to realising the intention of the new OOCD framework when it goes live.

10.226 The CoLP told us that availability of drug support services is a significant issue, compounded by the fact that each borough commissions services separately for its own residents. Many offenders do not offend in the borough within which they live, so it can be difficult for the force to offer a diversionary route because they do not have a contract in place with a provider in the necessary borough (see para 10.204).

[674] In line with recommendations made by the Independent review of drugs by Professor Dame Carol Black - GOV.UK (www.gov.uk) and the government's subsequent drug strategy From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)

10.227 As a result, the CoLP have, as part of their pilot in preparation for implementation of the new OOCD framework, secured a provider who will signpost eligible offenders to services available in the area in which they reside. These include online courses and e-learning for lower-level drug offenders, such as those found in possession of small quantities of cannabis. This is, however, based on an 'offender pays' model, which may not always be ideal given the economic realities and potential issues with addiction experienced by many of those subject to S&S or otherwise arrested for drug-related offending.

10.228 The force told us that a hardship fund to allow those without means to access the service will be available. While means to pay will be assessed as part of the associated needs assessment, we think there is at least some possibility that those expected to pay will fail to do so. In our view, this is likely to then risk a formal CJS disposal, although the CoLP plan to explore demand for a hardship fund and related issues as part of the pilot, to inform future considerations regarding funding sources and support longer-term solutions.

10.229 Despite outstanding questions regarding the operation and funding of diversion schemes, the principle of diversion instead of criminal sanction for lower-level cannabis offences has a reasonable degree of public support (certainly more so than for offences involving Class A drugs). This would likely be further enhanced by educating communities about how schemes work, and their potential to reduce reoffending and support people to avoid harms associated with criminalisation.[675]

10.230 Pointing out the potential for diversion schemes to route people into drug education and treatment is important as over half the public (54%) have agreed these form appropriate responses to drug possession. In comparison, one-fifth (20%) considered a custodial sentence suitable, with almost half (49%) seeing a fine as fitting punishment.

Arrests for cannabis offences

10.231 During the year to March 2023, 60,013 people in England & Wales were arrested on suspicion of a drug-related offence(s).[676] The MPS were responsible for more than any other force or region (unsurprisingly, given the force comprises very many more police officers)[677], making up 25% (n=15,424) of the total (the CoLP made 343, taking the London total to 15,767). The north-west recorded the second highest number at regional level (n=8,433) and Greater Manchester the next highest at force level (n=3,474).

[675] Crest Advisory (2022). *Reducing flows into the criminal justice system: polling on out-of-court disposals and diversion*. Crest.
[676] See Table A_07, Arrest summary data tables: police powers and procedures, year ending 31 March 2023 (second edition). A*ccessed 14th August 2024.*
[677] See Table 1, Police Workforce, England and Wales: 30th September 2023 – Data Tables. Home Office. Available at Police workforce, England and Wales: 30 September 2023 - GOV.UK (www.gov.uk) *Accessed 4th September 2024.*

10.232 Because they are responsible for the majority of the drug-related S&S made in London, we concentrate in this section on arrests and other outcomes following stops made by the MPS. As the CoLP were able, however, to provide us with a bespoke breakdown of outcomes relating specifically to S&S made on the grounds of suspicion of cannabis-related offending, those figures merit repeating here (see also paras. 10.65–66).

10.233 During the year to June 2023, the CoLP made 1,253 drug-related S&S. These represented 54% of the total number of S&S (n=2,326) made during that period. Of those drug-related S&S, bespoke analysis revealed 65% (n=809) related specifically to cannabis.

10.234 For 16 of those 809 cannabis-related S&S's, no outcome was recorded. In around half (49%, n=393), No Further Action (NFA) was taken. Of the remaining 400 cases, almost half (n=195) resulted in arrest. A further 28% (n=112) ended in a drugs warning, and the remainder (23%, n=93) in some other type of disposal. Meaning of all 1,253 drug-related S&S made that year by the CoLP, 16% ended in arrest specifically for cannabis

10.235 Returning to the MPS, of the 86,062 drug-related S&S made by the force in the calendar year 2023 (as at time of writing), 12% ended in arrest, as shown in Table 6:

Table 6: Outcomes from MPS-led drug-related stop and searches, 2023*

Outcome	n	%
Arrest	10,466	*12*
Community Resolution	10,930	*13*
Penalty Notice for Disorder (PND)/Fixed Penalty Notice (FPN)	3,428	*4*
Postal Charge Requisition/Court Summons	1,769	*2*
Caution	128	*<1*
No Further Action (NFA)	59,341	*69*
Total	**86,062**	**100**

* *Source:* MOPAC Action Plan Data Dashboard | London City Hall

10.236 These figures mask substantial variation by borough. In twelve boroughs, more than 12% of drug-related S&S in 2023 ended in arrest, with the highest proportion in Lewisham, followed by Lambeth (20% and 17% respectively). In contrast, Barking & Dagenham, Havering and Hillingdon made the fewest arrests, at 7%, 9% and 9%.

10.237 Routinely available data do not show how many people are arrested for cannabis as opposed to Class A drug offences. But given its dominance in recorded drug offences overall, it is reasonable to assume the majority of drug-related arrests are associated with cannabis.

10.238 Data released to the Mayor of London[678] by the MPS revealed cannabis was specifically cited in 5,825 arrests made by the force in 2023. While an increase on the 1,047 cannabis-related arrests made in 2022, it is significantly lower than the number of arrests for possession or possession with intent to supply cannabis made by the force in recent years, which in 2020 numbered 17,458 and in 2021, totalled 13,870.[679]

10.239 That said, figures are likely to be an underestimate of the total number of cannabis-related arrests because data recording means the type of drug was not specified in an unknown number of cases. More broadly, the limited data mean determining longer-term trends in arrests (whether numbers of arrests made or numbers of people arrested) specifically for cannabis has not been possible.

10.240 It is not clear how many arrests were initiated by an S&S, nor in 2023 how many were for cannabis possession compared to supply (in 2020, 2021 and 2022, possession accounted for, respectively, 37%, 41% and 46% of all MPS arrests for possession and supply). We think it reasonable to assume, however, based on wider S&S and recorded crime data, that a significant proportion across all years probably resulted from S&S.

10.241 We note too that, during the year to March 2023, the MPS made 15,424 drug-related arrests.[680] Assuming a similar number were made during the calendar year 2023, then the 5,825 cannabis-related arrests conducted that year would comprise almost 40%, i.e. a considerable element of the drug arrest workload for the MPS.

Disproportionality in arrests and subsequent outcomes

10.242 Disparities in criminal justice outcomes begin with inequalities in relation to police contact, most notably through use of S&S.[681] Unfortunately, available data limit the extent to which disparities can reliably be further explored with respect to drug, or cannabis, offending. Routinely published figures do not show how many people from different ethnic groups are arrested for drug offences, never mind for specific drugs, in individual police forces.

10.243 Overall arrest rates, however, show that in England & Wales black people are disproportionately more likely to be arrested than people belonging to any other

---

[678] '*Can you provide data on how many people were arrested for cannabis-related offences in 2023? Please break this down by borough and ethnicity*.' Reference 2024/0080. Cannabis (1) | London City Hall *Accessed 15th March 2024*.

[679] Available at https://www.met.police.uk/foi-ai/metropolitan-police/d/february-2022/cautions-arrests-supplying-possession-of-cannabis-january2020-january2022/ Note that the number of unique individuals arrested will be lower than the number of arrests as some will have been arrested more than once over the course of the reporting period.

[680] See Table A_07, Arrest summary data tables: police powers and procedures, year ending 31 March 2023 (second edition) *Accessed 15th March 2024.*

[681] Stott, C., Radburn, M., Kyprianides, A. & Muscat, M. (2021). *Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review*. Commission on Race and Ethnic Disparities. Available at Understanding ethnic disparities in involvement in crime – a limited scope rapid evidence review, by Professor Clifford Stott et al - GOV.UK (www.gov.uk)

ethnic group. In 2022/23 the rates per 1,000 population stood at 20 for people from a black background, 13 for those from a mixed background, 9 for those of white background, 8 for people from an Asian background and 8 for those from any other group.[682]

10.244 In London, however, we were able to gain a little more insight. In almost half (48%, n=2,480) of the 5,174 arrests made by the MPS in 2023, where cannabis was mentioned on the custody record and ethnicity was stated, the arrestee was black. (Arrests recorded as involving cannabis totalled 5,825 when including those where ethnicity was not stated, see para.10.238.) Just over one-third (36%) of arrests were of a person from a white background (n=1,847).[683]

10.245 Data provided by the MPS in response to an earlier Freedom of Information (FOI) request shed further light.[684] In 2021, white arrestees were more likely to be dealt with via a caution (rather than proceed to investigation) than arrestees from other ethnic groups – see Table 7. (Figures refer to post-arrest cautions but these can be issued without arrest: in 2021, the MPS dispensed a total of 875 cannabis-related cautions).[685]

Table 7: Outcomes of MPS-led arrests for cannabis by ethnicity, 2021

	Caution		Investigation: possession		Investigation: intent to supply	
	n	%	n	%	n	%
White (n=4,635)	250	*46*	3,218	*34*	1,167	*30*
Black (n=5,501)	153	*28*	3,719	*39*	1,629	*41*
Asian (n=2050)	75	*14*	1,311	*14*	664	*17*
Other (n=1,757)	65	*12*	1,217	*13*	475	*12*
Total* (N= 13,943)	**543**	***100***	**9,465**	***100***	**3,935**	***100***

Source: https://www.met.police.uk/foi-ai/metropolitan-police/d/february-2022/cautions-arrests-supplying-possession-of-cannabis-january2020-january2022/

* Excludes cases where ethnicity was not stated. The total number of custody records made out in 2021 where cannabis was noted was 14,423: Cautions = 553; Possession = 9,844; Intent to supply = 4,026.

10.246 In almost 40% of arrests where ethnicity was stated, the arrestee was from a black background, and in 28% of records indicating a caution was dispensed, the

[682] See Table A_04, Arrest summary data tables: police powers and procedures, year ending 31 March 2023 (second edition). *Accessed 14th August 2024.*

[683] See footnote #678. *Accessed 15th March 2024*.

[684] Available at https://www.met.police.uk/foi-ai/metropolitan-police/d/february-2022/cautions-arrests-supplying-possession-of-cannabis-january2020-january2022/

[685] https://assets.publishing.service.gov.uk/media/6466287fe14070000cb6e1ef/out-of-court-disposals-2022.xlsx Included offences of production, supply and possession with intent to supply a Class B drug, and possession of cannabis. *Accessed 30th January 2024.*

arrestee was black. In contrast, while one-third (33%) of arrests were of a person from a white ethnic group, this group accounted for 46% of records ending in a caution.

10.247 Put another way, 5.4% of all cannabis-related arrests of people from a white ethnic group ended in a caution, compared with 2.8% of people from black backgrounds. Thus, white arrestees were almost twice as likely to be cautioned than black arrestees.

10.248 Given the likelihood of being S&S multiple times is higher for black than white Londoners, the lower rate of cautioning is not surprising. Those caught with cannabis on two or more occasions are unlikely to be eligible for a non-arrest outcome (and may be arrested on the first occasion, depending on circumstances and police use of discretion).

10.249 The majority of all groups, however, were investigated for possession or intent to supply cannabis. Here the disproportionality was less marked, i.e. 69% of white (n=3,218) and 68% (n=3719) of black arrestees were investigated for possession, with 25% (n=1,167) and 30% (n=1,629) accordingly investigated for supply.

10.250 While outcomes of specific cannabis-related arrests are unknown, where an investigation was mounted for possession or intent to supply it will either have concluded with NFA or relevant evidence passed to the CPS. They review the case and apply a two-stage legal test: if the evidence is assessed as sufficiently strong to mean a court is more likely than not to find the defendant guilty, *and* it is in the public interest to prosecute, an arrestee will be prosecuted.

Prosecutions, convictions and sentencing for cannabis offences[686]

10.251 The CPS told us the number of prosecutions for cannabis offences has dropped, in line with those for other illegal drugs. In 2010, 10,450 prosecutions were brought in England & Wales where the principal offence was production, supply and possession with intent to supply (PSPWITS) cannabis, with a further 26,422 for possession. By 2022, they had dropped to 5,324 and 12,350 – falls of around 49% and 53% respectively.

10.252 This is not surprising given the role of S&S for drugs, as their numbers fell by 44% across England & Wales between 2010/11 and 2022/23 (from 595,212[687] to 331,856).[688] Notably, there is no evidence to suggest drug use rose over that period. And fewer prosecutions mean fewer convictions: those for PSPWITS fell

[686] Unless otherwise referenced, sources for prosecution, conviction, sentencing and court statistics are at: Criminal Justice System statistics quarterly: December 2022 - GOV.UK (www.gov.uk) All-offence prosecutions and convictions data tool; Outcomes by Offence data tool; Magistrates Court data tool; Crown Court data tool.
[687] Table SS.02, Stops and searches tables (Police Powers and Procedures England & Wales 2010/11) *Accessed 1st February 2024.*
[688] Table SS_03, Stop and search summary data tables: police powers and procedures, year ending 31 March 2023 *Accessed 1st February 2024.*

from 8,230 in 2010 to 5,469 in 2022[689] (a drop of 34%), and for possession from 25,158 to 11,256 (a fall of 55%).

10.253 Despite the falls, however, cannabis-related offences continue to exert significant pressure on court resource, representing 45% of the overall drug prosecution caseload in 2022 (a total of 39,514 drug-related prosecutions were brought that year).

10.254 The CPS suggested that, where a defendant is charged with possession only, it is a first offence and the amount involved is small, they are unlikely to be prosecuted (dealt with instead via an OOCD). Unfortunately, without case file analysis, administrative data alone shed little light on whether any of those who do reach court are first-time offenders or whether aggravating factors, including a history of similar offending, have supported prosecution and any subsequent sentencing.

10.255 All criminal cases (with adult defendants) begin in the magistrates' court, but the nature and severity of the offence determines whether a case is tried there or at Crown Court. Summary offences must be heard in the magistrates' court, either-way offences in either court (subject to a magistrate's decision, although a defendant can choose to be tried by Crown Court jury). Indictable-only offences must be heard at Crown Court.

10.256 Cannabis-related offences are triable either way.[690] Reflecting, however, their relative seriousness, PSPWITS offences are more likely to be heard in the Crown Court than possession offences: in 2022, just under half (49%) of supply offences in England & Wales were sent for trial at Crown Court, with around the same proportion convicted in the magistrates' court. In London, slightly more were heard at Crown Court (53%) and slightly fewer convicted in the magistrates' court (40%).

10.257 In comparison, and as we heard from the CPS, most cannabis possession offences are heard by magistrates: in 2022, only 2% of cases across England & Wales were sent for trial at Crown Court (2.7% in London), with 88% convicted in the magistrates' court.

10.258 A conviction for PSPWITS, not surprisingly, attracts a harsher sentence than possession. As shown in Table 8, in 2022 over one-third of PSPWITS offences attracted a custodial sentence (average length of 16.6 months) and a further

[689] A defendant committed from magistrates' to Crown Court may not have both courts' processes complete within the same year, in which case they would be counted for each stage in the year that the court where it took place completed. This means for a given year, convictions may exceed prosecutions or sentences may not equal convictions. Defendants who appear before both courts may also be convicted at the Crown Court for a different offence to that for which they are counted as having been proceeded against at magistrates' court, where the offence is changed after committal.

[690] See Drug Offences Definitive Guideline (sentencingcouncil.org.uk) *Accessed 1st February 2024.*

third a suspended sentence.[691] In comparison, 2% of those convicted of possession were sent to custody (average length of 1.5 months).

Table 8: Outcomes of convictions for cannabis offences at all courts in England & Wales, 2022

Outcome	Production, supply & possession with intent to supply (PSPWITS)		Possession	
	n	%	n	%
Absolute discharge	2	<1	104	1
Conditional discharge	89	2	2,219	20
Immediate custody	2,074	36	232	2
Suspended sentence	2,053	35	128	1
Community sentence	1,191	21	1,445	13
Fine	303	5	6,081	56
Unknown	43	1	27	<1
Otherwise dealt with	37	1	674	6
Total sentenced	5,792	100	10,910	100

Source: Criminal Justice System statistics quarterly: December 2022 - GOV.UK (www.gov.uk) Outcomes by Offence data tool. Totals may not sum to 100% due to rounding.

10.259 Those given community or suspended sentences are actively managed by the Probation Service (adults) or Youth Offending Teams (young offenders) for the duration of their sentence. Offender managers ensure offenders comply with sentence requirements, which can include unpaid work, observing a curfew or attending a treatment and rehabilitation programme.

10.260 In London, proportionally slightly fewer of those sentenced for cannabis possession (n=3,672) and for PSPWITS (n=1,057) were sent to custody in 2022, when compared with the national average: just under 2% (1.7%, 62 offenders) and around one-third (32%) respectively, with average sentence lengths of 1.1 months for possession and 14.4 months for PSPWITS.

10.261 Overall, 14%, (n=2,306) of the 16,702 cannabis-related offences sentenced in 2022 received an immediate custodial sentence. Any time served in prison has widely documented detrimental effects on the individual, their family (particularly dependents), friendships and communities. Prison exacerbates harms already caused by a conviction, and, while costs to HMPS are dwarfed by those resulting from more serious crimes and thus longer prison sentences, they are not minor (see para.10.289).

[691] A custodial sentence of between 14 days and up to two years is suspended for a specified period. The offender does not go to custody but has opportunity to serve their sentence in the community, in accordance with court-imposed requirements: non-compliance means they will likely be imprisoned to serve the original custodial term.

Disproportionality in prosecutions, convictions and sentencing for cannabis offences

10.262 Racial disparities seen in S&S and arrests not surprisingly flow into subsequent stages of the justice system, most notably for defendants from black backgrounds, who are over-represented at each stage.[692]

10.263 Disparities are particularly marked among those prosecuted and convicted of cannabis offences in London. Despite representing 14% of the capital's population in 2021[693], as Table 9 shows, black Londoners made up 44% of those prosecuted and convicted for possession and just over one-third of those prosecuted (36%) and convicted (37%) for PSPWITS in 2022.

10.264 While at 39% slightly more defendants prosecuted and convicted of PSPWITS were white, far fewer were prosecuted for cannabis possession (28%). As over half of London's population overall was white (54%), this group was therefore under-represented (as were Asian Londoners). For black defendants, the opposite was true.

Table 9: Prosecutions and convictions* for cannabis offences in London by ethnicity, 2022

		Production, supply and possession with intent to supply		Possession	
		n	%	n	%*
White	Prosecutions	327	39	959	28
	Convictions	*329*	*39*	*854*	*29*
Black	Prosecutions	298	36	1,491	44
	Convictions	*310*	*37*	*1,315*	*44*
Asian	Prosecutions	134	16	552	16
	Convictions	*121*	*14*	*493*	*17*
Mixed	Prosecutions	39	5	259	8
	Convictions	*44*	*5*	*213*	*7*
Other	Prosecutions	37	4	119	4
	Convictions	*35*	*4*	*101*	*3*
Total**	Prosecutions	835	100	3,380	100
	Convictions	*839*	*100*	*2,976*	*100*

Source: Criminal Justice System statistics quarterly: December 2022 - GOV.UK (www.gov.uk) Outcomes by Offence data tool. Totals may not sum to 100% due to rounding.
* Some convictions correspond to prosecutions brought in preceding years.
** Excludes cases where ethnicity was not stated. The total numbers of i) prosecutions and ii) convictions for PSPWITS were 1,008 and 989. The total number of i) prosecutions and ii) convictions for possession were 4,340 and 3,798.

[692] See footnote #591, Fig. 1.01.
[693] With 21% Asian, 6% mixed ethnicity and 6% from any other background. Regional ethnic diversity - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk) *Accessed 2nd February 2024.*

10.265 Black defendants are also more likely to have their cases heard at Crown Court. In 2022, 48% of those charged with PSPWITS were tried in the higher court, compared with 42% of white defendants. While the majority of possession offences were heard in the magistrates' court across all ethnic groups, black defendants were almost twice as likely to have their case go to Crown Court than white defendants (2.9% compared with 1.6%).

10.266 At least some of that difference is probably explained by black defendants being more likely than others to choose a Crown Court trial[694] (in 2022, 26% chose to do so, compared with 19% of defendants from a mixed ethnic background, 17% of Asian and other defendants, and 15% of white defendants). The extent to which this holds true for drug offences, specifically cannabis, is unclear, although we have no reason to believe the situation is any different.

10.267 Research suggests many non-white defendants, continuing from a reluctance to admit guilt when found in possession of drugs, do not believe they will receive a fair hearing in the magistrates' court. This can mean they plead not guilty and choose a jury trial, where they feel they will be treated more fairly, despite the higher sentencing powers available at Crown Court if convicted.[695]

10.268 In London, however, there was little difference. Around half of both black and white defendants charged with PSPWIT were heard at Crown Court (51% and 49% accordingly). Just under 3% of both groups charged with possession were transferred to the higher court (2.8% of black defendants and 2.7% of white).

10.269 With respect to sentencing outcomes for offences in 2022, these were broadly similar across ethnic groups,[696] although ethnic minority drug offenders were more likely to be given custodial sentences than those from white (British) backgrounds. White defendants also received on average lower custodial sentence lengths than those from other ethnic backgrounds.

10.270 It is possible this was driven by a higher rate of guilty pleas among white defendants (which tend to result in shorter custodial sentences). Without detailed case analysis, however, the relative role of other factors (including the quantity of drugs involved and the part played by the defendant in the crime) cannot be determined.

10.271 For cannabis offences, the racial disparities seen nationally in sentencing of drug offences overall appear reversed. In 2022, 28% of defendants from a black background who were sentenced for a PSPWITS offence across England & Wales were sent to custody, compared to 34% of white defendants.

10.272 Consider those from the white British group separately, however, and the more usual pattern reappears. Less than one-fifth of that group (17%) received an

[694] See footnote #591.
[695] See footnote #665.
[696] See footnote #591.

immediate custodial sentence for a PSPWITS offence, compared with 76% of defendants from a white non-British background (including white Irish).

10.273 In London the situation was no different. Almost one-third (30%) of black defendants sentenced for a PSPWITS offence received immediate custody, as did 35% of all white defendants. This latter figure, however, masks the fact that 21% of white British offenders were sent to custody compared with 56% of the white non-British group.

10.274 While far fewer custodial sentences were passed for the less serious offence of possession of cannabis, proportionally more black defendants than defendants from any white background were sent to custody in England & Wales (3% and 2% respectively) and in London (2% versus 1%).

10.275 But while fewer white British offenders received custody for cannabis possession than those from a white non-British background nationally (2% compared to 3%), in London the position was reversed. Here, 2% of white British defendants were sent to custody, compared with 1% of white non-British defendants.

10.276 Overall, across England & Wales during 2022, over 2,300 individuals served time in prison for a cannabis offence at some point (n=2,074 for PSPWITS, n=232 for possession). Around one-quarter of the 9,206 custodial sentences handed to those convicted of drug offences that year were therefore in response to cannabis. (The number in custody at any one time for such offences is lower – for example, on 30th June 2024, 33 people were in prison for possession of cannabis).[697]

Cannabis use among those managed by the justice system

10.277 It was put to us that cannabis use among offenders managed by the Probation Service and Youth Offending Teams in London is rife. Around 7,000 offenders among a caseload of c.22,000 had, we were told, reportedly admitted some use of the drug when their individual needs and risk of further offending were assessed.[698]

10.278 Assessments and discussion with offenders highlight how frequently cannabis is part of daily life and, as it was put to us, increasingly so over recent years. This is across the caseload, not just among those convicted of cannabis offences. Key drivers are reportedly easement of mental health problems and anger-related issues, particularly for younger offenders, which chimes with evidence we heard elsewhere (see chapter 4).

[697] See Table_1_A_11, Annual Prison Population 2015-2024. Available at Offender management statistics quarterly: January to March 2024 - GOV.UK (www.gov.uk) *Accessed 5th September 2024.*
[698] The primary tool used with offenders aged 18 and over is known as the Offender Assessment System (OASys). The tool assesses needs and risks in eight domains: accommodation; education, training and employment; relationships; lifestyle; drug misuse alcohol misuse; thinking and behaviour, and attitudes.

10.279 Those working with offenders in the community reported that many have been using the drug since a young age, with early-years trauma and frequent exposure to violence part and parcel of their lives. Regular use of high-potency cannabis is normalised, mirroring much of what was put to us more broadly about cannabis use, particularly among young people across London's communities.

10.280 Despite perceptions of self-medication among some offenders who use cannabis, those who manage them felt it has a detrimental effect. Particularly for regular users, the drug was considered to be at least partly responsible for isolating them still further from law-abiding society, threatening compliance with sentence requirements and compounding wider needs.

10.281 Some suggested that making cannabis more easily available through a relaxation of the legal framework would jeopardise attempts to successfully rehabilitate those for whom life is already fraught with challenge. On the other hand, its illegal status arguably continues to expose them to associated risks that threaten broader compliance with the law and, more specifically, individual sentence requirements.

10.282 Practitioners reported that cannabis use can seriously threaten an offender's capacity and motivation to engage with and meet the terms of a suspended or community sentence. And the stakes are high. Persistent failure for those on a suspended sentence is likely to mean serving the original sentence in custody. Those on a community sentence risk additional requirements, sentence extension or, in the most serious cases, revocation in favour of a custodial sentence.

10.283 However, we heard how difficult it is for offender managers working in London to secure mental health and addiction support for those on their caseload struggling with cannabis use. As we discuss in chapter 9, mental health services in the capital (and across the country) are hugely oversubscribed: funding and provision has not kept pace with rising demand, particularly since the Covid-19 pandemic.[699]

10.284 Even where services are available, funding to commission them is limited. We heard offender management tends to prioritise those with addiction to more serious drugs, particularly heroin, due to the need to focus resource on the high-harm/high-risk caseload, i.e. offenders most likely to commit a serious further offence.

Demand on police and justice system resources

10.285 A substantial amount of policing and wider criminal justice (and Border Force) resource goes into tackling the production, supply, retail and consumption of

[699] Also reported in Black, C. (2020). *Review of Drugs (parts 1 & 2)*. Home Office. Available at Independent review of drugs by Professor Dame Carol Black - GOV.UK (www.gov.uk) *and* Home Affairs Committee (2023). *Drugs: Third Report of Session 2022–23*. House of Commons. Available at Drugs - Committees - UK Parliament

illegal drugs. Based on 2010/11 prices, the annual cost of UK drugs enforcement was estimated in 2013 to be £1.1 billion,[700] of which £370 million were costs to policing, £680 million were borne by the CJS and £70 million by the Border Force.

10.286 In 2024 prices[701] this equates to an overall price tag of over £1.65 billion (including £554 million in policing costs, £1 billion CJS costs and £105 million for Border Force). And given its dominance in recorded drug crime, cannabis-related enforcement activity is likely to drive a substantial proportion of these costs.

10.287 Costs related specifically to dealing with cannabis sales and consumption have also been estimated for policing, criminal justice procedures and the implementation of sentencing following convictions for associated offences (using 2010 prices).[702] In 2024 prices, these equated to over £157 million for the total cost of cannabis policing alone.

10.288 The cost of administering a formal cannabis warning in 2010 was estimated at £150, or £224 in 2024 prices. If all 96,628 cannabis possession offences recorded in the year to September 2023 had been dealt with by a formal warning only, the cost to police would be around £21.6 million. In reality, of course, many proceeded further into the CJS with costs increasing at each stage.

10.289 The most expensive criminal sanction is a prison sentence. In 2022, the average custodial sentence length for cannabis possession offences was 1.5 months. For PSPWITS offences, it was 16.6 months. Assuming all those thus sentenced (232 for cannabis possession, 2,074 for PSPWITS) were released from custody at the halfway point as per sentencing guidelines,[703] this means offenders convicted of possession spent around 3 weeks in prison, and those convicted of PSPWITS around 34 weeks (8 months, 12 days).

10.290 The average cost of housing one person in prison for one year is almost £50,000 (£47,434 based on 2021–22 prices),[704] so one week costs HM Prison Service (HMPS) around £900.[705] The cost of three weeks in prison for cannabis possession is therefore £2,736, and the cost of 34 weeks in custody for a PSPWITS is around £31,000.

10.291 Which equates to annual costs of around £635,000 for imprisoning those convicted of cannabis possession, and around £64 million for those convicted of

[700] Mills, H., Skodbo, S. & Blyth, P. (2013). *Understanding organised crime: estimating the scale and the social and economic costs. Research Report 73*. Home Office. Crown Copyright. Available at Understanding organised crime: estimating the scale and the social and economic costs (publishing.service.gov.uk)
[701] Using Inflation calculator | Bank of England *Accessed 5th September 2024.*
[702] Bryan, M., Del Bono, E. & Pudney, S. (2013). *Licensing and Regulation of the Cannabis Market in England & Wales: Towards a Cost–Benefit Analysis*. The Beckley Foundation and the Institute for Social and Economic Research University of Essex.
[703] Determinate prison sentences – Sentencing (sentencingcouncil.org.uk) *Accessed 6th February 2024.*
[704] Costs per prison place and costs per prisoner 2021 to 2022 summary (publishing.service.gov.uk) *Accessed 6th February 2024.*
[705] £912.20 per week.

PSPWITS, making the total cost to HMPS per year of cannabis-related offences almost £65 million.

10.292 There are also, of course, costs associated with other sentencing outcomes, particularly community sentences. Although these will vary according to the nature and number of conditions attached, they are generally dwarfed by costs of imprisonment.

10.293 Then there are the human costs of custody. Very short prison sentences are widely recognised to provide no opportunity for rehabilitative or substance abuse work. They serve solely to punish and around 60% of adults sentenced to six months or less in custody reoffend within a year of release.[706] The detrimental impact of imprisonment and a prison record on family and friendship ties, employment (current and future) and mental health, are well known.

10.294 Locking up those convicted of cannabis possession offers, in our view, no meaningful benefit to anyone, instead causing significant harm to those imprisoned. While we recognise that aggravating factors (including a prior record of similar convictions) may mean a magistrate or judge feels it necessary to impose the harshest of sentences, our view is that any period in custody is too harsh relative to the offence of possessing cannabis sufficient for personal use.

10.295 When it comes to PSPWITS, we similarly consider imprisonment of over one-third of those convicted to be a poor use of prison places, which are in increasingly short supply.[707] While a much greater proportion of those convicted of more serious Class A PSPWITS offences were sent to custody in 2022 (69%, n=5,907, average sentence length 50.8 months), in our view cannabis poses significantly less risk of both individual and societal harm. We are unconvinced that one-third of PSPWITS offences are serious enough to warrant a custodial sentence.

10.296 Where non-medical cannabis use is at least decriminalised, individuals found in possession of the drug for personal use no longer face sanction and associated consequences of criminalisation. Demand on justice system resources inevitably falls as a result. (Where legalised, it falls more significantly, although arguably this might be offset by increased demand elsewhere, on health services for example, see chapters 7 and 8).

10.297 It is undeniable that not subjecting hundreds of thousands of people every year firstly to S&S on suspicion of cannabis possession, then to arrest, charge, prosecution and, where convicted, a criminal sentence, would free up CJS agencies to concentrate on more serious crime – as demonstrated in the Lambeth 'experiment' (see chapter 4). The effective de-penalisation of

[706] Table C2a, Proven reoffending tables (3 monthly), July 2022 to September 2022. Available at Proven reoffending statistics: July to September 2022 - GOV.UK (www.gov.uk) *Accessed 5th September 2024.*
[707] As at 30th August 2024, the prison population in England & Wales stood at 88,350. Operational capacity was 89,543. See Population Bulletin. Available at Prison population: weekly estate figures 2024 - GOV.UK (www.gov.uk) *Accessed 5th September 2024.*

possession of cannabis for personal use across the borough for a period of time allowed police to reallocate resources elsewhere.

10.298 That said, jurisdictions that have adopted a less stringent approach to non-medical cannabis than the UK arguably do not have justice systems that became awash with resources. Whether savings are genuinely cashable remains a significant question.

10.299 Indeed, one estimate (albeit a decade old) suggested financial benefits to the CJS of a fully regulated market (i.e. where production, distribution/supply and sale are legalised alongside possession) would be relatively modest. Inclusive of savings to policing, court procedures and custody and community sentencing, alongside tax on earnings lost during incarceration, the estimated total was around £300 million (in 2009 prices).[708] Slightly more recent analysis estimated annual savings inclusive of both criminal justice and health expenditure would be approximately £300 million.[709]

10.300 On the other hand, while legalisation may not offer huge financial benefits to policing and the CJS, neither, it seems to us, does it materially increase pressures with respect to wider justice considerations. Crime rates do not skyrocket following introduction of more permissive approaches, and research has reported little evidence of drug-induced crime committed by people who use cannabis. One analysis reported only a small amount of volume crime (acquisitive and violent) could be attributed to activities of those involved in supplying cannabis.[710] We think it unlikely this would change with any shift in the legal framework.

Legislative interplay: the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016

10.301 To our mind, it is a quirk of legislative timelines that natural (botanical) cannabis is controlled in the MDA at all (see chapter 2 on the history of how cannabis came to be scheduled under dangerous drugs legislation in the first place). Had more recent legislation, namely the Psychoactive Substances Act 2016 (PSA),[711] existed when the MDA was enacted, we are confident this would have been viewed as a more appropriate vehicle of control.

10.302 The PSA, an attempt to end sales of what were known as 'legal highs', responded to evidence of the potential of such substances (synthetic or natural) to cause various health and social harms. It prohibits production, sale and supply (including possession with intent to supply) of any psychoactive substance not otherwise exempt (see para.10.307). If convicted, an individual may face up to seven years in prison, an unlimited fine, or both.

[708] See footnote #702, p.104.
[709] Snowdon, C. (2018). *Joint Venture: Estimating the Size and Potential of the UK Cannabis Market*. IEA Discussion Paper No.90, p.39. Available at iea.org.uk
[710] See footnote #702.
[711] Psychoactive Substances Act 2016 (legislation.gov.uk)

10.303 The PSA does not, however, prohibit possession of psychoactive substances (except where a person is in a custodial setting). One of the reasons for this, it was put to us, was the widespread use of legal highs at the time. Had possession become illegal, it would have risked criminalising very many people. Indeed, during passage of the PSA, the responsible Minister noted in Parliamentary debate that the government did not wish to criminalise individuals for possession of psychoactive substances.[712]

10.304 We think this applies equally to the use of cannabis. In widespread use, its inclusion in the MDA means many people in possession of small amounts risk what can be distressing and even harmful interactions with law enforcement, irrespective of whether a CJS sanction (which can include prison) results. Moreover, based solely on suspicion, many more people not in possession of cannabis are liable to similar interactions.

10.305 We are not in favour of sending people to prison where their only or principal offence is possession of cannabis. On the basis of evidence put to us, we are clear that use of the drug carries some risks, but remain unconvinced those are sufficiently widespread to justify the sentencing options available while it remains under the MDA. In this, we agree with the view expressed in the Runciman Report.[713]

10.306 We therefore consider the PSA to be a more appropriate vehicle through which to control the use of natural cannabis for non-medical purposes in the twenty-first century. **Natural cannabis should be removed from the MDA, meaning as a psychoactive substance it would fall under the auspices of the PSA** (R30).

10.307 We are confident that cannabis meets the definition of a psychoactive drug, as set out in s.2 of the PSA, namely:

> *2. Meaning of "psychoactive substance" etc*
>
> *1) In this Act "psychoactive substance" means any substance which:*
> *(a) is capable of producing a psychoactive effect in a person who consumes it, and*
> *(b) is not an exempted substance (see section 3).*
>
> *(2) For the purposes of this Act a substance produces a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system, it affects the person's mental functioning or emotional state; and references to a substance's psychoactive effects are to be read accordingly.*

[712] Mike Penning MP, Minister for Policing, Crime & Criminal Justice: Psychoactive Substances Bill [Lords], vol. 600, 19 October 2015, c.737. Psychoactive Substances Bill [Lords] - Hansard - UK Parliament *Accessed 26th April 2024.*
[713] See footnote #558, chapter 7, para.37.

10.308 In s.2(1b), section 3 refers to exempt substances listed in Schedule 1. Included are medicinal products, alcohol, nicotine, tobacco, caffeine and food – so long as they do not include any psychoactive ingredient. Schedule 1 also includes controlled drugs (within the meaning of the MDA 1971), making natural cannabis and synthetic equivalents (namely synthetic cannabinoid receptor agonists, SCRAs) currently exempt.

Implications of bringing natural cannabis under the Psychoactive Substances Act 2016

10.309 Removing natural cannabis from the MDA would bring it under the purview of the PSA. This would, we think, go some way towards reducing (though not eliminating, as evidence elsewhere indicates, see chapter 7) the disproportionality in policing felt particularly by black communities across London. Because the PSA does not prohibit possession of psychoactive substances, the use of S&S solely on suspicion of possession of cannabis would no longer be permissible.

10.310 Undoubtably matters of disproportionality are a symptom of wider issues, as discussed by Baroness Casey[714] and others. We do not consider this recommendation to be the solution per se but think it would be a good start. Indeed, as one witness expressed, were possession of cannabis no longer a cause for S&S it would *'…not [be] a panacea but would go a long way towards repairing some of the damage'*.

10.311 Treating cannabis within the law in this way would also help ease disparities between those who can and those who cannot afford to purchase legally prescribed medical cannabis for relief of symptoms of ill health.

10.312 Production, distribution/supply, sale and importation/exportation of natural cannabis would, under the PSA, remain illegal activities. However, the maximum sanctions for associated offences under this legislation compared with the MDA would, in our view, be more commensurate with the risks posed by cannabis relative to other controlled drugs. Synthetic cannabinoids would remain wholly controlled by the MDA, reflecting their increased risk of harm.

10.313 In making this recommendation we have borne in mind the levels of public support for alternative legal approaches to non-medical cannabis (see chapter 6), set against a dislike of public consumption of the drug.

10.314 We find little evidence to suggest moving control of cannabis from the MDA to the PSA would cause use to rise overall.[715] (See also para.7.157). Put another way, we agree with the suggestion made by the ACMD that there is little evidence of use reducing as a result of prohibition of possession.[716]

[714] See footnote #606.
[715] See also discussion in Stevens A., Eastwood N. & Douse K. (2024). In defence of the decriminalisation of drug possession in the UK. *Drug Science, Policy and Law, 10*. doi:10.1177/20503245241239200
[716] UK drug advisers recommended decriminalising possession in 2016, leak reveals | Drugs policy | The Guardian *Accessed 26th April 2024.*

10.315 We consider it unlikely that levels of public consumption would materially change, although acknowledge this is a risk. It is therefore important to ensure as far as possible that cannabis consumption does not further interfere with, or cause irritation to, the wider public. We therefore **recommend local regulations (byelaws) should be deployed to prohibit and therefore prevent consumption of cannabis in public spaces, including parks, squares, beaches and pedestrian pavements** (R31).

10.316 Moreover, ensuring the production, supply and sale of cannabis remain illegal continues to allow police the power to address related behaviours such as dealing. As was put to us, particularly where this takes place in public spaces it can adversely affect perceptions of individual and community safety.

10.317 We considered whether reclassifying cannabis within the MDA would be more appropriate and concluded that we do not wish to reopen this debate. Having been previously reclassified as a Class C drug, in 2009 cannabis was moved back to Class B, where it has remained since despite calls for it to be reinstated in Class C. While we consider Class C more appropriate given risks of cannabis relative to other drugs (death due to toxicity is, for example, negligible), as long as it remains listed anywhere in the MDA then two key issues remain.

10.318 Firstly, the possession of cannabis remains a criminal offence and, due principally to application of S&S powers, this aspect of the law continues to be felt disproportionately, particularly by black communities. We heard time and again how badly the expectation and experience of S&S affects both individuals and wider communities across London.

10.319 And secondly, where a person who uses cannabis is caught carrying small quantities, there is a chance – albeit slim in most cases – that prosecution and even prison might follow. While the maximum custodial sentence for possession of Class C drugs is two years rather than five for Class B,[717] as above we consider any prison sentence a disproportionate sanction for personal possession. More broadly, risk of prosecution and potentially prison clearly has little deterrence effect given widespread use of cannabis.

10.320 Reclassifying cannabis as a Class C drug would, in our view, do very little to address either of these consequences of the current law, which can pose in some cases considerable risk of harm to those affected.

10.321 Furthermore, retaining cannabis within the MDA compounds complexities with respect to its medical use. If found in possession, those with a prescription (see chapter 11) can avoid police action (as long as they are not smoking their prescribed medication, which remains a criminal offence).[718] Those who find

[717] See s.5 of the MDA 1971, available at Misuse of Drugs Act 1971 (legislation.gov.uk) *Accessed 25th April 2024.*
[718] See s.16A(3) of the Misuse of Drugs Regulations 2001 as Amended by Regulation 4 of the Cannabis Regulations 2018 and s.18(1) of the MDA 1971.

cannabis alleviates symptoms of ill health but who, because they cannot afford to access it through legal channels, instead resort to the illicit market, do not have that protection.

10.322 We have also had regard to conclusions drawn in recent years by the United Nations (UN), World Health Organization (WHO) and International Narcotics Control Board (INCB), namely that criminalising possession of cannabis (or any illicit drug) is not only disproportionate but fails to stem use. They, too, refer to the harm that criminalisation causes to life chances, as well as the distress and trauma of S&S and arrest, and associated detrimental impacts on how people view the police and engage with them in the future.

10.323 Relatedly, we recognise that, if no longer criminal, a mechanism must be put in place to prevent the disclosure of prior criminal records of those who have sustained an historic caution or conviction for cannabis possession. This means what was categorised as an offence at the time will no longer be disclosable.

10.324 While not as comprehensive as expungement (adopted elsewhere, see chapter 7) because the record is not deleted, we consider the most expedient way of preventing disclosure to be adaptation of the existing system. This prevents a caution or conviction being revealed in eligible circumstances. Current disclosure rules mean that cautions and convictions for certain offences are 'protected', meaning they will not be disclosed after 6 years in the case of a caution and 11 years where there is a conviction (subject to eligibility criteria). We **recommend the regime governing disclosure of criminal convictions should be amended so that cannabis possession offences are protected from disclosure, regardless of the date of offence** (R32).

10.325 And of course, criminalisation further stigmatises those who choose to use drugs, which may deter help-seeking behaviour among those in need of treatment and support.[719] We acknowledge that, in some cases, the justice process can route those in need into such services (where they exist), but consider that, if self-referral no longer required admission of illegal drug consumption because possession was decriminalised, uptake would be higher.

10.326 Recognition of these considerations is leading to a global shift in how drug possession for personal use is viewed and responded to. A total of 31 UN agencies (under the Chief Executive Board of the UN, which represents all UN agencies including the United Nations Office on Drugs & Crime, UNODC) have now signed up to a common position first articulated in 2019, which calls on member states to consider decriminalisation and adopt alternatives to arrest following an instance of drug possession.

[719] For example, less than one-third (29%) of 1,470 UK students in higher and further education surveyed about drugs reported feeling confident to disclose use to their institution without fear of punishment. *Students Organising for Sustainability UK, Students and Drugs Survey 2020–21 (2021)*, p.41. Students and Drugs Survey - Research | SOS-UK *Accessed 14th March 2024.*

10.327 To our mind, treating cannabis under the PSA rather than the MDA represents a reasonable response both to this call and to issues specific to the UK context. Our proposal is also, we believe, in line with advice submitted to government by the ACMD towards the end of 2016 (which remains unpublished). That, too, highlighted the inequitable way in which drug possession more broadly is treated in the MDA as compared to the PSA.[720]

10.328 We acknowledge it is not a perfect solution to addressing other harms associated with prohibition. Issues related to violence and exploitation, inherent in aspects of the illicit drug trade, remain. As do the stigma associated with use of what otherwise remains an illegal drug, and the risk of consumption of contaminated product not subject to regulation and quality controls. We accept, too, that any potential to realise economic benefits associated with the legalisation of production, supply and sale remains out of reach.

10.329 That said, in our view the extent of such benefits, net of any costs connected with, for example, increased demand on public health, remains unclear. And while demand on police resources would reduce further (beyond those associated with no longer criminalising possession of small quantities of cannabis) and some savings would be afforded to the CJS, to what extent, and whether these would be cashable, similarly remains unclear.

10.330 Thus, we do not go so far as to recommend wholesale legalisation, for reasons that are explored in more detail elsewhere in our report. Principal among these is what we consider likely to be a heightened risk for some people, in some circumstances, of adverse health consequences of cannabis use – particularly where use is frequent and involves high-potency forms of the drug.

10.331 Until evidence from elsewhere is more conclusive as to the impact of legalisation on that risk, we consider removing cannabis from the MDA to allow it to be controlled under the PSA to be, for now, the most appropriate way of addressing some of the more significant harms we find associated with the current legal framework in this country.

10.332 There is one further related matter to which we have given thought, which is the somewhat contradictory position that no longer criminalising cannabis possession, while continuing to treat production and supply as criminal offences, creates: people who choose to use the drug remain reliant on the illegal market, with all the risks of access that this entails. The public also recognise this tension.[721]

10.333 One solution, which falls short of legalisation but might go some way to addressing the issue, is to permit those who wish to, and are able, to cultivate a very small number of cannabis plants at home. This has particular merit for those

[720] See footnote #716. Accessed *26th April 2024.*
[721] See footnote #11.

who find the drug alleviates symptoms of ill health but who cannot afford the high costs generally associated with its acquisition (see chapter 11). We think it is a measure that merits consideration, irrespective of the position adopted by government with respect to wider legalisation.

10.334 That said, we do not recommend the law on home cultivation be reformed as yet. Instead, we **recommend that central government explore the possibility of permitting limited home cultivation, drawing on evidence from jurisdictions elsewhere that allow it (such as Washington D.C.). But home cultivation should not be legalised until such time as there is clear evidence it significantly reduces connection with illegal suppliers, and has public health benefits** (R33). A better understanding of whether the practice reduces demand for product offered by illegal dealers, without simply creating a parallel market through over-production, would be valuable. In future, the legal definition of cannabis production could be amended to exclude limited home cultivation.

11. CANNABIS FOR MEDICAL PURPOSES

While not initially within scope of our inquiries, as we progressed the importance of UK law regarding medical cannabis, its recent history[722] and the implications for legalisation of non-medical use became increasingly clear. We welcome coverage of the subject in the recent report on drugs issued by the Home Affairs Committee (HAC)[723] and, while we go into more detail, our findings broadly align with theirs in this area.

We begin this chapter by setting out how the current law regarding use of cannabis for medical purposes was arrived at. We then explain the different categories of cannabis-based medical products that may be prescribed for eligible patients, by whom and for what kind of physical and mental health conditions.

We look at why the NHS is more limited in prescribing unlicensed cannabis-based medicines than the private health sector, as little seems to have changed since a review five years ago of barriers to access via NHS prescription[724]. We also explore implications of the way the system is structured for those who find cannabis alleviates their symptoms. This includes costs, as well as the risk of criminal sanction faced by those struggling to secure an NHS prescription but who cannot afford a private prescription, meaning they may turn to the illicit market.

We finish by describing the medical cannabis industry, the supply chain, and several operational challenges. Establishment of a medical industry is an important part of development of legal non-medical markets, as it provides infrastructure, knowledge and operational capability to meet demand. Indeed, expansion of the market in Germany, where medical cannabis has been legal since 2017, likely played a role in advancement of recent debates in the country regarding legalisation of non-medical cannabis (see chapter 7).

A brief history of cannabis used for medical purposes in the UK

11.1 As set out in chapter 2, cannabis has been used around the world for millennia for a range of purposes, including to treat pain and various medical (physical and psychological) ailments. Its use in this regard is well documented and cannabis-based products were legally available in the UK, via the NHS, until 1971 (although the drug had not, apart from a brief period of popularity in the late nineteenth century, been in widespread medical use).

[722] For a detailed synopsis see 'Accessing Cannabis-Based Medicinal Products, 2009–21' (chapter 8) in Taylor, S. (2022). *Remedicalizing Cannabis: Science, Industry, and Drug Policy – Intoxicating Histories*. McGill – Queen's University Press.
[723] Home Affairs Committee (2023). *Drugs: Third Report of Session 2022–23*. House of Commons, chapter 8. Available at Drugs - Committees - UK Parliament *Accessed 29th September 2023.*
[724] NHS England & NHS Improvement (2019). *Barriers to accessing cannabis-based products for medicinal use on NHS prescription: Findings and Recommendations*. Gateway Reference number: 000842. Available at https://www.england.nhs.uk/wp-content/uploads/2019/08/barriers-accessing-cannabis-based-products-nhs-prescription.pdf *Accessed 5th August 2024.*

11.2 At which point, the Misuse of Drugs Act 1971 (MDA, 'the Act') came into force and cannabis for any purpose (medical or non-medical/recreational) became a Class B controlled substance, meaning it was illegal to possess, supply, produce or import/export. Its classification meant it was considered to have *'no known or limited medical use'*, thus ending medical prescriptions for cannabis. This mirrored the designation of cannabis in the United Nations 1961 Single Convention on Narcotic Drugs (ratified in the UK in 1964, amended by the 1972 protocol, and hereafter 'the Convention') as having *'extremely limited medical or therapeutic value'*.

11.3 Article 2.5 (b) of the Convention, however, allowed governments the power to permit the prescription of cannabis and cannabis resin products without renegotiation of the international conventions, where they were satisfied that '*prevailing conditions… render it the most appropriate means of protecting the public health and welfare…'*.[725]

11.4 The UK, however, was not at that time satisfied this was the case and natural cannabis and its extracts remained prohibited for both medical and non-medical use. A manufactured, synthetic cannabinoid, however, which mimics the effects of THC, the principal psychoactive compound found in natural cannabis, was permitted. Nabilone was duly licensed in 1982 for hospital-based treatment of chemotherapy-related nausea, where a patient was deemed unresponsive to other treatments.[726]

11.5 The Runciman Report[727] details why cannabis in its natural plant form had previously been considered unsuitable for medical use. Having, however, assessed the various perspectives and their underpinnings, and considered findings from several other reviews, the authors concluded there was in fact evidence of therapeutic benefit for people with certain serious illnesses, and that these benefits outweighed any potential harm (to the individual).

11.6 Accordingly, they agreed with the recommendation from the House of Lords Select Committee on Science and Technology in 1998[728] that cannabis and cannabis resin be moved from Schedule 1 to Schedule 2 of the Misuse of Drugs Regulations 1985 (which allow changes to the classifications or scheduling of drugs listed in the MDA 1971).

11.7 Had the government accepted that recommendation, it would have permitted the possession of cannabis for medical purposes, with doctors able to prescribe, albeit as an unlicensed medicine, and pharmacists able to supply.

---

[725] FINAL ACT OF THE UNITED NATIONS CONFERENCE (unodc.org) article 2.5 (b) p.3. *Accessed 6th September 2023.*

[726] House of Lords (1998). Science and Technology Ninth Report: Chapter 5 – Medical Use of Cannabis and Cannabinoids: Review of the evidence, para.5.11, Box 4. Available at House of Lords - Science and Technology - Ninth Report (parliament.uk) *Accessed 1st August 2024*.

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

[728] See footnote #726. *Accessed 25th September 2023.*

11.8 Notably, a report from the British Medical Association (BMA) around the same time also recommended specific cannabinoids be rescheduled for medical prescription. Crucially, it connected that with the need for further understanding, recommending that impacts on receiving patients should be monitored long-term and research into potential therapeutic effects of cannabis on specified conditions be undertaken.[729]

11.9 The government, however, rejected the recommendation from the Select Committee, leading the Runciman Report to issue the same recommendation, alongside another calling for cannabis to be transferred from Class B to Class C of Schedule 2 of the MDA. In recognition of the time this would likely take, the report also recommended creation of a *'defence of duress of circumstance on medical grounds for those accused of possessing, cultivating or supplying cannabis'.*[730]

11.10 They had thus accepted evidence of the medical relief that cannabis was considered to bring to some serious health conditions, and sought to protect users in advance of a change to the drug's legal status.

11.11 Nothing changed, however, until 2010, when the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK licenced a prescription-only cannabis-based medicine (in the form of an oral spray) for treatment of spasticity resulting from multiple sclerosis (MS).[731] Nabiximols – commonly known by the brand name 'Sativex®' – contained both of the two principal active elements in botanical cannabis, namely delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).[732]

11.12 However, the National Institute for Health and Care Excellence (NICE) believed Sativex® offered poor cost-effectiveness, meaning the NHS resisted funding its prescription for qualifying patients. It was not until 2014 that the NHS in Wales agreed to fund Sativex® for MS patients, and some years later that it became available on the NHS in England, Scotland and Northern Ireland (see next section).

11.13 So, until 2018 cannabis remained largely prohibited for both non-medical and medical use in the UK. Continued to be listed as a Schedule 1 drug in the Misuse of Drugs Regulations (MDR) 2001,[733] it was thus deemed – with the exception of Sativex®, which had been reclassified as a Schedule 4 drug – to have no therapeutic value.

[729] British Medical Association. (1997). *Therapeutic Uses of Cannabis.* Harwood Academic Publishers, UK.
[730] See footnote #727, para.68, p.113. *Accessed 25th September 2023.*
[731] For detailed background see Crowther, S.M., Reynolds, L.A. & Tansey, E.M. (Eds) (2010). *The Medicalization of Cannabis*. Wellcome Witnesses to Twentieth Century Medicine (40). London: Wellcome Trust Centre for the History of Medicine at UCL.
[732] See chapter 4 for brief description of components of botanical cannabis.
[733] The Misuse of Drugs Regulations 2001 (legislation.gov.uk)

Recent changes to the status of cannabis for medical use in the UK

11.14 In 2018, an important shift took place with respect to acceptance of the potential medical value of cannabis – at least in terms of a limited number of severe health conditions. A two-part review commissioned by the Home Secretary (the Home Office, HO, has responsibility for drug policy and licencing in the UK)[734] concluded evidence had emerged of the medicinal benefit of cannabis for certain conditions, and recommended cannabis-based products for medicinal use (CBPMs) of appropriate medical standard be moved from Schedule 1 to Schedule 2 of the MDR 2001.

11.15 The impetus for this review originated, at least in part, in an ongoing high-profile publicity campaign that began earlier in 2018.[735] This focused on the plight of two children suffering rare forms of very severe epilepsy that cannabis-based medication (of a different type to Sativex®) procured from outside the UK had been alleviating. Their parents had attempted to bring this into the UK from Canada and the Netherlands (where CBPMs were legally available), whereupon it had been confiscated at the border.

11.16 The review led to the rescheduling of CBPMs via regulations enacted in November 2018 and set out in the Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018.[736]

11.17 The move permitted, in certain circumstances, the prescribing of cannabis-based products that fall into one of three categories, depending on their scheduling under the MDR 2001 and whether they have received marketing authorisation from the MHRA (or its European equivalent, the European Medicines Agency). A follow-up report commissioned by the HO from the Advisory Council on the Misuse of Drugs (ACMD) and published in 2020[737] sets out the details, but broadly they are as follows:

i. **Licensed cannabis-based products for medicinal use (CBPMs):** no products currently available in the UK fall into this category.
ii. **Licensed cannabis-based medicines:** three such products are available in the UK, namely Sativex® (containing natural THC and CBD in spray form), Epidyolex® (natural CBD only, taken via oral solution) and Nabilone (man-made THC only, taken in capsule form).
iii. **Unlicensed CBPMs**: these include certain strains of herbal cannabis in flower or bud form. Levels of THC and CBD vary but are typically higher than those present in licensed medicines. Recommended route of administration is

[734] Part one was led by the then-Chief Medical Officer for the UK government, part two by the Advisory Council on the Misuse of Drugs (ACMD).
[735] See for example https://www.theguardian.com/society/2018/jul/26/medicinal-cannabis-how-two-heartbreaking-cases-helped-change-law *Accessed 5th August 2024.*
[736] The Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018 (legislation.gov.uk)
[737] Cannabis-based products for medicinal use (CBPMs) in humans (publishing.service.gov.uk) *Accessed 25th September 2023.*

through a medical vaporiser device, and cannabis oils (containing THC) are also available for oral administration.

11.18 To qualify as a CBPM, a product must:[738]

- Contain cannabis, cannabis resin, cannabinol or cannabinol derivatives.
- Be produced for medicinal use in humans, and
- Be a medicinal product, or a substance or preparation for use as an ingredient of, or in the production of an ingredient of, a medicinal product.

11.19 Prescribing of both unlicensed CBPMs and licenced cannabis-based medicines is very limited and unlicensed CBPMs are particularly difficult to access via the NHS. This is due to concerns regarding safety, efficacy and quality: herbal cannabis cannot be exactly replicated time and again because it is a botanical. This means it fails the test required for licenced medicines – namely that what is dispensed on one occasion is guaranteed to be identical to that dispensed on a subsequent occasion, within and across patients.

11.20 There also remains a lack of what clinicians and regulators deem sufficiently high-quality evidence (notably from comparative randomised controlled trials utilising large numbers of patients) of the effects of unlicensed CBPMs in medical settings to treat a variety of conditions, including chronic pain.

11.21 The lack of reliable and replicable evidence, together with concerns regarding potential exposure to unknown harmful effects of component elements and fears of diversion to non-medical users once prescribed, means the Royal College of Physicians (RCP) and NICE do not support the use of unlicensed CBPMs for most medical purposes. Their position is reflected in associated guidance and recommendations[739]. While not mandatory for the NHS to follow that guidance, in reality practitioners tend not to prescribe outside its parameters, so unlicensed CBPMs are practically available largely through paid-for private healthcare only.

11.22 This lack of support from influential stakeholders and advisory bodies is undoubtably a blocker to any future increase in use of unlicensed CBPMs, meaning what is in effect a two-tier system (as we discuss below) will continue to exist.

11.23 Ongoing research is beginning to address the evidential issue, including through the Cannabis & Me study led by King's College London[740] (funded by the Medical Research Council, MRC, who have supported a substantial body of wider work into the effects of cannabis, including research exploring its impact on development of schizophrenia).[741] The study focuses on effects of cannabis on the brain and how biological, behavioural and environmental factors might impact those effects, considering the role of different strains and potency of the drug.

---

[738] See the Royal Pharmaceutical Society's *Medicines, Ethics and Practice* guide, edition 46, July 2023.
[739] See for example https://www.nice.org.uk/guidance/ng144/chapter/Recommendations *Accessed 5th August 2024*.
[740] See King's College London spearheads the largest ever independent study into cannabis use - King's College London (kcl.ac.uk) *Accessed 5th October 2023.*
[741] See Medical Research Foundation | Dissemination programme to debunk… *Accessed 25th March 2024.*

11.24 Separately, the Project Twenty21 (T21) study[742] is exploring the impact of unlicensed CBPMs on a range of symptoms including pain relief, insomnia, anxiety and post-traumatic stress disorder (PTSD). We consider, however, that investment in a more comprehensive programme would hasten generation of reliable evidence of the extent and nature – including side effects – of medicinal impacts of cannabis. (This would also ensure opportunity for exaggeration either of the therapeutic benefits or, conversely, the lack of such benefits, would be significantly reduced.) In this regard, we agree with the recommendation made by the HAC, namely that:

> *'…the Government supports researchers to conduct randomised control trials into the effectiveness of CBPMs to treat chronic pain. If the evidence base supports this, and it is deemed to be cost-effective, we recommend that the Government enables the use of CBPMs for this purpose and works with clinicians to ensure that it is a treatment option in appropriate cases.'*[743]

11.25 We go further, however, and **recommend that research programmes such as the T21 and Cannabis & Me studies should be funded to explore the effectiveness of CBPMs in treating a wider range of conditions, including but not limited to chronic pain. These must be funded and led by independent, objective bodies such as the Medical Research Council** (R34).

Licensed cannabis-based medicines

11.26 Licensed cannabis-based medicines are available via NHS prescription[744], although they are heavily regulated and available only for a limited number of conditions, namely:

- Children and adults with rare, severe forms of epileptic related seizures (Epidyolex®).
- Vomiting or nausea caused by chemotherapy (Nabilone).
- Adults with muscle stiffness and spasms caused by MS (Sativex®).

11.27 If conventional medicines have failed to provide relief, a GP may refer a patient to a doctor listed on the Specialist Register of the General Medical Council (GMC), whose role is to decide if medical cannabis is the right option. In 2019, around 96,000 doctors were listed on this register,[745] but we heard that fewer than 200 have applied and been approved to prescribe medical cannabis.

11.28 Those specialist doctors may then make an initial prescription for Sativex®, Epidyolex® or Nabilone. A GP (as well as nurses and pharmacists) may issue subsequent prescriptions under a principle known as 'Shared Care', although they must have formal direction to do so and in practice are often reluctant.

---

[742] Led by Drug Science.
[743] See footnote #723, para.234. *Accessed 29th September 2023.*
[744] https://www.medicines.org.uk/emc *Accessed 5th August 2024*.
[745] Medical register reaches 300,000 for the first time - GMC (gmc-uk.org) *Accessed 27th September 2023.*

11.29 It was suggested to us by several witnesses that GPs and other partners in multi-disciplinary teams (MDTs) lack understanding of the medicines and their applications. This is in part because medical education and training (including for associated professions such as pharmacists and pharmacy technicians) tends not to cover the endocannabinoid system, or at least does not do so in any depth (see chapter 9.)[746] The currently limited nature of their permitted applicability also means a GP is likely to have few patients presenting symptoms eligible for Sativex®, Epidyolex® or Nabilone.

11.30 It was also suggested fear of reputational risk may be a factor: the use of cannabis in medical treatment remains contentious with a certain degree of stigma – no doubt in part because of the aforementioned lack of support among key bodies and alongside wider stigma associated with recreational use of an illegal drug. As a result, doctors may harbour some professional concern about defending prescription of medicines involving cannabis in medical spheres.

11.31 Add in the time constraints and daily pressures faced by NHS doctors and others involved in primary care and it is not surprising that, firstly, relatively few have sought the additional training required to join the Specialist Register, and, secondly, may be uncomfortable with assuming legal responsibility for a medicine and the consequences of its use (standard requirements of any prescriber) about which they know very little, if anything at all.

11.32 This, too, applies to pharmacists who not only are also liable for the products they dispense but must understand relevant supply chains and availability of medicines. We look in more depth at supply chains for medical cannabis later in this chapter.

11.33 Moreover, while the Explanatory Memorandum to the MDR 2001[747] states GPs can in fact prescribe licensed cannabis-based medicines, NHS England guidance[748] advises the practice is limited to doctors on the Specialist Register. While not mandatory, GPs are understandably reluctant to operate outside that guidance, which means in practice that first prescriptions are issued by a specialist prescriber and relatively few prescriptions overall for these licensed medicines have been issued to date – a total of 10,244 over a three-year period (see Table 10).

11.34 The NHS Business Services Authority was able to identify a unique patient for between 47% and 82% of those 10,244 prescriptions issued for each licensed medicine. This means that, while the figure is likely to be an underestimate, at least 1,479 NHS patients received a licensed cannabis-based medicine between 2020 and 2023.[749]

---

[746] See also section 3.3, Barber, S. & Rough, E. (2021). *Medical Use of Cannabis*. House of Commons Library, No. 8355. CBP-8355.pdf (parliament.uk) *Accessed 27th September 2023*.
[747] The Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018 (legislation.gov.uk) para.7.15. *Accessed 19th July 2024.*
[748] See footnote #64 in Barber, S. & Rough, E. (2021). *Medical Use of Cannabis*. House of Commons Library, No. 8355. CBP-8355.pdf (parliament.uk) *Accessed 27th September 2023*.
[749] Refers to prescriptions issued in England and dispensed in England, Wales, Scotland, Guernsey, Alderney, Jersey and the Isle of Man.

Table 10: Number of prescriptions issued in England for licensed cannabis-based medicines, 2020–2023

	Licensed cannabis-based medicine prescriptions issued in England*			
	Sativex® (n)	Epidyolex® (n)	Nabilone (n)	Total (n)
2020/21	2,112	2	578	2,692
2021/22	2,688	4	489	3,181
2022/23	3,833	36	502	4,371
Total	8,633	42	1,569	10,244

**Source:* bespoke analysis conducted for the LDC by the NHS Business Services Authority (NHSBSA). Figures refer to prescriptions issued in England and dispensed in England, Wales, Scotland, Guernsey, Alderney, Jersey and the Isle of Man. They differ slightly from published statistics, which include only prescriptions issued and dispensed in England, available at Prescription Cost Analysis – England – 2021/22 | NHSBSA

11.35 It seems to us that a better understanding among healthcare professionals – as well as associated leadership bodies and regulators – of the endocannabinoid system and how cannabis products might treat various symptoms of ill health would be beneficial. Low levels of knowledge are not, however, unique to the UK – including in jurisdictions where medical cannabis has been legal for a much longer period of time.

11.36 Indeed, the experts who reviewed Canada's Cannabis Act reported similar, despite medical cannabis being legal across the country since 2001. They found the lack of information, guidance and training on the use of cannabis for medical purposes to negatively impact on patient care (although noted steps taken by nursing and pharmacy professions to improve matters for their members).[750]

11.37 In our view, it is a matter for the various health bodies and regulators (including the RCP, NHS England, NICE and the General Pharmaceutical Council, GPhC) to explore scope for addition of cannabis-related material to relevant education and training curriculums. Unquestionably there will be constant pressure to add new material in relation to a very wide range of medical considerations, and it is for those experts to consider cannabis as a subject relative to other priorities.

11.38 However, in support of advancing basic knowledge across the sector, **health bodies should consider how recommendations in the Canadian Review to provide information and evidence on the use of cannabis for medical purposes could be drawn on and actioned in England. This should include use of both licensed and unlicensed CBPMs** (R35).

Unlicensed CBPMs

11.39 Unlicensed CBPMs, i.e. strains of whole-plant cannabis grown for medical use (and containing various ratios of CBD and THC alongside a range of terpenes –

[750] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca pp.70–1, recommendations 44 & 45. *Accessed 26th March 2024.*

see chapter 4) are known as 'specials'[751] due to their unlicensed status. The initial decision to prescribe an unlicensed CBPM must legally be made by a doctor listed on the Specialist Register[752] who has determined the product to be a valid treatment option following exhaustion of traditional medical routes. Provision does exist for continuation of prescribing by a doctor or other qualified health professional not on the Register – but this must remain under the direction of the specialist.

11.40 This means that technically, unlicensed CPBMs are available through the NHS where a doctor on the Specialist Register has agreed suitability. Because of their unlicensed status, however, applications must be made to the local trust for funding – and these, we heard, are almost always turned down. As we understand it, to date fewer than ten such applications have been approved.

11.41 This is likely due at least in part because of the current lack of endorsement for their use from the likes of NICE and the RCP, due to the challenge of demonstrating efficacy in the traditional way (via double-blind, placebo-based randomised controlled trials). As a result, the overwhelming majority of unlicensed CBPMs are prescribed via private healthcare.

11.42 Based on evidence presented to us from those involved with medical cannabis – as suppliers, prescribers or patients – we are inclined to agree with the view expressed to the Health & Social Care Committee in 2019 that guidelines governing prescribing of unlicensed CBPMs (and licensed cannabis-based medicines) are too restrictive[753]

11.43 Given the hundreds of compounds contained in the cannabis plant, the number of permutations that would need to be rigorously tested in the way of simpler medical formulations used in conventional medicine would be nigh on infinite. This suggests a different approach to testing and guidelines for medical cannabis that better accounts for its natural composition would be beneficial.

11.44 Certainly, those we heard from who prescribe and dispense unlicensed CBPMs were optimistic about their potential to optimise quality of life. No one argued they are a panacea, but they were described as having elicited very positive outcomes with relatively minimal side effects.

11.45 And patients themselves have similarly testified to the notion that medical cannabis has improved symptoms of a range of mental and physical health conditions, often allowing a reduction in use of traditional medicines (see also para.11.66) with reportedly few side effects.[754]

---

[751] Defined by the MHRA as a product which "has been specially manufactured or imported to the order of a doctor, dentist, nurse independent prescriber, pharmacist independent prescriber or supplementary prescriber for the treatment of individual patients". See footnote #724, para.8.

[752] NHS England » Cannabis-based products for medicinal use (CBPMs) *Accessed 19th July 2024.*

[753] Oral evidence - Drugs policy: medicinal cannabis - 19 Mar 2019 (parliament.uk) Q51. *Accessed 28th September 2023.*

[754] Beckett Wilson, H. & Metcalf McGrath, L. (2023). 'It's a big added stress on top of being so ill': The challenges facing people prescribed cannabis in the UK. *International Journal of Drug Policy, 122*. Elsevier.

11.46 This does not mean, however, that cannabis used to relieve symptoms of ill health is without risk, particularly when over-used. The Canadian Review, for example, spoke of adverse effects including anxiety and paranoia.[755] There is also emerging evidence of the potential for medicinal cannabis to elicit symptoms of Cannabis Use Disorder (CUD, see chapter 8).[756]

11.47 There are difficulties in isolating those who take the drug solely for medical reasons from those who use it for non-medical purposes, or indeed for both. Symptoms of CUD, however, most commonly withdrawal and tolerance, have been reported in up to 25% of people using cannabis for medical reasons.[757] As with non-medical cannabis, higher frequency of use and certain demographics (such as being younger and male)[758] may increase risk.

11.48 The potential for medical-use patients to develop CUD suggests those being prescribed unlicensed CBPMs should be regularly assessed for symptoms. The extent to which this happens currently, however, is not clear to us. Collation of assessment data would also help medical professionals and researchers develop a more complete understanding of population-level prevalence of the disorder among patients, particularly as the medical cannabis industry expands.

11.49 The potential for adverse effects should be made clearer than, in our view, is apparent at present. We accept the need to develop understanding of risks and variance according to reason for use (some evidence, for example, suggests treating chronic pain with medicinal cannabis may heighten risk of CUD)[759] and explore how these might be mitigated through type and strength of the drug. Public health messaging should underline the fact that using cannabis to alleviate medical symptoms, whether authorised by a medical practitioner or not, is not risk-free.

11.50 As with non-medical cannabis, risk of adverse consequences of medical use is probably heightened by use of high-potency product. As a result, those who find the drug alleviates symptoms but who cannot afford the cost of private prescription may be more exposed, as the vast majority of cannabis available through the illicit market is high-strength. We discuss the ramifications of affordability later in this chapter.

11.51 More positively, licensed products must meet stringent quality controls so prescribing doctors can be confident in safety and consistency. In practice this

[755] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.83.
[756] Lapham, G.T., Matson, T.E., Bobb, J.F., Luce, C., Oliver, M.M. … & Bradley, K.A. (2024). Prevalence of Cannabis Use Disorder and Reasons for Use Among Adults in a US State Where Recreational Cannabis Use Is Legal. *JAMA Network Open, 6*(8). doi:10.1001/jamanetworkopen.2023.28934
[757] Dawson, D., Stjepanović, D., Lorenzetti, V., Cheung, C., Hall, W. & Leung, J. (2024). The prevalence of cannabis use disorders in people who use medicinal cannabis: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 257*. Elsevier.
[758] Ibid.
[759] Ibid.

means they must meet the EU Good Manufacturing Practice (GMP) standard. Importation (all are currently imported products, though this is changing, see para.11.100) requires MHRA approval and an HO import license. All clinics in England are audited by the Care Quality Commission (CQC) and dispensing pharmacies in Great Britain are regulated by the GPhC.

11.52 Largely available only via a small infrastructure of private clinics and pharmacies, specials may be considered suitable, for eligible patients, for treatment of a wider range of medical needs than licensed cannabis-based medicines. This is due to their greater range of respective strengths, formulations, and ratios of constituents (namely CBD and THC).

11.53 Eligible patients are those with a particular diagnosis from a health professional (GP, specialist consultant etc) who have tried two non-cannabis-based treatments without success. Diagnoses include those for Alzheimer's disease, Crohn's disease, glaucoma, endometriosis, pain and nausea, as well as a range of mental health conditions including anxiety, depression and PTSD.

11.54 Medical cannabis patients range in age from their late teens to their nineties, though those aged under 25 are treated as a vulnerable group due to risks that cannabis poses to the developing brain (brain maturation does not complete until around the age of 26; see chapter 8). Prescriptions are accordingly lower in volume and strength and are largely limited to oil-based products. Given evidence suggesting heightened risk of CUD in younger users, this is welcome.

11.55 As with all private healthcare, an eligible patient must pay for the service and prescribing specialist doctors (many also have NHS roles) work with private medical cannabis clinics, of which several operate in the UK. The standard process adopted by most if not all is as follows:

i. Prospective patient applies (typically online) and shares their medical records (or gives permission for the clinic to access on their behalf).
ii. The application is reviewed by a clinical team, who will invite the applicant to book an online consultation if eligible. As per regulations, a key criterion is that the condition for which medical cannabis is sought must be registered with the GP.
iii. A further regulatory requirement stipulates applicants must have tried and exhausted two other forms of prescription medicine or alternative therapy (e.g. anti-depressant medication, acupuncture).
iv. Symptoms or a formal diagnosis of psychosis will almost always render an individual ineligible (see chapter 8 for discussion of the dynamic between psychosis and cannabis use).
v. A clinical MDT assess whether medical cannabis would be suitable and agree a prescription.
vi. If approved, a prescription is sent to a pharmacy (of which there are around 20 across the UK currently set up to readily provide medical cannabis) and issued to (usually) the patient's home. Cannabis flower prescriptions are typically intended for use with a dry-herb device that allows it to be heated

and inhaled as a vapour; other products are designed for topical application or oral intake. Patients must sign a waiver confirming they will neither smoke a dry herb prescription[760] nor pass it to anyone else.

11.56 Regulations require a follow-up appointment 30 days after the prescription is issued, after which two further 30-day prescriptions can be issued before the cycle begins again. Patients must pay for all appointments and prescriptions.

11.57 As part of the consultation process, prescribing clinicians discuss with the patient any experiences of illegal cannabis and what they seek from medical cannabis. This typically involves consideration of the terpenes that might benefit particular conditions, as well as the most effective levels of CBD and THC. An important element of the process, this ensures patients are well acquainted with constituents of the cannabis plant and how they feature in their medicine.

11.58 The relationship with a patient's GP is key. A clinic is required to share with the GP all consultation notes and prescriptions, and, if a prescriber considers there to be medical issues beyond the focus of the cannabis consultation, they will advise a patient returns to their GP. Similarly, the GP should keep the clinic informed of any changes in the patient's condition or other prescribed medication.

11.59 The GP also plays an important role in ensuring patients do not sign up to receive prescriptions from more than one clinic simultaneously: a patient can transition from one clinic to another but must have a discharge letter from the first. If a GP receives a request from a second clinic but has not seen a discharge letter, they should refuse the request.

11.60 This is presumably in an attempt to avoid the situation in the 1950s and 1960s with respect to private-sector dispensation of opiates and cocaine for medical use: patients seeking access through more than one practitioner was common.[761]

11.61 Clinics report receiving several thousand enquiries a month from prospective patients, of which around 10% are typically deemed eligible for a consultation. The majority of those (80–85%) go on to receive a prescription, although the relatively small number of doctors on the Specialist Register limits the speed at which prescriptions can be issued.

11.62 We heard this is more acute in cases where cannabis is sought for mental health conditions, as the Register is particularly low on psychiatrists able to prescribe cannabis. While initiating the prescription of medical cannabis remains limited to doctors listed on the Specialist Register, given the number of patients seeking such treatment is rising it would seem prudent to encourage more doctors – especially psychiatrists – to add this responsibility to their portfolio.

---

[760] Smoking prescribed cannabis medication is a criminal offence; see s.16A(3) of the Misuse of Drugs Regulations 2001 as amended by Regulation 4 of the Cannabis Regulations 2018 and s.18(1) of the MDA 1971.
[761] Mold, A. (2008). *Heroin. The Treatment of Addiction in Twentieth Century Britain.* Northern Illinois University Press.

11.63 In terms of demand for unlicensed CBPMs, a total of 89,239 prescriptions were issued between November 2018 and July 2022[762] (there are no official figures on the number of patients issued those prescriptions, though one recent estimate put it at around 20,000).[763] While these data cover a slightly different and longer time period (almost four years) they nonetheless highlight a large gap between the number of NHS prescriptions issued for licensed cannabis-based medicines (10,224 over three years) and private prescriptions for unlicensed CBPMs – albeit the two types meet different medical needs.

11.64 And private prescriptions do not come cheap: we understand average monthly costs (including initial consultation, prescriptions and follow-up fees) can exceed £300, depending on amount and type of product required. Some clinics offer a discounted rate for those on limited means (and participants in the T21 study, see para.11.24, are also eligible for a discount on certain products) but nonetheless the costs attached to private consultations remain unaffordable for many.

Drivers for choosing prescribed unlicensed CBPMs

11.65 People using cannabis for medical purposes find it provides relief where conventional medication has failed: their aim is to treat their condition, not get high. Particularly common among those with conditions causing severe and chronic pain is a desire to stop taking prescription opioids – a desire shared by government and health bodies who have raised considerable concern about opioid prescribing rates in the UK.

11.66 So much so that there has been a recent crackdown on opioid prescribing[764] and it seems to us anything that can help this effort should be fully considered. One survey (supported by the cannabis industry) reported the majority of participating medical cannabis patients were previously prescribed pharmaceuticals for their condition: since using prescription cannabis, 38% claimed to have stopped their use entirely while 46% reported using fewer.[765]

11.67 It was put to us that around 90% of patients seen by private clinics have previously self-medicated with illegal cannabis (the survey above reported similar – 87% of participants reported consuming cannabis before accessing a medical prescription).[766] And while a handful are referred to a clinic by their GP, most self-refer as the GP focus tends to be on licensed medicines. This is unsurprising given the lack of systematic education regarding how cannabis affects the body and the way in which CBPMs operate.

[762] Written questions and answers - UK Parliament UIN 117459, tabled on 6 January 2023, answered on 13 January 2023. *Accessed 28th September 2023.*
[763] Survey reveals broad spectrum of issues facing UK cannabis patients (cannabishealthnews.co.uk) *Accessed 29th September 2023.*
[764] NHS England » Opioid prescriptions cut by almost half a million in four years as NHS continues crackdown *Accessed 28th September 2023.*
[765] See footnote #763.
[766] Ibid.

11.68 Despite this, wider research undertaken in support of our inquiries (see Appendix C) suggested the public largely feel use of cannabis for medicinal purposes is appropriate if prescribed by GPs or other healthcare professionals. An inherent public trust in medical models of management leads to an assumption that cannabis would be safe in these circumstances, and that the healthcare system would prescribe appropriately.

11.69 Despite the costs associated with accessing private prescriptions, increasing numbers of people who use cannabis for medical purposes are turning to the legal rather than illegal market (though it remains unaffordable for many) and numbers are expected to continue to rise (albeit slowly). Drivers for this include:

- Legality: many feel more comfortable using cannabis for medical purposes where they have a prescription to prove it, if challenged by police or others when carrying or using it in public. (This is a significant issue, to which we return below.)
- Cost: medical cannabis can be competitively priced against the illegal market, with prices for dried flower ranging from around £4 to £13 a gram (illegal market prices average around £10 a gram for the same). For those who live in areas where the illegal market commands higher prices, medical product can in fact be cheaper (though consultation fees of course bump up overall cost).
- Unadulterated product: medical cannabis has not been sprayed or otherwise adulterated. Patients can also be confident they are receiving a product that contains the levels of THC and CBD claimed, which is tailored to their individual medical needs.
- Greater balance between THC and CBD: some users do not wish to consume the high-strength cannabis commonly available through the illegal market, finding a better balance with CBD is more effective in addressing their symptoms.

11.70 In terms of strength of medical cannabis, patients are typically prescribed product containing levels of THC below that common in illegal product but higher than that in licensed cannabis-based medicines. Higher-potency product is reserved for patients where the standard level (16–19%) is no longer effective. This can prove challenging for prescribers as patients will often argue they need stronger prescriptions.

11.71 Demonstrating uncertainties in the composition of illegally sourced cannabis, however, is the fact that, on first consuming medical product, patients are reportedly often surprised. It can be stronger than expected based on what they think they've been buying from the illegal market.

11.72 It was suggested to us that in some cases, having supplemented or replaced illegal with prescribed cannabis, a patient has reduced the amount they use to control their condition. This is an important consequence and would benefit from further, systematic research to explore the extent to which it features across patients and conditions.

11.73 Medical cannabis patients often do not relinquish purchases from the illegal market though, and a number continue to grow cannabis at home. These provide fallback options in case a prescription is i) not available (the UK's fragile infrastructure with respect to supply of medical cannabis means prescriptions cannot always be fulfilled as intended, see para.11.91) or ii) delivered quickly. While dispensing pharmacies operate a next-day delivery service, this cannot compete against the 'within the hour' 24/7 doorstep delivery often offered by illegal dealers, especially in London.

11.74 And many entering the medical market from the illegal also have strong, long-term relationships with their dealers and find the cannabis they provide meets their medical need, so are reluctant to put a complete stop to the arrangement. This is an issue we explored in chapter 7 in the context of challenges of transitioning users from illegal to legal markets for non-medical cannabis.

11.75 And then there is the issue of cost. Many who find cannabis alleviates one or more symptom of poor health continue to rely on the illegal market because they cannot afford the costs of private access. Indeed, one recent estimate suggested 1.8 million people in the UK source illicit cannabis to provide relief from a wide range of symptoms that can often very seriously affect quality of life.[767]

11.76 While illicit product costs can broadly equate to those applicable to private prescriptions, there are of course no regular consultation fees payable in order to access that product. And in our view, the overall costs of accessing unlicensed CBPMs have created a two-tier health system for people suffering conditions from which cannabis products may offer relief.

The implications of a two-tier system

11.71 Those unable to sustain what can be a considerable financial burden are left accessing (or home-growing) illegal cannabis and incurring risks associated not only with illegal transaction but with consuming product of unknown provenance and quality. Moreover, they cannot prove a legal reason for possession if challenged by police. According to the estimate above, this equates to very many people potentially putting themselves at risk.

11.72 Indeed, even where a patient is able to produce a legitimate prescription that matches cannabis found in their possession, it is not always well understood or accepted. We heard this has on occasion resulted in a patient being placed in overnight police custody while officers follow up with the prescribing clinic.

11.73 Encouragingly, at least one clinic now has the means to immediately issue a legal document to a patient's mobile phone to verify their prescription. This still, however, requires a police officer to understand that cannabis is legal for medical purposes for patients with a corresponding prescription (and that, in some

[767] Rise in people using cannabis to treat health conditions - but doctors warn patients are putting themselves at risk | UK News | Sky News *Accessed 28th September 2023.*

instances, the product may appear indistinguishable from illegal cannabis being used for non-medical purposes).

11.74 It is unfortunate that, despite recommendations from several authorities over recent decades that more be done to ensure police are aware of the possibility of cannabis use to alleviate symptoms of some medical conditions,[768] as we understand it there has been little meaningful change.

11.75 **We thus recommend forces across England & Wales, including the Metropolitan Police Service, should routinely ensure officers are aware of the law surrounding use and possession of cannabis for medical purposes, and are familiar with its prescription** (R36).

11.76 This recommendation, however, only safeguards those able to afford a legal (private) prescription for unlicensed CBPMs (as NHS access remains near impossible). We heard evidence from representatives of Cancard, an organisation that issues cards identifying holders as people with a condition that qualifies for a prescription of medical cannabis but who cannot afford to pay, so may seek cannabis illegally to meet their health needs.[769] The intention is to protect card holders from criminal sanction or from having their cannabis confiscated if found in possession of the drug.

11.77 Supported by the Police Federation and designed in partnership with doctors (although neither the BMA nor the RCP support it), the card is available to adult users certified by a GP as suffering from a condition eligible for a legal cannabis prescription. The initial card costs £29 and is valid for 12 months, after which a holder must resubmit medical evidence of their continued need for cannabis and is charged £19 per year thereafter.

11.78 Alongside a 24/7 helpline to support police officers to respond appropriately to card holders, Cancard provide free training to help police understand the law governing medical cannabis. This sets out the conditions for which it is a legally permitted treatment, the various forms that medical cannabis can take, and the different routes of prescription.

11.79 Despite the Cancard offer, however, the two-tier system operating with respect to unlicensed CBPMs is, to our mind, not acceptable. It is deeply unfair that many people who find cannabis provides relief from conditions that adversely affect their quality of life are unable, because of financial constraints, to access it through legal channels.

11.80 It seems to us the law now takes the position that, for some people, unlicensed cannabis can alleviate some health conditions. In practice, such products are only really obtainable through private clinics at what, for many, equates to very

[768] Including a recommendation made by the BMA, see British Medical Association. (1997). *Therapeutic Uses of Cannabis.* Harwood Academic Publishers, UK.
[769] See footnote #722.

considerable cost. Equally, however, we recognise there may be training implications and attendant costs, plus issues with priorities, if NHS prescribers were more widely equipped to routinely prescribe unlicensed cannabis products.

11.81 We also recognise, of course, that wider NHS prescribing risks the health service effectively providing access to forms of an otherwise illegal drug that is used widely for non-medical, recreational purposes. We fully accept that this ultimately may not be the right idea. However, the possibility, with all the attendant risks and opportunities to manage those, should at least be investigated.

11.82 We therefore **recommend, if sufficiently robust, favourable conclusions emerge from research recommended in R34, that further research be undertaken into training and cost implications of equipping the NHS to provide unlicensed CBPM product scripts more widely, where (initially) sanctioned by a doctor on the Specialist Register. This should consider the potential burden on those doctors in the context of their overall burden as front line practitioners, as well as the opportunity costs of prescribing traditional medicines (including opiates) over unlicensed CBPMs. Findings should inform decisions as to whether the current system should be changed and the implications of doing so for medical cannabis supply chains should be considered** (R37).

The medical cannabis industry: supply and operation

11.83 Despite growth in the market, in addition to difficulties faced by patients with respect to both access and cost, the industry faces challenges that arguably result from the legislative model governing the supply chain and clinic operations. Data shared by some of those we heard from suggest it is not easy to make a profit. This is partly due to subsidies provided by clinics to cover costs of specialist prescribing doctors, which can be over 50%. Across the sector, profit is reportedly made primarily on prescriptions.

11.84 Despite an often evangelical level of positivity surrounding the economic potential of legal cannabis industries, at least some parts of the medical market have to work hard to maintain investors. And it was put to us that in Canada and various US states, where unlicensed CBPMs have been available for some time, the industry as a whole has seen increasing numbers of insolvencies and bankruptcies.

11.85 These problems are not limited to the medical market. That said, it was suggested that, where cannabis is legalised for non-medical use, depending on the framework deployed the demand for medical product can be suppressed as patients opt for a non-medical equivalent to avoid additional costs of consultations.

11.86 Despite this, UK clinics are largely optimistic about the medium to longer term. We heard the market is currently estimated to be worth around £50 million, supporting around 25,000 registered patients. With clinics registering new patients each month, the sector is widely seen as a growth market. There is

some concern, however, that available supply may be insufficient to meet rising demand.

11.87 This is somewhat ironic because the UK is the world's biggest producer and exporter of legal cannabis for medical and scientific purposes.[770] Jazz Pharmaceuticals (previously GW Pharmaceuticals) became, in 1998, the first UK-based cannabis cultivator to obtain licences from the HO and MHRA which allowed them to cultivate, possess and supply cannabis for research into medical use.

11.88 They became, and remain, the sole producer and distributor of Sativex® and Epidyolex® but are not licensed to produce cannabis for unlicensed CBPMs. And until recently (see para.11.100), no UK-based cultivator has been licensed to produce cannabis for this purpose for use in the UK.

11.89 This means the cannabis plant that is cultivated for medical purposes and from which unlicensed CBPMs are derived (either in dried flower form or extracts used for oils, vapes and oral ingest) must be sourced by UK clinics from overseas. Most of it (which we heard amounts to around five tonnes annually) is imported from Europe, with smaller amounts coming from Canada and Australia.

11.90 All products adhere to EU Good Manufacturing Practice (EU-GMP) standards and are manufactured in sterilised conditions to ensure no contamination. In addition to products being tested several times throughout the process for pesticides, heavy metals and microbial growth, rigorous tests are also applied to confirm CBD and THC levels in end products.

11.91 Once a supplier is approved by a clinic, the process of acquiring registration and import licences from the HO and MHRA can take several months. And until recently, clinics were limited in the amount of product they could import at any one time. Supply issues could lead to over reliance on particular products and stocks – particularly of new or renowned products – could be depleted quickly, leaving prescriptions unable to be fulfilled in a timely way.

11.92 Demand for particular products can also be raised by patients sharing positive experiences on social media – although the content of prescriptions is ultimately the decision of the prescriber. While a patient may request a certain product, it may not necessarily be what is prescribed.

11.93 The time required to replenish depleted stocks can often be significant, given reliability on overseas products and a consequently lengthy and complex supply chain. This, of course, risks a patient (re)turning to the illicit market.

[770] Buchanan, I., Booth, L. & Brien, P. (2023). *Economic contribution of medicinal cannabis: Debate pack 14 April 2023*. Number CDP-0086 (2023). House of Commons Library. CDP-2023-0086.pdf (parliament.uk) *Accessed 29th September 2023.*

11.94 We heard, too, about the opposite problem, whereby clinics end up with a surplus of product that has to be destroyed. This can result from poor-quality product being received by patients, which is then returned (it can, for example, arrive mouldy as a result of the length of time between harvest, packaging, shipping and delivery).

11.95 Supply chain issues were raised with us by those witnesses who were themselves users of cannabis for medical purposes, and research elsewhere has reported challenges with last-minute changes to prescriptions because a patient's usual product is out of stock. This can often mean an unexpected price hike, with the sudden inability to access a product that had been working well in alleviating symptoms causing stress and anxiety.[771]

11.96 It was also put to us that the quality of medical cannabis supplied to the UK has not always been the highest (though compliant with necessary standards and regulations) because the market is relatively small. As this slowly changes and demand rises, quality is improving as cultivators overseas achieve a greater return from the UK market – but it is taking time. We heard that in some cases this, again, can cause patients, frustrated with quality issues and cost of consultations, to return to the illegal market.

11.97 Issues are compounded by marketing restrictions governing prescription medicines in the UK. These mean clinics cannot advertise the various cannabis products they offer, only the services they provide. They do so to varying degrees in social and print media and increasingly via television adverts, often focusing on raising awareness that cannabis for medical purposes is legal and promoting patient experiences.

11.98 The general restrictions arguably mean discussion about the effects of different types of cannabis products on a wide range of conditions, alongside guidance around sensible consumption, is not possible. That said, some clinics are investing in celebrity or influencer endorsements, using well-known figures to explain, for example, how to access legal unlicensed CBPMs, or how to travel abroad with prescribed medical cannabis – a situation that many users find difficult to navigate.

11.99 While there remains some desire to advertise specific products themselves (e.g. particular strains of cannabis offered by a clinic), it is difficult to see how this could ever be permitted for a product provided as a medicine.

Future supply and implications

11.100 Several UK-based cultivators are in the process of preparing and applying for HO and MHRA licences to supply the UK medical market (for both flower- and extract-based prescriptions) but we understand only two – Celadon and Glass Pharms – are likely to be able to start supplying substantial quantities of product

[771] See footnote #754.

in the foreseeable future. Other smaller operators are thought to be some way off licensing, never mind production.

11.101 Their core market will be the UK and product will comply with UK GMP standards (rather than EU GMP), which means that, unlike in jurisdictions elsewhere where cannabis is grown for medical use, in the UK it must be grown indoors in order to meet particularly stringent regulations regarding risk of contamination.

11.102 Once operational, facilities should significantly reduce reliance on product imported from overseas, and a much shorter supply chain will ensure product reaches distributing pharmacies, and therefore patients, more rapidly. This ought to mean product is less likely to deteriorate so patients can be more confident of consistently high-quality medical cannabis, and there should be fewer challenges with respect to clinics and pharmacies having access to adequate stock.

11.103 Indeed, at time of writing, Celadon told us they had completed phase one of operational implementation and produced the first four harvests, amounting to around 40kg of medical cannabis across three different strains (each suited to addressing different health conditions). Future harvests are expected every three weeks.

11.104 How overall price will fare remains to be seen. Production costs may well be lower in overseas facilities, but import costs might mean that, ultimately, domestically produced cannabis will be competitively priced. And a domestic medical market with a strong, resilient supply chain is relevant for our primary considerations regarding how cannabis use for non-medical purposes should be treated within the law.

11.105 A medical community and a general public familiar with, and accepting of, cannabis for treatment of medical conditions, recognising that patients can live and work in mainstream society without difficulty, would presumably help cement demand for product. This in turn helps create the necessary conditions for a robust supply chain.

11.106 As we heard, too, an established medical market is typically an important forerunner to any move away from prohibition of non-medical use. It creates an infrastructure with at least some knowledge and delivery capability to meet emerging demand, whether for medical or non-medical cannabis.

11.107 But the UK's medical cannabis market remains in its infancy, particularly in comparison to other jurisdictions. In Canada, medical cannabis has been legal since 2001 and at time of writing it is legal in 38 US states, four territories and Washington D.C. (though state laws vary regarding how it is produced, distributed and consumed, and the conditions it is used to treat). California became the first US state to legalise cannabis for medical use in 1996, and ten years later the majority have followed suit.

11.108 In Europe, the position varies. While cannabis remains illegal for medical purposes in several countries, established medical markets have existed elsewhere for some time, albeit for varying conditions and with differences in permitted products. Not all, for example, allow cannabis flower for medical use. Medical cannabis has been available in countries including, for example, the Netherlands since 2003, Denmark since 2011, Italy from 2013, Norway since 2016, Luxembourg, Germany, and Greece from 2017 and Portugal and Malta since 2018.

11.109 Elsewhere, in 2013 Uruguay became the first country in the world to legalise cannabis for both medical and non-medical use in parallel, and medical use was also legalised in Australia (at federal level) in 2016. It is increasingly being prescribed in the latter to young men presenting to doctors with anxiety and sleep problems, allowing immunity from prosecution in states where use of the drug is otherwise illegal.

11.110 We considered the position of several of these jurisdictions with respect to legality of non-medical cannabis in chapter 7, including the variety of approaches taken and the evidence so far in terms of associated consequences.

12. EDUCATION AND CANNABIS

While we did not explore education strategies for, or cannabis use among children and young people in depth, accounts from frontline practitioners informed our consideration of public health and harm reduction. While our focus is school-aged children, the impact of cannabis on processes of brain development, which continue until a person reaches their mid-twenties, means it is important that young adults, too, are educated about ways to lessen the risks of cannabis use.

In this chapter, we set out what we heard about consumption of cannabis during the school day: while it is not widespread, there are obvious consequences for behaviour and performance. Similarly, dealing within school premises is very problematic and poses a number of challenges, which establishments deal with in different ways.

We explored why practitioners thought young people used cannabis and their views of the risks in doing so, as well as their perceptions of awareness, or acceptance, of the potential for risks among young people themselves.

Finally, we considered the challenges faced by schools in delivering compulsory, age-appropriate, credible education about cannabis, exploring the likely adequacy of content, stage of the curriculum at which it is introduced, and different approaches to delivery.

The reality of cannabis in London's schools

12.1 We set out the national picture in terms of prevalence and drivers of cannabis use among children and young people, as well as sources of the drug, in chapters 4 and 5. Evidence we took from witnesses working with young people across London in a range of school and other settings supported that picture. Not only did this highlight use of cannabis by a substantial minority of schoolchildren (described as endemic by one borough), it illustrated several considerations regarding education and harm reduction.

12.2 It is a universal truth that many young people experiment with alcohol, smoking and sex. So too will they experiment with drugs and, as shown by countless numbers of surveys and statistics, as well as our own inquiries and forerunners, cannabis is no exception. It was put to us that education strategies must be realistic about the fact of relatively widespread cannabis use among young people, while acknowledging the context and drivers, methods of consumption and the consequences – both positive and adverse.

12.3 Compared with the consequences of alcohol, the effects of cannabis are often perceived as similar or less harmful, perhaps in part because they can be less obviously dramatic: being drunk tends to be behaviourally more obvious than being high. And many young people see cannabis simply as an alternative to alcohol in terms of an aid to relaxation and recreation.

12.4 Some therefore view the approach to cannabis use by authority figures as somewhat hypocritical. Parents, teachers and other adults admit to use of alcohol and tobacco as a means of coping with stress, as well as to enhance relaxation and have fun. Young people, some of whom eschew alcohol and cigarettes but who might choose cannabis for arguably similar reasons, feel they face critical judgement and ultimately criminalisation for doing so.

12.5 The majority of young people who try or go on to use cannabis more regularly do not do so within school hours or on school premises. It is therefore not thought very common for them to bring cannabis into school, either for personal use or to sell to others. In some establishments, particularly those offering alternative education provision,[772] searches on entry are largely considered to be an effective mechanism of preventing drugs being brought onto school premises where pupils have tried to do so.

12.6 That said, cannabis edibles pose a particular (and increasing) problem due to the ease with which they can be concealed, often in plain sight: largely odourless, they typically resemble legitimate foodstuffs. We heard several anecdotes of children becoming very unwell as a result of consuming edibles during school hours, and it is also not unheard of for a child or young person to smoke a joint en route to school in the morning.

12.7 Cannabis consumption before or during school has obvious consequences. While it was put to us that incidents are relatively rare, we heard about children falling asleep at their desk or being unable to concentrate, with increased levels of apathy and decreased motivation to learn. More serious effects are possible too – one school reported around one or two incidents a term where an ambulance is required to treat a child rendered incapacitated by cannabis consumption during the school day.

12.8 Children known or suspected by schools to be using cannabis are often flagged for other safeguarding reasons including challenges at home, vulnerabilities to criminal exploitation and difficulties with mental health. We also heard about a substantial overlap with deprivation and poverty (as we discuss elsewhere).

12.9 Where dealing cannabis does take place on site, it presents a significant problem for a school. All those we heard from operate 'zero tolerance' policies that stipulate dealing must result in automatic permanent exclusion – but this is not always activated when it results from, for example, instruction from parents or criminal gangs and where young people have little perceived agency. In some cases, schools seek a mentor figure to support the pupil concerned, to help them understand the heightened risk of harm of cannabis use for young people, and the dangers of dealing and criminal gang involvement.

[772] Alternative provision establishments cater for children and young people who require greater care and support. This includes those excluded, or at risk of such, from mainstream school for behaviour reasons, and those who are experiencing severe emotional or behavioural difficulties.

12.10 Others would almost certainly immediately exclude a pupil for dealing cannabis within school grounds, due to the risk of reputational damage and pressure from the governing body. Such a move is not without significant concerns regarding the likelihood of heightening safeguarding risks faced by the young person, particularly with respect to increased vulnerability to gang involvement.

12.11 Where a pupil is permanently excluded or has otherwise demonstrated challenging behaviour to the extent that they cannot be managed in mainstream school, they will usually be referred to an alternative education setting. These pupils are more likely than their peers remaining in mainstream settings to have had contact with the criminal justice system by the point of referral, and we heard how a substantial driver of that contact can be involvement with cannabis. Most have been caught in possession of or dealing the drug and some, particularly those involved in gang or county line activity (see chapter 5), end up carrying a weapon because they feel threatened by members of opposing factions.

12.12 There was broad acceptance among those who work with young people that cannabis use, for some at least, is a critical problem. It increases wider risks not only to individual health but of being caught up in criminality, with all the associated implications for longer-term life chances – particularly if caught carrying a weapon. There were mixed views, however, as to the extent to which a legally regulated market for cannabis represented the most appropriate solution.

Awareness of the risks of cannabis use among young people

12.13 Young people are well aware that cannabis is legal for non-medical use elsewhere in the world; this is driven at least in part by celebrity endorsements and US-based influencer activity on social media platforms (see chapters 4 and 5). The fact that it is illegal in the UK, and thus growing, selling and possessing the drug all carry the risk of criminal conviction, can come as a surprise.

12.14 Those working with children and young people referred to the fact that some parents use cannabis openly within the home environment, which likely contributes to views that cannabis is not harmful, or at least is no more so than alcohol or tobacco. It can also serve to undermine messages delivered in school about the risks of cannabis.

12.15 Children reportedly often remonstrate with their parents for use of alcohol and tobacco, where evidence of harm is widely accepted and discussed. But unless adult users understand and accept that cannabis too can pose a risk, heightened in certain circumstances and for some individuals, it is difficult to similarly embed messages around harm.

12.16 Older children (Years 10 and 11, i.e. aged 14–16) are widely thought to believe cannabis use is *'not a big deal'*, particularly when compared to other illegal drugs. The disparity referred to by witnesses across sectors about the legal status of cannabis compared with alcohol and tobacco is reportedly also often raised by

young people: this can, it was suggested, make school-based discussions about relative harms and rationale for the legal position somewhat challenging.

12.17 While largely cognisant and accepting of risks associated with alcohol and tobacco, research shared with us suggested that among young adults (aged between 16 and 24) there is some disbelief that cannabis can be addictive, whereas tobacco addiction was commonly acknowledged.[773] This was reinforced by evidence put to us from local authorities that highlighted how young people often consider themselves 'social smokers' of cannabis, when in fact they are likely to be addicted. One borough referred to a boy smoking up to 20 joints a day, wholly unaware of the risks attached to such heavy use.

12.18 Beliefs about reduced levels of risk associated with cannabis can be accentuated by narratives around vaping, widely understood as a less harmful means of consuming nicotine than smoking tobacco. Many are unaware, however, that as a means of consuming cannabis without tobacco, vapes, or e-cigarettes, are not necessarily safer, despite the avoidance of nicotine.

12.19 Cannabis that is vaped rather than smoked tends to be more concentrated, i.e. it contains higher levels of THC. It is also no less likely to be adulterated with synthetic compounds than smoked cannabis, heightening the possibility of harmful effect. Indeed, a chemical added to some THC-containing vapes in the US has been identified as one of the major causes of lung injury associated with use of the devices (E-cigarette, or Vaping Product, Use Associated Lung Injury, EVALI).

12.20 Moreover, the risk of developing EVALI is likely to be higher when vapes or e-cigarettes containing THC are obtained from informal sources rather than commercial outlets,[774] i.e. where there is greater risk of adulteration.

12.21 Young adults receiving treatment for psychosis and cannabis addiction similarly told us they considered vaping cannabis to be lower-risk than co-consuming with tobacco. Clinicians confirmed there is relatively low awareness of the dangers of adulterated product and the potential for vapes to be much more potent than a user expects.

12.22 We also heard of young cannabis users increasingly turning to edibles as an alternative to smoking cannabis with tobacco, due both to ease of consumption and greater awareness of the health risks associated with nicotine. There are, however, several mistaken beliefs about edibles – namely that they are less potent than herbal cannabis and less harmful because there is no parallel consumption of tobacco.

[773] Walsh, H. (2023). Unpublished PhD findings shared with the London Drugs Commission.
[774] The Centers for Disease Control and Prevention (CDC) reported that, of EVALI patients in the US who reported using vapes containing THC and provided information on their source, almost 80% had obtained them from informal sources, including friends, family, dealers and online outlets. See Outbreak of Lung Injury Associated with the Use of E-Cigarette, or Vaping, Products | Electronic Cigarettes | Smoking & Tobacco Use | CDC *Accessed 19th March 2024.*

12.23 The reality is they can be very much stronger. Without proper understanding of dosing (relative to a person's size, metabolism, tolerance, recency of consuming non-cannabis foodstuffs etc) and awareness of the fact that psychoactive effects take longer to take hold than when the drug is smoked, it is easy to consume too much. This is particularly the case where dose sizes are unclear or unrealistic – we heard, for example, of one dose equating to two small gummies from a much larger bag, or to one-fourteenth of a cookie.

Cannabis education in schools

12.24 Coverage of drug use and associated considerations is compulsory in state schools (primary and secondary) under the Relationships Education, Relationships and Sex Education and Health Education (England) Regulations 2019.[775] The topic is made compulsory in independent schools under the Personal, Social, Health and Economic (PSHE) curriculum.

12.25 While clearly required as part of the statutory education programme, we understand there is little guidance provided centrally in terms of specific content on cannabis, beyond key messages to impart around illegal drugs more broadly. The Department for Education (DfE) provides a range of training materials on which schools are encouraged to base their provision and suggests these be adapted to suit the needs of different contexts.[776]

12.26 This tends to mean, as it was put to us, there is something of a postcode lottery in play, with different schools taking different approaches. Most tend not to broach cannabis in detail until students reach Year 9, although schemes of work in earlier years, including those focusing on mental and physical health as well as grooming and county line activity, will touch on drug use more widely.

12.27 This means that, before the age of 13, most young people have little to no formal education regarding cannabis, which feels to us to be a gap. Statistics suggest that – while a very small minority – some children have in fact used the drug before they reach 13 and most will almost certainly have heard of it, often through the media (including social media). Some will likely have been exposed through family or peer networks, particularly where cannabis plays a role in cultural and religious settings.

12.28 Moreover, for whatever reason some children and young people may never have been exposed to formal drugs education. It was put to us that a substantial number of those found by police in possession of small quantities of cannabis and referred to a pre-arrest diversion programme run in the West Midlands by Cranstoun (see chapter 10) recall no such input through their formal schooling.

[775] Relationships Education, Relationships and Sex Education and Health Education guidance (publishing.service.gov.uk) *Accessed 21st May 2024.*
[776] Ibid.

12.29 Where drugs education does take place, statistics bear out the focus on Year 9. Surveys show almost three-quarters of Year 9 pupils (72%) reported receiving lessons covering drugs during 2021, compared with 48% in Year 7 and 60% in Year 11.[777] Cannabis content focuses primarily on the law, consequences of use for mental and physical health and wider social and economic implications of the drugs trade.

12.30 There is desire among young people themselves for more information. Just under half of Year 7–11 pupils felt their school had provided sufficient information about drugs (just over half felt they received sufficient information about alcohol and tobacco). This is not perhaps surprising given the frequency with which most schools report delivering lessons about drugs, namely less than once a term (but at least once a year).[778]

12.31 Several witnesses we heard from suggested drugs education should begin before secondary school, to reflect modern life and day-to-day realities of many children and young people. This mirrors suggestions made during the review of Canada's Cannabis Act,[779] where stakeholders suggested tailored material appropriate for different life stages should be introduced from grade three (around eight years old). And this attracts some degree of public support in Great Britain: over one-quarter of those polled by YouGov in 2021 thought education about recreational drugs should begin at age 10 or younger (though one-fifth felt it should not be delivered until children were 13 or older).[780]

12.32 Indeed, it was put to us that children as young as nine, outside London as well as within the capital, are often well aware of different types of drugs. The lack of routine engagement on the subject in school, however, means there is little chance of countering messaging that children may be exposed to elsewhere.

12.33 We also heard that more could be done post-GCSE to help young people make informed choices about cannabis, recognising that by this stage many will likely have tried the drug. Indeed, evidence put to us suggested young adults may find it difficult to find accessible, credible (from their perspective) information, describing much of what they see as unbalanced with little recognition of why they may choose to use cannabis.[781]

12.34 The overwhelming message tends to be 'cannabis is illegal, do not use it'. Because this fails to resonate with lived realities of the drug for many, or to acknowledge its perceived potential for bringing some relief of, for example, symptoms of anxiety and stress, may tend to disregard the material. Instead, they develop understanding and knowledge about cannabis from personal experiences

[777] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Table 12.2. *Accessed 14th December 2023.*
[778] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Tables 12.3, 12.7. *Accessed 14th December 2023.*
[779] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.33.
[780] Q30, Big_Surveys_Drugs_Y1 (w) (for non drug users).xlsx (d3nkl3psvxxpe9.cloudfront.net) *Accessed 1st August 2024*.
[781] Walsh, H. (2023). Unpublished PhD findings shared with the London Drugs Commission.

and those of their peers, as well as online unregulated content – often through chat forums such as Reddit.

12.35 This risks development of erroneous beliefs about the potential risks of cannabis – that it is not addictive, for example, or that herbal cannabis sourced from a known dealer is 'natural' and therefore safer. We heard about work undertaken by Cranstoun in partnership with the Rave Aid Crew[782] to develop pragmatic, non-authoritative advice for young people. This recognises the realities of drug-taking, addresses common misconceptions and focuses on educating those who choose to use drugs to reduce the risk of harm.

12.36 Advocates of more comprehensive drugs education – both within and outside the sector – were keen to better understand what age-appropriate material looks like for children at key touchpoints. Attenuating messages so they engage children and young people but avoid glorifying drug use was recognised as a difficult balance, particularly given the ways in which drugs and the potential to make a lot of money from the trade are widely referenced in popular culture, including music and film.

12.37 We heard about the Drugs, Alcohol and Resilience Training (DART) delivered by the City of London Police (CoLP) to year 6 pupils (aged 10–11) attending two primary schools within the remit of the City of London Corporation (CoLC). Focusing on the nature of choices related to drugs and alcohol, this might offer useful insights for development of similar packages to be run elsewhere. **We recommend the CoLC should commission independent evaluation of DART and, if appropriate, the Mayor should explore potential for it to be delivered in primary schools across London boroughs** (R38).

12.38 We note the finding reported in the most recent inspection of the CoLP that some schools were reluctant to engage with police in wider prevention and intervention work.[783] While the force has since introduced schools officers to help address this, it is worth bearing in mind the potential for similar reluctance elsewhere when considering delivery mechanisms for expansion of school-based education around cannabis and drug use.

12.39 Other materials have also been developed based around research on the effects of cannabis, expressed through children and young people's lived experiences of its use. Not in widespread use across the statutory education sector, they are drawn on by a small number of London-based charities working with young people.[784] While we welcome such endeavours, the lack of signposted provision within mainstream settings means it is likely only a small number of schoolchildren are reached.

---

[782] A grassroots activist organisation providing drug welfare services and harm-reduction advice to the free party scene.

[783] His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2021). PEEL 2021/22: Police effectiveness, efficiency and legitimacy – An inspection of the City of London Police, p.16. *Accessed 19th March 2024.*

[784] Medical Research Foundation | Spreading the word about harmful 'skunk' *Accessed 27th March 2024*.

12.40 **The Mayor should consult with parents, schools, youth workers, substance-use services and other organisations such as Cranstoun to consider how more comprehensive content focusing on risks of cannabis use could be systematically introduced to younger children, and revisited during post-16 education, in meaningful, age-appropriate ways. Existing resources, including the DART material, should be considered, as should the efficacy and appropriateness of police involvement in delivery** (R39).

Content of cannabis education

12.41 We heard mixed views on this. Some considered school-based resources to be inadequate, relying too heavily on academic, government and medical material. Perceived to lack credibility among young people, it reportedly fails to engage. The PSHE Association is the most common source drawn on by schools in preparation for lessons about drugs (as well as alcohol and tobacco), followed by DfE guidance:[785] while we have not examined the material or explored the views of young people, it may not succeed in striking the most effective tone to reach this audience.

12.42 It was put to us that material may not cover the role of cannabis in different cultural and religious settings, nor adequately explain the ramifications of a criminal conviction for future life opportunities, including, for example, travel to the US.

12.43 But at the same time, for some young people consequences of this nature, particularly when set against some of the perceived positive aspects of cannabis consumption and dealing (see chapter 5), may have little resonance. Foreign travel, for example, will feel completely out of reach for many. This illustrates the complexity and nuances of issues that education must help draw out.

12.44 For some teachers, the illegal status of non-medical cannabis is a barrier to open, honest and practical conversations with pupils. While recognising that some will experiment with the drug, any discussion of experiences is inevitably more challenging where admission of use is admission of criminality. Certainly, we heard that beginning with messages around illegality and criminal consequences can easily shut down perhaps more useful conversations about the effects of taking cannabis and how to manage risk.

12.45 Moreover, we heard of fears among senior leaders that drugs education can risk suggesting a school has a drug problem, sparking negative publicity and discouraging future applications. There are concerns, too, that discussion of consumption methods and relative advantages and disadvantages with respect to harm reduction risks being seen as enabling young people to engage in illegal behaviour.

[785] Smoking, Drinking and Drug Use among Young People in England, 2021: Data tables - NHS Digital Table 12.9. *Accessed 14th December 2023.*

12.46 This in turn raises fears of parental or guardian anger, which we heard can manifest if a school goes beyond the illegal status of cannabis and the 'Just Say No' approach – which is reportedly often how the issue is presented in the home.

12.47 We heard similar views from other jurisdictions, some of whom reflected that comprehensive education packages about cannabis were beginning to be made easier following the introduction of some model of legal regulation – although progress is slow. Stakeholders consulted as part of the Canadian review,[786] for example, commented that previous prohibition continues to exert a lasting influence on many education initiatives that remain focused on abstinence and risk.

12.48 They advocated for initiatives to refocus and address what is considered to be continuing and widespread misinformation about cannabis. Indeed, the review panel recommended development of evidence-based school prevention programmes, alongside other interventions, to help young people make better decisions about cannabis use. Avoiding or delaying onset, as well as how to engage in lower-risk behaviours, were identified as key messages.[787]

12.49 The situation seems similar in London and across the UK. We heard that misinformation about cannabis is rife, not only among children and young people but among adults too. Addressing this should be a crucial part of education programmes: we agree with the approach advocated by the Canadian review whereby pupils are enabled to make more informed choices and, where they continue to choose to try cannabis regardless of its illegal status, can better guard against risks of misuse.

12.50 Among those working with young people outside school settings, we found a widespread view that current provision of cannabis education is limited, lacks detail and fails to adequately engage young people. In part this was thought to be through a failure to acknowledge the range of drivers of use and effects – including the positive impacts that some derive from using the drug.

12.51 We heard how material lacked detail about the impact of edibles, specifically their strength, how quickly they take effect and how long that effect can last. If the effect is unpleasant or overpowering, a consumer cannot simply stop consuming: a joint can be extinguished but, once an edible(s) has entered the body, a person is at its mercy until it becomes sufficiently diluted. Given that use of edibles is reportedly on the rise, this lack of information is a considerable gap.

12.52 Youth workers told us that focusing on legal and health implications of cannabis use can lead many young people to switch off: it is arguably part of the 'teenage condition' to take risks and, where those risks are associated with something that is a daily reality for many, there is little traction.

---

[786] Legislative Review of the Cannabis Act: What We Heard Report - Canada.ca p.33.
[787] Legislative Review of the Cannabis Act: Final Report of the Expert Panel - Canada.ca p.28, recommendation 4. *Accessed 27th March 2024.*

12.53 Moreover, many young people deliberately choose to use cannabis because they believe it to be an effective means of coping with previous or ongoing trauma, or to otherwise alleviate symptoms of mental health distress (although the relationship between cannabis and mental health is complex, as is the potential for side effects).

12.54 Simply telling those involved with cannabis to desist is, as was put to us, likely to fall on deaf ears, particularly where selling is concerned. As we discuss in chapter 5, for some young people, particularly those from very deprived backgrounds, selling the drug offers a way to make money easily and the lure can be very strong, particularly in areas of London where differences between affluence and poverty are stark.

12.55 Completing school and achieving the necessary qualifications would of course support young people to earn a decent wage legitimately in due course – but the pull of immediate opportunity, irrespective of illegality, can be difficult to combat in the face of poverty.

12.56 In terms of health, the risks of cannabis are not considered by children and young people in the same bracket as Class A drugs, which tend to be associated with those seriously unwell crack and heroin addicts often visible in local communities. For young people living chaotic lives often characterised by anxiety and trauma, the risks of cannabis addiction and other associated health harms are likely to seem the least of their problems. Indeed, for many the drug is considered an accessible means of help in the (perceived or real) absence of other sources, including clinical services.

12.57 That said, we heard how young people are largely unaware of the detrimental impact that cannabis use has on the developing brain, or that their brain does not reach full maturation until they reach their mid-twenties. Simply helping pupils understand this, with no associated judgement or pronouncement, might, it was suggested to us, achieve greater cut-through.

12.58 Focusing on exploitative aspects of cannabis was also thought helpful. Setting out how organised crime gangs groom young people into becoming involved in dealing or moving cannabis (through 'free' drugs, or 'gifts' of money or material goods) would raise awareness so they *'…know the price attached. You don't get anything for free'*. While those in their mid-teens make up the majority of vulnerable people involved in county lines, those of primary school age are also at risk,[788] meaning the subject should at least be introduced (appropriately) before secondary education.

12.59 Directly confronting why young people choose to use cannabis, signposting alternatives to self-medicating particularly mental health conditions via the drug,

[788] See Criminal exploitation of children and vulnerable adults: county lines (accessible version) – GOV.UK (www.gov.uk) *Accessed 21st May 2024.*

was considered by some to be more important than its illegality – although such alternatives are under immense pressure and access can be difficult.

12.60 Such a shift in focus was underlined by powerful testimonies we heard from parents whose children have tragically died following drug use. They emphasised that education of children, parents and wider society to help those who choose to use illegal drugs to do so more safely is paramount to preventing deterioration to, or loss of, life.

12.61 We did not hear directly from those working with young people in further education settings (i.e. post-16, following secondary school), but heard that material designed to inform understanding among this group of the effects of cannabis (as well as other drugs) is available.

12.62 Accessible harm reduction advice also forms a core part of content towards which we were pointed and which is aimed specifically at university students (i.e. from age 18) – namely the 'Staying Safe Programme'. **The Mayor should consider ensuring all establishments across London that provide education post-18 are aware of and have access to such materials, and signpost this to all students at the point of entry** (R40).[789]

Delivery of cannabis education

12.63 We heard concerns that teachers, given their wider roles in school, may lack credibility to deliver educational material about cannabis. This risks compounding the problem of inadequate content that fails to speak to lived realities of many pupils.

12.64 The review of Canada's Cannabis Act 2018 illustrated how youth perceptions of message credibility vary according to source. The most effective messengers were reportedly trusted adults, peers, and people with lived experience – authority figures tended not to be seen in the same way.

12.65 Whether teachers are perceived as trusted figures or authority figures presumably depends at least to some extent on the nature of their relationship with pupils. We heard how powerful and transformative it can be when they do connect on sensitive issues, but at the same time that, more often than not, teachers tended not to have the credibility to guide sufficiently open, realistic discussions on drug use.

12.66 The importance of consistency between school and home messaging was also highlighted. Getting families involved in discussions might not only reinforce drug education but serve to inform parents and guardians too about harm reduction and the risks to young people of cannabis use (although we acknowledge the likely challenges where cannabis is used routinely within the home environment).

[789] See for example video trailers at Staying Safe Programme *Accessed 4th April 2024.*

12.67 Local workshops, held in partnership with schools in parts of some London boroughs, were highly spoken of as an alternative means of delivering cannabis education. These are led by substance use workers and other professionals from youth-focused organisations, who bring similar experiences and backgrounds as many of the young people they work with.

12.68 Based on feedback from young people, youth workers and local authority representatives described these providers to us as trusted voices. They considered them much better able to facilitate open discussion of lived experiences and to speak credibly to young people not only about their views but about the risks, particularly of heavy use which considerably heightens the likelihood of adverse consequences.

12.69 Such providers are, however, entirely dependent upon local knowledge, capabilities and partnerships, which speaks to the patchwork nature of wider commissioning practices across London, with each borough individually responsible for acquiring services to meet the needs of their local population (see chapter 9). The universality of cannabis use, however, means a majority of children and young people are likely to be offered the drug, and many of those will go on to try it. Some will become regular users, and the risks of being drawn into associated criminal activity play out across boroughs.

12.70 Overall, it seems to us that provision of education focusing on cannabis and associated risks is random and patchy across London's schools. Beyond the DfE adding more detailed content to its mandatory syllabus and associated guidance, there seems to be no legal way to ensure provision is consistent and uniform.

12.71 We therefore recommend that **representatives of schools, parent bodies, substance-use services and other organisations involved in localised endeavours, as well as developers of material designed for post-18 students, form a working party. This should aim to produce detailed, age-appropriate guidance for use across London's schools, to help young people better understand the risks and make more informed choices.** (R41)

13. CANNABIS SOCIAL CLUBS

Pioneered in Spain, the 'Cannabis Social Club' (CSC) model operates in several places across the world as a means of facilitating access to cannabis – whether the drug is legalised or not. We discuss international CSCs in more detail in chapter 7 and focus in this chapter on their operation in this country.

We begin by describing the CSC model more broadly, and then set out what we understand about their presence in the UK, including their genesis and asserted aims. By means of a case study, we illustrate how one such CSC operates today, exploring its structure and membership as well as how the club fits within the local community and its relationships with authorities, including the police.

We end by offering our reflections on the CSC model, including some of the challenges as we understand them and the importance of positive local relationships to their successful operation.

Features of the Cannabis Social Club model

13.1 Central to the CSC model is a non-profit approach to production and supply of cannabis. While other non-profit legal models have been proposed (based on CSCs and regulation of other substances or potentially addictive behaviours or activities),[790] none as yet have been adopted so across the world, where non-medical cannabis is legal, profit-based models dominate (with some notable exceptions, see chapter 7 and para.13.3).

13.2 A CSC typically operates by making available to its membership cannabis that is grown by members, owners or a grower with links to the club. In some, membership fees are inclusive of cannabis (and are set according to expected consumption). In others, the fee permits access to the club, with further charges made for the cannabis a person wishes to consume. Some – but by no means all – are open to temporary membership for non-residents (such as tourists), usually by way of a fee for one-time access.

13.3 Despite the dominance of profit-based models where non-medical cannabis is now legal, the CSC approach is gaining popularity and lies at the heart of alternatives to prohibition being explored elsewhere, notably in Malta, Germany and Switzerland. Clubs are also one of the three supply routes (in addition to non-profit pharmacies and home cultivation) permitted in Uruguay.

13.4 Irrespective of jurisdiction, members must almost always be a resident aged at least 18. The maximum number of members a club can register varies, however,

[790] See Pardal, M., Kilmer, B., d'Auria, S., Strabel, T., Galimberti, S., Hoorens, S., Decorte, T. & Senator, B. (2023). *Alternatives to profit-maximising commercial models of cannabis supply for non-medical use*. Santa Monica, CA: RAND Corporation, 2023. https://www.rand.org/pubs/research_reports/RRA2190-1.html

as does the amount of cannabis a member can receive daily (up to a maximum monthly allowance) and the amount a club may store in the premises.

13.5 Clubs also vary with respect to facilities. Some offer a space for members to consume cannabis and socialise, others act solely as a collection point. We are not aware of any that sell or otherwise permit consumption of alcohol on site, but many offering social spaces sell or otherwise provide soft drinks and snacks.

13.6 Where cannabis remains illegal for non-medical use, CSCs can provide a route – albeit unregulated – to acquisition of cannabis with a clearer provenance, allowing users to avoid some of the risks associated with purchases from a street or other type of dealer.

Cannabis Clubs in the UK

13.7 Despite continued illegality of non-medical cannabis and only relatively recent permissions afforded to medical use, CSCs have existed across the UK for some time. Operating physical premises or based solely online, in 2018 they were estimated to number over 80,[791] and numbers have likely risen since. Many are registered with the non-profit UK Cannabis Social Clubs (UKCSC) organisation, which advocates for legalisation of non-medical cannabis and acts in a semi-regulatory capacity for its member clubs.

13.8 While clubs provide cannabis for medical and non-medical use, several were born out of a desire to offer quality, home-grown product with known THC and CBD content for those who found the drug provided relief from symptoms of ill health. They sought to reduce reliance on street cannabis, which, as very often the product of forced labour overseen by criminal gangs, makes many people who wish to use it uncomfortable. It can also be poor quality, even adulterated with dangerous synthetic compounds, and comes with little or no accurate information about strength and composition. Some clubs also wished to offer a safe space for users to consume in company, should they wish.

13.9 It was put to us that this remains a core aim of the CSC community. As we set out in chapter 11, many whose ill health symptoms are alleviated by use of what are known as unlicensed cannabis-based products for medicinal use (CBPMs) and who would likely be eligible for a private prescription cannot afford to meet the costs.[792] Others who can afford to do so may struggle to find a safe space to consume their medication – for many, their home environment is not appropriate. And as we heard, even those in possession of a prescription to support their use are liable to police challenge if found consuming in public.

[791] See In Their Own Words: The Story of the UK's Cannabis Social Clubs - Volteface *Accessed 4th March 2024.*
[792] While in theory unlicensed CBPMs can be obtained through the NHS, it is very difficult and as far as we understand it, only a handful of such prescriptions have so far been provided. Prescriptions can also be obtained through private health care, at cost to the individual – see chapter 11.

The Exhale Harm Reduction Centre (Teesside Cannabis Club): a case study

Origins

- Set up ten years ago, the club sought to provide home-grown cannabis to those using it to treat ill health. Its first iteration, which operated for 18 months with local police aware and tacitly supportive, also attracted other drug sellers and users. As a result, it closed down, reopening elsewhere two weeks later with measures in place to address the early operational issues.

The current model

- Since 2018 the club, rebranded the Exhale Harm Reduction Centre (EHRC), has been situated on a local high street, providing cannabis to members seeking medical or non-medical effects. They must be aged over 21 and provide appropriate forms of identification to be accepted. Annual membership costs £120, with discounts for those aged over 65, in receipt of disability benefits, NHS and Fire Brigade workers, and serving or ex-military personnel.
- The building has a plain exterior and CCTV deployed inside and outside, and those wishing to enter must be admitted by a member of staff. Access to the consumption room is via a locked internal door, meaning only registered members may gain entry and the club keeps control of who and how many members are inside at any time.
- Five paid staff manage entry, sales and refreshments, run the consumption room and supervise members. Open for several hours over five days a week, the club occasionally hosts live events and we heard how several users, particularly the elderly, regularly socialise there, smoking or vaping cannabis alongside a cup of tea.
- VAT registered, operating costs are covered by membership fees and sales of cannabis (which amount to around one-third of the club's income) and merchandise. Cannabis grown by members and distributed through the club is dated and labelled: risk of it making its way onto the streets is managed through limits on daily purchases and prices set at a level that offers little value in attempting to sell product on.
- Now focused on harm reduction, staff are trained to identify and support members who might benefit from help with mental health or substance abuse. Partnerships with local providers mean the club is well placed to signpost into services with their details, alongside material on safer cannabis use, shared with members upon joining.
- In turn, the club increasingly receives enquiries from people referred through their GP or other health services, including those seeking to desist from Class A drug use. It was put to us that awareness of the club's partnership with a private cannabis clinic, providing access to advice about medical use, is becoming more widespread across the local health sector. Where affordable and desirable (it may be neither), the club helps members access prescriptions for medical cannabis where other medications, including opiates, have failed.
- Its role in supporting users of cannabis for medical purposes has also been recognised by the council, which afforded the club 'essential service' status following its closure during the first Covid-19 lockdown in 2020. That had led to notable adverse effects, particularly for members relying on it for medical-use cannabis, so during subsequent lockdowns the club was permitted to operate a click and collect service.

- In line with law prohibiting smoking in enclosed work- and public places, cigarettes cannot be consumed in the club. Tobacco alternatives are provided for those who wish to smoke cannabis in diluted form and vapes are available. Consumption of other drugs, alcohol or drinks purchased outside is forbidden.

Membership

- Over 800 members are registered with the club, ranging from their early twenties to their late eighties. Older members are common among those advised to approach the club by GPs after experiencing adverse consequences from use of opiates and other medication prescribed for a range of health complaints.
- Several members use the club to access cannabis for medical use but do not wish to pursue a private prescription. Some cannot afford to; others, including medical doctors, are deterred because, despite the drug now being legal for such use, a certain stigma remains and they do not want it on their medical record.
- While most collect their cannabis and consume at home, a minority consume on site because of opportunities to socialise, or because consumption elsewhere is difficult. This can result from terms of rental agreements, disapproval from house-hold members or complaints from neighbours if cannabis is smoked outside.

Relationships with local authorities and the public

- The club's model was developed in partnership with local senior police and their tacit support, along with that from the regional Police & Crime Commissioner and the local council, remain key to its continued operation.
- Occasional attempts to close it down tend, we heard, to be led by officers unaware of that senior support, which highlights the somewhat precarious nature of the club's existence as personnel changes could risk more significant attempts at closure. For now, though, an ethos shared by the local police, council and several local politicians that possession and use of drugs should be seen through a health rather than criminal justice lens ensures the club continues to operate largely unimpeded.
- Local public knowledge is relatively high, helped by increasing media coverage. The club is something of an 'open secret' and its presence attracts little public dispute (its location in a more industrial rather than residential area is likely helpful). Its substantial filtration unit ensures there are no issues with smell.
- Keen to support the community, the club ploughs surplus funds into local projects. It has turned down offers of substantial investment from international cannabis companies to maintain its focus on providing a service for local people, and control over how surplus proceeds are deployed.

The future

- The EHRC is growing, with three or four new members each week. It is receiving increasing interest from public authorities outside the area, including police forces, who are keen to explore the possibility of adopting a similar model.
- The club is also exploring ways in which it might access a range of funding streams in order to build on partnerships with local mental health providers and support their provision of services across the community.

Reflections on the CSC model

13.10 Active management of a CSC is crucial to ensure members are properly registered, access appropriately restricted and the provenance of cannabis received and distributed is known and assured. Where that happens, arguably the model represents a means of reducing the risk of consumption of adulterated product. It also means people who choose to use the drug are more cognisant of the strength of their cannabis and do not need to source it through street dealers, with all the associated risks that entails.

13.11 The EHRC demonstrates how a CSC can support wider harm-reduction efforts and provide credible advice on how to lessen the risks of using cannabis. Indeed, this is a key aspect of the model developed in Malta. Where partnerships exist, a CSC's ability to signpost or actively link members into drug and alcohol treatment, as well as providers of mental health and other support, is to our mind a valuable benefit.

13.12 Evidence suggests belonging to a CSC does not tend to increase individual rates of consumption.[793] While merchandise sales and its increasing membership base means the EHRC generates increasing income from fees (after operating at a loss for some years), restrictions on the amount of cannabis each member can purchase mean the level of funds raised beyond operating costs will remain limited. There is therefore little incentive to encourage members to increase consumption, unlike in the profit-based models seen in the majority of jurisdictions which have legalised cannabis for non-medical use.

13.13 That said, it is unclear whether the existence of a CSC drives up consumption among local populations through encouraging previous non-users to try cannabis. We recognise the challenges inherent in answering this question but consider it worthy of investigation.

13.14 **Given the central role played by Cannabis Social Clubs in approaches being developed in Malta and Germany, City Hall should maintain a watching brief on how those proceed. Consideration should be paid to any indications of a subsequent rise in prevalence of cannabis use and adverse health outcomes, as well as any reduction in demand or burdens on criminal justice systems and changes in take-up of other illegal substances and alcohol** (R42). (Accepting the difficulties in unpicking whether any change in prevalence is genuine or an artefact of increased willingness to report use of a now legal drug in those jurisdictions).

13.15 Licensing and some form of regulation will no doubt be critical to ensuring any CSC that legally provides access to cannabis complies with restrictions laid out in the corresponding legal framework and effectively manages, with the support of law enforcement, risk of infiltration by criminal operatives.

[793] See for example Parés-Franquero, Ò., Jubert-Cortiella, X., Olivares-Gálvez, S., Díaz-Castellano, A., Jiménez-Garrido, D.F. & Bouso, J.C. (2019). Use and Habits of the Protagonists of the Story: Cannabis Social Clubs in Barcelona. *Journal of Drug Issues, 49*(4), pp.607–24. doi.org/10.1177/0022042619852780

13.16 We heard that clandestine clubs operate across the UK (likely not registered with the UKCSC), a number of which are thought to be run by criminals who use the model to complement sales of cannabis via street dealer networks, which they also control. In these instances, a club offers opportunity to increase criminal profit though membership fees.

13.17 Rather than providing access to a safe space for quality-assured cannabis purchase and consumption, alongside harm-reduction advice, these so-called clubs simply offer the same poor-quality, sometimes adulterated product available on the street. In some cases, we heard, they have also provided a store for weapons and stolen property, discovered through police raids.

13.18 Unfortunately, it is perhaps an inevitable consequence of the continued illegality of CSCs in this country. Without the tacit understanding and tolerance of local police, while cannabis continues to be prohibited it is difficult to see how the risk of criminal involvement can be easily withstood. Arguably, the EHRC's success in maintaining its focus on harm-reduction practices lies at least in part in its relationship with the local police.

13.19 It is, therefore, difficult to see how the model could easily be replicated under the auspices of the UKCSC without mandated cooperation from every police force and its associated Police & Crime Commissioner.

APPENDIX A: TERMS OF REFERENCE

Purpose of the London Drugs Commission

The Misuse of Drugs Act is now 50 years old and our approach to tackling drugs, and the harm they cause, has been largely consistent throughout that period. But drugs remain a scourge on society and a significant driver of violent crime. It is time for a fresh look at and new ideas on the legal framework in the UK, to consider what is needed to reduce the harm caused by drugs in society.

The purpose of the London Drugs Commission will be to assess the latest evidence on the effectiveness of our drugs laws, with a specific focus on cannabis. It will analyse alternative policy options and instigate an overdue national debate on this important issue. The Commission's findings will aim to inform and drive effective and lasting change and will build on research already commissioned by the Mayor of London to assess the effectiveness of cannabis enforcement in tackling violence across the capital.

Scope of the Commission

The Commission will consider the impact and effect of current cannabis laws on crime, particularly violent crime, public health and economic outcomes. It will explore police enforcement of those laws, and look at support and treatment services for addicts, seeking to improve understanding of these issues.

The Commission will examine the latest evidence from the UK and across the globe on the harms of cannabis, the best methods of prevention, the most effective criminal justice responses (including in terms of tackling organised crime), the public health benefits of different approaches and any other relevant factors.

Informed by comparative research and oral and written evidence, the Commission will make recommendations for the best ways to improve the current legal framework and practice in the following areas:

i. The legal framework for regulating the use of cannabis.
ii. Criminal justice responses – legal enforcement and regulation.
iii. Public health responses – prevention; risk factors; treatment and support systems; and
iv. Any other areas the Commission determine relevant.

The Commission will report to the Mayor of London with policy recommendations for City Hall, the government, the police, the criminal justice system and public health services. Those recommendations will include how best to ameliorate practice in London within the existing legal framework.

The Commission will not consider the legalisation of Class A drugs, which the Mayor has been clear must remain illegal.

Consultations and submissions will be invited, and expert parties will be given the opportunity to provide evidence.

APPENDIX B: MEETINGS & SUBMISSIONS

Without the engagement and input from very many people, our work would not have been possible: we are hugely grateful for their generous participation. The following is a list of individuals and organisations who contributed either in person or in writing:

MEMBERS OF PARLIAMENT

Karen Buck, former MP, Westminster North

Dr Rupa Huq MP, Ealing Central & Acton

Andy Slaughter MP, Hammersmith & Chiswick

Sam Tarry, former MP, Ilford South

All Party Parliamentary Group on Drug Policy Reform

LONDON ASSEMBLY MEMBERS

Shaun Bailey AM

Elly Baker AM

Andrew Boff AM

Krupesh Hirani AM

Caroline Russell AM

Dr Onkar Sahota, former AM

Sakina Sheikh, former AM

LOCAL AND CITY GOVERNMENT

London Council Leaders

Cllr Muhammed Butt, Leader, Brent Council

Cllr Kaya Comer-Schwartz, Leader, Islington Council

Damien Egan MP, Bristol North East, formerly Mayor and Leader, Lewisham Council

Cllr Gillian Ford, Deputy Leader, Havering Council

Cllr Barry Rawlings, Leader, Barnet Council

London Council Chief Executives and senior officials

Adrian Ash, Executive Director, London Borough of Merton

Curtis Ashton, Director, Young Islington, London Borough of Islington

Helen Bailey, Chief Executive, London Borough of Sutton

Niall Bolger, Chief Executive, London Borough of Hounslow

Gary Connors, Assistant Director of Community Safety, London Borough of Newham

Keith Daley, Head of Substance Misuse, London Borough of Tower Hamlets

Carolyn Downs, Chief Executive, London Borough of Brent

Althea Loderick, Chief Executive, London Borough of Southwark

Iain McDermid, Assistant Director for Adult Integrated Commissioning, London Borough of Lewisham

Anna Raleigh, Director of Public Health for Westminster City Council and the Royal Borough of Kensington and Chelsea

Chris Rowney, Violence Reduction Network, London Borough of Croydon

Dudu Sher-Arami, Director of Public Health, London Borough of Enfield

Claire Symonds, Chief Executive, London Borough of Redbridge

Louise Watkinson, Assistant Director of Public Protection, London Borough of Bromley

Kirsten Watters, Director of Public Health and Integrated Children's Commissioning, London Borough of Camden

Greater London Authority

Vicky Hobart, GLA Group Director of Public Health

The Young People's Action Group (The Violence Reduction Unit, London City Hall)

The Youth Practitioners Advisory Board (The Violence Reduction Unit, London City Hall)

CRIMINAL JUSTICE AGENCIES

Joanna Coleman, Deputy Chief Crown Prosecutor, Crown Prosecution Service, (London North)

Chris Farrimond, Director, National Crime Agency

Henry Smithers, Head of Region (London), Youth Justice Board

Kilvinder Vigurs, Regional Director, London Probation, HM Prison & Probation Service

POLICING

UK

Chief Constable (Ret.) Mike Barton CBE

Assistant Commissioner Paul Betts, Operational Policing, City of London Police

Lord Bernard Hogan-Howe QPM

Commander Umer Khan, Policing Operations & Security, City of London Police

Lord Brian Paddick

Sir Mark Rowley QPM, Commissioner, Metropolitan Police Service

Superintendent Richard Waight, Head of Investigation Services, Specialist Operations, City of London Police

Wendy Williams CBE, HM Inspector of Constabulary and Fire & Rescue Services

International

Chief (Ret.) Brendan Cox, Director of Policing Strategies, Law Enforcement Assisted Diversion, National Support Bureau

Lieutenant Diane M. Goldstein (Ret.), Law Enforcement Action Partnership

Commissioner John Harrington, Minnesota Department of Public Safety for the U.S. State of Minnesota

Tom Synan, Chief of Police, Newton (Ohio)

POLICE & CRIME COMMISSIONERS

PCC Joy Allen, Durham

PCC Alison Hernandez, Devon & Cornwall

PCC Chris Nelson, Gloucestershire

PCC Mark Shelford, Avon & Somerset

PCC David Sidwick, Dorset

CENTRAL GOVERNMENT

Other officials from:

Crown Prosecution Service

Ministry of Justice

EDUCATION

Will Berridge, Assistant Headteacher, Park View School

Ammie Ferguson, Assistant Headteacher, Park View School

Christopher Lamb, Headteacher, Enfield Grammar

Shelley-Ann Sobers, Operational Safeguarding Lead, Park View School

Ms Cathy Stygal, Headteacher, Mayesbrook Park School

Andrew Webster, Headteacher, Park View School

HEALTH CLINICIANS AND ACADEMICS

Professor Emeritus H Valerie Curran, Clinical Psychopharmacology Unit, University College London

Mark Dronfield, Senior Operations Manager for City of Westminster, Hammersmith & Fulham and the Royal Borough of Kensington & Chelsea, Turning Point

Dr Emily Finch, Consultant Addiction Psychiatrist, South London and Maudsley NHS Trust, Clinical Director, Addictions Clinical Academic Group, & Chair of Addictions Faculty, Royal College of Psychiatrists

Roz Gittins, Chief Pharmacy Officer & Deputy Registrar, General Pharmaceutical Council

Professor Ian Hamilton, Department of Health Sciences, University of York

Professor Sir Robin Murray, Professor of Psychiatric Research, King's College London

Dr Diego Quattrone, Consultant Psychiatrist, Lewisham Hospital

Dr Anne Schlag, Head of Research, Drug Science

Professor Sir John Strang, Head of Addictions Department, King's College London

NOT-FOR-PROFIT ORGANISATIONS & CHARITIES

UK

Viv Ahmun, Chief Executive Officer, Blaksox

Elizabeth Burton-Phillips MBE, Founder, DrugFAM

Hazel Cheeseman, Chief Executive, Action on Smoking and Health (ASH)

Martin Drewry, Director, Health Poverty Action

Robbie Eyles, Youth Justice (Crime) Solicitor, Just for Kids Law

Katrina Ffrench, Founder and Managing Director, UNJUST

Rebecca Gray, Chief Executive Officer, The Maudsley Charity

Megan Jones, Partnership Director, Cranstoun

Jason Kew, Senior Innovative Practice Officer, Centre for Justice Innovation

Fiona Measham, Founder, The Loop

Abshir Mohamed, Community Peacebuilder, The 4Front Project

Kirsty Morrison, Head of Relationships, Cancard

Hope Chilokoa Mullen, Community Organiser, The 4Front Project

Temi Mwale, Co-Director, The 4Front Project

Juan Fernández Ochoa, Campaigns & Communications Officer, International Drug Policy Consortium

Miranda Paris, Centre for Justice Innovation

Kusai Rahal, Co-Director, The 4Front Project

Jason Reed, Executive Director, LEAP UK

Steve Rolles, Senior Policy Analyst, Transform Drug Policy Foundation

Paul Rompani, Chief Executive Officer, DrugFAM

Julia Ryland-Henchoz, Co-Executive Director, LEAP UK

Harry Shapiro, Director, Drugwise

Lucy Slade, Head of Policy, Centre for Justice Innovation

Vicky Unwin, Anyone's Child

International

Kassandra Frederique, Executive Director, Drug Policy Alliance

Shanel Lindsay, Entrepreneur Director, Parabola Centre and founder & CEO, Ardent Life

Kristin Nevedal, Vice Chair, Cannabis Advisory Committee & co-founder, International Cannabis Farmers Association

Cat Packer, Director of Drug Markets and Legal Regulation, Drug Policy Alliance, Vice Chair, Cannabis Regulators of Color Coalition, & cannabis policy practitioner at The Ohio State University Moritz College

Òscar Parés, Deputy Director, International Centre for Ethnobotanical Education, Research and Services, Barcelona

Lisa Sanchez, Director, Mexico United Against Crime

INTERNATIONAL POLICY EXPERTS, REVIEWERS AND REGULATORS

Dr Oyedeji Ayonrinde, Associate Professor, Departments of Psychiatry & Psychology, Queen's University, & member of the Canadian Cannabis Act Expert Review Panel

Dr Nuno Capaz, Head of the Portuguese Dissuasion Commission

Helen Clark, Commissioner, Global Commission on Drug Policy, former Prime Minister of New Zealand & Administrator of the United Nations Development Programme

Professor Patricia J. Conrod, Department of Psychiatry & Addiction, University of Montreal, & member of the Canadian Cannabis Act Expert Review Panel

Ruth Dreifuss, Commissioner and former Chair, Global Commission on Drug Policy, former President of Switzerland & Head of the Federal Department of Home Affairs

Bob Lessel, Coordinator, Luxembourgish Inter-Ministerial Cannabis Task Force, Ministry of Health, Luxembourg

Lynda L. Levesque, Crown Prosecutor, Government of Alberta, & member of the Canadian Cannabis Act Expert Review Panel

Leonid McKay, Executive Chair, Authority for the Responsible Use of Cannabis, Malta

Honourable A. Anne McLellan, Senior Advisor, Bennet Jones, former Deputy Prime Minister of Canada and Minister of Public Safety and Emergency Preparedness, & Task Force Chair on Cannabis Legalization and Regulation

Nazlee Maghsoudi, Manager, Policy Impact Unit, Centre on Drug Policy Evaluation, Toronto

Karen Mamo, Manager, Policy, Research and Harm Reduction, Authority for the Responsible Use of Cannabis, Malta

Dominique Mendiola, Senior Director, Marijuana Enforcement Division, Office of Marijuana Policy, Colorado

Dr Jane Philpott, Dean of Queen's University Faculty of Health Sciences and Director of Queen's School of Medicine, Commissioner, Global Commission on Drug Policy, & former Canadian Minister of Health

Morris Rosenberg O.C., Chair, Canadian Cannabis Act Expert Review Panel, former Canadian Deputy Minister of Justice, of Health and of Foreign Affairs, & former Deputy Attorney General

Ean Seeb, Governor's Special Advisor on Cannabis, Colorado

Professor Peter Selby, Head of the Mental Health and Addiction Division, Department of Family & Community Medicine, University of Toronto, & member of the Canadian Cannabis Act Expert Review Panel

CANNABIS INDUSTRY

Paul Allen, Co-Founder, Celadon Pharmaceuticals Plc

Gary Carroll, Police adviser on drug policy, organised crime and expert witness, Celadon Pharmaceuticals Plc

Stuart Cornwell, Business Development Director, Celadon Pharmaceuticals Plc

Marika Graham-Woods, Executive Director, Cannabis Trades Association

Stephen Kon, Chief Legal Adviser, Mamedica

Lewis Koski, Chief Strategy Officer, Metrc

Nick Morland, Chief Executive Officer, Tenacious Labs

Nick Pateras, Chief Executive, Lyphe Group

Sian Philips, Executive Director, Cannabis Trades Association

Peter Reynolds, Executive Committee member, Cannabis Industry Council & President of CLEAR UK

Jon Robson, Founder & Managing Director, Mamedica

Dr Callie Seaman, Co-Chair, Cannabis Industry Council

James Short, Co-Founder & CEO, Celadon Pharmaceuticals Plc

Dr Niraj Singh, Psychiatry Consultant, Mamedica

Sarabjeet Sira, Clinical Operations Officer & Superintendent Pharmacist, Mamedica

Andrew Tyler, Chief Marketing Officer & Head of Digital, Mamedica

Tom White, Managing Director, Global Counsel

RESEARCH AND ACADEMIA

UK

Bisola Akintoye, University of Kent

Professor Sir John Aston, Statistics in Public Life, University of Cambridge

Professor Julia Buxton, British Academy Global Professor, Manchester University

Dr Tom Freeman, Director of the Addiction & Mental Health Group, University of Bath

Dr Kojo Koram, Department of Law, Birkbeck University

Professor Susanne MacGregor, London School of Hygiene & Tropical Medicine

Amber Marks, Criminal Law & Co-Director, Criminal Justice Centre, Queen Mary University

Professor Jim Mills, Centre for the Social History of Health and Healthcare, University of Strathclyde

Dr Mark Monaghan, Criminology, Sociology & Social Policy, University of Loughborough

Professor Alex Stevens, Criminal Justice, University of Kent

Professor Harry Sumnall, Substance Use, Liverpool John Moores University

Dr Lucy Troup, Reader in Psychology, University of the West of Scotland

International

Professor Daniel Bear, Faculty of Social and Community Services, Humber College, Ontario

Professor Jonathan Caulkins, Operations Research & Public Policy, Carnegie Mellon University

Dr Davide Fortin, Aix-Marseille University

Emeritus Professor Wayne Hall, National Centre for Youth Substance Use Research, University of Queensland

Professor Andrew Hathaway, Department of Sociology and Anthropology, University of Guelph

Stijn Hoorens, Director of RAND Brussels & Senior Research Lead, RAND Europe

Professor Caitlin Hughes, Centre for Crime Policy and Research, Flinders University

Professor Keith Humphreys, Psychiatry & Behavioral Sciences, Stanford University

Beau Kilmer, McCauley Chair in Drug Policy Innovation & Co-Director, RAND Drug Policy Research Center, California

Professor Simon Lenton, Director, National Drug Research Institute, Curtin University

Professor (Assistant) Meredith Meacham, Department of Psychiatry & Behavioral Sciences, University of California, San Francisco

Professor (Associate) Akwasi Owusu-Bempah, Department of Sociology, University of Toronto, & Director of Research for the Campaign for Cannabis Amnesty

Professor Rosalie Pacula, Elizabeth Garrett Endowed Chair in Health Policy, Economics, & Law, Price School of Public Policy, University of Southern California

Dr Mafalda Pardal, Research Leader & European lead, RAND Drug Policy Research Centre

Professor Rosario Queirolo, Department of Social & Political Sciences at the Universidad Católica del Uruguay

Professor Peter Reuter, Director of Programme, Economics of Crime and Justice Policy, University of Maryland

Professor Alison Ritter, Director, Drug Policy Modelling Program, University of New South Wales

Professor Thomas Friis Søgaard, Department of Psychology & Behavioural Sciences, Centre for Alcohol and Drug Research, Aarhus University

OTHER

UK

Ben Bond, facilitator, Cannabis Clinic for Patients with Psychosis, South London and Maudsley NHS Foundation Trust

Adrian Brearey, Main Manager, Exhale Harm Reduction Centre

Michael Fisher, Founder, Exhale Harm Reduction Centre

Ad Gridley, PEER mentor, Cannabis Clinic for Patients with Psychosis, South London and Maudsley NHS Foundation Trust

Robert Jappie, Partner (Regulatory), Fieldfisher

Chris Snowden, Head of Lifestyle Economics, Institute of Economic Affairs

Sharon Thompson, Novel Foods Policy Advisor, Food Standards Agency

Paul Tossell, Team Leader, CBD and Radiological Policy Team, Food Policy Division, Food Standards Agency

Patrick W

International

Dr Kenneth Finn, Medical School, University of Colorado

Pat Oglesby, Attorney, tax policy consultant and founder & CEO of the Center for New Revenue

WRITTEN SUBMISSIONS

We were grateful to receive written submissions and materials from a range of individuals and organisations:

UK

Action on Smoking & Health

Black Thrive (via London Borough of Lambeth)

Centre for Evidence Based Drug Policy

Centre for Justice Innovation

City of London Police

Dr Tom Coffey, Senior Health Policy Adviser to the Mayor of London & Vicky Hobart, GLA Group Director of Public Health

Conservative Group on the Greater London Assembly (via correspondence from Emma Best AM, Deputy Chairperson, Health Committee)

Cranstoun

Trishna Gautama, Teacher of Citizenship, Religious Education and Personal, Social, Health & Economic Education, Stoke Newington School

Chief Constable Dr Richard Lewis, Drugs Lead, National Police Chiefs Council

Liberal Democrat Group on the London Assembly

London Borough of Barking & Dagenham

London Borough of Bromley

London Borough of Haringey

London Borough of Richmond Upon Thames

London Borough of Southwark

London Borough of Wandsworth

Richard Malkin, Jodie Lynn & Naba Siddiqui, Dual Diagnosis Practitioners, Cannabis Clinic for Patients with Psychosis, South London and Maudsley NHS Foundation Trust

Chief Constable Sir Andy Marsh QPM, CEO, College of Policing

Metropolitan Police Service, London

David Sidwick, Police & Crime Commissioner, Dorset

Hamish Stewart, Chair, London Cannabis Legalisation Commission

Dr Hannah Walsh, King's College London

International

Lieutenant Diane M. Goldstein (Ret.), Law Enforcement Action Partnership

Lars Küthe, Chief Detective Inspector, Frankfurt Police, Germany

MEETINGS & VISITS

We also attended wider events and made several visits:

Celadon Pharmaceuticals, Birmingham

International round table co-hosted by the All Party Parliamentary Group for Drug Policy Reform and UNITE

Mamedica Clinic, London

Study Tour of Cannabis Social Clubs, Barcelona

APPENDIX C: LONDONERS' PERSPECTIVES ON USE OF CANNABIS

As part of our evidence gathering we ran an opt-in survey, available online over the summer of 2023 to those living or working in London, to investigate perspectives on non-medical cannabis use. Data tables are presented below. Totals may not sum to 100% due to rounding.

A total of 153 responses were received, although not every respondent answered every question so base sizes vary. Most respondents (n=126, 82%) lived in London, with the remainder (n=27, 18%) working but not living in London.

These results cannot be considered representative of Londoners' views more broadly due to the methodology employed and the small sample. Findings have not been weighted to improve representativeness.

Demographics

Gender	n	%
Male	83	*62*
Female	38	*29*
Other	12	*9*
Total	133	*100*

Age	n	%
16–24	20	*13*
25–34	51	*33*
35–44	39	*25*
45–54	26	*17*
55–64	10	*7*
65+	7	*5*
Total	153	*100*

Ethnicity	n	%
Asian/Asian British	5	*4*
Black/African/Caribbean/ Black British	13	*10*
Mixed/multiple	6	*5*
White	92	*70*
Other	5	*4*
Prefer not to say	11	*8*
Total	132	*101*

Sexuality	n	%
Bisexual	18	*14*
Gay or lesbian	8	*6*
Heterosexual	90	*69*
Other	4	*3*
Prefer not to say	10	*8*
Total	130	*100*

Disability	n	%
No	100	*76*
Yes	21	*16*
Prefer not to say	10	*8*
Total	131	*100*

Household status	n	%
Owned outright	33	*25*
Mortgage	36	*27*
Rented (council/local authority)	6	*5*
Rented (housing association)	9	*7*
Rented (private landlord)	41	*31*
Other	7	*5*
Total	132	*100*

Views on cannabis

How much of a problem is recreational cannabis use in your local area?	n	%
A big problem	10	*7*
Somewhat of a problem	12	*8*
Not really a problem	39	*25*
Not a problem	89	*58*
Don't know	3	*2*
Total	153	*100*

What do you think are the most common effects desired by those who use cannabis? (Choose up to 3)	n	%
Relaxation	108	*71*
Management of psychological discomfort (e.g. stress, anxiety)	*79*	*52*
Pain relief	*73*	*48*
Improved sleep	51	*34*
To have fun	39	*26*
To be sociable	26	*17*
To get stoned	22	*14*
To reduce or cope with boredom	12	*8*
Detachment from reality	11	*7*
Peer acceptance	*7*	*5*
Don't know	4	*3*
Total (respondents)	152	*N/A*

**Respondents gave up to three answers, so totals do not sum to 152 or 100%.*

What do you think are the most common harms from which people who use cannabis may be at risk? (Choose up to 3)	n	%
Lung health problems	90	*59*
A criminal record	*72*	*47*
Paranoia	43	*28*
Psychosis	31	*20*
Loss of motivation	31	*20*
Dependence	30	*20*
Problems with memory	26	*17*
Panic or anxiety	17	*11*
Difficulties in learning new things or studying	*7*	*5*
Mood swings	5	*3*
Violence	5	*3*
Intense nausea and/or vomiting	3	*2*
Suicide	0	*0*
Don't know	5	*3*
Total (respondents)	152	*N/A*

**Respondents gave up to three answers, so totals do not sum to 152 or 100%.*

Who do you think is most vulnerable to any harmful effects of cannabis? (Choose up to three)	n	%
Those aged under 16 years	107	*70*
People with a current mental illness	66	*43*
People with a family history of psychosis or other major mental illness	65	*43*
Pregnant women	39	*26*
16–24-year-olds	37	*24*
25–34-year-olds	5	*3*
35+-year-olds	1	*<1*
Don't know	9	*6*
Total (respondents)	152	*N/A*

Respondents gave up to three answers, so totals do not sum to 152 or 100%.

Cannabis and the law

What is your understanding of the criminal law related to cannabis?	n	%
Production, supply and use of cannabis for any reason are criminal offences	29	*19*
Production, supply and use of cannabis for recreational purposes are criminal offences, but production, access and use for prescribed medical purposes is legal	105	*70*
Production and supply of cannabis is a criminal offence but possession of small amounts of cannabis for personal use is permitted	9	*6*
Don't know	6	*4*
Total	149	*99*

In the UK, cannabis is classified as a class B drug and is therefore illegal (unless prescribed for medical purposes). Below are several ways in which the current law is applied and enforced. For each, please tell us whether you think it is likely to be effective or ineffective in helping manage or reduce any harmful effects that can be associated with using recreational cannabis.

	Being convicted of producing and supplying cannabis risks up to 14 years in prison, an unlimited fine, or both		A person caught in possession of cannabis for their own use risks up to five years in prison, an unlimited fine, or both		Police are able to issue a warning and/or an on-the-spot fine of £90 if they discover an individual to be carrying a small quantity of cannabis deemed for personal use		A police officer has the power to stop and search any person if they have reasonable grounds to suspect they are carrying cannabis	
	n	%	n	%	n	%	n	%
Very effective	6	*5*	5	*4*	4	*3*	2	*2*
Fairly effective	11	*8*	6	*5*	15	*11*	9	*7*
Fairly ineffective	21	*16*	14	*11*	20	*15*	20	*15*
Very ineffective	93	*70*	105	*79*	92	*69*	98	*74*
Don't know	2	*2*	3	*2*	3	*2*	4	*3*
Total	133	*101*	133	*101*	134	*100*	133	*101*

Below are different ways that cannabis is managed in different countries to try to manage or reduce the risk of harmful impacts that can be associated with its use. Please select which ONE of these models you would most support being used in London.

	n	%
Production, supply and possession of cannabis for recreational (i.e. non-medical) use remain criminal offences as now	4	*3*
Production and supply of cannabis for recreational use remain criminal offences but possession of up to a specified (small) amount for personal use results in diversion from criminal proceedings to assessment and support (e.g. drug education or a drug treatment programme). Refusal to engage could result in referral back to the criminal justice system.	5	*4*
Production and supply of cannabis for recreational use remain criminal offences but possession of up to a specified (small) amount for personal use is a minor non-criminal matter which could attract an administrative penalty (e.g. a fine).	1	*<1*
Production and supply of recreational cannabis for sale remain criminal offences, but an individual may grow up to a specified (small) number of plants for personal use OR they may join a cannabis club where their personal allowance is transferred to a registered grower who supplies members for consumption on club premises.	13	*10*
Production, supply, and use of cannabis for recreational use are legal activities and regulated by the government. The recreational cannabis market is controlled by the government in a not-for-profit model.	39	*29*
Production, supply, and use of cannabis for recreational use are legal activities and regulated by the government. The market is commercial (i.e.: a for-profit model), but producers and vendors (sellers) must have a licence to operate.	69	*51*
None of these models	*2*	*1*
Don't know	1	*<1*
Total	134	*100*

APPENDIX D: LONDONERS' VIEWS ON LEGAL APPROACHES TO CANNABIS

As part of our evidence-gathering we added two bespoke questions to the quarterly survey of public attitudes that is run by the Mayor's Office for Policing and Crime.

These explored Londoners' views of how non-medical cannabis should be treated in law, and were added to the quarter 2 (July–September) survey wave in 2022/23.

Data tables are presented below (totals may not sum due to rounding).

Thinking about cannabis laws in the UK, which one of the following statements comes closest to your view?

Question	n	%
The sale and possession of cannabis should remain criminal offences as now	2,024	*42*
The sale of cannabis should remain a criminal offence but possession should be regarded as a minor non-criminal matter	1,398	*29*
The sale and possession of cannabis should be legally permitted (sometimes called legalisation)	1,398	*29*
Total	**4,820**	***100***

Do you think the police should do more or less to control cannabis use in your community?

Question	n	%
Do more	2,362	*49*
What they do now is about right	1,591	*33*
Do a little less		*9*
Do a lot less	868	*10*
Total	**4,820**	***100***