Cannabis and health[†]

MICHAEL FARRELL and BRUCE RITSON

Cannabis is the most commonly consumed illegal drug and self-reported consumption has continued to grow through the 1990s (Farrell *et al*, 1998). There is little controversy around the reported rise in its use but also little clarity about what has driven this rise. The health effects of cannabis can be discussed with greater dispassion as evidence accumulates. This evidence ranges from discussion on the long-term health effects of cannabis to the debate on the potential therapeutic benefits of cannabinoids in some medical conditions.

Discussions on the health effects of cannabis have often been the lynchpin of the other key debate on the legal status of cannabis. Indeed, it has been argued that the scientific investigation and deliberation on the health effects would resolve decisions on whether to legalise or not. The papers in this issue on the legal, social, psychological, pharmacological and therapeutic aspects of cannabis indicate the complexity of the debate which clearly has no simple right or wrong answer. There is mounting evidence of the adverse physical effects (Ashton, 2001, this issue) and the psychological effects of cannabis (Hall & Solowij, 1998; Johns, 2001, this issue). However, while there is need for an awareness of the negative effects, they are not impressive compared to the adverse effects of tobacco and alcohol misuse. This is not to argue that cannabis should be given the same status as tobacco and alcohol but to recognise a factual comparison. There is a tendency among the proponents of cannabis legalisation to argue that cannabis is devoid of adverse health effects and to ignore the evidence that cannabis itself can induce significant levels of dependence (Hall & Solowij, 1998).

The social and legal status of cannabis cannot be determined simply by the claims for or against on health grounds. Indeed, one of the key determinants of legal status is likely to be social and moral attitudes to a range of psychoactive substances and the anxiety that some patterns of social behaviour are strongly linked. MacCoun & Reuter (2001, this issue) argue that The Netherlands has all but legalised cannabis by regulating its supply through coffee shops. Such an approach is pragmatic. However, it is an unbalanced equation in that it sanctions the consumption of the drug but not the supply and so retains the broader criminal element within this arrangement. The data from The Netherlands are mixed in that they appear to indicate that the coffee shop arrangement has resulted in a form of commercialisation and marketing of cannabis which promotes its further use. It is unclear what effect this social policy has had in Europe as a whole. However, it also indicates that the ready supply of cannabis has not fed the growth of an illegal drugs market to the extent that would concern individuals with serious reservations about changing the current control approach to cannabis.

Added to this is a fresh debate with contributors such as the House of Lords Technical Committee and the British Medical Association on the therapeutic use of cannabis and other cannabinoids. There is a clear need for an evidence-based approach to the therapeutic use of these compounds.

Robson's (2001, this issue) call for compassionate cannabis prescribing is attractive. But it risks placing a complex social problem within an inappropriate medical framework which, while surmounting immediate problems, is unlikely to be the long-term solution to the therapeutic use of cannabis. Studies have begun under the aegis of the Pharmaceutical Society which may go some way towards an evidence-based debate on the therapeutic use of cannabis. However, it is likely that in the longer term the issue of cannabis for a range of medical disorders will be seen as a medicinal matter, as is the case with homoeopathy and other complementary medicines. The therapeutic role of cannabinoids will require separate evaluation.

The body of knowledge on cannabis and cannabinoids continues to grow. The social response to it will be shaped by changing social values along with greater clarity of the issues involved.

REFERENCES

Ashton, C. H. (2001) Pharmacology and effects of cannabis: a brief review. *British Journal of Psychiatry*, **178**, 101–106.

Farrell, M., Howes, C., Taylor, C., et al (1998) Substance misuse of psychiatric comorbidity: an overview of the OPCS National Psychiatric Morbidity Survey. Addictive Behaviour, 23, 908–918.

Johns, A. (2001) Psychiatric effects of cannabis. British Journal of Psychiatry, 178, 116–122.

Hall, W. & Solowij, N. (1998) Adverse effects of cannabis. *Lancet*, **352**, 1611–1616.

MacCoun, R. & Reuter, P. (2001) Evaluaiting alternative cannabis regimes. *British Journal of Psychiatry*, **178**, 123–128

Robson, P. (2001) Therapeutic aspects of cannabis and cannabinoids. *British Journal of Psychiatry*, 178, 107–115.

MICHAEL FARRELL, MRCPsych, National Addictions Centre, London; BRUCE RITSON, FRCPsych, Royal Edinburgh Hospital, Edinburgh, UK

Correspondence: Dr Michael Farrell, National Addictions Centre, 4 Windsor Walk, London SE5 8AF. E-mail: m.farrell@iop.kcl.ac.uk

(First received I7 November 1999, accepted I3 December 1999)

[†]See pp. 101–128, this issue.