RCPsych Review of Cannabis: medicinal cannabis and cannabis for recreational use

Call for Evidence

About the Review

The Royal College of Psychiatrists is undertaking a review to develop a College position on:

- cannabis use in the UK and how this relates to mental health, incorporating evidence on the biological, psychological and social effects of cannabis
- the use of medicinal cannabis in relation to mental illness.

About this Call for Evidence

RCPsych's review is beginning its work by asking those with expertise and personal experience of medicinal cannabis and cannabis for recreational use to provide relevant evidence. Those who might wish to respond are:

- Academics with experience in these fields;
- patients/service users;
- carers and family members;
- members of staff in mental health services (NHS, independent, or voluntary);
- providers of mental health services (NHS, independent, or voluntary);
- charities or voluntary sector organisations with an interest in this area;
- individuals or organisations working in the criminal justice system;
- other relevant people, bodies or groups.

Responses will be used to inform our areas of inquiry and final reports.

Please read carefully

In completing this consultation, you should understand that your responses may be quoted and used in reports or other outputs from the College.

If you would like us to anonymise your response (i.e. so that you or your organisation cannot be identified in any reports or outputs), then please tick or mark this box: ☐

What this consultation covers

RCPsych's review and this call for evidence cover two separate areas – recreational use of cannabis and medicinal cannabis.

The RCPsych's review extends UK-wide, which will be the context in which it writes, though we are looking to collect all the relevant evidence internationally.

<u>Recreational cannabis</u>

This consultation is looking to gather evidence on recreational cannabis use and will focus on the following topics:

- The prevalence and strength of cannabis used in the UK;
- what effects cannabis use has directly on the likelihood of people developing mental illness;

- criminalisation and marginalisation of cannabis users in the UK and the effects this has on people's mental health;
- synthetic cannabis;
- why people start to smoke cannabis, where this leads them and why they continue or why they stop;
- effects of changes in services in the UK;
- global evidence of effects of different legal approaches;
- reducing mental health harms of cannabis use;
- priorities for research.

Medicinal cannabis

This consultation is looking to gather evidence on medicinal cannabis and will focus on the following topics:

- Medicinal cannabis used to treat mental illness;
- Guidance for clinicians prescribing medicinal cannabis;
- Research needed on medicinal cannabis used to treat mental illness and the barriers to this research;
- Any links between the prescription of medicinal cannabis and the prevalence of recreational use;
- pathways in and out of cannabis for medicinal use.

How to respond to this consultation

This consultation is looking to gain a clear perspective on what the evidence base is on both areas – we ask that people focus on firm evidence, and limit stating personal opinions as much as possible. Please do not feel you have to answer all the questions below – please limit your responses to what you consider to be your area of expertise and where you feel you can add value.

Please provide references wherever possible.

The below boxes are not sized to anticipate answers, please expand as required, do keep your answers as brief and as pertinent as possible.

Please return a completed version of this form to policy@rcpsych.ac.uk by 5pm on Monday 10th June 2019.

About you

Name:	Release
Organisation name (if responding on behalf of an organisation).	Release is the UK's centre of expertise on drugs and drugs law.

Part1: Recreational Cannabis

Part 1A: Prevalence of cannabis in the UK

1. What is the prevalence of recreational cannabis use in the UK? How has this changed over the past ten years?
In the last ten years 'last year use' of cannabis amongst 16 – 24 year olds and 16 – 59 year olds has remained largely stable according to the Crime Survey of England and Wales (CSEW). The most recent data estimated that in 2017/18, 16.7 per cent of young people had used cannabis in the last

12 months, compared to 17.6 per cent in 2007/08 (which was not a statistically significant decrease). The significant fall in cannabis use occurred in the early to mid-2000s according to that survey. However, it should be noted that there are limitations to the survey in that it is a household survey, the CSEW excludes important drug-using populations, such as students in halls of accommodation, people in custodial and other secure settings and rough sleepers. In addition, the survey asks people to admit to criminal activity and clearly some will be uncomfortable to do so. Therefore, it is likely this is an underestimate of prevalence in England and Wales.

2. What evidence is there for the strength of cannabis used in the UK? How has this changed over the past ten years?

During the early to mid-2000s there was a shift in the market, with a significant increase in domestic production of cannabis using hydroponics and a significant decrease in imported cannabis. Reports have indicated that this shift led to the production of cannabis which was high in THC (one of the main psychoactive ingredients) and low in CBD (which has anti-psychotic properties), although as an illegal market it is difficult to properly assess the quality of cannabis. However, if it is accepted that this trend occurred this directly attributable to the illicit nature of the market, essentially the absence of legal controls mean that there is no quality standards.

3. What is the evidence on the regional differences of the prevalence and strength of cannabis in the UK?

We are not aware of any studies which analyse the regional difference in cannabis strength. In terms of prevalence the CSEW analyses personal characteristics including regional differences, in terms of cannabis the lowest reported last year use of cannabis was in the West Midlands at 5 per cent prevalence. The highest prevalence was reported in South West at 9.4 per cent. However, we would refer to our point above about the limitations of the survey and of assessing cannabis quality in an illegal market.

4. What evidence is there for presence of contaminants such as fentanyl in cannabis used in the UK? How has this changed over the past ten years? Are these trends replicated globally? Have different legal approaches around the world had an effect on these trends?

Release is not aware of any evidence that cannabis has been laced with fentanyl anywhere in the world and we are concerned that this is simply another drug scare story, based on the current US administration making this assertion without any evidence to back it up. It makes no sense from the production process to introduce fentanyl into the cannabis market. We also doubt whether fentanyl in a cannabis joint would have any psychoactive effect, given the high combustion point of fentanyl.

Part 1B: The link between cannabis and mental illness

1. What evidence is there for a link between cannabis use and mental illness (psychosis and others)? What is the strength of the evidence? *When answering this question, please consider which individual components of cannabis are relevant and how other factors such as age, frequency of use, genetics etc. affect the levels of risk involved and specify the extent to which evidence points to causation or association.*
This is not Release's area of expertise but we would ask the College to consider rates of schizophrenia, whether there has been a demonstrable increase that aligns with increased prevalence in cannabis use and whether the evidence demonstrates causality rather than mere association. Our understanding is that this is not the case but there seems to be limited studies in the public domain about rates of this illness. The particular experiences of communities of colour in this area are under-researched and merit further consideration.

Part 1C: Criminalisation of cannabis

1. What evidence is there on the extent to which laws criminalising cannabis-based activities are being enforced?
With respect, the first question that the College should consider is to what extent the current law is effective at deterring drug use – which arguably is the main aim of criminalisation. The evidence shows us that this is a failed policy which does not deter consumption of controlled drugs. The Home Office 2014 Drug: International Comparators report compared the experiences of countries around the world, some of whom took a punitive approach to drug use (for example, Japan and Sweden) and some who do not criminalise drug use or possession (Uruguay and Portugal). That report concluded that they "did not in our fact-finding observe any obvious relationship between the toughness of a country's enforcement against drug possession, and levels of drug use in that country". Release's report into decriminalisation looked at 25 countries that had ended criminal sanctions either for all drugs or for cannabis only; none experienced statistically significant increases in prevalence, in some countries it went up slightly, in some it went down. Furthermore, Professor Alex Stevens' review into the impact of liberal reforms of cannabis laws on adolescent use found no correlation in levels of use and the change in legislation. This is a failed policy that does not prevent drug use but does create significant harms to health and to social outcomes, as outlined below. The harms of criminalisation have been well documented. The law is applied disproportionately, with people of colour and those living in poverty being targeted by drug law enforcement; BME individuals are policed and prosecuted for drugs at a higher rate than their white counterparts, which is fuelling ethnic disparities. In 2016/17, black and Asian people were stopped and searched for drugs at almost 9 times and 3 times the rate of white people, and were convicted of cannabis possession at 12 and 2 times the rate of white people, despite lower rates of self-reported drug use (including cannabis use specifically) providing prima facie evidence of discrimination. It is important to note the vast majority of police stop and searches are for drugs, accounting for nearly 60 per cent of all stop and searches. Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) estimates that 70 per cent of all drug searches are for personal possession. This analysis was based on their inspection of 8,000 search records. It is again estimated that a third of all stop and searches, not only drug searches, are for cannabis possession alone. Racial disparities pervade drug law enforcement, with the disproportionate use of drug searches carrying through to sentencing. Black people are more likely to be arrested as a result of stop and search than white people, but less likely to be given an out of court disposal. Arrests from drug

searches halved for white people between 2010/11 and 2016/17, but remained stable for black people. Black people were also prosecuted for drug offences at more than eight times the rate of white people.

From a mental health perspective consideration needs to be given to the impact of over policing, in the form of repeated stop and searches, on the black community. Release has supported young black people who have been subject to such searches on a daily or weekly basis, often on the grounds that the police can 'smell cannabis', which undoubtedly is a stressful and oppressive experience that can impact on a person's wellbeing and their mental health.

Beyond the inequitable application of the laws the damage of a criminal record can be devastating, affecting employment and educational opportunities, stigmatising people and even impacting on their ability to travel to other countries. The experience of criminalisation and incarceration itself can also be deeply traumatic.

In terms of enforcement most police force areas continue to criminalise people for possession of cannabis. In the last decade 395,871 people have been criminalised[1] in England and Wales for cannabis possession offences – of those 20 per cent (80483) were children and 39 per cent (155413) were young adults.[2] There is an opportunity for police to issue out of court disposals for cannabis possession including a street warning and an on the street fine (Fixed Penalty Notice), neither result in a criminal record, however the use of these disposals have fallen significantly in recent years. In 2018 police issued 25,583 cannabis warnings compared to criminalising 18,536 people, in relation to those criminalised 28 per cent were 20 years old or younger.

Although it is not the norm, people are still imprisoned for cannabis possession offences:

- In the last 10 years 3,718 people have been given a custodial sentence, this figure was 339 people in 2017;
- In the last 10 years 1651 young people aged 10-24 were given a custodial sentence, this figure was 137 in 2017;
- In 2017, 40% of people receiving a custodial sentence for cannabis possession were aged between 10-24; and
- In the last decade, 44% of people receiving a custodial sentence for cannabis were aged 10-24.

As the College will be aware the impact of imprisonment can have significant and deleterious effects on people in terms of their physical and mental health.

There is some variation in policing drugs, with four police forces – Durham, Avon & Somerset, Thames Valley Police, and North Wales – implementing diversion schemes for people caught in possession of any drug including cannabis.

Durham's scheme, 'Checkpoint', diverts people after arrest on the condition that they undertake a four month programme to address their offending behaviour. Engagement with the programme leads to a suspension of criminal justice proceedings, successful completion will result in no further action being taken.[3] Some initial findings from the pilot period found those who were diverted to Checkpoint had lower reoffending rates compared to those who were subject to out of court disposals, such as cautions. The Checkpoint cohort reoffended at a rate of 14.6 per cent in the 12 months following participation compared to 21.9 per cent for those receiving out of court disposals.

Participants in Checkpoint also reported improved outcomes in relation to: substance misuse; alcohol misuse; accommodation; relationships; finances and mental health.[4]

Durham's scheme initially included drug possession offences, but due to the success of the scheme this has been extended to include low level supply offences, where the offender is determined to be a user/ dealer. [5]

Whilst Durham's diversion scheme occurs after arrest, Avon and Somerset Police force have implemented an on the street diversion programme in Bristol for those caught in possession of drugs for their own personal use. The 'Drug Education Programme' ('DEP') was initially launched as a pilot in 2016, initial findings came from the first six months of the programme (1 April 2016 – 30 November 2016) by comparing outcomes for people caught in possession of drugs to those caught during the baseline period (1 April 2015 – 30 Novemberl 2015) prior to the implementation of the scheme.

These findings are similar to that of Durham Police, with attendees of the DEP less likely to re-offend when compared to those who had gone through the criminal justice system during the baseline period. The majority of attendees at the DEP reported cessation or reduction in their drug use. Avon and Somerset police also reported that the DEP saved police officers significant resources, the majority of officers reported that a referral to DEP took less than 30 minutes compared to previous disposal methods taking two to four hours. Officers reported that the reduced burden of diverting drug possession offences to the DEP meant that it freed them up to focus on other tasks. Interestingly, the evaluation from Avon and Somerset Police also found that the new approach under DEP led to better relations between the police and people who use drugs, where, when people were treated not as criminals but as those needing care and treatment, they were more likely to cooperate with police officers. [6]

2. What are the reasons for law enforcement's attitudes to the criminalisation of cannabis?

Please see our answer to the question above for more detail, however, it is worth noting that cannabis policing is a particularly easy hit rate for police. The use of as 'smell of cannabis' as a reasonable ground for stop and search is difficult to challenge and although police have been instructed that 'smell' should not be a sole ground for a search they have circumvented that by adding statements such as 'looked dazed' to establish reasonable suspicion. This is arguably one reason why cannabis searches dominated stop and search statistics – it is also worth noting that in nearly 3 out of 5 searches no drugs are found. This figure increases for black people who are less likely to be found in possession of a controlled drug.

3. What evidence is there for the different ways people are affected following criminalisation?

Beyond the information provided above other factors to consider include:

- *Young people* who are found to be in possession of drugs are given a criminal record consequentially diminishing future education, employment and life opportunities. Many

further education institutions have disciplinary measures for students who are found in possession of drugs, which can include temporary exclusion and permanent expulsion from studies[7] – please refer to Question 1D on exclusions.

- Criminalisation undermines effectiveness of prevention & treatment and people less likely to contact emergency services for fear of further criminalisation and arrest. They are also less likely to disclose their cannabis use to medical professionals thus undermining the therapeutic relationship.

Essentially, the balance here is about the harms of criminalisation versus harms of cannabis and there is little doubt that not only is criminalisation unnecessary it is also deeply damaging.

Part 1D: Marginalisation of cannabis users

1. What evidence is there of other forms of marginalisation caused by use of cannabis – exclusion from school, losing jobs, stigma etc.?

Criminalisation – Arguably the most significant form of marginalisation experienced by people who use cannabis relates to the criminalisation of possession for personal use and low-level supply. Please refer to Question 1C on criminalisation.

Stigmatisation – Stigma, discrimination and the demonisation of people who use drugs (including cannabis) is reinforced through use of dehumanising language and the fact they are defined as criminals first and foremost.

Exclusion from education – Schools and higher education institutions (including universities and colleges) across the UK exclude students from education, on both a temporary and a permanent basis, for a range of behaviours related to the use of cannabis – the most common being possession of cannabis for personal use.[8]

Employment – Employers are also reluctant to hire people with a history of cannabis use, many of which have a 'zero tolerance' policy and incorporate random drug testing as part of the recruitment processes as well as being grounds for dismissal[9]. People can be dismissed from their job for testing positive for cannabis, without necessarily having been under the influence of cannabis while on the job.

Driving – As the threshold level of Delta-9-Tetrahydrocannabinol (i.e. the main psychoactive ingredient in cannabis) for roadside tests is extremely low (2 mcg/L blood), and well below the 5mcg/L blood limit recommended by the Wolff Committee[10], "frequent/heavy users will have a store in their system that can re-release so may test positive after many days even if they haven't used"[11]. This means that people can be banned from driving for a minimum of 12 months, fined an unlimited amount of money and/or face up to 6 months in prison, without necessarily being under the influence of cannabis while driving. In addition to the negative impacts associated with having a criminal record, this can also create additional issues around employment (particularly if the person needs to drive for work), car insurance, and traveling to countries like the US.[12]

Housing – Neighbour complaints to the police or local authority, for example where a neighbour claims to have smelled cannabis, can lead to a person being evicted, as this will constitute a breach of their tenancy agreement. People can also be prosecuted under section 8 Misuse of Drugs Act 1971 for 'knowingly permitting' the occupier of a premises to smoke cannabis, for example where a parent is prosecuted for their child smoking cannabis in the house.[13]

2. How many people are affected by this and in what way are they affected?

Criminalisation – Please refer to Question 1C on criminalisation and ethnic disproportionality in cannabis policing and prosecutions.

Stigmatisation – This can present significant barriers to accessing health services, thereby undermining the effectiveness of prevention and treatment[14]. Mothers who have a history of drug use, are likely to be hesitant to access treatment due to a fear of losing custody of their children[15]. Similarly, pregnant women who use drugs and are "accused of endangering the foetus"[16], which can deter them from accessing vital health services. Additionally, people of colour, sex workers and those identifying as LGBT+ also face substantial vulnerabilities and are less likely to access drug services citing social exclusion, experience of discrimination and a lack of cultural needs amongst barriers[17].

Exclusions – In the 2016/17 academic year, there were 565 permanent exclusions and 9,075 fixed period exclusions that were 'drug or alcohol related', from state-funded primary/secondary and special schools in England.[18] Over the same period, there were 361 drug-related school exclusions in Scotland.[19] Release is also concerned that BME pupils may be disproportionately excluded from school for cannabis-related reasons, given the evidence that pupils from Traveller of Irish Heritage and Gypsy/Roma ethnic groups and Black and Mixed ethnic groups are disproportionately excluded from schools[20]. Research undertaken by Release and the National Union of Students also found that in the 2016/17 academic year there were at least 21 permanent exclusions from higher education for possessing a drug for personal use across the UK.[21] The report also identified a number of other punitive institutional responses to students that are caught possessing drugs, including temporary exclusion, reporting the student to the police, referral to fitness to practice procedures (for example where a medical student can be barred from practicing medicine), and the use of surveillance measures such as drug swab testing and sniffer dogs on campus. While it is not possible to identify cannabis-related exclusions from these data sets, it is fair to assume that a significant proportion of these will relate to cannabis, given the high prevalence of cannabis use among young people compared to other drugs. Beyond the immediate impact of being excluded from education, exclusions seriously impede young peoples' life chances, for example by: "losing the opportunity to gain qualifications; being refused admission to other universities/colleges, particularly if their fitness to practise (to join a certain profession) has been called into question; debt from tuition fees; loss of potential earnings from graduate employment; marginalisation; stigmatisation; estrangement from family or family financial support being revoked."[22] A recent study also found that pupils excluded from school at 12 were 4 times as likely as other children to be jailed as adults[23], suggesting that exclusions increase exposure to the criminal justice system.

There is no publicly available data on the number of people who use cannabis affected by marginalisation related to employment, driving and housing. Nevertheless, Release has supported a number of clients over the years, who have experienced marginalisation in these areas, through our legal and expert witness services. Please refer to Question 1D (1) on the impacts of marginalisation in these areas.

Part 1E: Synthetic cannabinoids

1. What effect have synthetic cannabinoids had on the use of cannabis in the UK and mental health in general and what effects has it had on the groups in which it is used most commonly?
To be clear, Synthetic Cannabinoid Receptor Agonists (SCRAs) are a product of prohibition and the UK's enforcement-led approach to drugs as producers sought to produce products that mimicked cannabis but which fell outside the legislation. [24] Unlike Cannabis, SCRAs are a variation of chemically diverse compounds - as of December 2017 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was monitoring more than 670 substances including 51 substances that were reported for the first time during 2017.[25] Available evidence suggests that SCRA use is prevalent amongst some of the most disenfranchised and marginalised populations, such as the street homeless, socially excluded teenagers and people in prison with fewer life opportunities.[26] Arguably the SCRAs that are currently on the market are not comparable to cannabis and people are now seeking out these substance for its specific psychoactive effects.

Part 1F: Pathways in and out of cannabis

1. What evidence is there for why people start to use cannabis for recreational use, where this leads them and why they continue or stop?

Part 1G: Services:

1. What evidence is there for changes in services in the past 10 years affecting the use of cannabis in the UK and the harms associated with it? *Please include details of all relevant services, including addiction, mental health, children's and social services.*
Local authorities became responsible for funding and commissioning drug services under the Health and Social Care Act 2012, while facing an estimated 37.3% reduction in central government funding between 2010/11 and 2015/16[27]. As a result, "drug misuse treatment" faced more reductions in funding than any other public health area in 2016/17 with a 14% reduction in funding between 2015/16 and 2016/17[28]. Net expenditure on adult drug and alcohol services has decreased by 19 per cent in real terms between 2014/15 and 2018/19[29]. There was also a 9% reduction in 2016/17 compared to 2015/2016 for specialist young people drug treatment services[30]. These services cater for young people and are important given the development needs, legal framework and safeguarding obligations, which adult services may not be equipped to deal with or understand. Cuts to drug services are a "false economy"[31] – Public Health England estimates that for every £1 invested in drug treatment there is a £4 social return[32]. In its review of commissioning, the Advisory Council on the Misuse of Drugs rightly concluded that *"the quality and effectiveness of drug misuse treatment is being compromised by under-resourcing"*[33]. Release is seriously concerned that, in the context of substantial disinvestment in drug treatment and harm reduction services and a recovery agenda, evidence-based harm reduction interventions for cannabis are being undermined. Further to this, vital investments for specialist drug treatment and harm reduction services that provide support for additionally impacted people who use drugs, such as people of colour/BAME communities; single parents, particularly those who are accessing DV services; sex workers; LGBT+; those living with disabilities; those with precarious citizenship status should be prioritised.

2. What evidence is there of outcomes of patients treated for cannabis-related disorder in mental health services?
People with coexisting drug and mental health problems are not receiving an appropriate assessment of their needs as the quality of care is undercut by the organisation of services. Despite 41 per cent of people starting drug treatment in England stating they had a mental health need in 2017/18, "contractual arrangements in statutory services block people with a dual diagnosis, forcing them to refer to voluntary sector bodies"[34]. It is important that individuals are not turned away from either drug treatment or mental health services but rather are supported through an open-door policy. Release clients who present with a dual diagnosis will often be told by mental health services that they cannot be treated until they have addressed their drug dependency, despite the fact their drug use is a coping mechanism to deal with their mental health problems. This approach leaves vulnerable, marginalised people without the specialist support they need.

Part 1H: Global Evidence of effects of different legal approaches

1. What is the global evidence of the effects that different legal approaches to use, supply and production of cannabis have on use of cannabis (including prevalence of use, purity, components and strength) and the effects on mental illness and rates of mental illness?
Release advocates for decriminalisation, in recognition that the evidence from other countries demonstrates that this approach can effectively reduce harms. Research undertaken by Release looked at 25 countries across the globe that had decriminalised personal use and possession of drugs – the majority of countries that we looked at had decriminalised possession of all drugs, only handful had restricted the policy to cannabis possession. As such Release would like to outline the evidence from these countries in relation to all drugs, and would respectfully ask the College to consider extending the review of the College's position to all controlled substances not just cannabis. Decriminalisation has been associated with reduced rates of recidivism, reduced burden on police resources and savings to the public purse related to social costs. By decriminalising the possession of controlled drugs for personal use, resources could be diverted from the criminal justice system into health and other services for people who use drugs (PWUDs). Portugal decriminalised by ending criminal sanctions for possession of all controlled drugs in 2001, while also investing in harm reduction initiatives, treatment and prevention. Now people caught in possession are instead referred to a dissuasion committee to see whether they need help to address their substance use – in over 80 per cent of cases proceedings are adjourned. The drug-related death rate in Portugal was "4 deaths per million in 2017, which is lower than the most recent European average of 22 deaths per million". Other positive outcomes have included: • Decrease in use amongst problematic users & young people becoming dependent on drugs such as heroin; • Decrease (over 40 per cent) of the estimated numbers of people who inject drugs; • Increased treatment engagement; • Significant decrease in HIV and TB transmission; • Decrease in prison population; • Reduced burden on criminal justice system allowing police to focus on serious crimes; • Improved relationship between the community and police; and • Decrease (18 per cent) in the social costs of drug use in the first 10 years of decriminalisation

The Czech Republic also decriminalised the possession of all illicit drugs in 2010. One influencing factor was a cost-benefit analysis of Czech drugs legislation in 2002 that was undertaken by the National Drug Commission. After a two-year evaluation research found that penalisation of controlled drugs had: not affected availability; prevalence increased; there were higher rates of initiation of drug use amongst young people; and social costs increased significantly.[35]

The rate of drug-related deaths is 22 per million in the Netherlands, 16 per million in Spain, 5 per million in the Czech Republic, 8 per million in Italy, 4 per million in Portugal and 21 per million in Germany (EMCDDA Country Drug Reports 2019). These rates are all significantly lower than the UK's drug related death rate of 74 per million of the population (EMCDDA, 2019). While the lower rates of drug-related deaths in these countries will not necessarily stem from the legal framework, it is nonetheless noteworthy that all of these countries have ended criminal sanctions for drug possession offences under various models of decriminalisation. Arguably, better health outcomes can be achieved when drug dependency is viewed through the lens of public health rather than criminal justice.

Decriminalisation is also associated with positive social outcomes. Research from Australia compared outcomes for individuals who had been criminalised for cannabis possession, to those who had received civil sanctions. Of those criminalised 32 per cent reported a negative impact on employment compared to 2 per cent who were given civil sanctions, for accommodation it was 16 per cent versus 0 per cent. Furthermore, 32 per cent of respondents who were criminalised reported further contact with the criminal justice system compared to zero per cent of respondents who received a civil penalty.[36]

The United Nations System Chief Executives Board for Coordination (UNCEB) recently called for the decriminalisation of drug possession for personal use, joining the likes of the World Health Organisation and the Global Commission on Drug Policy.

To reiterate we would respectfully ask that the College take a broader view on current drug policy in the UK and support the decriminalisation of all controlled drugs in recognition of the positive health and social outcomes that can be achieved, especially for some of the most marginalised in society.

In relation to the effects of regulating cannabis as they have done in 10 US states, Uruguay and Canada (with quasi legal models also existing in Spain and the Netherlands) we would refer to the evidence submitted by Transform Drug Policy Foundation.

Part 1I: Reducing harm

1. What evidence is there on the most effective methods of reducing the mental health harms associated with cannabis use and the specific effects of cannabinoids?

The most effective way to reduce harms is to end the criminalisation of people who use cannabis, and all controlled drugs. Release can simply not imagine how criminalisation can be viewed as a positive for the people who use drugs, especially those who need to engage with psychiatric services. As stated, the evidence for decriminalisation is clear, drug use does not go up but it can create a safer environment for people to access services therefore having a positive effect on their mental health.

2. What evidence is there on the ways in which people are educated on the effects of cannabis?

There is limited evidence for the effectiveness of drugs education in its current format. In terms of problematic use this is often driven by adverse childhood experiences (ACEs) and mental health problems, to address this Release would advocate for a scaling up of trauma and mental health services in educational instructions beginning at primary school. More broadly we support harm reduction education, in recognition that some people, including young people, will use drugs and we should be advising them to use as safely as possible.

Part 1J: Research

1. What do you think are the top two priorities for researchers looking into the relationship between cannabis and mental health?
1. Harms of criminalisation – researchers should focus on the current policy context and how that contributes to harm experienced by people who use cannabis. 2. Research in the UK and other parts of the world focus on the harms of cannabis rather than the potential benefits. Research shows cannabis is less harmful than alcohol, consideration should be given to the benefits of cannabis use in terms of enjoyment, relaxation and social cohesion.

Part 1K: Other comments

1. Is there anything you would like to add to the above, or any other key areas the Review should be focussing on?
N/A

Part 2: Medicinal Cannabis

Part 2A: Medicinal cannabis products for mental illnesses

1. How strong is the evidence-base for cannabis-based medicinal products for use to treat mental illness? *When presenting your evidence, please clarify what mental disorder and what treatment you are referring to.*
Please see attached our joint briefing to the Health and Social Care Committee on medical cannabis which addresses some of the issues raised in this call for evidence.

2. What action, if any, do you think should be taken by governing bodies and clinicians to reflect this evidence-base?
As above

Part 2B: Guidance on medicinal cannabis

1. What guidance is required for clinicians on how they should prescribe medicinal cannabis in the UK, especially in relation to possible adverse mental health effects and also other effects including impaired driving ability?

As above

Part 2C: Research into medicinal cannabis

1. What research is needed into the use of medicinal cannabis for treating mental illness?
This is not within Release's area of expertise but we support the submission of Drugscience.

2. What barriers are in place preventing research into medicinal cannabis for use for mental illness?
As above

3. How can these barriers be overcome?
As above

Part 2D: Link between medicinal cannabis and recreational use

1. What evidence is there internationally of a link between the prescription of medicinal cannabis the prevalence of recreational use?
We are not aware of any specific studies addressing this issue.

Part 2E: Pathways in and out of cannabis for medicinal use

1. What evidence is there for people's pathways into use of medicinal cannabis and their pathways to continued use and out of its use?
This is not our area of expertise.

Part 2F: Other comments

1. Is there anything you would like to add to the above, or any other key areas the Review should be focussing on?
As stated considering the evidence for decriminalisation from other countries, we would encourage the College to consider widening this review to include all controlled drugs.

[1] By criminalised we mean those who have been convicted of being in possession of a controlled drug and/or those that have received a caution -as this can be used against the individual at a later date in the context of Disclosure and Barring Checks which can effect employment and educational opportunities
[2] ONS (2018) Criminal Justice System statistics quarterly: December 2017
[3] Durham Constabulary (2018) 'Critical Pathways – Checkpoint', https://www.durham.police.uk/Information-and-advice/Pages/Checkpoint.aspx (accessed 25 March 2018)
[4] Durham Constabulary & Durham Police and Crime Commissioner (2017), *"Checkpoint: An Innovative Programme to Navigate People Away from the Cycle of Reoffending: Implementation Phase Findings",* Durham PCC (provided via email by Durham PCC on 16 March 2018)
[5] https://www.independent.co.uk/news/uk/home-news/drugs-addicts-heroin-not-face-prosecution-durham-police-chief-constable-mike-barton-a8063486.html - WILL ASK DURHAM FOR A BETTER REFERENCE
[6] Luckwell J. (2017) *'Drug Education Programme Pilot: Evaluation Report',* Avon and Somerset Constabulary, 17 March 2017, Pg. 4- 5 (provided by Avon and Somerset police by email 15 March 2018)
[7] NUS and Release (2017) 'Taking the Hit': Student drug use and how Institutions respond
[8] Ibid.
[9] UK Drug Policy Commission (2010) Getting Serious about Stigma: the problem with stigmatising drug users
[10] Report from the Expert Panel on Drug Driving (2013) Driving under the influence of drugs
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