SOUTH AFRICAN SOCIETY OF PSYCHIATRY

# SASOP POSITION STATEMENT ON CANNABIS
## Compiled by the Addictions SIG

South Africa, like many other countries, has recently found itself having to re-assess current laws pertaining to the availability and safety of the cannabis plant and its products.

SASOP notes with concern a growing public perception of cannabis as a 'harmless' plant, and that few measures have been instituted to address this.

The Global Burden of Diseases Study (2010) estimates that 2 million years lived with disability were attributed to cannabis (Degenhardt et al, 2013). The South African Community Epidemiology Network on Drug Use (SACENDU) reports that, during the 2nd half of 2016, cannabis was the most common primary substance of abuse for persons younger than 20 years presenting to treatment facilities in all areas across South Africa, except for the Free State, Northern Cape and North West. It is estimated that 1 in 6 teenagers who experiment with cannabis will become addicted to it (Volkow et al, 2014).

Human brain development and maturation is a process that is guided by the body's endogenous cannabinoid system and occurs until the early 20's. Exposure to phyto-cannabinoids (cannabinoids obtained from the cannabis plant) during this vulnerable period may disrupt the process of brain maturation and affect aspects of memory, attention, processing speed and overall intelligence (WHO, 2016). Cannabis use during the adolescent period may cause lasting cognitive deficits, even after sustained abstinence (Meier et al, 2012).

A review article by the WHO (2016) concluded that current evidence points to a modest contributory causal role for cannabis in schizophrenia and that a consistent dose-response relationship exists between cannabis use in adolescence and the risk of developing psychotic symptoms or schizophrenia.

**RECOMMENDATIONS**

1) Any change to the legislation regulating cannabis use should be undertaken in consultation with all the relevant stakeholders, be based on good quality scientific evidence and take into consideration the availability and accessibility of current drug addiction treatment resources in South Africa.

2) SASOP concurs with the Executive Committee of the Central Drug Authority (CDA) of South Africa that the approaches to combat the use and abuse of psychoactive substances should include harm reduction (interventions aimed at reducing the harmful consequences associated with substance use), supply reduction and demand reduction/preventative strategies (Stein, 2016).

3) SASOP agrees with the Executive Committee of the CDA that there is currently insufficient evidence to predict the long-term consequences of the legalization of cannabis.

The ease of accessing an intoxicating substance may have an underestimated impact on the initiation, frequency and amount of use, and the subsequent risk of developing a substance use disorder (Budney et al, 2017). Legalization should therefore not be considered at this point.

4) The decriminalisation of cannabis removes the criminal penalty related to the use of cannabis; it allows for a distinction between a drug dealer and an individual experimenting with or addicted to a drug. While SASOP supports the human rights of all individuals, we argue that a decision to protect those addicted to substances should not be viewed as a simple binary decision based on criminal penalties. In 2001 Portugal augmented the decriminalization of illicit substances with drug dissuasion commissions, increased the number of facilities offering detoxification and therapeutic admissions, increased the number of drug education campaigns and refocused policing efforts on large scale trafficking operations. The decriminalization of cannabis must be preceded by and augmented with similar socially responsible strategies for it to be successful in South Africa.

5) Available evidence does not support the strong positive public opinion and anecdotal reports favouring medicinal cannabis, except for its demonstrated benefits for chronic pain, spasticity due to Multiple Sclerosis and weight loss associated with HIV (Whiting et al, 2015).

Good quality evidence does however exist regarding the frequently occurring side effects of cannabis such as confusion, dizziness, diarrhea, euphoria, fatigue and hallucinations (Whiting et al, 2015).

Any potential benefit obtained from cannabis must therefore be weighed against its risk of causing addiction, psychosis, cognitive impairments and a 2.6 times greater likelihood of motor vehicle accidents (Li et al, 2012). SASOP further notes with concern the growing evidence linking cannabis use with an increased risk of an acute myocardial infarction (Mittleman et al, 2001; Goya et al, 2017) as well as an ischaemic stroke (Wolff et al, 2011; Hackam et al, 2015; Rumalla et al, 2016).

6) SASOP commends the Medical Control Council's decision to limit the use of cannabis for medicinal purposes to registered prescribers and for individuals in which an acceptable justification is provided.

7) SASOP supports ongoing research on the use of cannabis for medicinal purposes to ensure that its purported and potential benefits can be scientifically measured against medical and societal risks.

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