FREEDOM OF INFORMATION REQUEST REFERENCE NO 2022-054

Your request has now been considered under the Freedom of Information Act 2000 (the Act) and we provide our response below.

You asked:

After reading your statements in several news articles, in which you call for cannabis to be reclassified as Class A, equal in harms to crack and cocaine, under FOI, please provide the evidence with which you support your claims and would justify such drastic, draconian and devastating legislative reforms.

Furthermore, having authored a collection of evidence into the effects of cannabis upon human health, I would like to consider your evidence in comparison with the body of evidence curated by myself and "We The Undersigned".

Please take the time to read this body of evidence, which disproves the Gateway theory and proves the prohibition of cannabis is fraudulent and infringes fundamental human rights

https://www.amazon.co.uk/Fight-Rights-Freedom-Choice/dp/1838440119

Your request for information has been considered under the Freedom of Information Act 2000 (the Act) and our response is as follows:

Mr Sidwick was expressing his opinion, which was informed by a variety of external sources. Under the Freedom of Information Act, we are not required to produce material that exists in someone's head, nor to provide information owned by other organisations. Therefore, the answer to your enquiry is 'no information held'. Nevertheless, we are able to supply the submission made by the Police and Crime Commissioner to the Home Affairs Select Committee which may prove useful. It is attached at Appendix A.

DORSET POLICE & CRIME COMMISSIONER DAVID SIDWICK

24 August 2022

Dame Diana Johnson
Chair
Home Affairs Committee
Email: homeaffcom@parliament.uk

Dear Dame Diana,

After I had presented at the Home Affairs Committee on 15 June 2022, you specifically asked me to make a written submission. I waited for an official invite to do so, and what in particular you wanted me to cover, but I may have misunderstood and so have decided to submit my general views on this area. Please note that while I have added references this is not a scientific submission but opinion.

Regarding adding value, I believe I may have a somewhat unique perspective having, prior to becoming Police and Crime Commissioner for Dorset and Co-Chair of the APCC Addiction and Substance Misuse Portfolio, fulfilled two roles of relevance:

1. Central Nervous System Therapy Director on the UK Management Board of Parke-Davis and having responsibility for the chronic pain franchise. This included direct responsibility for gabapentin, pregabalin and ketamine, as well as assessing cannabinoids and opiates as competitors or as possible prescription drugs.

2. Owner and Managing Director of STAC Consultancy, which facilitated the medical education of over 17,500 secondary care physicians and specialist nurse practitioners in difficult to treat areas such as chronic pain, epilepsy and multiple sclerosis amongst others and advised other pharmaceutic companies on pain and epilepsy drug marketing. The chronic pain experience was particularly relevant as, through our Pain Masterclass programme, we were regarded as the gold standard for secondary care education in this area.

I also have close family experience of drug addiction and the issues around it.

The above experiences have given a broad understanding of how to assess clinical work and the issues around treatment in those areas. Basically, this gave good assessment of clinical data and also a good understanding of the drug industry and treatments for chronic pain which is a useful lens for this subject.

We discussed the following subjects and here is the detail and references as appropriate. At the end of this submission are some recommendations. The three subjects covered are:

A. From Harm to Hope
B. Legalisation of Cannabis
C. Consumption Rooms

A. From Harm to Hope

For three years as a candidate for Police and Crime Commissioner I was very clear that there were three things needed to address the harm of illegal drugs in our society: tough enforcement, effective rehabilitation; and impactful education. From Harm to Hope (FH2H)[1] provides a strategy that I believe will be a gamechanger as it addresses all three areas.

Tough enforcement is being delivered locally in Dorset through two main operations:

1. Operation Scorpion, which is a regional approach instigated by five PCCs with their five forces to make the South West a hostile environment for drug dealers and anti-social drug users. It throws a ring of steel around the South West and in its first instigation took nearly £500,000 of drugs and cash. In Dorset alone, aside from the warrants served, £10,000 of heroin was taken from a car on its way from Merseyside.

2. Operation Viper is Dorset's approach to county lines and drugs which operates continually. It is new since April and links up the county lines task force to three new Neighbourhood Enforcement Teams. These operate across Dorset and on the first day alone a warrant was served which led to nearly £100,000 of drugs, both illegal and prescription, being seized and a number of arrests.

Further data on these operations are available from Dorset Police should they be required.[2]

The world class treatment aspiration in FH2H is to be lauded. The only barrier to it achieving its objective is if the new investment is skewed too far towards harm reduction and away from effective rehabilitation. The use of naloxone and some needle exchange is necessary but the focus with the new investment needs to be targeted at abstinence and also across drug types. A focus on opiates alone will not address the increase in cocaine deaths that is currently being seen, nor the general addiction amongst our young people (including that of cannabis which is the most prevalent drug for those in treatment)[3].

The third aspiration in FH2H is to cut intergenerational demand for drugs. This currently discusses the use of sanctions for possession as outlined in the recent White Paper. This is to be applauded with certain caveats, ie those sanctions need to be created with all drugs in mind and fit to all demographics. It would be wrong to focus only on the stereotype of the middle-class cocaine user and ignore other scenarios.

I feel strongly that there is not enough focus as a whole on illegal gateway drugs. The common term of 'recreational drugs' is, I believe, misleading and detrimental. It implies health and wide-open spaces. In reality cocaine, cannabis, ketamine and MDMA are dangerous addictive substances that can harm or kill those taking them. We need both society and particularly for government, to not give any hint of permission or condonement of their use.

The key to changing this, however, is not a criminal justice solution but understanding what education will work and to start raising boundaries whether moral or practical at an early age. FH2H discusses trying to address university use. The problem is far earlier – drug gangs use the term 'Tiny' to describe an infant member and I have been made aware of children as young as eight acting out drug behaviours as play in the school playground. What is needed is a whole system and age view and the passionate commitment of the Department of Education as a partner to address this. There needs to be a societal mission to really engage with this issue and be clear that drug taking is harmful.

B. Legalisation/Decriminalisation of Cannabis

For the avoidance of doubt cannabis, when I use the term, refers to THC containing substances. The current cannabis products contain significantly higher concentrations than in the past.

The argument for the legalisation of cannabis is topsy turvy – those advocating it constantly ask for proof of cannabis being negative rather than making a case for cannabis to prove itself a positive addition to society.

The arguments they put forward are that (i) cannabis is not a gateway drug; (ii) it is harmless and safe; and (iii) if legalised/decriminalised then there would be less crime overall and money could be diverted from law enforcement to treatment.

Taking these arguments in turn:

i. Cannabis as a Gateway Drug

There are a number of arguments that together provide a case for this assertion. Rather than a clinical definition, a more real-world definition of "gateway" as meaning an increased desire or opportunity for taking Class A drugs is taken here. The following arguments and evidence support this gateway statement.

The alcohol argument uses the paradigm of alcohol to explain why cannabis can be seen as a gateway drug. Put simply, people do not just drink low alcohol, or 'light' beers alone – they can gravitate to stronger beers (analogous to stronger concentrations of cannabis) and to other forms of alcohol (analogous to Class A drugs). Common sense tells us this may occur with illegal drugs.

In addition, drug tolerance, or the reduced reaction to a drug following its repeated use, is a widely understood concept within pharmacology. Regular users of cannabis can develop tolerance, meaning they must use larger amounts or higher concentrations to achieve the same effect. Common sense tells us this will occur with illegal drugs, and persistent users over time may gravitate towards Class A drugs.

The Business Model evidence fits with everything that is seen on the ground. There are countless case histories of young people starting on cannabis and gravitating to Class A drugs. Dame Carol Black in her first review clearly shows the business model[4] – drug dealers want users to gravitate to more addictive Class A drugs that not only give more profit per unit but allow greater power to be exerted over individuals to leverage other criminal activity. It is indicative that young people most commonly treated for addiction are those on cannabis. No child ever went to a drug dealer for heroin for their first deal – they would all have started with a bit of weed.

The Neurophysiology argument looks at the anatomy of receptors in the brain - firstly in animals[5] and also in humans[6]. This shows close relationships between cannabinoid receptors and opiate receptors including receptor linkage. Also, cross-sensitisation is thought to occur with heroin.[7] I would suggest that these two points together adds further weight to the argument.

Finally, there is empirical evidence, where decriminalisation has been piloted, that an increase in Class A drug usage was demonstrated. This was shown in Lambeth in 2014, where cannabis was decriminalised and the hospitalisation for Class A drugs increased by 40 - 100%.[8]

The multi-drug use argument also adds weight to this. In Scotland over 8000 users were surveyed and over 75% of cannabis users also take between 2 and 10 other drugs.[9] Intuitively, and with all other evidence pointing that way, they have added to their first drug so either there was an addictive reason for a different experience, or it is purely due to increased access to the supply channel.

ii. Cannabis is not harmless but is an addictive and harmful drug

In the late nineties, a lot of drug companies were researching for chronic pain treatments. Chronic pain is a huge market but requires a symptomatic remedy and also a long-term treatment and as such any such drug has to be safe and effective. Efficacy in chronic pain needs to be demonstrated above the placebo effect and for pain that is 30-50%, so there is a high bar to prove a product works. The side effects that would preclude a product licence were those that were in any way either life threatening, eg carcinogenic or teratogenic (birth defects).

Cannabinoids were unable to get such a product licence and have been unable to do so since. To demonstrate that it is viable it would require large scale clinical studies in reputable peer reviewed journals. For that investment to occur it would need to satisfy safety criteria. That has not occurred.

The risk – benefit decision however is changed for more serious or life threatening circumstances and that is why it is entirely rational to restrict cannabis use to secondary care initiation in serious or potentially fatal conditions where other licenced preparations have failed. This is proportionate and in keeping with other untested or unsafe pharmaceuticals.

It is therefore counter intuitive to support widespread use of a substance that has significant safety issues. It is completely ridiculous to suggest that it should be sold and easily available to the general public.

There is now epidemiological data available from countries and states where there has been criminalisation. This coupled with the new science of genomics means that there is now a unified mechanism that explains why different morbidity occurs.

Cannabis affects 59% of the human genome and therefore can be seen to affect a significant number of bodily systems.[10] In the US this is acknowledged with tiny genotoxin labels on legal products.

The work of Professor (Albert) Stuart Reece and Professor Gary Hulse from University of Western Australia brings all this together. It provides an explanation for the mental health issues seen, as well as flagging other long term health implications from cannabis use. I believe even if they were only half correct this would have huge public health ramifications and this, in association with previous work on psychosis and the gateway issue, provides a clear rationale for not weakening legislation but to strengthen it. I have attached their latest review paper summarising the data to date.

I would recommend that you give Professor Reece a hearing specifically on this – it would be a huge risk to ignore this large body of emerging data much of it published in renowned peer reviewed journals. Their references are shown separately at the end of this submission.

Although there will be other bodily systems implicated such as cardiology and gastro-intestinal, there are four areas to highlight in particular:

Psychosis and Mental Health

Its effect on mental health and particularly psychosis is well known as an issue for cannabis. There have been a number of pieces of evidence in this regard recently:

- In Portugal there has been a 30-fold increase since decriminalisation.[11]
- In the US every four minutes someone is hospitalised for cannabis induced psychosis.[12]
- In Scotland there has been a significant increase (74%) in hospitalisation for psychiatric issues.[13]

- There are other serious mental health conditions such as depression, schizophrenia and autism. The last has been predicted by 2030 to be 60% higher in US States that have legalised cannabis.[14]

Cancer

There appears to be a causal link for cannabis with the most common male cancer – testicular cancer – the most common female cancer – breast cancer – and also common cancers in children amongst others. This has been demonstrated in the US and Europe. [15,16]

Birth Defects

The implication that cannabis has an intergenerational detrimental effect was first suggested in Hawaii.[17] It has now been correlated across both the Europe[18] and US[19]. These include highly significant life threatening or life changing defects such as gastroschisis or phocomyelia. This is concerning as it would appear that cannabis demonstrates similar risks to thalidomide which was the very reason we have a strengthened drug regulatory system.[20]

Premature Aging

There has long been felt that markers of aging such as teeth loss and greying hair/loss were connected with drug use. There is now a clear explanation for why this should be connected to cannabis. It has been shown that cannabis use can accelerate aging by 30% at the age of 30. This could be a way to make the case to young people to not take cannabis in the first place.[21,22]

I would also like to draw your attention to road safety. There has been a significant increase in deaths due to cannabis use in the states where it has been legalised. Particularly noteworthy are Washington State and Colorado.[23,] There is evidence that in addition to the psychoactive effects, cannabis also directly affects the optic nerve causing a loss of peripheral vision and inability to process glare. The latter has implications for driving at night. It would be useful to contact Dr Phillip Drum, a Pharmacist in California with a special interest in cannabis and road safety for more details on this issue.[24]

Finally, cannabis also can kill as witnessed by the death of Damilola Olakanmi [25]. This was actually due to cannabis sweets and this packaging to appeal to young people and children is deliberate targeting and particularly disgusting given the toxicity of the substance.

iii. Cannabis legalisation/decriminalisation will reduce addiction and pressure on the criminal justice system

It can be seen that decriminalisation is a half-way house that just removes cannabis from the criminal justice system but still leaves it being produced illegally. No benefit would accrue and where this has occurred harm has risen significantly. Portugal has been seen as the leader in decriminalisation but there are issues and, for example, Mayor Rui Moreira of Opporto is a believer in re-introducing the criminalisation of drugs to try and get their street criminality under control.[26] Whether legalisation or decriminalisation, the empirical and anecdotal evidence points in all cases in the opposite direction. Let us take a common-sense view and answer the question of what would be the scenarios if cannabis was legalised:

1. Cannabis with a limited strength of THC is legalised

That will mean that with advertising and promotion more people will try the product and become addicted to cannabis. Production is heavily regulated. That will lead to a larger market for drug dealers selling cheaper alternatives to the legal strength and a stronger form of cannabis. It still leads to an increase in Class A drug use as the business model takes hold. No drug dealers give up their illegal activity and their market has been increased; or

2. All cannabis is legalised – no matter what the strength

More advertising and promotion as across all strengths. Production is heavily regulated. Drug dealers produce cheaper and illegally as they ignore regulations, health and safety, etc. Enforcement is opaquer around technical arguments with fines and sanctions being less through bodies like trading standards etc. The market increases for all and drug dealers have an even larger and increasingly groomed pool to drive Class A use. This is exactly the situation in America with some estimates of the cannabis market in California being 80-90% illegally supplied.[27] It is very clear that the drug dealers have not gone away just adapted their business model to take advantage of a new more fertile environment.

In summary, cannabis is an addictive harmful substance that currently is being championed for profit over harm. The only people who would benefit would be the manufacturers and financiers both legal and illegal. Harm and addiction would increase to the detriment of our young people and society as a whole. Does the committee want to recommend and facilitate the widespread use of a toxic substance potentially more dangerous than thalidomide?

I can speak for the Conservative Group of Police and Crime Commissioners in that we are against both decriminalisation and legalisation of all illegal drugs including cannabis.

C. Consumption Rooms/Heroin Assisted Treatment Rooms/Overdose Prevention Rooms

The broad arguments, I believe, are as follows:

- Morality – some of my PCC colleagues hold strong beliefs that it is not moral to help an individual take a toxic substance that is doing them harm. This is particularly the case when it is funded by the taxpayer
- Legality – it is illegal and unless there is primary legislation to change that then that will remain the case
- Facilitation – by making it easier and safer to commit an addictive act it reduces the barriers to said addiction, which could increase the likelihood of drug taking being normalised, and
- Opportunity cost – even if you can remove the arguments above then I would still need the following to be proven. Chiefly, that this intervention is more useful to society than the use of the funding put into either tougher enforcement, effective rehabilitation or diversion, awareness and education interventions. Most operations I have reviewed cost £800k - £1.2m per year, for a relatively low number of clients.

For a pro-consumption room argument to be convincing it would need to be a pilot that could take into account the needs of both the community and society as a whole as well as that of the individual. It would need to be followed over a significant length of time. If there is such a study that demonstrates that the individuals are rehabilitated towards abstinence, the community sees a reduction in crime and the society does not see an increase in drug taking per se then I would say that there is an active discussion to be had. To date, most consumption rooms or similar schemes cannot fulfil those criteria and solely look at the issue from the point of view of the individual.

Closing Remarks

Finally, here are some suggestions for recommendations that could supplement both From Harm To Hope and the White Paper on possession:

1. Efforts should be made to ensure that, among the general population, there is a greater awareness about the harm derived from illegal gateway drugs. This should include age appropriate education in the primary school syllabus.
2. There should be greater treatment and enforcement focus on all illegal drugs, not just heroin.

3. There should be no further discussion about legalisation or decriminalisation of cannabis unless it is proven to pass the efficacy and safety criteria as a pharmaceutical product for general use, such as relief of pain, as a first step.
4. Sanctions for drug dealing near a school or to children under eighteen should be significantly toughened.
5. Modern slavery and child abuse should be considered in all cases of county lines exploitation.

The above submission draws together a number of threads and arguments that address the issues that I discussed at the end of my verbal presentation.

Thank you for giving me the opportunity to raise these points.

Yours sincerely

David Sidwick
Police and Crime Commissioner

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