

CONFIDENTIAL

**A REPORT
OF THE
NATIONAL COMMISSION ON GANJA
TO
Rt. Hon. P.J. PATTERSON, Q.C., M.P.
PRIME MINISTER OF JAMAICA**

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EXECUTIVE SUMMARY

The National Commission of Ganja, pursuant to its terms of reference and after a period of exhaustive consultation and inquiry from November 2000 to July 2001, involving some four hundred persons from all walks of life, including professional and influential leaders of society, is recommending the decriminalisation of ganja for personal, private use by adults and for use as a sacrament for religious purposes.

The Commission, after reviewing the most up-to-date body of medical and scientific research, is of the view that whatever health hazards the substance poses to the individual – and there is no doubt that ganja can have harmful effects, these do not warrant the criminalisation of thousands of Jamaicans for using it in ways and with beliefs that are deeply rooted in the culture of the people. Besides, there is growing evidence that the substance does have therapeutic properties.

The Commission interviewed over three hundred and fifty persons in all the parishes, and received written submission from over forty. The overwhelming majority of these share the view that ganja should be decriminalised for personal, private use. Many of them are personally opposed to the smoking of it. The Commission is persuaded that the criminalisation of thousands of people for simple possession for consumption does more harm to the society than could be done by the use of ganja itself. The prosecution of simple possession for personal use and the use itself diverts the justice system from what ought to be a primary goal, namely the suppression of the criminal trafficking in substances, such as crack/cocaine, that are ravaging urban and rural communities with addiction and corrupting otherwise productive people.

Decriminalisation of ganja will require appropriate amendments to the Dangerous Drugs Act, in particular Sections 7C and 7D.

The Commission, after very careful consideration of the legal issues involved, concludes that decriminalisation will in no way breach the United Nations Drug Conventions, which have been ratified by Jamaica. Especially is this so, when arguments of human rights, including the proposed Charter of Rights being discussed by Parliament, are taken into account.

Accordingly, the National Commission is recommending:

1. that the relevant laws be amended so that ganja be decriminalised for the private, personal use of small quantities by adults;
2. that decriminalisation for personal use should exclude smoking by juveniles or by anyone in premises accessible to the public;
3. that ganja should be decriminalised for use as a sacrament for religious purposes;

4. that a sustained all-media, all-schools education programme aimed at demand reduction accompany the process of decriminalisation, and that its target should be, in the main, young people;
5. that the security forces intensify their interdiction of large cultivation of ganja and trafficking of all illegal drugs, in particular crack/cocaine;
6. that, in order that Jamaica be not left behind, a Cannabis Research Agency be set up, in collaboration with other countries, to coordinate research into all aspects of cannabis, including its epidemiological and psychological effects, and importantly as well its pharmacological and economic potential, such as is being done by many other countries, not least including some of the most vigorous in its suppression; and
7. that, as a matter of great urgency Jamaica embark on diplomatic initiatives with its CARICOM partners and other countries outside the Region, in particular members of the European Union, with a view (a) to elicit support for its internal position, and (b) to influence the international community to re-examine the status of cannabis.

ACKNOWLEDGEMENT

The National Commission on Ganja acknowledges with gratitude the hundreds of people, old and young, male and female, artisans, workers, farmers, clerical workers, health, legal and other professionals, managers, unskilled and unemployed persons, policemen, clergy, self-employed, and visitors, who thought the work of the Commission serious and worthwhile enough to be interviewed or to send written submissions, letters and electronic mail.

We thank the Staff of the Office of the Prime Minister (OPM), in particular Mrs Deta Cheddar, the Secretary to the Commission, for facilitating our work, to the OPM in Montego Bay, and to the Local Government Officers and Social Development Commission staff in the parishes, who provided logistic and other support. The Jamaica Information Service made invaluable contribution by bringing the work of the Commission to the general public. Our thanks go as well to the various members of the communications media, who kept alive public interest in the work of the Commission.

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PREFACE

For well over a hundred years, ganja has become the subject of considerable debate and investigation, beginning with the much celebrated India Hemp Commission of 1894, which was followed by no fewer than ten landmark Commissions and studies. Notable among these was the Commission of scientists and experts set up by Mayor La Guardia of New York in 1938, which took six years to complete its Report. Despite the favourable reviews of both these Commissions, yet another study was commissioned by the United States National Institute of Mental Health, subsequently renamed the National Institute of Health, on the long term effects of cannabis use. Led by Dr Vera Rubin of the Research Institute for the Study of Man and Professor Lambros Comitas of Columbia University, the study assembled a panel of United States and Jamaican scientists from the University of the West Indies, and carried out their extensive study in Jamaica from in 1970 and 1971. This study did not find any negative effect that might be attributable to chronic ganja use, but although it provided a basis for some States in the United States to ameliorate their positions, the debate has not only continued but intensified, in the wake of considerable increase worldwide in the smoking of cannabis, especially in the North Atlantic countries.

Then in 1977 the Jamaican Government set up a Joint Select Committee “to consider the criminality, legislation, uses and abuses and possible medicinal properties of ganja and to make appropriate recommendations.” The Committee while rejecting legalisation, on account of Jamaica’s obligation to the 1961 Convention, unanimously concluded that “[t]here was however a substantial case for decriminalizing the personal use of ganja.” It recommended specific amelioration of the law, and that there should be “no punishment prescribed for the personal use of ganja up to a quantity of 2 ozs. by persons on private premises.” It further recommended that ganja be lawfully prescribed for medicinal use.

The fact that these recommendations have been shelved, and that the work of reputable scientists have been ignored would lead the sceptic to suggest that that could well be the fate of the present Commission. Contributing in no mean way to the scepticism is the factual consideration that the original proscription against ganja was never based on medical evidence, but now medical evidence is being sought to justify its continued ban. In recommending decriminalisation for personal use, we do not share the pessimism.

After nine months of consultation and reflection, visits to every parish and hearings amounting to 3776 pages of transcriptions, the Commission is convinced that its recommendations will not go the way of those of all previous commissions and studies, notwithstanding the difficulties that will confront the Government due to Jamaica’s ratification of UN Conventions that seek to prohibit cannabis, except for research and medical-scientific purposes. The reason for the Commission’s sanguineness is what it has uncovered as an overwhelming national and growing international consensus that cannabis should be decriminalised, or at least differentiated from other banned substances.

Nationally, the consensus reaches across the lines that once divided us historically, and that continue to divide us socially, to wit party, class and religion, where none seemed to have existed before, even at the time of Joint Select Committee twenty-five years ago.

Internationally, hardly a week goes by without some intimation of changing attitudes to cannabis. In many States of the United States of America the use of cannabis for medical purposes has been declared legal. Earlier this year Health Canada, Canada's Ministry of Health, issued regulations to create a government-regulated system for using cannabis for medical purposes, the first country to do so. This action has been quickly sanctioned by Parliament which now makes cannabis legal in Canada for terminally ill patients and those suffering certain painful debilities. In June 2001 the British press reports on the launch of a pilot scheme in London in which cannabis offenders are simply warned and sent on their way, instead of being cautioned, arrested, charged and tried. A British Parliamentary Committee is soon to review the matter. British practice lags far behind those of the Dutch and of a growing number of other European countries which have simply decriminalised the personal use of small quantities of cannabis. Portugal, according to press reports, has taken the very bold step of decriminalising the use of all banned substances. An international momentum is clearly underway.

The Report seeks to capture the extent of this national consensus. This is set out in Chapter 3, the main body of the report, but not before a discussion of the methodology (Chapter 1) by which we have undertaken our work and arrived at our conclusions, and a review of the most up-to-date scientific reports (Chapter 2). Having presented this, the Report turns to consider the legal and political implications of our general recommendation, in Chapter 4. One critical issue raised by many experts and witnesses is the attitude of the United States, and this too is taken into account in the context of discussion on our international treaty obligations. The Report concludes with a summary of the recommendations, in Chapter 5, which is followed by the Appendices.

TERMS OF REFERENCE

Whereas there has been long and considerable debate in Jamaica regarding the decriminalisation or non-decriminalisation of ganja in well-defined circumstances and under specific conditions,

Whereas differing views have been urged on the advisability of allowing the possession of specified quantities of ganja, its permissible use by adults within private premises, while continuing to prohibit its smoking by juveniles or by anyone on premises to which the public ordinarily has access,

Whereas some Groups have proposed that its use as a sacrament for religious purposes ought to be sanctioned,

Whereas there is a body of scientific opinion which attests to its medicinal qualities and clinical value,

Whereas serious questions have been raised as to its impact on health, on patterns of social behaviour, its implications for the economy and possible effects relating to crime and security,

Whereas there are international treaties, conventions and regulations to which Jamaica subscribes that must be respected,

In consideration thereof a National Commission is hereby established, with the following of Reference:

- (i) To receive submissions or memoranda, hear testimony, evaluate research and studies, engage in dialogue with relevant interest Groups, and undertake wide public consultations with the aim of guiding a national approach.
- (ii) To indicate what changes, if any, are required to existing Laws or entail new legislation, taking account of the social, cultural, economic and international factors.
- (iii) To recommend the diplomatic initiatives, security considerations, educational process and programme of public information which will need to be undertaken in light of whatever changes may be proposed.
- (iv) To consider and report on any other matter sufficiently relating to the foregoing.

- (v) To make such interim reports as it may deem fit and a final Report within a period of nine months from the first sitting.

September 2000

CHAPTER 1

METHODOLOGY

1. Guided by our Terms of Reference the National Commission of Ganja (NCG) visited every parish capital except one, in addition to several other townships. Exception was Black River, the capital of St Elizabeth, substituting instead, on advice, the market town of Santa Cruz and the seaside village of Treasure Beach.
2. Hearings were of two sorts. The first was *in camera*, in order to provide those who wished the privacy to state their own views in confidence, and without fear of intimidation, recrimination or exposure.
3. The Commission also held hearings in public, in squares, markets and street corners of inner city communities and rural townships, in an effort to reach people who might not have been aware of the Commission or its presence, or who, though aware would otherwise not bother to respond.
4. Aware that a Commission set up to look into the decriminalisation of ganja at the present time would necessarily attract more of those in favour of changing the laws than those against any change, and fearing that in the midst of a vocal majority in favour of decriminalisation those against any amelioration might be inclined to be reticent, the Commission made it a special point of inviting the views of those it believed held conservative positions. Thus, apart from declared Christians interviewed as part of the general public, the Commission interviewed members of the Linstead Baptist Church, the President and students of the United Theological College of the West Indies, His Grace the Archbishop of Kingston, the Lord Bishop of Jamaica, the Chairman of the Church of God in Jamaica, the Reverend Dr Garnet Brown, and two theologians of St Michael's Seminary.
5. Written submissions were also received voluntarily from many persons, most of them living in distant parts of Jamaica or abroad, by post or electronic mail.
6. Scores of organisations and professionals were targeted and invited to submit. While no more than 40% of organisations responded, due largely, we believe, to the fact that most had not worked through a position, those that did were of enormous import to the Commission.
7. The Commission also undertook a literature review, focusing on the most up-to-date summaries, owing to the voluminous corpus of medical and scientific studies that have been on-going all over the world in the course of the last twenty-five years.
8. A comprehensive review of the relevant laws and United Nations Conventions was made, and expert advice sought from legal luminaries.

9. Finally, the Commission availed itself of the opportunity of one of its members on a business trip to The Kingdom of The Netherlands to familiarise itself with practices in that country, one of a few in Europe to have *de facto* decriminalised and regulated cannabis use in small quantities.

CHAPTER 2

THE MEDICAL-SCIENTIFIC LITERATURE

INTRODUCTION AND BACKGROUND

Cannabis sativa plant is called 'ganja' in India and Jamaica, 'marijuana' in North America, 'hif' in North Africa and 'dagga' in South Africa. The plant produces a resin often referred to as 'hashish'.

As early as 2737 BC the Chinese Emperor Sheng Nun described cannabis as a superior herb and for centuries it was embraced unreservedly (Cole 2000). There are records of its use in Arabic medicine dating back to the 8th century. Cannabis sativa was used for over a thousand years as a textile and medicine in Arabia, Mesopotamia, Persia, Egypt, China, India and extensive areas of Europe (Lozano 2001). In 1901 a United Kingdom Royal Commission concluded that cannabis was relatively harmless and not worth banning (Cole 2000).

Cannabis sativa was classified in the 18th century by Carl von Linne. It was first admitted to western pharmacopoeias in the 1800s. In 1839 W.B. O'Shaghnessy at the Medical School of Calcutta observed its use in the indigenous treatment of various disorders and found that tincture of hemp was an effective analgesic, anticonvulsant and muscle relaxant (Grinspoon 2000). It was included in the British, United States and Indian Pharmacopoeias up to 1932, 1941 and 1966, respectively.

Ganja was brought to the West Indies in the middle 19th century by East Indian labourers who came primarily to Guyana, Trinidad and Jamaica. Up until the early years of the 20th century it was widely used as a folk medicine and did not appear to constitute a major social problem.

Beginning in the 1920s, interest in cannabis as a recreational drug grew. During the 1960s and 1970s there was a large increase in the use of smoked cannabis as an intoxicant in the USA and Europe. Starting in the 1980s there has been renewed interest in the potential medicinal uses of cannabis and its derivatives.

RESEARCH

There have been many commissions over the years looking at the effect of cannabis. Some of these are:

- Indian Hemp Drug Commission 1894
- Panama Canal Zone Report 1925

- LaGuardia Commission Report 1944
- The British Wooten Report 1969
- The Canadian La Dain Commission Report 1970
- National Commission on Marihuana and Drug Abuse (USA) 1972
- The Dutch Baan Commission 1972
- Commission of the Australian Government 1977
- National Academy of Science Report (USA) 1982
- Report by the Dutch Government 1995
- Report to the House of Lords (Britain) mid 1990s

There is also extensive research at a number of levels. The use of cannabis engenders strong feelings and many of the research reports reflect this. There is a strong body of opinion that sees cannabis as harmful and advances 'scientific evidence' to prove this. On the other hand there is an equally strong body of opinion that feels that cannabis has been unnecessarily vilified and that it has relatively minor harmful effects and great potential for medicinal use. This group also advances 'scientific evidence' to prove its point. It is therefore necessary to analyse the 'scientific evidence' bearing in mind the source and especially to note those items agreed on by both groups and done by independent groups such as the World Health Organization (WHO).

EPIDEMIOLOGY OF GANJA USE IN JAMAICA

Ganja is widely used for recreational, medicinal (folk medicine) and religious purposes in Jamaica. The 1990 Carl Stone study among respondents age 15 and over island wide showed 47% in the Metropolitan areas and 43% in the rural areas who had ever used ganja. The usage was higher among males than females but cut across all social, educational and economic groups. In the upper income group 46% of males and 25% of females had tried ganja, the figures for the middle income group were 33% of males and 10% of females, and for the lower income group 52% of males and 18% of females.

A national lifestyle survey carried out by the Ministry of Health in 1993 reported that among Jamaicans 15 – 49 years old 37% of the men and 10% of the women had ever used ganja.

A 1997 survey by Ken Douglas among 8,000 in-school adolescents, grades 9 to 13, found 27% had had lifetime ever-use of smoked ganja, a significant increase from the 20% reported in a 1986 school study. In the 1997 study 20% reported ever use of ganja tea. Turning to current use over the preceding 30 days, the study showed 8% had smoked ganja and 6% had had ganja tea.

Recent data coming out of Treatment and Rehabilitation Centres published in the National Council on Drug Abuse *Infosum* for October 2000 shows that some of the clients admitted with a history of smoking ganja had their first use as early as between 5 and 9 years old.

Of 282 clients who went into treatment for a ganja habit in 1999-2000, 4% started using the drug from age 5 to age 9, 26% from age 10 to age 14 and 3% from age 15 to age 19, that is one-third of them started smoking ganja at the age of 19 or below. These figures show the widespread use of ganja in Jamaica and the early age of initiation.

Other studies have sought to look at any link between traffic accidents, trauma and drug use. The role of alcohol is well recognised but the possible causative role of ganja is less clear. Francis *et al.* (1995), in a pilot study of alcohol and drug-related traffic accidents and deaths in two Jamaican parishes, found evidence of alcohol intake in 77.5% of fatalities and 35.5% had alcohol levels above the legal acceptable limits; 22.5% of road traffic fatalities tested positive for cannabis and 3.2% for cocaine.

McDonald *et al.* (1999) took sera and urine samples from 111 trauma patients seen at the Accident and Emergency Department of the University Hospital of the West Indies, Jamaica, over a three-month period. Alcohol levels were tested in the blood and the urine was tested for metabolites of cannabis and cocaine. Results showed 38% of patients negative for any drug, 62% positive for one or more drugs; 15% for alcohol only, 15% for alcohol and cannabis, 25% for cannabis only, 5% for cannabis and cocaine, 1% for cocaine only, and 1% for all three.

Many patients admitted to the psychiatric services on the island report ganja use. For example, approximately 60–80 % of males admitted to the Cornwall Regional Hospital Acute Psychiatric Unit in 1999 gave a history of ganja use, although this was not necessarily the reason for their admission (Abel 2001).

PHARMACOLOGY

Cannabis sativa contains 400 known chemicals. The family of chemically related 21-carbon alkaloids found uniquely in the cannabis plant are known as cannabinoids. There are sixty different cannabinoids. One of these, *delta-9-tetrahydrocannabinol* (THC), is the most abundant and accounts for the intoxicating properties of cannabis. THC dissolves readily in fat but not in water. When smoked, THC is rapidly absorbed into the blood stream, giving perceptible effects within minutes. When taken by mouth peak effect may not occur for hours but last much longer. The THC also persists in the brain longer than in the blood, so that psychological effects persist for some time after the level of THC in the blood begins to fall.

THC is widely distributed in fatty tissue of the body, whence there is slow release, thus producing low levels of THC in the blood for several days after a single dose, although there is no evidence that any significant pharmacological effects persist for more than 4-6 hours after smoking and 6-8 hours after ingestion.

It is now recognised that THC interacts with a naturally occurring system in the body, known as the cannabinoid system. THC takes effect by acting upon cannabinoid receptors. Two types of cannabinoid receptors have been identified, namely the CB1 receptors and the CB2 receptors.

CB1 receptors are present on nerve cells, in the brain and spinal cord as well as in some peripheral tissues; CB2 receptors are found mainly in the immune system and are not present in the brain (NCDA1998).

The CB1 receptors are distributed differentially in the various regions of the brain, in a pattern that is similar throughout a variety of mammalian species, including humans. Most of the receptors are in the basal ganglia, cerebellum, cerebral cortex and hippocampus. A rough correlation appears to exist between the distribution and some of the effects of cannabis. For example, binding sites in the hippocampus and cortex are linked to the subtle effects of cannabis on cognitive function, while those in the basal ganglia and cerebellum may be associated with cannabis-produced ataxia (WHO 1997).

From animal experiments, CB1 receptors seem to mediate pain relief, memory impairment, control of movements, lowering of body temperature and to reduce gut activity. It is also assumed that they mediate the intoxicant effects of THC (NCDA 1998).

Little is known about the physiological role of the more recently discovered CB2 receptors, found in macrophages (white blood cells) in the spleen, but they seem to be involved in the modulation of the function of the immune system.

The presence of this cannabinoid system has implications for further research into the effects of cannabis on the body and the potential beneficial uses of cannabis.

EFFECTS OF CANNABIS

Acute effects

A state of euphoric intoxication is induced. There is mild intoxication, relaxation, increased sociability, heightened sensory perception and increased appetite. In higher doses acute effects can include perceptual changes, depersonalisation and panic (WHO 1997).

Other behavioural changes associated with cannabis intoxication include loss of time sense, sensation of 'high', anxiety, tension and confusion (Matthew *et al.* 1993). Intoxication with cannabis leads to slight impairment of psychomotor and cognitive function, which is important for those driving a vehicle, flying an aircraft or operating machinery. Subtle impairment of cognitive function may persist for twenty-four hours.

There is sufficient consistency and coherence in the evidence from experimental studies and studies of cannabinoid levels among accident victims to conclude that there is an increased risk of motor vehicle accidents among persons who drive when intoxicated with cannabis (WHO, 1997). Cannabis can impair various components of driving behaviour, such as braking time, starting time, and reaction to red lights or other danger signals. However, persons under the influence of cannabis may perceive that they are impaired and where they can compensate, they do so.

Such compensation may not be possible when they are presented with unexpected events and hence the risk of accidents remains higher following cannabis use (WHO 1997).

A study carried out on the effects of cannabis on aircraft pilot performance showed that cannabis use impaired flight performance at 0.25, 4, 8, and 24 hours after smoking. These results suggest that human performance while using complex machinery can be impaired as long as 24 hours after smoking as little as 20mg of THC, and that the user may be unaware of the drug's influence (Leirer *et al.* 1991).

There is a short-term effect on the cardiovascular system. There can be an increase in the heart rate and lowering of the blood pressure. This would be of concern in persons with ischaemic heart disease (angina).

A single dose of cannabis for an inexperienced user, or an over-dose for a habitual user, can sometimes induce a variety of intensely psychic effects, including anxiety, panic, paranoia and feelings of impending doom. These effects usually persist for only a few hours.

Signs of intoxication include blood-shot eyes, lack of coordination, enhanced sensations and perceptions, increased appetite, dry mouth, possible dizziness and nausea.

Effects on the Brain—Psychiatric/Psychological

Cannabis (THC) is said to affect the neurons (brain cells) in the information processing section of the hippocampus, the part of the brain that is responsible for memory and the integration of sensory experiences with emotion and motivation.

Literature on both sides recognise that short-term memory can be affected in the acute phase of ganja intoxication. This does not seem to affect recall of previously learned items but does appear to interfere with the learning of new material. Researchers note great variation in results to cognitive testing and point out that individual response to marijuana varies considerably (Zimmer and Morgan 1997).

Marijuana's effect on cognition in the real world seems to depend on the time and place people choose to use marijuana and the tasks they are performing. In the laboratory, marijuana temporarily impairs short-term memory and learning. In real world structured settings, such as the classroom, it is likely to have similar effects (Zimmer and Morgan 1997).

Several studies have shown that cannabis appears to increase the perceived rate of the passage of time. Cannabis is also known to impair psychomotor performance in a wide variety of tasks, such as handwriting and tests of motor coordination.

There is less agreement about the long-term effects of ganja on the brain. Some authorities state that chronic marijuana use interferes with the interplay of chemical and electrical impulses between brain cells, causes shrinkage and death of brain cells.

However, other authorities point out that the experiments showing death of brain cells were carried out in animal models exposed to concentration of THC about 100-fold higher than even a heavy marijuana user would be exposed to. It is stated that in other studies exposing monkeys to amounts equivalent to 4-5 marijuana cigarettes a day for a year these findings could not be replicated (Zimmer and Morgan 1997). The early claims of gross anatomical changes in the brains of chronic cannabis users have not been substantiated by later studies with high-resolution computerized tomography, in either humans or primates (Rimbaugh *et al.* 1980; Hannerz and Hindmarsh 1983).

It is felt that learned behaviours, which are dependent on the hippocampus, deteriorate after chronic exposure to THC and that chronic abuse of cannabis is associated with impaired attention and memory. It is also reported that prenatal exposure is associated with impaired verbal reasoning and memory in pre-school children (Abel 2001).

Zimmer and Morgan point out that during the past thirty years, researchers have found, at most, minor cognitive differences between chronic marijuana users and non users, and the results differ substantially from one study to another. Based on this evidence, it does not appear that long-term marijuana use causes any significant permanent harm to intellectual ability. Even animal studies, which show short-term memory and learning impairment with high doses of THC, have not produced evidence of permanent damage.

Studies (Fletcher *et al.* 1996) have shown that the long-term use of cannabis leads to subtle and selective impairment of cognitive functioning. Prolonged use may lead to progressively greater impairment, which may not recover with cessation of use for at least 24 hours (Pope and Yurgelum-Todd 1995) or 6 weeks (Solowij *et al.* 1991), and which could potentially affect functioning in daily life.

Not all individuals are equally affected. The basis for individual differences needs to be identified and examined. There has also been insufficient research to address the impact of long-term cannabis use on cognitive functioning in adolescents and young adults, and on different age groups and genders (WHO 1997).

The Diagnostic Statistical Manual IV for classification of disorders and diseases recognises the following conditions:

- Cannabis Dependence
- Cannabis Abuse
- Cannabis Intoxication
- Cannabis Induced Psychotic Disorder
- Amotivational Syndrome
- Cannabis Induced Anxiety Disorder
- Cannabis Induced Mood Disorder.

Cannabis dependence is seen as compulsive, habitual use and not a physiological dependence or addiction. Tolerance to most of the effects of cannabis has been reported in individuals who use cannabis chronically (Abel 2001).

Studies conducted over many decades in a variety of settings have found that when high-dose marijuana users stop using the drug, withdrawal symptoms rarely occur and when they do, they tend to be mild and transitory (Zimmer and Morgan 1997). The presence of withdrawal symptoms is one of the markers for addiction. It is therefore felt that cannabis is a weakly addictive drug but does induce dependence in a significant minority.

However, in the WHO report, **Cannabis: a health perspective and research agenda**, it is stated that clinical and epidemiological research has clarified the status of the cannabis dependence syndrome. A reduced emphasis on the importance formerly attached to tolerance and withdrawal symptoms in diagnostic criteria for dependence has removed a major reason for scepticism about the existence of a cannabis dependence syndrome.

Research using standardised diagnostic criteria has produced good evidence of a cannabis dependence syndrome that is characterized by impairment, or loss of control over use of the substance, cognitive and motivational handicaps which interfere with occupational performance and are due to cannabis use, and other related problems such as lowered self-esteem and depression, particularly in long-term heavy users. As with other psychoactive substances, the risk of developing dependence is highest among those with a history of daily cannabis use. It is estimated that about half of those who use cannabis daily will become dependent (Anthony and Helzer 1991).

Since tolerance and withdrawal symptoms are still widely regarded as diagnostic criteria of substance dependence, it is worth noting that there is abundant experimental evidence of tolerance to many of the effects of cannabis. There is not yet universal agreement about the production of a withdrawal syndrome (WHO 1997).

Apart from the acute psychic effects noted previously, cannabis intoxication in some instances may lead to a longer lasting toxic psychosis involving delusions and hallucinations that can be misdiagnosed as schizophrenic illness. This is transient and clears up within a few days of termination of cannabis use.

It is well established that cannabis can exacerbate the symptoms of those already suffering from schizophrenic illness and may worsen the course of the illness (NCDA 1998; WHO 1997).

The occurrence of an “amotivational state” in long term heavy cannabis users with loss of energy and the will to work has been postulated. However some feel that this represents nothing more than an ongoing intoxication (NCDA 1998).

Studies of high school students show that heavy marijuana use is associated with academic failure. Heavy marijuana users have lower grades and lower career aspirations than occasional users or nonusers. Heavy marijuana users are also more likely than occasional users or nonusers to drop out of school before graduation. However, most high school students who use marijuana heavily were performing poorly in school before they began using marijuana. Most have a number of emotional, psychological, and behavioural problems, often dating back to early childhood (Zimmer and Morgan 1997).

It is therefore possible that the underlying problems lead to the marijuana use rather than the marijuana being the cause of all the problems. When studies control for other factors marijuana use makes no significant contribution to high school student's academic performance (Zimmer and Morgan 1997).

It is noted that there are a number of factors that influence the effects cannabis may have on an individual. These include:

- Potency of the cannabis (the THC content of marijuana is said to have increased from the 1960s to the present time and varies among different plants)
- The route of administration
- The smoking technique
- The dose
- The setting
- The user's past experience
- The user's unique biological vulnerability to the effects of cannabis.

Effects on other organ systems

Respiratory System

Tobacco smoking causes a number of lung diseases, including chronic bronchitis, emphysema and cancer. Except for their active ingredients—nicotine and cannabinoids—bacco smoke and marijuana smoke are similar with a greater concentration of the carcinogenic benzathracenes and benzpyrenes in marijuana smoke.

In the United States, marijuana smokers typically inhale more deeply and retain smoke in their lungs longer than tobacco smokers. As a result, marijuana smokers deposit more dangerous material in the lungs each time they smoke. However it is said to be the total volume of inhaled toxic material over time that matters and not the amount inhaled per cigarette. It is further postulated that even heavy marijuana smokers never reach the smoke consumption levels of heavy tobacco smokers (Zimmer and Morgan 1997).

Theoretically, the risks to the respiratory tract of smoking marijuana are similar to those of tobacco smoking. In human studies, it has been shown that the principal respiratory damage caused by long-term cannabis smoking is an epithelial injury of the trachea and major bronchi (WHO 1997). The alveolar macrophage, the key cell in the lung's defence against infection, has been shown to be impaired by cannabis smoke in both animal and human studies (WHO 1997). Studies suggest that regular cannabis consumption reduces the respiratory immune response to invading organisms. Further, serious invasive fungal infections as a result of cannabis contamination have been reported among individuals who are immuno-compromised, including a series of patients who were affected by AIDS (Denning *et al.* 1991).

These findings suggest that persistent cannabis consumption over prolonged periods can cause airway injury, lung inflammation, and impaired pulmonary defence against infection. Epidemiological studies that have adjusted for sex, age, race, education, and alcohol consumption, suggest that daily cannabis smokers have a slightly elevated risk of respiratory illness compared to non-smokers.

Reproductive System

Studies, including a Jamaican study, have shown lowered sperm count and motility in ganja smokers compared to non-smokers (NCDA 2001). There is no demonstrable difference in testosterone level or levels of female sex hormones. In neither male nor female have researchers produced evidence of permanent harm to reproductive function from either acute or chronic marijuana administration. There is no convincing evidence of infertility related to marijuana consumption in humans (Zimmer and Morgan 1997).

Results from research looking at effects of cannabis smoking in pregnancy vary. Some reports point to an increased risk of early foetal death, decreased foetal weight and premature birth. In animal studies, THC has been shown to produce spontaneous abortion, low birth weight and physical deformity—but only with extremely high doses, only in some species of rodents, and only when the THC is given at specific times during pregnancy. Studies with primates show little evidence of foetal harm from THC (Zimmer and Morgan 1997).

There is reasonable evidence that cannabis use during pregnancy impairs foetal development, leading to a reduction in birth weight, perhaps as a consequence of shorter gestation, and probably by the same mechanism as cigarette smoking, namely, foetal hypoxia (WHO, 1997).

There is ongoing research, for example the Ottawa Prenatal Prospective Study, looking for possible effects of prenatal exposure to cannabis on later development. So far there is no consistent evidence of any significant difference in the development of children exposed to prenatal cannabis as against those not so exposed. The study suggests that any long-term consequences of prenatal exposure to the child are very subtle. (Fried 1980; Fried 1995).

Another study suggests that in utero exposure to cannabis can affect to some degree the mental development of the growing child (Day *et al.* 1994).

MEDICINAL USES OF CANNABIS

The medicinal uses of cannabis are well documented in the modern scientific literature. Using either smoked cannabis or extract preparations from the cannabis, researchers have conducted controlled studies.

The broad range of potential therapeutic applications of cannabinoids reflects the wide distribution of cannabinoid receptors throughout the brain and other parts of the body.

The possibility of distinct subtypes of cannabinoid receptors and the probable development of new compounds to bind selectively to these receptors, as either agonists or blockers, may well open the door to the selective treatment of a number of disorders.

Areas in which cannabis has been shown to have therapeutic use are:

- Reducing nausea and vomiting
- Stimulating appetite
- Promoting weight gain
- Diminishing high intraocular pressure from glaucoma

There are also reports of use of cannabis for:

- Reduction of muscle spasticity from spinal cord injuries
- Reduction of muscle spasticity and tremors in multiple sclerosis
- Relief of migraine headaches
- Depression
- Seizures
- Insomnia
- Chronic pain

Although an anti-emetic effect of THC had been suggested as early as 1972, the first report of a placebo-controlled trial came in 1975 from one of the top oncology centres in the USA (Hollister 2001). An oral preparation, dronabinol, has been used especially in cancer chemotherapy patients for control of the side effects of nausea and vomiting. Although smoked marijuana is often preferred by the patients, whether it is superior to orally administered THC has not been tested in controlled comparisons (Hollister 2001). Smoked cannabis is more immediate in its effects than oral THC. Cannervert is also available for use in motion sickness.

The use as an appetite stimulant is of particular use in cancer and AIDS patients. In the USA, approximately 16 per cent of the total AIDS population suffer from the progressive anorexia and weight loss known as AIDS wasting syndrome. An open pilot study of dronabinol in patients with AIDS-associated wasting syndrome showed it effective in increasing weight as well as being well tolerated (Hollister 2001).

The international literature recognises the role cannabis can have in reducing intraocular pressure in glaucoma. Local researchers, Professor Hon. Manley West and Dr. George Lockhart developed the extract Cannasol, which is now registered and used in the treatment of glaucoma. Another product, Asmasol, was developed based on the Cannasol research, for the treatment of cough, cold and bronchial asthma. There was also work done by the late Professor Sir John Golding and Professor West towards developing a protocol for use of a cannabis preparation in the control of pain in terminally ill patients (NCDA 1998).

In Europe, cannabis has been anecdotically reported to help in the symptoms associated with multiple sclerosis. Published trials have shown some positive results especially for spasticity, the pain associated with spasticity, tremor and urinary bladder control (NCDA 1998). An antispasmodic action of THC was confirmed by the first clinical study (Petro and Ellenberger 1989).

There is undoubtedly need for much further research into the potential of the medicinal use of cannabis and its extracts.

CONCLUSION

Information on the effects of cannabis on physical and psychological functioning has increased greatly, as has knowledge of the extent and patterns of use. However, there is still a need for further research in several important areas, including clinical and epidemiological research on human health effects, chemistry and pharmacology, and research into the therapeutic use of cannabinoids. Moreover, there are important gaps in knowledge about the health consequences of cannabis use (WHO, 1997).

There needs to be continued objective research and ongoing public education about all aspects of Cannabis sativa use.

CHAPTER 3

THE FINDINGS

A. WIDE PUBLIC CONSULTATION

The overwhelming majority of persons appearing before the Commission feel that ganja should be decriminalised, but are united in restricting its use to private space and to adults. Their arguments are presented in this section.

(1) personal benefits

These range from miraculous-like cures to relief from simple colds, but they include well-known ailments and symptoms such as asthma and glaucoma. The Commission received many personal testimonies of benefits from either smoking ganja or ingesting it as tea or medicine steeped in rum. We heard the tale of a woman whose beast of burden was cured from the ashes stuffed in a wound; of a man stricken as a schoolboy with dengue fever, who drank the tea and was cured overnight; of a former Jamaica Constabulary Force member whose chronic hypertension, after nineteen years of prescribed medication, completely disappeared with the now regular smoking of ganja. We quote the story of a prominent professional stricken with cancer, who not only was “violently against ganja in the first place”, but also at one time shared responsibility for ensuring that the country’s exports were drug-free. Saved by the anti-nausea properties of ganja, but carrying a moral burden of falling on the wrong side of the law, he carefully and in measured wording argued that “*to impose restrictions and to impose the taint of illegality on something that may be used really as a home remedy, like mint tea or ginger tea or cerasse tea or whatever it is, creates an additional burden for those who are ill and imposes, it seems to me, a situation which reduces their ability to fight and overcome the condition which they are in*”.

The stories of the personalised benefits of ganja are so deeply entrenched in the folklore of the people that we do not think any warnings as to its danger or attempt to suppress its use by punitive sanction stand any chance of success. More so because of recent scientific advances in manufacturing legal drugs from it as well as much publicised changes permitting “medical marijuana” at State levels in the United States and in Canada.

(2) *God and the natural order*

The Commission interviewed many people for whom the present laws fly in the face of God, the Creator. Their argument is that ganja is a natural, not a man-made, substance, given by God to be used by mankind as mankind sees fit, the same way that He provides other herbs and bushes. As a natural substance, ganja does not even have to be cultivated. Spread by birds and other vectors, it grows wild. It therefore cannot be eradicated. God also created other poisonous herbs but none of these is subject to the prohibition imposed by the law. In the simple words of a thirty-two year old handyman in Montego Bay, *“the weed don’t really have no revenge carrying because it comes from God. He created all earth, trees, seeds, you know, so if you are going to fight against it you are fighting against what He does. You already know that man fight against a lot of things that He does. If you are going to charge a man for it you have to charge God because God make it.”* Or in the words of a sixty-five year old retired postal service worker, *“I hate to hear the word legalise, because how can you legalise the thing that God create? People must think weh dem talking, man. God say every herb is made for man, so God wen wrong when he mek ganja? God wen wrong? I tell you I hate to use the word legalise because you can’t legalise weh God create, because God a God!”*

Among many people we spoke with in the streets, the influence of Rastafari mythology was clearly felt. One eighty-year old male Evangelist, who spoke of ganja as a creation of God, echoed the belief that it first appeared on the grave of King Solomon.

With such deeply-held religious views, which cut across gender and age, many regard the existence and prosecution of the laws against ganja as evil.

(3) *not a crime*

We met no one who regarded the simple possession or use of ganja as a crime in itself. There were those few, who, opposed to any change whatever, saw it as criminal by definition, that is criminal because the law says it is. But of the hundreds of people who spoke no one saw the drinking of ganja tea, or folk remedy use, as a socially harmful act belonging to the category of offenses against other persons. In other words, ganja use to them is not immoral. Many Christians found smoking in general to be reprehensible, if not sinful, and so categorised ganja smoking, but they too saw nothing essentially criminal about drinking it for tea or using it for medication.

(4) *inequity*

Universally, in the Commission's visits throughout the island, the views were everywhere the same: it was grossly unfair that alcohol and tobacco already proven to be more harmful substances were legal but ganja was criminal. "*What happen to tobacco weh a kill nuff people and a give people cancer*", angrily asked a young man in an inner city community, "*how dem legalise that and have that pon di shelf?*" His colleague-participant in the street corner interview before the Commission, replied: "*A pure hypocrisy dem keep up pon we. You know what a man tell me se and me have fi look pon him? The man look pon me and say, 'Is not everybody weh you see poor is fool'. And one o' di thing weh dem a use pon wi is dem thing deh like herb*" [This is all hypocritical. Do you know what a man told me that made me respect him? The man said, 'Not everyone poor is a fool.' And herbs is one of those things that think we do not see through].

The difficulty of reconciling the legal status of tobacco, a known cause of lung cancer, or alcohol, a known cause of death, with the illegal status of ganja, not known in its entire history for having been the cause of a single death, led some to speculate that this was a form of the whiskey-drinking classes trying to keep down the poor man from having his "poor man whiskey", or of the "white people" suppressing the colonial peoples of Asia, Africa and the Americas, or, finally, of the liquor and tobacco companies stifling potential competition.

(5) *alleviation of stress*

Stress alleviation is a personal benefit, but we single it out because of the peculiar psychological effect attributed to it by so many we spoke with. A man told us of his experience, when, as a young man, he had taken a resolve to kill a policeman who was relentless in harassing him, but how a smoke of ganja calmed him, put the conflict in perspective, and saved the lawman's life as well as his own.

This calming effect was cited by many. According to one rural landowner who himself has been a chronic user, the legalisation, which he believed could not be mooted at the present time, would "*reap untold benefits in terms of social calm, in terms of reducing the friction that exists between the people and the police*". His views were echoed by a thirty-two year old inner city resident, who explained that "*more time you wi deh pon the road and some likl punk wi get you pissed off, and you do so bam, you burn a spliff, you cool, you just easy. It calm you down. That is what me know it do, it do for the body. It calm you.*"

A resident in yet another inner city community explained to the Commission the importance of ganja in the prisons: "*You see all a man weh deh pon long sentence? A herbs a man use and run him sentence! That is why you see herbs haffi smuggle inna jail, no care what happen—herb dem man-deh use and run dem sentence!*" [Take the case of a man on long sentence. It's the herbs he uses to cope with his sentence. That's why the herbs has to be smuggled into prison, no matter what—it's herbs those men use to cope with their sentences].

He went on to say of themselves, “*We weh deh pon di road, we a prisoner, too, because we deh in a little segment. A herb we have fi use fi keep our control said way! A it mek we can go on day to day underneath dem stress ya weh wi a face. A herb wi have fi bun more time fi hold it and so that we don’t do silly things!*” We understood him to mean that they too, although technically free, were prisoners of the ghetto, their “little segment”, and resorted to ganja to keep control over themselves, to keep from doing “silly things”, that is running afoul of the law.

(6) criminalising the non-criminal

Many were the submissions to us that addressed the danger to society already posed by criminalising ganja. A corollary of (c) above, the lumping of ganja users together with men who have committed serious crimes against the person only serves to corrupt them. According to many, the jailed ganja offender is often forced into a situation where unless he exhibits “bad man” ways he cannot survive the lock ups, or where he develops sympathy for hardened criminals or enter into relations with them. Having gone in as a law-abiding person, except for ganja, which no one regards as wrong, he returns a bitter opponent of the rule of law.

Others, including one officer of the law, identify the criminal problem with ganja as coming not from its effect on the user but from the illegal and immoral activities surrounding the growing and trafficking of it. Their views coincide remarkably with the views of experts who cite the effect of Prohibition in the United States up to the 1930s. Complete legalisation of all banned substances, these experts argue, would cripple the criminal syndicates and organisations that are reaping vast amounts of wealth controlling the production and distribution, and by placing the emphasis on education and rehabilitation would be less costly to State and society than the efforts to suppress.

(7) crack/cocaine

Almost everywhere it went, in town, in country, the Commission heard tell of the scourge which crack/cocaine addiction has had on communities. In terms of social impact, ganja use was far less a threat than cocaine addiction. A sixty-two year old housewife in a passionate statement, told the Commission:

As I stand up here, I have a son and him have eight subjects in CXC. And if I stand up here him will sell me. I can’t take mi eye off him. Him break mi place and him do all manner of evil. Sometimes me say me would a buy something and poison him kill him. Me naw tell you nuh lie, you know. Mi say I woulda give him a good plate a food and see him dead. Mi tired a it, me get fed up. Well if him did a smoke the ganja, me nuh think him woulda gwaan so. The coke mash up the people-dem. A dat the people must hail out on, not the ganja. I don’t smoke and I don’t know what dem get from it, but I believe a di coke dem fi stan up pon.

This mother's pain was intense and personal. But other depositions made before the Commission represented that serious erosion of the social fabric, which once guaranteed the stability and sociality of community life, has been taking place. The corruption crack/cocaine has brought about poses, they believe, a serious threat to the society. They link the call to decriminalise ganja to the urgent need to curb the cocaine menace.

B. VIEWS OF EXPERTS AND INFLUENTIAL LEADERS

Written and oral submissions were made by a number of professionals, volunteers and persons of influence in the country, whose expertise and special interest make their views compelling.

(1) Professional and volunteer workers with Addicts

In their own individual capacities, several professionals and volunteers declared their support for the decriminalisation of ganja to the extent set out in the Terms of Reference. Their arguments cover some of those proffered by the general public, for example the inconsistency where tobacco and alcohol are concerned, but include as well:

- (i) the fact that ganja is not manifestly harmful for the majority of people who use it in one form or another;
- (ii) the inability to suppress it by legal means;
- (iii) the wasteful use made of the criminal justice system, in terms of its human and financial resources; and
- (iv) the compromising of the anti-drug message.

In relation to (iv) the views of two experts are well worth quoting *verbatim*.

Expert 1: In our school programme there is no perception of harm in the use of ganja, none whatsoever. So, let us say the education is the key.

Expert 2: It is very, very hard to convince these young people that they should not smoke it.

Expert 1: Personally, I am not so sure whether decriminalising would make a big difference. Our young people are trying to give us a message and we are not listening to them. They have not bought [our] message, and for some reason the education that we have been giving them maybe has not been clear. They are getting cross-messages.

Chairman: Are you saying that young people are using...ganja as a way of telling us something?

Expert 1: I think the fact that the usage is so widespread and it is growing, not just here, but right throughout the world, I think they are trying to tell the world that “we are not buying your message”.

Expert 2: I think what you are saying is that the type of education that is out there, what young people are saying is that “we don’t believe that is so”. So it comes back to who develops the policies and who develops the materials. Most of them [who develop the policies and materials] don’t really understand what this drug is all about anyway. And if you tell a child that marijuana is going to impair their memory, but their mothers and their grandmothers and everybody around them have been using it for the last twenty years and they don’t see any harm, they are not going to believe the message. So I think, when we look at the message, the type of education, it needs to be developed by people who really know, people who are in recovery, people who work with young people every day, people who used the drugs themselves.

Expert 1: Not tying the message of ganja in with other drugs. There has been a tendency that a drug is a drug is a drug. And drug education went across [like that]. And, really, from my own experience working with young people, that is not working. We have to be much more specific in the fact that we are doing education on ganja, that it is specific and we are not linking it with a drug like cocaine.

The gist of this excerpt is that current education to discourage ganja use by children lacks credibility. For it to succeed, ganja should be separated from hard drugs, its criminal status reversed, and the education around it framed and carried by people with personal experience of the substance. All the experts, and indeed all but a very few of the over two hundred users and non-users who made depositions, argue that ganja, particularly in the form of smoking, should be kept away from children. Many were the examples brought to us of students, almost always boys, who became demotivated after beginning to smoke ganja. To convince such young people to refrain requires an entirely different strategy from that adopted for the control of other substances, particularly crack/cocaine.

(2) Counselling Psychologist

A trained Counselling Psychologist, with many years experience working at the Bellevue Mental Hospital, and in managing a drug rehabilitation centre, spoke on his own behalf.

Carefully distinguishing between the legal status of cannabis and its effects, he presented a case that the legal status of the substance was not due to its effects. The same was true of the 1919 ban on cocaine under the Harrison Act in the United States, as well as the ban on alcohol and the lifting of the prohibition in 1933. The 1937 ban on marijuana was not guided by medical knowledge. What motives there were, he opined, could have been economic, but he was convinced from his historical research that medical motives were not the reason.

Turning to the effects, the Psychologist pointed out that it was true that ganja had ill effects, in particular as a dis-inhibitor in young users. But, both those who supported and those who opposed the status quo, by being one-sided, were victims of a jaundiced view. “Those who support the legalisation sometimes speak as if the drug has absolutely no harmful effect. I think they are speaking maybe not out of ignorance but out of anger for the lies that have been told on the drug, to the extent that they ignore some of the truths in their defense of it. The harm that marijuana can cause cannot in any way justify it being illegal. If that were the case, we should maybe make ackee illegal, because by far ackee contains one of the most deadly substances that human beings can ever come in contact with.”

He supports decriminalisation, pointing to the threat to the rule of law entailed in maintaining laws that cannot be enforced.

(3) *CODAC*

Under the National Council on Drug Abuse, scores of Community Development Action Committees (CODACs) operate at community level. The Commission heard from individual members in several areas of the country, all of them supporting decriminalisation. One of the most persuasive, however, was the Coordinator of a CODAC from a working-class community in Kingston.

“The community supports conditionally the decriminalisation of possession of ganja for personal use, not because it is harmless—all smoking is harmful, but under the present law otherwise law-abiding persons are treated as criminals. The smoking of ganja should be a health concern and not a criminal matter; not an act for punishment but a matter of medical instruction and help. In addition, for every individual arrested and charged, several are not apprehended. One youth is held at a corner and taken to the police lock-up, but hundreds of individuals blow ganja smoke in the face of other spectators at the National Stadium unchallenged. Feelings of partiality and injustice are harboured and people lose respect for the system of law.”

The Coordinator addressed several critical issues. One was the gap created between the community and the police. Young men refrain from joining the well organised Police Youth Clubs because as ganja smokers the clubs bring them too close to the police, who they feel more easily frame a smoker than a non-smoker.

The women also—mothers, sisters, girlfriends—dislike the police for harassing their sons, brothers and spouses over a splif “while they, the police, are having dealings with the ganja men.”

More critical is the need to look beyond the fact that young people are using cannabis, to **why** they are using it. Faced with deep emotional and psychological problems, some of them peculiar to their stage of development, others to their social and economic status, they turn to ganja.

“We have found that in our community six youngsters who were involved in firing guns—they say they were defending the area from others, in all these cases their fathers were gunmen, killed by gunmen. In two instances the fathers were thieves, killed by the police. Now, somehow they seemed able to go along with this, until they reach fifteen, sixteen, and then the anger starts to come out.

One young person says he hates every May and June. Why? We found out. Mother’s Day is in May and Father’s Day is in June, and he knows neither mother nor father. And this is somebody who has been to a Technical High School, and he is under so much stress sometimes. So when he said, ‘Do you know that I used to defend a gun?’ I said, ‘Well, I am not surprised.’ He said, ‘I used to hold up people, too, you know.’ The emotional problems, what happens inside! They are having real problems, emotional problems. I think we tend to talk to them but we don’t listen to them. We don’t hear what they have to say.

I think it is established that most of the youngsters are regularly abusing ganja because of these other emotional and psychological problems and they all tell us that it is a comfort. It relaxes them. Nearly every single one whom we have spoken with tell us this, that, you know, when you are out there the weekend, [and] you don’t have anything to eat and there is no work, nothing, and somehow these things come across to you. And then they sit down there and the pressure comes on, and then they take it [ganja].

Now, two boys are having similar problems, stressed out. One his mother takes to her doctor and the doctor prescribes a tranquilizer. The other on the street has no mother, no money—his tranquilizer is a splif. The trouble is that he keeps using it, because I suppose it is like you are having a headache, you take Panadol or Phensic. When this comes up for him, he just takes another splif and forgets what is happening. Now when you try to take that away from him, he becomes very angry and turns against the whole system, and says, ‘Look, all of you are against us!’”

The CODAC’s answer is a strategy that focuses not on the evils of ganja but on demand reduction, in the context of attending to the root problems. In this way the respect of the youths is won and they are inclined to take advice. Such a strategy, however, necessarily demands decriminalisation as the first step, before being able to tackle the emotional and social problems. Hence, the CODAC’s recommendations:

- “(1) For private personal use as a cigarette splif and bush tea, a lineament, on private premises—no arrest.
- (2) Smoking it in public places, public gatherings, a misdemeanour, and that is for openly disrespecting the law, and putting non-smokers at the risk of intoxication. In that case—a ticket, as in a traffic offence. The person receives a ticket to appear in the Drug Court.
- (3) Students eighteen years and under smoking it in public should be taken to the Principal for the school to decide if the school will undertake to provide counselling or other support for that student, or if the Principal feels that the case should go to the Drug Court.”

The Coordinator drew attention to the canvassed opinion of Guidance Counsellors from fourteen schools, most of whom opposed decriminalisation, their major concern being that it would remove the one barrier preventing students from smoking ganja. But in his opinion, the Counsellors were ill-informed, “they do not fully understand what is involved”.

(4) *The National Council on Drug Abuse (NCDA)*

The Chairman of the NCDA presented to the Commission the position of the Council on the decriminalisation of ganja. Premised on its mission to reduce the supply and demand of illicit substances and the abuse of licit ones, the Council works with other agencies in implementing prevention projects.

The Council notes the important derivatives of ganja being marketed for medical use, but is aware of its acute effects, which have implications for learning and motor skills, and the possible negative effects of chronic use on production in both the private and public sectors. It is aware as well of the psychosis produced by excessive use and of marijuana-modified psychiatric states, which worsen certain psychiatric illnesses.

Notwithstanding all this, and in light of the worse effects produced by other substances that are legally available, the Council “support[s] the decriminalization of ganja, such as to allow the possession of small, specified quantities, by adults for use within private premises,” with a number of measures aimed at primary prevention, protection of the general public, and rehabilitation of habituated users.

Decriminalisation would have to take into account Jamaica’s obligations to the treaties and conventions it has signed and ratified, but the Council “is aware that many countries are considering the modification of their laws in respect to Ganja.”

What led the Council to adopt such a position? “I can tell you,” replied the Chairman of the Council. “One—the way it became a criminal act was totally unacceptable in this day and age. It should not have been there in the first place.

Two—when we examined the other substances now which are available and legal, we see that the damage that those things cause are much more potent than the evidence we have for ganja.... When you think of alcohol, the organ damage which results from alcohol you would be appalled—cancer of the throat, cancer of the stomach, cirrhosis of the liver, cancer of the liver, testicular atrophy, brain damage, pancreatitis, heart disease—can I stop there? Okay, let’s talk about tobacco—lung cancer, throat cancer, cancers, emphysema, heart disease, hypertension. Those substances are legal and available. So, ... even though it has psychological influence, to use a splif should not be a criminal act.”

The Council’s position is the result of seminars and workshops, which included scientific and legal presentations.

(5) *Medical Association of Jamaica*

The President of the Medical Association of Jamaica spoke on behalf of the Association.

The Association is of the view that the present laws of criminalising people for small amounts “is probably having a worse effect than if it had been legalised,” though the Association is not recommending legalisation. Possession of small amounts for personal use, within the confines of the home and not in public places, as long as this does not impinge on the rights of others to be at peace with themselves, could be decriminalised.”

(6) *The Chief Medical Officer*

The Chief Medical Officer of Health, Dr Peter Figueroa, spoke to the Commission in his own individual capacity as an epidemiologist. He began by reminding the Commission of the widespread cultural significance of ganja, substantiated by a 1993 lifestyle survey which found an “ever smoked” incidence of 37% among men of ages 15 to 49, and 10% among women of similar age. Forty percent of these men and 22% of these women were what he would define as heavy users, that is they smoked three or more times weekly. Listing some of the side-effects to both short-term and long-term use, he drew the conclusion that “the use of ganja is adverse to good health and needs to be discouraged,” but proposed that a different approach ought to be adopted to those substances that are culturally endemic from those that are newly introduced into society. “I am of the view,” he said, “that criminalising ganja use when the use is personal and private does not make any sense.” It does not, because, if the objective is to reduce use, experience (certainly with cigarette smoking) shows that prevention is more effective than treatment and rehabilitation. “[F]or me decriminalisation is simply a platform in order to better control and prevent the use of ganja. My own view is that to try any kind of educational programme in a climate of criminalisation, you are not going to get anywhere, given the endemic use and the strongly-held confirmed views.”

But even in a decriminalised context, education, though necessary, will not be enough to make prevention successful.

Again, drawing from his wide experience with tobacco use, the Chief Medical Officer said: “There are studies to show that where educational programmes are put in place with young people—serious programmes, starting from young age right through school, if you don’t have the other measures in place, what happens is [that] the cigarettes are promoted.” Other measures include limiting access through taxation and banning use in certain spaces, and serious health warnings with every purchase. In the case of ganja these must include measures that provide an environment supportive of the education, such as banning its use in public. “Decriminalisation,” he emphasised, “is a platform for a strategic reduction of ganja use in the society, not for freeing up a lifestyle.”

(7) *Political Leaders*

The Commission presents the views of two leaders in representative politics, one a medical practitioner and member of the Jamaica Labour Party (JLP), the other a practicing attorney and member of the People’s National Party (PNP).

- (i) According to Dr Horace Chang, from a professional point of view “I don’t see the risk involved in the use of ganja justifies it being made an illegal drug.” He reminded the Commission that from as early as the 1970s a youth organisation he had established within the JLP called for decriminalisation. This position was taken to Parliament by Dr Percy Broderick, and resulted in the setting up of a Joint Select Committee of the House and Senate. Nothing came of it, however, so “we have kind of come full circle twenty-three years later”.

The medical problem with ganja, as far as he saw, was ganja psychosis, which affected no more than 0.5% of users. Most legal drugs had side effects, anyhow, often more serious and far-reaching than ganja. It was better, he felt, to educate around the risks than to ban wholesale a substance that was quite clearly cultural.

He raised what he saw as a far greater problem, that of cocaine, and shared with us his opinion that for the amount of cocaine seemingly passing through Jamaica, the number of persons addicted ought to have been greater. That it was not he attributed to ganja. “Culturally the strongest opponents [of cocaine] I find at the street level and in our poorer socio-economic group are people who actually use ganja. I find [they] just take a position that the ‘white lady’ will ensnare them”. In other words, the culture around ganja functions as a buffer against the spread of cocaine.

- (ii) According to Mr Ronald Thwaites, ganja use by the young people in the constituency he represents in the city of Kingston, “is very much an antidote to boredom, a sense of uselessness and an inability to, by other means of occupation and recreation, actualise [their] best dreams.”

He cites the example of some young men taken from his communities, the type who would have been smoking ganja, many of them with criminal records, put through the National Youth Service programme of personal discipline and social reconstruction, and who were so completely rehabilitated, that they were able to move into positions of assistant sports masters in primary schools. Thus, once gainfully employed they have little need ganja.

For him, the prosecution of ganja, especially with respect to small quantities, and the way the interdiction is carried out, only serves to bring the law into disrepute. “One thing that the law must never do is fly in the face of the mores of a people for an extended period of time, where despite consistent interdiction, education and a standard being maintained by the law, it is still consistently at odds with their dominant social pattern”.

Of far greater concern is crack/cocaine. “If I”, said Mr Thwaites, “were ever to resile from being an abolitionist [as far as capital punishment is concerned], it would not be so much for murder as for the purveyors of the hard drugs, and cocaine especially. Those who spread cocaine in this community and crack, are not only murderers, they are mass murderers. And it is a reproach to the system of Government and the canons of law-abiding behaviour that we spend our time and our money voted for national security running after small quantities of ganja when I can identify for you—and I have identified for the police and the Ministry of National Security, at least four crack houses in this constituency, and nothing has been done!” This double standard, he was sure, was not lost on the people. It set “their teeth on edge against the law, against the whole tissue of social authority.”

He concluded that, though not personally in favour of the use of ganja, it ought no longer to be proscribed by criminal law.

(8) *Law Enforcement Officers*

Also not to be ignored are the views of law enforcement officers. We first interviewed a retired Assistant Commissioner of Police, and a Sergeant of Police.

- (i) The retired Assistant Commissioner of Police, with forty active years in the JCF at all levels, interacting with the general public, observing the changes in beliefs over the period, and being party to the enforcement efforts before, during and after the period of mandatory sentencing, comes to the position that the possession of cannabis below a certain weight should not be a crime. That it has remained for so long on our statutes as a crime, which, aside from the sentence one serves, remains on one’s record “is one of the most destructive aspects”, one that has “a most deleterious effect on our young people”.

In support of decriminalisation for private purposes, he is of the opinion that the relations between police and citizen, in particular the poor, was flawed by our failure at Independence to inculcate within the Force “a deep respect for the individual and the individual’s home, however humble”. The power to enter and search a home is a power that normally should not be granted easily in legislation to the law enforcers.

- (iii) “To be frank”, according to a Sergeant of Police of a very large station, “for the small amount I think it costs the Government more to bring a person to court, than it costs the person. Because the paper that you write it on maybe costs more.”

The officer expressed the view that ganja smoking does not of itself contribute to crime. What does is the prohibition that drives cultivation and trafficking underground. “Whatever contribution to crime is like a person plants [and] somebody comes in to steal it. That is where the crime comes in. But to say that because somebody use it they go out there and steal, I don’t think that is a fact”.

(9) *His Grace the Most Reverend Roman Catholic Archbishop of Kingston*

His Grace, the Archbishop, presented to the Commission the view that ganja use ought not to be criminal. He based this conclusion on three principles. The first was the theological approach that in creating the world and everything in it, God created them good and created them for the use of mankind. Second, God invested in mankind stewardship and dominion over all things. This required mankind to investigate, with a view to understanding, the qualities and capabilities of the various plants and herbs, including even noxious ones. And third, in the exercise of dominion, mankind was also expected to exercise responsibility. “We always teach people, ‘Everything in moderation’. Anything that we do in excess, or abuse, is going to have ill-effects upon us.”

Based on these principles, His Grace confirmed that the decriminalisation of ganja for private use would have the blessing of the Roman Catholic Church. He emphasised that the views he expressed were personally shared by his fellow Bishops in Jamaica.

Moderation being one of the principles on which their position stood, His Grace saw no necessity to regulate quantities, and would therefore support the conscientious use by certain people for religious purposes. “My thing is to respect a person’s conscience and anything done in moderation, not abused. And if they see that it is something than can assist them in their prayer life and in approaching the divine, and [if] they genuinely and sincerely believe that God has provided it for them to assist them in that, then I can’t say to that ‘It is immoral’. And I can say to the Government to decriminalise it, unless the Government can say it is going to be abused in [the] act of worship.”

(10) *His Lordship, the Anglican Bishop of Jamaica*

“[To] be consistent with Christian morality,” the Lord Bishop said, “the fact that you are against something does not mean that it should be a criminal offence. I can think of maybe a thousand things that I would classify as one, and they are not criminal offences. In saying that, I would have no problem in decriminalising limited private use by adults of marijuana, without compromising my position that it is not something that [one] would consider to be good or healthy or right.” Sharing with the Commission views from a paper he had written on the subject in 1977 at the request of the Bishop at that time, which he remains in substantial agreement with, he distinguishes the recreational from the medicinal and religious uses of ganja. He supports the decriminalisation for private medicinal and religious use, but has reservations about recreational use, because, although ganja is not addictive, it exposes young people to other more dangerous substances. But, agreeing that in practical terms, it would be difficult to decriminalise for private and religious but not for recreational use, he declares it unjust for any law to target, as this one does, the young, vulnerable and poor. “If the intention is to protect the morality of these young people, then you certainly cannot protect it by sending them to prison where they will mix with hardened criminals and come out as criminals, whereas they were not before and needn’t have been.” Morality cannot be legislated, he says. Ways need to be found, he concludes, to reduce demand through alternative activities “that people could find more wholesome” in achieving the same objectives.

(11) *Lord Anthony Gifford*

Lord Gifford in an early appearance before the Commission spoke to a written brief he presented in support of the decriminalisation of ganja, but arguing as well for its complete legalisation. Cautioning that he was not himself a user of ganja, but that his approach was that of a human rights advocate, Lord Gifford made the following points.

In the first place, “if there is a substance which is derived from something naturally grown which gives a lot of pleasure to some, it should not in principle be bad just because it may be abused by others.” From a spiritual point of view, it is better to encourage people to use responsibly what God has given. Secondly, educating people, especially young adults, is more effectively done on the basis that something is permitted but that they should exercise caution with it. Thirdly, the prosecution of so many unfortunate defendants, most of them for smoking splifs, is nothing short of a violation of their human rights.

Drawing attention to the conundrum that would ensue were possession and use to be decriminalised but production and trafficking not, he urged the Commission “to grasp the nettle” and recommend that it be legalised. Only thus would ganja be extracted from the criminal fraternity, and a regime laid down to allow it to be grown, bought and sold, subject to basic controls.

He found The Netherlands solution, where ganja is decriminalised for use in specially designated cafes, but still illegal, as “a kind of half-way compromise”, which nonetheless, by separating ganja from hard drugs, has had the partial effect of reducing the use of the latter.

Lord Gifford drew the attention of the Commission to a recent judgment handed down by the Canadian court, which found the sanction against self-administered use of marijuana for medical conditions a violation of the right to liberty. In his opinion the Jamaica’s ganja laws are in violation of human rights.

(12) *The Rastafari*

It would have been remarkable, indeed, if the Commission did not receive depositions from the Rastafari community. Apart from the many Rastafari adherents interviewed in the course of the Commission’s hearings in various parts of the country, three delegations presented. The first, led by Abuna Foxe, came from the Church of Haile Selassie I, with branches in Kingston, New York and London. The second comprised elders of the Nyabinghi order, from Pitfour in the Montego Bay area, and led by Bongo Mannie and Ras Tafari, and the third was a team of three non-affiliated believers, led by Ras Iya. Two of these three delegations included women.

As is well known and in need of no repeating, the Rastafari cultivate the use of ganja for their religious purposes, although the tradition of giving it sacred status is of Indian derivation. As a community Rastafari have been advocating for its legalisation, or certainly defying its criminal status at great personal costs, for over half a century. Their appearance, therefore, presented the Commission with a valuable opportunity the more fully to appreciate the theological and ethical premises on which they justify and use ganja as a sacrament and a part of their way of life.

(a) The Church of Haile Selassie I

The leaders of the Church of Haile Selassie I base their justification of the use of the sacramental use of ganja on an analogous argument, using the doctrine of transubstantiation. In transubstantiation the bread and wine are transformed by the words of the priest into an entirely different material substance, namely respectively the body and blood of Jesus. In the same way, seeing that “in Rastalogy anything the word does not give a name to does not exist”, the pronouncement of the Rastafari priest transforms the herb into “the body of the mighty Trinity”.

In their ritual practice the sacred herb is placed on an altar, called a tabu, and blessed by the priest. Some of it is separated and placed into a censer and the congregation blessed with it. “The women is on the right hand side, the men on the left. So, what the priest do: him went over the women and she say ‘Bless me’, and him make a chant over her head, and ... she inhales and she says a prayer on herself. And she let it out. That send it to the heavens—it is a communion.”

Thus is the administering of the sacrament done, all present taking turns inhaling the sacred fragrance. The rest of the substance is distributed *ad libitum* in small quantities to adult male members—“our women don’t smoke ganja”, to take home at the close of the ceremony for their own private use. The leaders limit this distribution to members twenty-one years old and over, and stress their rejection of the recreational use of it. Ganja is “not for any form of enjoyment or desire”, explains Abuna Foxe. “In Rastalogy we believe that the Goliath is the lower self and David is the higher self. For us to kill that lower self we have to control the five senses, kill desire. We believe that when one is being initiated into those principles then one would see herb not as something to get high on, but as part of the body of Christ which gives strength. ...It is not like I want to get a drink of white rum to get high off, but [to] become one with the Creator.”

This ritual the Church has been able to perform in London and in New York, where there is greater discourse on and respect for human rights. Not so in Jamaica, however. “Historically, Rasta in Jamaica is a criminal, murderer, etc.”

(b) The Nyabinghi Elders, Pitfour Tabernacle

The exposition of the Nyabinghi elders begins with the well-known Rastafari cosmological argument that God created all things—plants and animals, and mankind itself, to which He has given knowledge of them. Herbs, according to the Bible, were created for the use of man. But by creating a man-made world, placing it in opposition to God’s creation, “man has become God. He starts to dictate to us or to those that take the divine law, [that] lead to the divine law—because God create herbs [and] gave man the knowledge. Who therefore should come between [man and] that plant? You smoke it, I eat it. You drink it. Who cares if they that smoke want to kill themselves, you understand?” The law, as a man-made imposition, ruptures the divinely created relation between man and the natural order.

Of all the herbs, ganja occupies a special, spiritual place in the livity of Rastafari. First and foremost is its place in the ceremonial rituals held five or six times a year, known as a nyabinghi, or “binghi” for short, which takes place in one of the tabernacles dedicated for these purposes. The tabernacle itself and its grounds being sacred, all commercial transactions are taboo for the duration of the binghi, which could last up to twelve days. In preparation, therefore, Rastafari farmers will grow the herb solely for the binghi, which they present as gifts to the High Priest on their arrival. The Priest places some on the altar, to be later used as incense, and stores away the rest, which he dispenses in a centrally located calabash for personal use, or on request.

Apart from the communing among and between brethren, sistren and entire families, two main activities characterise the binghi, one formal at night, the other informal, during the day. The lighting of a large bonfire, whose flames are kept alive for the duration of the binghi, signals the start of the ceremony at sunset. Just about then, the High Priest along with seven priests and seven matriarchs, followed by the children, enters the Tabernacle. After each priest and matriarch has prayed, the High Priest lights the herbs on the altar.

He will see to it that it is kept burning throughout the night, until sunrise. He makes an offering of ganja to each elder and matriarch, which they will smoke at will, while the children start the drumming and chanting. When the time comes for the House to enter and begin the formal binghi, the children withdraw, the drummers take over, the High Priest prays, and the chanting begins, continuing without break throughout the night. This ritual is repeated every night.

The informal activity is the reasoning. It will take place throughout the day. Ras Tafari described it for the Commission as “foundation reasoning,” because it is there that Rastafari attitudes to politics, theology, repatriation, reparation are shaped. “So the daily event is much more than the rituals at nights,” he concluded. The herb is integral to the reasoning “because herb stimulates that part of the thought that keeps us lucid, open and receptive, bearing in mind that we have one common interest. Before you talk you have got to make sure [that] what you talk does not disrupt the peace or the unity. And so, you have to find your own consciousness. With smoking herb everyone can go within themselves to find their own consciousness.”

The herb centrally available, every man builds a little spliff as he desires, but with a self-discipline that is mindful of the needs of others and wary of excess. But where they prefer, the group may send for a chalice. To use the chalice, “you have to be very mature, I would say clean-spirited.” One of the senior elders prays over the herb, calling on the name of Haile Selassie I for a blessing on those about to partake, and as the herb is cut up and sprinkled with water, the participating circle chants a psalm. In preparing the herb the elders more often than not mix it with ground tobacco, “which signifies balance. ” The pure or ital herb, which a few prefer, makes some people cough a great deal, others to develop a big appetite, or fall asleep. When balanced, however, it enables most “to sit and reason and smoke the whole night without getting overloaded.” After the substance is prepared and stuffed into the kochi, another psalm is said, and the pipe lit as someone holds a stick of matches or a piece of paper or corn trash. Each then takes his turn, the chalice moving from right to left, until the matter is exhausted.

Reasoning, declared Brother Tafari, “is what you call the most integral part of the Rastaman—to sit and reason and come into one common interest, whether it is political, economical, business, or about the state of the Jamaican Government.” The philosophy behind reasoning posits the Rastaman as the temple of God, within which God dwells. Smoking the herb is in actual fact burning “this fragrant incense within this temple unto Him, the Head, the Divine, the Highest Thought of man,” in order to stimulate this inner being through spiritual discourse, putting it above the mundane, the political. The herb, whether in the chalice or spliff, helps them to rise to this level and penetrate knowledge. To cite one example, it is through reasoning under the help of the herb, the Rastaman comes to the knowledge that Moses could not possibly have seen God “from the burning bush”, but “from burning the bush.” Moses “must have taken a spliff, because there was no God in no bush, because we read the Bible biblically, prophetically, literally, and so on.

So when we look at it, we see it is a cup, a chalice, and when him [Moses] sit up inna himself from a panoramic vision, he sees.”

The herb is thus “a sacred part of the Rastaman’s life, where he finds his inner self.” As he wakes in the morning he may smoke a spliff, say his prayers and be one with himself as he focuses to face the day. He uses herb not for recreation but for meditation, for finding the divinity in man. “We know God is one, but God is also found in man and it is out of that consciousness and presence of God in man that the Rastaman function and go and live day by day, knowing that He is dealing with him and direct[ing] him. And he could sit down with his herb and his consciousness within him. You find that the brethren walk five, ten miles to share that with his brethren—just to burn a spliff or chalice.”

(c) Ras Iya, Sister Ita and Sister Wood

In this third excerpt, the Rastafarians explain the meaning of the herb as a part of a way of life. Ras Iya does not smoke the herb, he eats and drinks it. “For me, eating and drinking it is full healing of the people, because it is medicinal control by creation.” Using a mortar to beat it into a pulp, if green, or to grind it, if dry, he combines it with other herbs, nuts and honey. As preventive medicine, he mixes it with other spices, such as bissy, nutmeg, garlic, pimento, ginger and orange peel. “That means if one keeps using this thing, no one would sick by accident.” In forty years of ingesting it in this way he has never experienced what it means to be sick or in pain.

Sister Ita gives an explanation that could shed light on what many experienced educators describe as a fall off in the motivation of many, sometimes brilliant, students. According to her ganja slows down those who smoke it, but in a beneficial way, taking them out of the world and into the hills, where “you will prefer the breeze of natural creation more than being in town.” It induces, she says, a state of mind in which material things become secondary and one begins to see oneself as a part of creation. “Most youths who use herbs are into a more sober, normal lifestyle than the downtown rush. It sobers one to a certain point where it takes you out of the rush, as I say, and it makes you more humble as well, more satisfied with what you have.” She describes it as “a kind of escape route for some youngsters”, from the pressure of life, by “creat[ing] a space where one can go, like [how] people would go to church. For it is the same way a youngster would go to the weed for.” And in this space they become satisfied with the little pennies from their little garden and the bowl of porridge they can afford.

(13) *Independent Jamaica Council for Human Rights (1998) Limited*

In a presentation to the Commission, the Independent Jamaica Council for Human Rights, led by Mr Dennis Daly, Q.C., made a case for removing ganja from the list of dangerous drugs altogether.

The Council based its position on several arguments: the smoking and possession of small quantities of ganja, representing the majority of cases prosecuted, do not infringe the rights of others; arrests and prosecutions are a drain on the justice system; rehabilitation, the objective of sentencing, is seldom realised because the activity is not considered wrong; the rights to liberty, privacy, security and freedom of religion are violated; the right to work, which the cultivation of ganja as a cash crop represents, is infringed; and sentencing does more harm than the use of ganja could cause an offender. The Council recommends that every individual should be able to cultivate, possess, sell, smoke and use ganja, that Rastafarians should not need any special permit to use it for their religious purposes, and that the court should have the power to treat addiction as a medical problem.

(14) *Dr Ronald Lampart*

A retired Medical Officer of Health, once in charge of the Princess Margaret Hospital, Dr Lampart traced for the Commission the “very sad, sad history” of the prohibition of ganja in the 1930s, charging racial motives in its suppression, since “up to that time marijuana was being smoked by the Blacks and the Hispanics.” He read from the biography of Anslinger, the Commissioner of Narcotics who in association with the Hearst-owned press led the campaign, to show the hysterical basis on which the legislation was passed, despite the objections of the American Medical Association. Dr Lampart testified that he worked for ten years with the Coptics, whose members smoked very hard and never once committed any offence other than breaches of the dangerous drugs law. If for no other reason than ganja’s proven medicinal value, he argued, it should be decriminalised. His position was that since it could not now be legalised, it should be made a regulated instead of a prohibited substance.

C. VIEWS AGAINST DECRIMINALISATION

The Commission heard from a very small but important minority, who expressed considered views that the law should not be changed. There were people who in their opening depositions opposed any amelioration of the law, but who on being posed questions by members of the Commission conceded that criminalising young people for small amounts or older people for medicinal use was not what they intended. Such positions, however cautious and reserved, are excluded from this Section, being considered part of the general body of opinion in favour of some measure of decriminalisation. We present only those of people who are definitively against it.

(1) *ill-effects*

The main argument among those in favour of the criminalisation of ganja possession and use is the negative effects they either see or have heard of. These seem to be of three sorts. The first, from their description of the symptoms, would seem to fit the now well-documented personality disorder referred to as ganja psychosis.

Having smoked it, the person loses control of himself, often behaving aggressively. But the aggression may follow only after other personality changes, including uncontrolled levity and paranoia.

In a letter to the Commission two parents wrote of their painful experience of seeing their twenty-two year old son gradually turn into someone they no longer knew. Their first sign of noticeable change was when “he began to appear amused at times when there was no apparent joke.” With increased use, a “new, unusually ‘philosophical’ person began to emerge, expounding on irrelevancies,” and manifesting mood swings, anger and frustration, “not entirely due to ganja smoking we must add in fairness, but certainly likely to be complicated by it.” Then came an aggressive stage, in which he threatened others and verbally and even physically attacked his own friends. At that stage he was smoking heavily. Now twenty-six years old, he remains like this, a member of the family, but one, who, compared to the son they knew, is like a “stranger in our house.”

With an experience like this, “we say an emphatic NO to legalization in today’s Jamaica”, at least not until “a reasonable and proper assessment of the effects of the majority of the many chemicals is made”. Ganja use “is a form of chemical Russian roulette. You don’t know what its effects are going to be on you! Our son gambled, and lost!”

A second effect would seem to be a sort of amotivational syndrome. The anecdotal evidence brought before the Commission is too repetitive to be ignored. The profile of the victims describes an adolescent male, whose interest in scholarly activity declines fairly sharply, who sleeps a lot in class, achieves below his potential and sooner or later drops out of school. Even those strongly in favour of decriminalisation are aware of this reaction and would like to see a ban imposed on the smoking of ganja by all students of primary and high school age.

The third effect is mainly physical, where the effect of smoking knocks out the person, or causes hallucination. Although the remedy of a quick infusion of sugar and water is well known, the experience is enough to convince some people that ganja is a dangerous substance and to harden their resolve that it should be kept illegal and criminal.

(2) proliferation

A second argument advanced is that decriminalisation is going to cause ganja to be more widely available than currently exists and more widely used. And if it is more widely used, there is bound to be more schoolboys using it. “Because, if it free, too much ruction, and no behaviour, and dem just come and smoke in front you face.” Among the likely consequences, then, according to this thirty-two year old mother, is the loss of respect that young children ought to show adults by not smoking in their presence. In addition, to quote an inner city resident, more people smoking ganja will mean more people that “it sheg up”.

(3) gateway

A third argument is that ganja is a gateway drug, leading to other substances, particularly crack-cocaine. Those who advance it see a progression from ganja to “seasoned spliffs” (ganja laced with cocaine), to crack-cocaine. Or, they see ganja as part of a “culture” of drugs. “Addiction didn’t start from just crack-cocaine, you know, it starts from little small use of drugs—tek a one beer, tek a drink o’ rum, smoke a small spliff.” Decriminalising the use of ganja seems a small step but it would lead to “a big blown out thing”, such as now affect many communities.

(4) smoking

Many who are adamant that ganja should remain criminal see smoking as essentially a harmful activity, regardless of the substance. Tobacco is bad enough already, and to add another substance is to make the situation worse. Some would be for criminalising the smoking of tobacco itself.

(5) Resident Magistrate

The position of a Resident Magistrate of twelve years of service in many parts of Jamaica, including the west and the Corporate Area of Kingston, was put to the Commission. Her Honour exhorted the Commission not to rush to recommend a change in laws “which our forefathers in their wisdom embraced, unless we have clear and sufficient justification for doing so.”

She argued that many persons brought before the court, though admittedly a small minority—a mere one or two out of every twenty, displaying violent, anti-social and aggressive behaviour, sometimes to the point of having to be restrained for a period of time, were, according to their own families, acting under the influence of ganja.

It would be, she suggested, a backward step to decriminalise ganja, in light of the damage already being done by tobacco, and in light also of the fact that “the jury is still out”, where the scientific evidence on ganja was concerned.

Many people alleged that ganja has stress-alleviation properties, but she did not believe changing its legal status on that account was justified.

“Are we therefore saying that we are going to legalise the sedation of our people? Is that what we are saying, so that they don’t experience emotional pain, stress, etc.? Should our effort [not] be instead in calling them out of themselves to look to their Creator to find solutions to their problems? All pain is not a bad thing. It can alert us that something is wrong and when we get past our threshold of pain tolerance then we can do something about it, like our forefathers who rose up against slavery. It is not okay for everything to be ‘irie’ and ‘no problem’. It is not okay. If this nation is going to go forward in this new millennium, we need to deal with the wounds, the psyche of our people—because certainly, the psyche of our people is wounded, and not give them legal justification for putting their pain to sleep.”

A better alternative to decriminalisation, she suggests, is what is now presently being envisioned in the setting up of the Drug Court, which will effectively remove drug offenders out of the ordinary justice system and treat them in a rehabilitative way.

In answer to the Commission's question whether preventing the use of small amounts of ganja in specified circumstances was acceptable as a matter of justice when the use of alcohol was not, she maintained that the abuse of other legal substances was enough of a problem already.

In short, her position was for amelioration of the laws, not for decriminalisation. And to that end she felt that with greater discretion the court could determine whether a certain quantity was being intended for trafficking as against use.

(6) *The Church of God in Jamaica (COGJ)*

According to its Chairman, "[t]he Church of God in Jamaica does not support the use of ganja privately or publicly. It is a moral position of the Church." Nonetheless, his view is "that if someone is using it privately on the advice of a medical practitioner, then to me it is quite alright." For those caught with the substance, "a first offence should not be seen as an habitual offence", and such persons should be made to undergo counselling instead of punitive sanction.

Commissioner: This lady is inadequately advised that this little ganja that she has in the vial helps some sort of pain. She is caught using it once, using it twice, she is caught using it thrice—now, remember you said that the first should be counselling. Are you suggesting that after the third time it would be just to really prosecute her and let her face the consequences, even if it means serving time in prison?

COGJ Chairman: No, I would not agree for someone, you know, [who] have a little thing in a vial and they really believe it helps the pain, and may well help too, I would not be in favour of criminalising her.

Commissioner: You wouldn't be in favour of criminalising her?

COGJ Chairman: No, I would not.

Commissioner: What about treating it as a misdemeanour then?

COGJ Chairman: Yes, I think there should be some form of sanction, but not as a criminal offence. ...

Now, you asked about the lady caught once, twice and three times. Well, I would say, this is the fourth time now, and maybe we should just take the bull by the horn and say people are going to use it, and so we will have to now specify the amounts, the form in which it is used, and so on, rather than the frequency.

Commissioner: That is right.

COGJChairman: Provided we are convinced that it is not going to be dangerous to their health or affect their body. I think we could stratify that and say for this group [it] will not be regarded as a criminal offence.”

Upholding the moral position of the Church of God in Jamaica against the use of ganja, the Chairman nevertheless believes that prescribed medical use should be permitted, that first offenders should be treated to counselling instead of criminal sanction, and that habitual folk medicinal use should be treated as a misdemeanour.

CHAPTER 4

THE LEGAL AND INTERNATIONAL CHALLENGE

Based on the foregoing, bearing in mind its terms of reference, and weighing carefully the issues raised and the arguments presented to us, the Commission has come to the unanimous conclusion that ganja should be decriminalised for adult personal private use.

Its criminal status cannot be morally justified, notwithstanding the known ill effects it causes in some people. It contravenes natural justice, seeing that it has been, like other natural substances, a part of the folk culture in Jamaica for decades prior to its criminalisation, a part of recognised medical practice for centuries, and a part of herbal lore for millennia in other parts of the world. Nor was its criminal status first recommended by scientific evidence, in any way remotely resembling the proliferation of research, some of it of questionable value, now being called on to justify its current status. Totally ignored is the centuries of accumulated folkways, which through common sense and native wisdom make up for what they lack in modern scientific rigour, and have developed their own modes of uses and limitations, providing valuable clues to well-being for the scientific community.

The Commission takes the view that, ironically, the criminal status of ganja poses a serious danger to society. By alienating and criminalising hundreds of thousands of otherwise law-abiding citizens, and by making the State in their view an instrument of their oppression rather than their protection, the law and its prosecution create in them disrespect for the rule of law. When the rule of law goes, anarchy sets in. Any law that brings the rule of law into disrepute is itself thus a threat to the stability of society.

Thirty years ago the eminent jurist, the late Aubrey Fraser, concluded that cannabis use could not be controlled by the punitive sanctions of the law. Thirty years on, from all the available evidence ganja use not only has spread, but has become defiantly more open. The justice system is severely challenged, its manpower diverted from focusing on more serious crimes, and its material resources consumed in the prosecution of a war that it cannot win.

The inequity that governs the legalisation and control of tobacco and alcohol, but the illegality of ganja cannot be rationally justified, and is indeed iniquitous, given that from all available medical evidence it is the least deleterious and harmful of all. Thousands of people die from cirrhosis of the liver due to alcohol abuse and from lung cancer caused by excessive, chronic smoking of tobacco, but from our research and the evidence presented to the Commission not a single death has ever been recorded from the use or abuse of cannabis.

This is not to say that ganja is not harmful. The Commission is convinced, in the face of the folk anecdotal and medical scientific evidence before it, that many, if only a small percent, of those who use or have attempted use of it are victims of harmful psychological effects. Of great concern are those of school age, many of whom are reported to experience a fall in motivation, that intellectual and emotional condition for educational achievement.

One group that has made recognised contribution to the development of the arts, and through it brought to our country wide international recognition and acclaim, deserve to be heard for the claims they make on the spiritual significance of ganja to them. It would be a sign of grave disregard and rejection not to accept as serious the meanings which the Rastafari attach to ganja use. That would be like appropriating the inspired achievements of Bob Marley for the glory he has brought our country, but dismissing as trivial and of no consequence the source of his inspiration, namely his religion.

The Commission is persuaded also, given the deeply rooted place of ganja in the culture of the people, that its decriminalisation could provide a buffer against the spread of the evil cancer, crack/cocaine. Decriminalisation separates it from cocaine and heroin, and offers a much better framework in which to focus the efforts against those substances. Under its criminal status ganja is classified alongside the others, even though its effect is nowhere the same. If it were declassified, we think ganja users could be enlisted in the fight against drugs, while at the same time become more open and receptive to sustained education as to its harmful effects.

And so, we turn to the knotty question, how is ganja to be decriminalised. Were it simply a matter for our country alone to decide, a simple repeal or amendment of the laws is all that would be necessary, seeing that there is such wide consensus. However, if Jamaica is not to isolate itself from the international community or to ignore geo-political sensibilities, it has to take careful account of its obligations.

The Laws

There are six Acts relevant to ganja in Jamaica, all of them the results of ratifying certain United Nations Conventions. The Acts are:

1. The Dangerous Drugs Act
2. The Money Laundering Act
3. The Drug Offences (Forfeiture of Proceeds) Act
4. The Mutual Assistance (Criminal Matters) Act
5. The Sharing of Forfeited Property Act
6. The Drug Court (Treatment and Rehabilitation of Offenders) Act, and The Drug Court Regulations.

The Dangerous Drugs Act addresses measures required under the *Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs, 1961*.

The remaining five Acts address measures required under the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*. A third Convention to which Jamaica is a party is the 1971 Convention on Psychotropic Substances. As this Convention seeks to control of psychotropic chemical substances, including certain derivatives of cannabis sativa, rather than cannabis sativa itself, it need not detain us.

For the purposes of this Commission the *Dangerous Drugs* and the *Drug Court Acts* are the relevant statutes.

Dangerous Drugs Act

The *Dangerous Drugs Act* responds to the legislative and administrative measures parties to the *1961 Convention* are required to adopt to limit the production, manufacture, export, import, distribution of, trade in, use and possession of drugs, except for medical and scientific purposes. The drugs defined by the Convention include cannabis, cannabis resin, extracts and tinctures of cannabis. In conformity, the *Dangerous Drugs Act* includes under its purview all parts of the plant known as ganja (cannabis sativa) from which the resin has not been extracted, as well as any resin, extract or tincture obtained from the plant.

Part IIIA of the Act renders it unlawful to import, export, or take steps to export ganja, and imposes a fine of up to \$500 for each ounce of the substance on conviction before the Circuit Court, or imprisonment of up to thirty-five years, or both. On conviction before a Resident Magistrate, the maximum fine is between \$300 and \$500 for each ounce, but not exceeding one-half million dollars, or three years imprisonment, or both.

The Act prohibits as well cultivating, gathering, producing, selling or otherwise dealing in ganja. It prohibits using the premises one owns or occupies for such purposes, or knowingly permitting such premises to be so used, and bans using a conveyance for transporting, selling or otherwise dealing in ganja, or knowingly permitting a conveyance to be so used.

But it is the prohibition of possession and smoking that is most relevant to the work of the Commission. Sections 7C and 7D of the Act state:

- 7C. Every person who has in his possession any ganja shall be guilty of an offence and—
 - (a) on conviction before a Circuit Court, shall be sentenced to a fine or to imprisonment for a term not exceeding five years or to both such fine and imprisonment; or

(b) on summary conviction before a Resident Magistrate, shall be liable—

- (i) to a fine not exceeding one hundred dollars for each ounce of ganja which the Resident Magistrate is satisfied is the subject-matter of the offence, so, however, that any such fine shall not exceed fifteen thousand dollars; or
- (ii) to imprisonment for a term not exceeding three years; or
- (iii) to both such fine and imprisonment.

7D. Every person who—

- (a) being the occupier of any premises knowingly permits those premises to be used for the smoking of ganja; or
- (b) is concerned in the management of any premises which he knows is being used for such purpose as set out in paragraph (a); or
- (c) has in his possession any pipes or other utensils for use in connection with the smoking of ganja; or
- (d) smokes or otherwise use ganja,

shall be guilty of an offence and shall be liable on summary conviction before a Resident Magistrate, in the case of a first conviction for such offence, to a fine not exceeding five thousand dollars or to imprisonment for a term not exceeding twelve months, or to both such fine and imprisonment, and in the case of a second or subsequent conviction for such offence, to a fine not exceeding ten thousand dollars or to imprisonment for a term not exceeding two years or to both such fine and imprisonment.

These are the Sections of the *Dangerous Drugs Act* which thousands of our citizens run afoul of and are punished. They are mainly young persons, but there have been cases of men of advanced years who have been hauled before the courts.

Decriminalisation would require amending the Act in such a way as to allow for possession of small amounts for personal private use by adults.

The Drug Court Act

The Drug Court (Treatment and Rehabilitation of Offenders) Act, consistent with the *1988 Convention*, adopts a health-related, rather than a punitive approach to drug use. It provides for the establishment of a Drug Court aimed at facilitating treatment and rehabilitation of drug offenders. It comprises a Resident Magistrate and two Justices of the Peace, one of whom must be a woman, specially appointed by the Minister.

Those brought before the Drug Court must be persons who appear to be dependent on the use of drugs but are of sound mind.

Where ganja is concerned, the Drug Court will hear cases involving smoking or otherwise using the substance, possession of utensils in connection with smoking, and possession of up to eight ounces of the matter. An approved treatment provider will provide the Court with an assessment of the person charged and pleaded guilty, in order to enable the Court to decide whether to order a prescribed treatment. On successful completion of the treatment he will be discharged and the offence not form part of his criminal record, unless convicted more than twice. Failure to comply or to complete the prescribed programme would result in the imposition of sentencing.

If the *Dangerous Drugs Act* were to be amended as indicated above, in order to provide for adult, private use of ganja, the *Drug Court Act* would have to be similarly amended. Provisions could be made to allow entry into the treatment and rehabilitation programme of persons who voluntarily seek such, or who have been referred by a competent authority, such as parents in the case of minors, or medical personnel, where it can be established that ganja is the cause of acts inimical to the safety of others.

But would such amendments be possible without breaching the *1961 Single Convention* and the *1988 Convention*?

1961 Single Convention

The *1961 Convention*, Article 4, is explicit on the general obligations of the parties:

The parties shall take such legislative and administrative measures as may be necessary:

- (a) To give effect to and carry out the provisions of this Convention within their own territories;
- (b) To co-operate with other States in the execution of the provisions of this Convention; and
- (c) Subject to the provisions of this Convention, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.

Under Article 4(c), the use and possession of cannabis, one of the Scheduled substances, is limited to medical and scientific purposes. And again, under Article 28(3), which speaks specifically to the Control of Cannabis, “The Parties shall adopt such measures as may be necessary to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant”

But it is Article 36, on Penal Provisions, specifically paragraphs 1 (a) and 1 (b), and Article 38, on Measures Against the Abuse of Drugs, that frame in greater detail the obligations of Parties. Article 36, paragraph 1 (a) reads:

Subject to its constitutional limitations, each Party shall adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation of drugs contrary to the provisions of this Convention, and any other action which in the opinion of such Party may be contrary to the provisions of the Convention, shall be punishable offences when committed intentionally, and that serious offences shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.

Use is not mentioned here as an offence, thus in theory it could be thought of as being excluded, making it possible to decriminalise use without contravening the Convention.

Paragraph 1 (b) of the Article presents the Parties the choice of conviction and punishment or treatment and rehabilitation. This is followed in greater detail in Article 38, where preventive measures, education, treatment and after-care, and training of personnel are called for.

Legal Expertise

The Commission sought the advice of international law expert, Dr Stephen Vasciannie of the University of the West Indies, and in a well-researched and thorough brief, this is what he wrote relative to the *1961 Single Convention*.

“[W]hen Articles 36 (1) (a) and (b) are read together, the legal situation seems to be as follows: (a) the Single Narcotics Convention requires States to subject certain activities concerning marijuana to criminal sanctions (including the cultivation, production, manufacture, possession, exportation and importation of that drug); (b) the Convention does not require States to prohibit the use (or consumption) of marijuana *per se*; and (c) in the event that an abuser of marijuana has committed an offence that would require criminal sanctions when committed by a non-abuser of the drug, it is open to the State to forego the application of criminal sanctions against the abuser.

On this reading of the Single Narcotics Convention, it would be possible for Jamaica to amend its national legislation in order to decriminalise marijuana use, and make its private use legal, without necessarily placing the country in breach of its obligations under the Convention.”

But, notes Dr Vasciannie, the difficulty that would arise from such a step would be the contradiction whereby ganja use would be legal but its procurement illegal. In his opinion, “[t]his seems quite unworkable.” However, the Commission has before it the experience of the Dutch, who, without being cited as breaching any of the Conventions, have adopted a contradictory, if pragmatic policy, giving restricted decriminalised status to cannabis distribution and consumption of small quantities, while applying penal sanction to its production, importation and trafficking.

According to *A Guide to Dutch Policy* put out by the Foreign Information Division of The Netherlands Ministry of Foreign Affairs, in cooperation with the Ministries of Health, Welfare and Sport, Justice, and Interior and Kingdom Relations, “[t]he use of drugs is not an offence under international agreements. Nor is it an offence in Germany, Italy, Denmark or, indeed, most countries of the European Union” (2000, p. 6). The Government sees itself in compliance with the *UN Conventions of 1961, 1971 and 1988*, not to mention other bilateral and multilateral agreements on drugs. The policy is based on the “principle of expediency”, whereby authorities are given “discretion to decide, on the grounds of the public interest, not to bring criminal action in a given case.” High priority is given to suppressing the sale of hard drugs and trafficking of large quantities of drugs, hard and soft, while low priority is given to curbing the sale and possession of soft drugs for personal use. In this context “soft drugs” refer to cannabis and its derivatives.

Thus, notwithstanding the evident contradiction of decriminalising personal use while suppressing the sale and trafficking, a half-way position, which some would reject, is nonetheless possible under the *1961 Single Convention*, which does not explicitly prohibit use. Noted retired Solicitor General, Dr Kenneth Rattray, in verbal communication with the Chairman of the Commission, argues that the omission of sanctions against personal consumption was not an oversight by the Parties to the Convention, but rather an attempt to set a threshold beyond which actions of the State could be deemed to be in breach of certain fundamental human rights. In this regard, there are three principles of human rights that governed and have governed this and other similar Conventions: the principles of the right to personal privacy, and the right to religious freedom, and the principle of proportionality, by which the sanction should be proportionate to the offence. That the Parties to the Convention would have been mindful of these constraints is clearly evident in the interpretations given the Convention by the Secretary-General’s *Commentary* on the Convention and by the International Narcotics Control Board, according to both of which the Single Convention intends the criminalisation of possession for the purposes of illicit trafficking and not for personal use.

Although Dr Vasciannie argues that had the negotiating Parties intended to limit possession to illicit traffic they would have said so, and therefore “[t]he fact that they did not must carry considerable significance in directing us to interpret Article 36(1) in keeping with the plain meaning of its text,” Dr Rattray, with considerable experience in international law, emphasises the contextual and interpretive framework of negotiated agreements and treaties. He is therefore of the opinion that the interpretation of the International Narcotics Control Board carries weight.

In addition, Dr Rattray argues, the interpretation of the Conventions must be done in the context of the obligations assumed under International Human Rights Conventions, which have been long recognised as an aid to interpretation, particularly in cases of uncertainty or ambiguity.

He further contends that there is a growing body of international jurisprudence, which recognises that International Human Rights Conventions are of a superior order to obligations under other Conventions, and that in case of a conflict or inconsistency between such obligations, the obligation under the Human Rights Conventions must prevail.

Since Jamaica is a Party to the International Convention on Civil and Political Rights, which protects against invasion of privacy as well as protects freedom of religion, those obligations would have to be considered in the determination as to whether any obligations under the Drug Conventions must yield to Jamaica's obligations under the International Convention on Civil and Political Rights.

In sum, therefore, decriminalisation of possession for personal use and of use itself does not breach the *1961 Single Convention*.

1988 Convention

The *1988 Convention* also does not explicitly criminalise personal consumption, but by bringing under the purview of the criminal justice system cultivation, purchase and possession for personal use, it goes further than the *1961 Single Convention*. The relevant article is Article 3, paragraph 2, which reads:

“Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.”

Translated into practice, it would have to be argued that by the strict letter of the law, the possession of an unlit spliff would constitute a criminal offence, but the smoking of it not. According to Dr Vasciannie, the same contradictions noted in respect of the *1961 Convention* would also apply, for

“Article 3 (2) would mean that all important stages preceding consumption, but not consumption itself, must be subject to the criminal law: the cultivator, the purchaser and the person in possession are all guilty of criminal offences in the perspective of the 1988 Convention. For parties to this Convention, therefore, decriminalisation for personal consumption would appear to be a position possible in form but implausible in practice.”

He examines other legal options available to Jamaica. Amendment as a possible route would require the Secretary-General to notify the Council and all the Parties of the amended text. A decision may be taken on the basis of the comments of the Parties, or the Council may convene a conference, whether or not objections are raised. If the amendment is not rejected within eighteen months of its circulation, it enters into force.

Given the fact that so many countries have seen it fit to ratify the Conventions (157 in the case of the *1961 Single Convention*, 154 in the case of the *1988 Convention*), and given also the relatively recent adoption of the *1988 Convention*, it is hardly likely, Dr Vasciannie believes, that Jamaica could muster enough support to carry such an amendment.

The other legal option for which provision is made is denunciation. By denunciation, the Secretary-General is advised by written instrument of the withdrawal of consent, which would then take effect the year following its submission. Legally, this is open to Jamaica to do, but, opines Dr Vasciannie, from a geo-political perspective it would make little sense. The Commission agrees.

The Commission does not, however, agree with his conclusion that while “the main drug conventions...do not in themselves require Jamaica to subject criminal sanctions to marijuana use...this does not necessarily permit decriminalisation in a manner that would be workable in Jamaica”, and that therefore “the *status quo*, with all its deficiencies, ought to be recommended.”

Given the clear intent of the Convention not to violate certain fundamental human rights, a workable if untidy arrangement is possible, which would seek no significant change in the *status quo* at present other than relief to the thousands who annually are brought before the court for personal use. The suppression of the growing, large scale trafficking and export of ganja would and must continue, not least to guard against decertification by the United States. The suppression of public use would also continue. What would cease is the prosecution of adults for the possession of small amounts for private use.

By itself that would not be enough, if we are to allay the fears of our partners that we are renegeing on our international obligations or to reduce the abuse of ganja, not to mention other substances. It would require, also, a sustained education campaign, to deepen the work already going on at community levels and in the schools. Such an approach is actually quite consistent with both the letter and spirit of Article 38 of the *1961 Single Convention*, on Measures Against the Abuse of Drugs.

1. The Parties shall give special attention to and take practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration fo thepersons involved and shall co-ordinate their efforts to these ends.
2. The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers of drugs.
3. The Parties shall take all practicable measures to assist persons whose work so requires to gain an understanding of the problems of abuse of drugs and of its prevention, and shall also promote such understanding among the general public if there is a risk that abuse of drugs will become widespread.

In the context of Jamaica, given the place of ganja in social and cultural life, decriminalisation represents the first step towards prevention, early identification, treatment and education. This is the unanimous position of all those working in the area of drug abuse. In the words of the Chief Medical Officer of Health, decriminalisation becomes a platform—one might say the only realistic platform, for demand reduction.

A realistic education campaign would seek to present in as balanced a way as possible the available experience and scientific knowledge of ganja, treating it as distinctly separate from all other substances, legal and illegal. It would continue to target, but now with greater confidence of success, young males who now needing no longer to fear condemnation and ostracism would be more ready to discuss it openly.

Decriminalisation will also require diplomatic efforts to join ranks with a growing number of Parties who unilaterally are taking measures to ameliorate their own anti-marijuana practices with respect to possession and use, our aim being to get the international community appropriately to amend the Conventions. In the Caribbean, where, according to a report by the Caribbean drug control Coordination Mechanism on 1999/2000 drug trends in the region, cannabis “is, in fact, the drug of choice” and “[u]nlike crack cocaine or cocaine...is, to a large extent, socially acceptable,” diplomatic initiatives to get CARICOM to adopt a single position will undoubtedly strengthen Jamaica’s ability to exert greater influence at the international level.

It will require, finally, practical proof that the country remains committed to the suppression of all drugs. Police interdiction of cocaine trafficking and use would need to be stepped up, which, if the Member of Parliament who appeared before the Commission is to be believed, is a matter of will.

The Commission has good reason to believe that it is the failure to do this that will threaten the country’s certification status with the United States, and not the decriminalisation of personal possession and use of ganja. Were even a single cocaine trafficker to be caught, tried and sentenced, it would enhance the country’s standing. The decriminalisation being recommended would free up more of Jamaica’s human and financial resources to focus on the trafficking of cocaine. According to a well-informed source, this is where the Americans are frustrated with Jamaica.

Human Rights

Decriminalising on the basis that the Conventions do not prohibit use does not constitute the only justifiable rationale. There may be a better way. The Commission is grateful to Lord Anthony Gifford for opening up the following consideration.

All the relevant articles of the Conventions are prefaced by constitutional limitations, variously phrased. For example, Paragraph 1 (a) of Article 36 of the *1961 Single Convention on Narcotic Drugs*, is qualified by the clause: “Subject to its constitutional limitations, each Party shall adopt such measures as will ensure etc.”

Paragraph 2 of Article 3 of the *1988 Convention Against Illicit Traffic* is similarly prefaced: “Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures etc.” In other words the Conventions pay due regard to the peculiarities of each country, such as would be reflected in its supreme law, the Constitution.

The Constitutional guarantees to individual rights and freedoms could normally have been invoked to allow personal use of ganja, as an expression of religious freedom or of the right to privacy, or other right, without breaching international obligations. Unfortunately, such a loophole would not now apply to Jamaica, because of a saving clause which allows the Jamaican Constitution to be superseded by any statute in existence prior to the appointed day when the Constitution came into effect. In the case of *Dennis Forsythe v. the Director of Public Prosecutions and the Attorney General*, in which Forsythe argued that his constitutional right to freedom of religion as a Rastafarian who used ganja for sacramental purposes, and his right to the privacy of his home were violated when he was charged with possession of the prohibited substance, the Supreme Court handed down judgment which included among other reasons the fact that Section 26 (8) of the Constitution plainly declared that “any law in force immediately before the appointed day shall not be held to be inconsistent with any of the provisions” of Chapter III of the Constitution which sets out the Rights and Freedoms of the Jamaican citizen. *The Dangerous Drugs Act* being in force prior to the appointed day was judged by the Supreme Court to be not inconsistent with the Constitution, and so Dr Forsythe's motion was dismissed. Thus, Jamaica cannot at the present time make use of the constitutional limitation clause allowed by the Conventions.

However, the *Charter of Rights* being debated for adoption by Parliament were it to take effect, would replace the existing chapter of the Constitution, override the saving clause of Section 26 (8) of the Constitution and pave the way for Jamaica to take advantage of the Constitutional Limitation clause. There are two Drafts, one by the governing People's National Party, the other by the Opposition Jamaica Labour Party.

The Government's Draft at Section 13 (2) reads:

Save only for laws that are required for the governance of the State in periods of public emergency, or as may be demonstrably justified in a free and democratic society, Parliament shall pass no law and no public authority or any essential entity shall take any action which abrogates, abridges or infringes--

- (b) the right to freedom of conscience, belief and observance of religious and political doctrines;
- (l) the right to protection for privacy of home and other property; enjoyment and beneficial ownership of property.

The Opposition Draft at Section 14 (1) reads:

Save only for laws that are required for the governance of the State in periods of public emergency or public disaster or as may be demonstrably justified in a free and democratic society, Parliament shall pass no law and no organ of the State shall take any action which abrogates, abridges or infringes:

- (c) the right to freedom of conscience, belief and observance of religious and political doctrines;
- (k) the right to enjoyment and beneficial ownership of property;
- (l) the right to respect for private and family life, privacy of the home and of communication.

Ganja could be decriminalised for personal use and justified under the constitutionally protected right of enjoyment of the privacy of one's home, and possession in limited quantities for such private use likewise decriminalised. Also to be decriminalised in like manner would be the possession and use of ganja in pursuit of the right to freedom to manifest religious doctrines.

As Lord Gifford points out in his written submission, in effect supporting the above point of Dr Rattray, international human rights conventions as well as recent judicial decisions in other jurisdictions add some weight to the argument.

The rights to privacy and to the freedom to manifest one's religion as contained in both Drafts of the Charter of Rights are consistent with Articles 17 and 18 of the International Covenant of Civil and Political Rights, and Articles 11.2 and 12.1 of the American Convention on Human Rights. These rights are not absolute, and both Drafts include provisions to override them, although the Opposition Draft Section 19 of the Opposition's Draft goes so far as to make void any law or rule of law if:

- (a) it requires or authorizes anything to be done in contravention of any provision of this chapter [i.e. the *Charter*];
- (a) it prohibits the exercise of any right or freedom protected by this chapter; or
- (b) if it restricts the exercise of any such right or freedom in a manner not authorized by this chapter.

The overriding provisions are, in the first place, those contained in the qualifier "Save only for laws, etc.", which cover emergency situations or such laws "as may be demonstrably justified in a free and democratic society." It is hard to see what kind of emergency could make it necessary to ban the private use of ganja, and equally how, given its cultural entrenchment and medical status, the criminalisation of ganja possession for personal use and the use itself could be "demonstrably justified in a free and democratic society." But the Constitutional Court would be called on to judge.

But secondly—and this is spelt out in the Government’s Draft, the private possession and use of ganja would be subject to any law “which is reasonably required—

- (a) in the interests of defence, public safety, public order, public morality, public health...;
- (d) for the purpose of protecting the rights or freedoms of other persons.”

It is conceivable that ganja use, even in private, could be challenged as being against public morality and public health, or for infringing the rights and freedoms of others. But here again the issue would be subject to argument before the Constitutional Court.

Recent decisions in the United States and Canada also strengthen the case for decriminalisation. We quote extensively from Lord Gifford’s written submission:

In *US v Bauer and others*, cited as 1996 WL 264776 (9th Cir. [Mont]), the United States Federal Court of Appeal had to consider a plea from Defendants charged with trafficking and possession of marijuana, that they had the right to a ‘religious use’ defence. They relied on the Religious Freedom Restoration Act, a U.S. statute which guaranteed freedom of religion. The District Court had held that the relevant marijuana law ‘substantially burdened the free exercise of the Rastafarian religion’, but decided that ‘the Government had an overriding interest in regulating marijuana.’ The Court of Appeal reversed the District Court’s decision. The court held that if the freedom of a person’s exercise of religion is substantially burdened, the Government had to meet two tests: (a) a ‘compelling governmental interest; and (b) that the application of the law is ‘the least restrictive means of furthering that compelling governmental interest.’ The Court found that the Government had not shown that a universal law against marijuana was the ‘least restrictive means’ of preventing the distribution of marijuana. Accordingly the defendants who were charged with simple possession would be re-tried, and they would have a defence if they could show that the use of marijuana was part of their religious practice as Rastafarians. The defendants charged with trafficking would have no such defence, since religious freedom was not involved.

The conclusion drawn by Lord Gifford is that “even in the United States, the possession of marijuana may be found to be legal by the courts if it is associated with the exercise of a fundamental right such as religious freedom.”

In the Canadian case of *R v Terrance Parker* (Docket C28372, decided on 31st July 2000), the issue concerned the use of ganja for medical purposes. The Ontario Court of Appeal considered the evidence concerning the harmful as well as the therapeutic effects of ganja, and in making its ruling applied Section 7 of the Charter of Rights, according to which only by virtue of ‘the principles of fundamental justice’ may the right to liberty and security of the person be infringed.

The Court found that “the marijuana laws did infringe Parker’s security in preventing him from undertaking a safe medical treatment for his condition of epilepsy. It held that a blanket prohibition did breach the ‘principles of fundamental justice’”, and so permitted the possession of marijuana for medical use. Significantly, the Court of Appeal took note of the fact that the United Nations *1988 Convention* had, as the Convention stipulated, to be subject to Canada’s constitutional principles and basic concepts of its legal system.

A year later, Canada became the first state to pass legislation making “medical marijuana” legal.

Clearly, then, a strong legal case for the decriminalisation of ganja for personal, private use exists once both Government and Opposition are agreed on the terms of the *Charter*, and it becomes law by Act of Parliament. Once it becomes law, the decriminalisation of ganja for personal use, based on the right of privacy of the home, and its decriminalisation for religious use, based on the right of observance of religious doctrines, could then be covered by the Constitutional limitation respected by the United Nations Conventions. Decriminalisation would not remove the patent contradiction exposed by Dr Vasciannie above, but it would be the more satisfactory of the two options in providing a sounder legal basis.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The National Commission on Ganja accepts that ganja is not entirely safe. Despite its proven folk medicinal qualities, its use can be injurious to health. There is evidence that for those who smoke it the inhalation of tar and other compounds can affect the lungs; that users can experience short term memory loss and delayed reaction time; and that among young people it can retard the learning process. There is also documented evidence that the substance can produce in some people a mentally disturbed state of ganja psychosis.

Notwithstanding these and other ill effects, the Commission is of the view that many, if not most, persons who use ganja in moderation suffer no apparent short or long term debility. Not only that, but its reputation among the people as a panacea and a spiritually enhancing substance is so strong that it must be regarded as culturally entrenched. As a result, the practice of criminalising the users of small quantities does far more harm than good to the society as a whole. The Commission is mindful also that there are legally available substances that have been shown to have physiological and psychological ill-effects that, based on current evidence, are more injurious than those of ganja. Such is the case with alcohol and tobacco.

It is the view of the Commission that the punitive sanctions administered by the justice system to users of small quantities is not only unjust but is a major source of disrespect and contempt for the legal system as a whole. Moreover, the punishment meted out to such offenders has not had and is not likely to have the desired effect of a deterrent. Administering the present laws as they apply to possession and use of small quantities of ganja not only puts an unbearable strain on the relationship of the police with the communities, in particular the male youth, but also ties up the justice system and the work of the police, who could use their time to much greater advantage in the relentless pursuit of crack/cocaine trafficking.

Accordingly the Commission recommends as follows:

1. that the relevant laws be amended so that ganja be decriminalised for the private, personal use of small quantities by adults;
2. that decriminalisation for personal use should exclude smoking by juveniles or by anyone in premises accessible to the public;
3. that ganja should be decriminalised for use as a sacrament for religious purposes;
4. that a sustained all-media, all-schools education programme aimed at demand reduction accompany the process of decriminalisation, and that its target should be, in the main, young people;

5. that the security forces intensify their interdiction of large cultivation of ganja and trafficking of all illegal drugs, in particular crack/cocaine;
6. that, in order that Jamaica be not left behind, a Cannabis Research Agency be set up, in collaboration with other countries, to coordinate research into all aspects of cannabis, including its epidemiological and psychological effects, and importantly as well its pharmacological and economic potential, such as is being done by many other countries, not least including some of the most vigorous in its suppression;
and
7. that as a matter of great urgency Jamaica embark on diplomatic initiatives with its CARICOM partners and other countries outside the Region, in particular members of the European Union, with a view (a) to elicit support for its internal position, and (b) to influence the international community to re-examine the status of cannabis.

APPENDIX A

Persons Who Made Oral Submissions

ST. JAMES

Montego Bay

NAME	AGE	OCCUPATION/GROUP AFFILIATION
1. Ms. Suzette Brown	27	Public/ Community Relations Officer
2. Brother Wolde Amanuel	55	Coordinator of the Ethiopian World Federation/Businessman
3. Mrs. Apollone Reid	47	Physiotherapist/Politician
4. Mr. Luther Irving	52	Businessman/ Sign Artist/Freelance Writer
5. Ras Tafari (Wilfred Johnson)	41	Member of Nyah Binghi Association; Herbal Practitioner
6. Sister Norma Birch	41	Member of Pitfour Nyah Binghi House/ Daughters Council
7. Bongo Mannie	49	A Chairman of Nyah Binghi House/ Farmer/ Electrical Engineer
8. Ras Malo	34	Rastafarian
9. Ras Hire	-	Non-Affiliated Rastafarian
10. Sister Ita	-	Non-Affiliated Rastafarian
11. Sister Wood	-	Non-Affiliated Rastafarian
12. Dr. Horace Chang	-	Medical Doctor/Politician
13. Mr. Lloyd Smith	-	Journalist/ Publisher
14. Unknown Male	40	Auto Mechanic/Hydraulic System Operator
15. Shop Attendant	-	-
16. Elder	70	-
17. Blacka		
18. Shorty	-	-
19. Bus Driver	-	-
20. Socrates	61	Roof Worker
21. Joseph	-	-
22. Unknown	53	Woodworker/Driver
23. Aba Shanty	50	Carpenter
24. Ras Astor Black	50	Developer of the Bob Marley School for the Arts in Trelawny
25. Miss M. Johnson	56	Common Labourer
26. Christopher Walker	38	General Manager of a Villa
27. Earnest Brown	41	Welder/Heavy Equipment Operator
28. W. Blake	70+	Builder

29. Clive Willoughby	24	Free Zone Worker
30. Mr Allen	65	Unemployed
31. Princess McIntosh	31	Worker in a Security Firm
32. Travis McFarlane	19	Teacher of Integrated Science
33. Eric Jackson	40	Plumber/ Construction Worker
34. Michael Williams	32	Mason
35. Mr Earl	47	Jeweller
36. Mabel Clarke	72	Dressmaker
37. Joan Campbell	26	Teacher of Primary and Junior High
38. David	15	Student
39. Archibald	37	Singer
40. Audley Reid	-	Canadian Singer

KINGSTON & ST. ANDREW

Balmoral House

41. Chantal Ononaiwu	21	Student at the Norman Manley Law School
42. Young Pioneer	-	Member of Rhythm Revelation Fan Club/ Boulevard Auto Air-Conditioning
43. Lindon Fairweather	66	Tiler
44. Monica Panton	57	Detoxification Unit, University Hospital
45. Mr Warren	49	Senior Social Worker, Bellevue Hospital
46. Mrs Abrahams	-	Addiction Alert Team
47. Jan Lopez	-	Addiction Alert Team
48. Everton Levy	-	-
49. Abuna Foxe	63	Head of the Church of Hailie Selassie I in Jamaica
50. Elder Junior Anderson	-	Member of the Church of Hailie Selassie
51. Trevor Sharras	-	Member of the Church of Hailie Selassie
52. Gabri Selassie (Trevor Campbell)	66	Woodworker
53. Winston Denton	44	Labourer
54. Unknown	57	Taxi Operator
55. Mavis Jarrett	62	Housewife
56. Ronald Thwaites	55	Member of Parliament
57. Anthony Wynter	25	Mason
58. Joseph Knight	-	Councillor/Caretaker, Rae Town Division
59. Wayne Malcolm	35	-
60. Webb	30	Businessman

Denham Town Community

61. Unknown	30	Higgler
62. Unknown	26	-
63. Unknown Male	-	-
64. Unknown Male	32	-
65. Unknown Male	30	-
66. Unknown Male	42	Welder
67. Unknown Male	20	-
68. Patrick	30	-
69. Unknown Male	32	Social Worker

Trench Town Community

70. Unknown Male	42	Rasta from Nyah Binghi House/ Unemployed
71. Unknown Male	38	Casual Labourer
72. Empress	39	Unemployed

Balmoral House

NAME	AGE	OCCUPATION/GROUP AFFILIATION
73. Dr. Winston Dawes	53	President of the Medical Association of Jamaica
74. Michael Gyles (Ras Mikeman)	54	Bee-keeper
75. Kenneth Sewell	62	Auto Body Repair Man
76. Errol Grant	47	Graphic and Sign Artist
77. Ronnie Wilmot	-	Coordinator of Rollington Town Community Development Action Committee
78. Mr. Lloyd Service	61	Retired Assistant Commissioner of Police
79. Jennifer Straw	-	Senior RM at Half –Way -Tree RM Court
80. Fennis Chung	69	Unemployed /Trailer Driver
81. Oral Robertson	26	Administrative Assistant in the Office of the Prime Minister
82. Samuel James Clayton	64	Electrical Engineer/Rastafarian
83. Roy Williams	56	-

84.	Judy Hylton-Grant	-	Rehabilitation Specialist for the Blind
85.	Patricia Howell	31	Student Teacher, Mico Teachers' College
86.	Miriam Thompson	23	Student Teacher, Mico Teachers' College
87.	Raymond Gordon	61	Attorney-at-Law
88.	Dr. Stephen Vasciannie	-	Attorney-at-Law / University of the West Indies
89.	Lord Anthony Gifford	-	Attorney-at-Law
90.	Rt. Rev. Edgerton Clarke	72	Roman Catholic Archbishop of Kingston
91.	W. Abel	-	Medical Doctor
92.	Mr. Dennis Daley, Q.C	-	Attorney-at-Law
93.	Marcus Goffe	-	-

United Theological College of the West Indies (UTC)

	NAME	AGE	OCCUPATION/GROUP AFFILIATION
94.	Rev. Dr. Gregory	-	President of the College
95.	Rev. Dr. Bevis Byfield	-	Tutor at UTC
96.	Dillon Burgin	-	Student at UTC
97.	Germaine Francis	-	Student at UTC
98.	Dr. Hyacinth Booth	-	Teacher at UTC
99.	Leslie Mowatt	-	Student at UTC
100.	Jeffrey Sheckleworth	-	Student at UTC
101.	Elton Watson	-	Student at UTC

Balmoral House

102.	Reverend Austin Milner OP	-	Dean of Studies at the St. Michael's Theological Centre
103.	Sister Theresa Jackson RSM	-	Director of the Pastoral Centre/Member of CAFFE
104.	Dr. Charles Thesigar	-	Chairman of the National Council in Drug Abuse

WESTMORELAND

Savannah-la-Mar and Negril

105.	Clarence Clark	44	Musician/Craftsman
106.	Leopold Green	41	Farmer
107.	Sebert Mcfarlane	-	Community activist/Chairman of the Bethel

		Town Community Development Committee
108. Oneil Brown	29	Attorney-at-law
109. Clive Brown	28	Artist
110. Samuel (Sammy)	50	Craftsman
111. Errol Bonnick	25	Singer
112. Devon Crooks	40	Tollgate Operator
113. Cherry Davis	46	Tollgate Collector
114. Lenbert Wlliams	-	Businessman (Store owner/ Exporter)
115. Mike	-	Proprietor
116. Renford Jones	51	-
117. Cary Wallace	-	Managing Director of Mariners Resort/ President of the Friends of the West End
118. Policeman	-	-
119. Thomas Fraser	59	Retired Teacher/American Citizen
120. Slice	35	Canadian/Self-Employed Businessman

CLARENDON

May Pen

121. Winsome Christie	34	Pharmacist
122. Texal Christie	-	Teacher (secondary level)
123. Ms. Wilson	-	Pharmacist's Assistant
124. Unknown	-	Sixth Form of Glenmuir High School/ Student
125. Unknown Male	38	Jewel designer/Maker
126. Unknown Male	42	Higglering
127. Unknown Male	48	Cane shopper
128. Unknown Male	26	Taxidriver
129. Sandra	-	Garvey Maceo Comprehensive High
130. Unknown Male	20	Hustler/Self-Employed
131. Unknown Male	22	Ganja Seller/Bus Loader
132. Marlon	25	Higgler
133. Unknown Male	29	Higgler

ST. CATHERINE

Spanish Town

134. Martin	22	Community College
135. Sonia	26	Practical Nurse
136. Abdul Wahid	18	High School Student
137. Mr. Romeo	40	Construction Worker
138. Mr. Leonard	42	Shipping Administrator
139. Mrs Lewis	42	Store Clerk

140. Mr. Paul	29	Electrical Welder
141. Shawn	24	Shop Attendant
142. Joseph	38	Clerical Officer/ Registrar General's Department
143. Cleveland Wright	62	Plumber/Mason/Entertainer
144. Colman	43	Worker with the Police Department
145. Shawn	17	Student
146. Morros O'Connor	-	Junior supervisor of a Security Firm
147. Angela	24	Juice maker
148. Troy Palcher	24	Barber
149. Mark	-	Student at U.T.E.C.H

Linstead,

150. Unknown Male	32	Chef
151. Unknown Male	35	Street Cleaner
152. Shy Guy	32	Farmer/Electrical Welder
153. Male	24	Barber
154. Derrick	55	Accountant
155. Sophia	20	Dancer
156. Uton	41	Plumber/School Warden
157. Mr. Byles	60	Juiceman/Rastafarian
158. Christopher Mckenzie	25	Construction Worker/Labourer
159. Obelick	28	Worker in Cook Shop
160. Tom	29	Instructor at H.E.A.R.T

Linstead Baptist Church Yard

NAME	AGE	OCCUPATION/GROUP AFFILIATION
161. Unknown	-	Geography Teacher
162. Tricia	-	Administrator in School Personnel Department, Ministry of Education
163. Colin	34	Internal Auditor, St. Catherine Co-op Credit Union
164. Desmond White	26	Pharmacist/Deacon

ST THOMAS

Morant Bay

165. Dr. Ronald Lampart	-	Retired Medical Officer/Owner of Private Practice
166. Mr. Milner	-	Electrician
167. Donald Barclay	-	Social Development Commission
168. Devon Blake	-	Information Technology Technician
169. Brenda Jones	-	Parish Co-ordinator, St. Thomas Homecoming

		Committee
170. Maxine Chin- Hew	-	Accountant/Visitor from England
171. Davina Simmons	-	Retired Nurse

Morant Bay Market
Participants anonymous.

172. Unknown	-	-
173. Unknown	-	-
174. Unknown	-	-
175. Unknown Male	-	-
176. Unknown	-	-
177. Unknown	-	-
178. Unknown	-	-
179. Unknown	-	-
180. Unknown	-	-
181. Unknown	-	-
182. Unknown	-	-
183. Unknown	-	-
184. Unknown	-	-
185. Unknown	-	-
186. Unknown	-	-
187. Unknown	-	-
188. Unknown	-	-
189. Unknown	-	-
190. Unknown	-	-
191. Unknown Female	-	-
192. Unknown	-	-
193. Unknown	-	-
194. Unknown	-	-
195. Unknown	-	-
196. Unknown	-	-
197. Unknown	-	-
198. Unknown	-	-
199. Unknown	-	-
200. Unknown	-	-
201. Unknown	-	-

ST. ANN

Browns Town

203. Mrs.Cameron	-	Cook
204. Unknown	-	Farmer
205. Mr.Riley	-	Businessman/Cableman
206. Lisa	17	Student, Northern Caribbean University

207. Unknown	-	Parish Manager
208. Unknown Male	27	Welder
209. Unknown Female	-	-
210. Unknown	-	-
211. Unknown Female		
212. Unknown Male	-	Plumber/Vendor
213. Unknown Male	81	-
214. Unknown	-	-
215. Unknown	-	-
216. Unknown	-	-
217. Unknown	-	-
218. Unknown	56	Farmer
219. Unknown	-	-

St. Ann's Bay

220. Marlon	-	-
221. Unknown	-	-
222. Unknown	-	-
223. Unknown	-	-
224. Unknown	-	-
225. Unknown	-	-
226. Unknown	-	-
227. Unknown	-	-
228. Unknown	-	-
229. Eric	-	-
230. Unknown	-	-
231. Unknown	-	-
232. Unknown	-	-
233. Unknown	-	-
234. Unknown Female	-	-
235. Unknown	-	-
236. Unknown Male	22	-
237. Unknown	-	High School Student

St. Ann's Bay Police Station

238. Unknown	-	Inspector of Police
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TRELAWNY

Falmouth

238. Mrs. Samuda	-	Librarian/Vice- Chairman of the Trelawny Drug Abuse Council
239. Mrs Manahan	-	-
240. Mr. Oshane	41	Plumber

241. Unknown	36	-
242. Unknown	65	Construction Worker
243. Unknown	18	Student
244. Unknown	19	Student
245. Derrick	35	Lifeguard
246. Unknown	-	Farmer
247. Unknown		Hustler
248. Unknown	-	-
249. Unknown Male	29	Conductor
250. Unknown Female	-	Dressmaker/Domestic Worker
251. Mr. Cousley	61	-
252. Ms. Ova	-	-

Duncans

253. Unknown	-	-
254. Unknown	-	-
255. Unknown	-	Farmer
256. Unknown	-	-
257. Unknown	-	-
258. Unknown	-	-
259. Unknown	-	-
260. Unknown Female	-	-
261. Unknown	-	Student/William Knibb High (5 th)

PORTLAND

Port Antonio

262. Bus-out	33	Taxi Operator
263. Blairy	37	Taxi Operator
264. Unknown Male	-	-
265. Kizzy- Ann	-	Unemployed
266. Clive	33	-
267. Richard	22	Taxi Operator
268. Manny	33	Taxi Operator
269. Brassiere	37	Taxi Operator
270. Moses	45	Taxi Operator/Chef
271. Martin	30	Merchandiser
272. Anthony Bell	29	Construction Worker
273. Christopher Lane	25	Hustler
274. Sandra Lane	26	Businesswoman/Vendor
275. Watika Thompson	19	Coordinator, Sans Souci
276. Tina	24	Self-Employed
277. Ronald	30	Plumber/Construction Worker/Fisherman
278. Nickleton	32	Self-Employed

279. Richard Maragh	40	Farmer
280. Mr.Hazel	-	-
281. Mrs. Mahadeo	-	Farmer
282. Luther Schlegel	33	Motel Owner
283. Edgar Roper	33	Labourer
284. Maxwell Coore	-	Teacher
285. Beverly Kerr	48	Librarian
286. Mona Henry	-	Social Worker

ST. MARY

Annotto Bay

287. Wayne Walters	20	Hustler
288. Howard Black	32	Conductor
289. Unknown Male	26	Unemployed
290. Yanique Sewell	19	Student
291. Tonnerre Young	16	Student
292. Patrick	30	Barber

Port Maria

293. Unknown Female	-	-
294. Creamy	36	Ice Cream Vendor
295. Unknown Male	70	Musician
296. Irvine Robinson	-	Sign Artist
297. Morris Edwards	25	Merchandiser
298. S. Dunbar	23	Labourer
299. Dwight Brown	27	Barber/Construction Worker
300. Leroy Lord	45	Taxi Operator
301. Maxine Lowe	26	Domestic Worker
302. Daniel Harrison	63	Painter
303. Jack	16	Vendor

ST. ELIZABETH

Treasure Beach

304. Celeste Anderson	-	Manager of Guest House/Chairman of the Treasure Beach Women/s Group
305. Gregory Wright	-	Gaming Operator
306. Alexander Lowe	-	Doctor/General Practitioner
307. Christian Ghisays	-	Manager of Guest House
308. Richard Sinclair	-	Businessman/Musician
309. Mark	-	Peace Corps Volunteer
310. Fowler	-	Italian Tourist
311. Unknown Female	-	High School Student

312. Renee Edmunds	-	American Graduate Student
313. Sheila Hamilton	-	-
314. Casey	31	-
315. Jason	-	-

Santa Cruz

316. Donald Shaw	49	Farmer
317. Bashment	27	Farmer/Distributor
318. Elder Gamon	77	Member of Church of Jesus Christ/Drug Abuse Committee in St.Elizabeth
319. Owen McKnight	58	Public Health Inspector
320. Unknown Female	34	Higgler
321. Terrence Gayle	42	Bus Driver
322. Unknown	49	-
323. Unknown Male	30	Unemployed/Welder
324. Unknown Male	65	-
325. Julian Keys	-	Social Development Commission (SDC)
326. Stephanie Brown	38	Community Development Officer (SDC)
327. Locksley Crew	62	Milwright/Vendor
328. Tamara Mullings	19	Student/Part-time Worker at SDC
329. Wilbert Rowe	-	Future's Group (Health Programme of Ministry of Health)

MANCHESTER

Mandeville

330. Miss Baker	-	-
331. Mr. Roache	-	Retired Civil Servant (Ministry of Agriculture
332. Angelo Lawrence	-	Journalist at the Gleaner Company
333. Mr. Owen Crosby	-	Attorney-at-Law
334. Barbara Bent	-	Businesswoman
335. Kerry-Ann Watson	-	Secretary
336. Ras Garfield	-	Farmer
337. Sian Berrick	-	Fashion Designer
338. Christopher Edwards	-	Farmer
339. O'Neil Livingston	-	Farmer
340. Nadia Wescar	17	6 th Form Student
341. Unknown Female	-	High School Guidance Counsellor
342. Ras Pinto	-	Engineer
343. Paul Pinto	-	Parish Councillor/Pastor
344. Roderick Roache	-	Agriculturalist
345. Trevor Johnson	-	Bailiff
346. Newton Ennis	-	-

347. Peter Dockery	-	Singer/Artist
348. Empress Norma	-	Fashion Designer

HANOVER

Lucea

349. Enid Gonzales	-	Retired Teacher/Senior Justice of the Peace
350. David Campbell	48	Duco man/Fisherman
351. Mr. Barnes	43	Unemployed
352. Irvine Grant	46	Farmer
353. Dennis Malcolm	37	Farmer

KINGSTON & St ANDREW

Balmoral House

354. Dr Peter Figueroa	-	Chief Medical Officer of Health
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Church of God in Jamaica H.Q.

355. Dr Garnet Brown	-	Chairman, Church of God in Jamaica
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APPENDIX B

LIST OF PERSONS WHO MADE WRITTEN SUBMISSIONS

NAME & TITLE	ORGANIZATION	ADDRESS	DATE
1. Donald J. Duff		12 Sunset Avenue Kingston 8	30.10.2000
2. A. Hugh Wilson		P.O. Box 4, Discovery Bay, St. Ann Tel: 973-2631	30.10.2000
3. Drug Abuse Secretariat	National Council on Drug Abuse	2-6 Melmac Avenue Kingston 5 Tel: 926-9002	Undated
4. Lord Anthony Gifford Attorney-at-Law		122-126 Tower Street Kingston Tel: 922-6056	06.11.2000
5. Addiction Alert Lifeline (Report)		57 East Street Kingston	Jan.-May 2000
6. Adon Joseph Rose President & CEO	Reggae, Gospel & Jazz Music Areas	Higgin Town P.A. St. Ann	10.11.2000
7. Lucious Leveine		Long Road Muirton Pen P.A. Portland	10.11.2000
8. Ms. Joan Basco- Grant		27 Oakdene Avenue Kingston 3	12.11.2000
9. Mr & Mrs Karl Aiken		C/o Dept. of Life Sciences, UWI, Mona Campus, Kingston 7	12.11.2000
10. Rev. Leeroy James Campbell		Ocho Rios P.O. St. Ann Tel: 972-2953	13.11.2000
11. Mr. Lloyd Service		P.O. Box 88 Stony Hill, Kgn. 9	20.11.2000
12. Mr. Nam Singh		288 NE 200 Terrace Miami, Fla. 33179	20.11.2000
13. Mr. Clarence Clarke President	Jamaica Manufacturers' Assn. Ltd.	85A Duke Street Kingston	22.11.2000

14. Mr. James S. Moss-Solomon		73 Harbour Street Kingston	24.11.2000
15. Mr. Bruce Golding President	National Democratic Movement	NDM House 3 Easton Avenue Kingston 5 Tel: 978-7973	21.11.2000
16. Mitchell Williams		Adult Correctional Centre, 2-4 Tower Street, Kingston	19.11.2000
17. B. Wiggan, LL.B (Hons) Student		Address omitted	14.12.2000
18. Mr. Robert McNamee		111 Prince Charles Drive, Apt. 309, Oakville, Ontario L6K 3X3, Canada	30.11.2000
19. Mr. Steve McDonald		Hopewell District Hanover Tel: 992-0229	08.12.2000
20. Dr. E.K. Riley- Miller		Apt. No. 1 Sunny Banks Gordon Town P.O. St. Andrew	14.12.2000
21. Dr. Jean A. Dixon Exec. Director	Scientific Res. Council	P.O. Box 350 Kingston 6 Tel. 927-1771-4	14.12.2000
22. Ms. Delsey Wallace		P.O. Box 310 Ocho Rios St. Ann Tel. 974-5021	24.11.2000
23. Dr. Winston Dawes President	Medical Association of Jamaica	19A Windsor Avenue Kingston 5 Tel. 946-1105-7	14.12.2000
24. Lucious Leveine		Long Road Muirton Pen P.A. Portland	12.12.2000
25. Hyacinth McKenzie		Long Road Muirton Pen P.A. Portland	12.12.2000
26. Ras Sydney DaSilva President	Rastafari Centralization Organization (R.C.O.)	20 Melody Drive P.O. Box 291 Kingston 4 Tel. 948-1128	16.11.2000

27. Ganja Land		E-mail: (www.ganjaland.com)	
28. Owen A. Seaton		22 Cornwall Avenue Independence City Gregory Park P.O. St. Catherine	20.12.2000
29. Beverley Lawton		Ozanam Home for the Aged 38 Mannings Hill Rd. Kingston 8	Undated
30. Samuel B. Bandara Acting Deputy Librarian	UWI Library	University of the West Indies, Mona, Kgn. 7	29.11.2000
31. Roger Williamson		Rose Hall District Linstead St. Catherine Tel: 903-2155-6	Undated
32. Fennis Chung		54 Bloomsbury Road Kingston 10	Undated
33. Anthony Gomes Trade Advisor		P.O. Box 2522 Constant Spring Kingston 8	2. 1.2001
34. Delsey Wallace		P.O. Box 310 Ocho Rios St. Ann Tel: 974 5021	24.11.2000
35. Owen A. Seaton		22 Cornwall Avenue Independence City Gregory Park P.O. St. Catherine	14.12.2000
36. Paul Thomas		Cornwall Mountain P.O., Westmoreland	Undated
37. Lindel Graham		Mullock Treadways P.O. St. Catherine	25.3.2001
38. Dr. Wendel Abel		C/o Bellevue Hospital 161/2 Windward Road Kingston	28.3.2001
39. Mr. Dennis Daley, Q.C. Director	Independent Jamaica Council for Human Rights (1998) Limited	131 Tower Street Kingston	28.3.2001
40. Claudius Thompson		Hounslow Mountainside P.O. St. Elizabeth	10.4.2001

41. Austin Jobson		P.O. Box 243 Montego Bay P.O. #1 ST. JAMES	29.5.2001
42. Dr. Stephen Vasciannie Senior Lecturer		Faculty of Law Mona Campus U.W.I. Kingston 7	12.6.2001
43. Dr. Charles Thesiger Chairman	National Council On Drug Abuse	2-6 Melmac Avenue Kingston 5	13.6.2001
44. Dr Jean Dixon	Scientific Research Council		
45. Professor Trevor Munroe	U.W.I.		

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