Cannabis – A human right

A Seed our Future Report (August 2023)

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Abbreviations

ACDM – Advisory Council on the Misuse of Drug
CBPM – Cannabis-based products for medicinal use
CMO – Chief Medical Officer
ECHR – European Court of Human Rights
HRA – Human Rights Act (1998)
MDA – Misuse of Drugs Act (1971)

MDR – Misuse of Drugs Regulations (2010)
SSHD – Secretary of State for the Home Department
UNODC – United Nations Office on Drugs and Crime

1.0 Introduction

1.1 Rationale for application of the four-stage proportionality test

Prior to the enactment of the Human Rights Act (HRA) (1998), applications for judicial review were assessed according to the principle of 'Wednesbury unreasonableness', which dictated that the courts would only challenge a decision if the measures in question were so unreasonable that no reasonable decision maker would have made it. However, its applicability to human rights cases was challenged in the case of *Grady v UK (1999)* which concerned the discharge of military personnel on the basis of their sexuality. Originally dismissed by both the UK's High Court and Court of Appeal on the basis that the action had not violated the Wednesbury unreasonableness principle, the European Court of Human Rights (ECHR) ultimately found that the action had been in breach of the applicants' rights under Article 8 of the European Convention on Human Rights.[1]

The ECHR also found that the case's dismissal by UK courts based on Wednesbury unreasonableness was in violation of the applicants' right to remedy under Article 13, and that "the threshold at which the High Court and the Court of Appeal could find the Ministry of Defence policy irrational was placed so high" that it excluded considerations of whether the action was in the service of a "pressing social need."

Following the implementation of the HRA in 2000, Lord Steyn argued in *Daly v Home Secretary [2001]*, that the Wednesbury test was not appropriate for assessing human rights cases.[2] After *Daly*, it was clear that cases brought under the Human Rights Act were to be decided on the basis of proportionality rather than under Wednesbury reasonableness. This principle has more recently been reaffirmed in *R (Lord Carlile) v Home Secretary [2014*], and, since *Bank Mellat v Her Majesty's Treasury [2013]*, a four-stage proportionality test has been considered the standard assessment for human rights cases.

Clarifying the nature of the proportionality test in *Bank Mellat*, Lord Reed stated that test must consider:

"(1) whether the objective of the measure is sufficiently important to justify the limitation of a protected right, (2) whether the measure is rationally connected to the objective, (3) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective, and (4) whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter."[3]

[1] *Smith & Grady v. The United Kingdom (1999)*, European Court of Human Rights, https://hudoc.echr.coe.int/tkp197/view.asp?i=001-4828
[2] *R (Daly) v Home Secretary [2001]* UKHL 26; [2001] 2 AC 532
[3] *Bank Mellat v Her Majesty's Treasury [2013]* UKSC 39, [2014] AC 700 [74]

Since *Bank Mellat*, the Supreme Court has frequently reaffirmed the four-stage formulation, with former Supreme Court President Lady Hale referring to it as the ‘standard approach’ for human rights cases.

By employing the four-stage proportionality test, this paper will demonstrate that the challenged measures within the Misuse of Drugs Act (MDA) 1971 and the Misuse of Drugs Regulations (MDR) 2001 fail on all four proportionality tests when assessing the balance of the objective to the severe curtailment of human rights.

Following Lord Reed’s proportionality test guidance, the remainder of this paper will assess the suitability and proportionality of cannabis classifications under the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. We will seek to answer the following questions:

- Does the prohibition of cannabis (via the scheduling within MDA/MDR) pursue a legitimate aim which is sufficiently important to justify an infringement on human rights?
- Is there a rational connection between the prohibition of cannabis and the objective of the measure?
- Is prohibition no more restrictive than necessary in order to achieve the objective?
- Is there, overall, a fair balance between the achievement of the objective and the harm done to the right?

2.0 Assessment

This section will consider the objective of the measures (the classification of cannabis as a Class B substance within Misuse of Drugs Act 1971, the continued Schedule 1 status for non-prescribed grown cannabis and the restrictive access to prescribed cannabis medicines via Schedule 2 of the Misuse of Drugs Regulations 2001, and the resulting prohibition of the possession and/or cultivation and/or non-commercial sharing of cannabis and cannabis products) against its aim (the prevention of the misuse of a drug, capable of having harmful effects sufficient to constitute a social problem), and assess whether it is sufficiently important to justify the limitation of protection contained within the Human Rights Act 1998.

2.1 Human Rights Act protections

In order to assess whether the 'legitimate aim' of cannabis classification and scheduling are sufficiently important to justify limitations on individual liberties afforded under the 1998 HRA, it is important to understand the nature of the protections afforded by the Act, and how they may be violated by the challenged measures. In particular, Articles 8, 9 and 14 of the HRA.

> **Article 8**
>
> *Right to respect for private and family life:*
>
> *1. Everyone has the right to respect for his private and family life, his home and his correspondence.*
>
> *2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

2.1.1 Article 8

According to the ECHR, the right to respect for private life under Article 8 encompasses the protection of an individual's 'autonomy' and 'physical integrity'.[4] It is under this protection that the prohibition of a medically useful controlled drug is subject to challenge.

Criminalising access to a drug that many consider essential to health, wellbeing and the prevention and treatment of numerous medical conditions requires individuals to choose between taking ownership of health decisions or severe ill health and potential criminal penalty. This limits personal autonomy by restricting an individual's medical decision making. By denying treatment for ill health or preventing ill health, it also infringes upon an individual's physical integrity.

However, Article 8 is a qualified human right, and infringement of it can be allowed if it is a proportional response to a public interest. Legitimate public interest is defined within the exceptions under which infringement may be permissible outlined in the second paragraph of Article 8; in particular, "public safety" and "the protection of health". The efficacy of current cannabis scheduling and classification in serving these aims will be examined further in section 2.2.

[4] ECHR (2022), *Guide on Article 8 of the Convention on Human Rights*, Council of Europe, https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiig7Tw0LuAAxU8TEEAHaawCFMQFnoECA4QAQ&url=https%3A%2F%2Fwww.echr.coe.int%2Fdocuments%2Fd%2Fechr%2Fguide_art_8_eng&usg=AOvVaw1oqBCg0hAwsga4iL4nzgcS&opi=89978449

2.1.2 Article 9

The protections afforded under Article 9 pertain to an individual's belief system and its practices. For many, negative experiences and outcomes from conventional medicine and pharmaceuticals has led to the development of a sceptical set of beliefs towards these treatments. These beliefs are manifested through a desire to seek and acquire alternative, more effective and less damaging forms of treatment.

Like Article 8, Article 9 is a qualified right subject to restriction when deemed to be in the public interest, as outlined in paragraph 2.

Article 9

Freedom of thought, conscience and religion

1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

2.1.3 Article 14

Article 14 prohibits discrimination "on any" grounds. The discrimination associated with the overly restrictive placement of cannabis can be viewed from a range of perspectives, including social, medical and economic. Perhaps the most egregious is the way that current regulations mean cannabis treatment is only available to those who can afford private healthcare, thereby discriminating against the economically worse off.

Article 14

Prohibition of discrimination

1. The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

2.2 Legitimate aims – public safety

The aims of medicinal cannabis prohibition (and prohibition more broadly) can be found in the introductory text of the Misuse of Drugs Act 1971, under which authority the Misuse of Drugs Regulations 2001 are enacted. According the text, the Act is designed "to make new provision with respect to dangerous or otherwise harmful drugs and related matters."[5]

These sentiments align with the overall purpose of the international prohibitionist regime, described variously as "tackling addiction" and "the social and economic danger" of drugs, being concerned with "the health and welfare of mankind" and "the public health and social problems resulting from the abuse of certain psychotropic substances."

Based on these statements, it is clear that the prohibition of cannabis is intended to pursue the interests of public health and safety. However, considering the low levels of harm resulting from cannabis - particularly when compared to substances with much less restrictive classification or scheduling, such as amphetamines and anabolic steroids, or even uncontrolled substances, such as alcohol and nicotine – it is difficult to argue that its prohibition serves to protect the public from any severe or unique risk. A 2016 report by the Royal Society for Public Health's (RSPH) ranked the top 10 most harmful drugs, based on factors including economic cost, injury to others, direct and indirect fatalities and crime. Alcohol was far and away the most harmful drug, with an overall score of 72, well clear of heroin on 55 followed by crack cocaine on 54; cannabis received a score of 20, ahead of only GHB (18) and benzodiazepines (15).[6] The two most significant factors in the harms determined for alcohol were economic cost and injury to others.

[5] Misuse of Drugs Act 1971, c.38, https://www.legislation.gov.uk/ukpga/1971/38/introduction

[6] Royal Society for Public Health (2016), *Taking a new line on drugs*, https://www.rsph.org.uk/our-work/videos/itn-films/itn-film-2016-championing-the-publics-health/rsph-2016/taking-a-new-line-on-drugs.html

Numerous reports, including many commissioned and funded by the government, have consistently concluded that cannabis presents limited risk to individual health or public safety.[7] A number of these reports have included the recommendation that cannabis be reclassified/rescheduled in order to reflect its low risk and prevent confusion with much more harmful substances of the same classification; these recommendations have been consistently ignored.

According to a 2002 report by the government's Advisory Council on the Misuse of Drugs (ACMD) "the high use of cannabis is not associated with major health problems for the individual or society," which is prima facie at odds with the legitimate aims of the policy. 8 A subsequent ACMD report in 2008, requested by then Home Secretary Jacqui Smith, also found "weak" and "inconclusive" links between cannabis use and physical, mental and social harms.9 In particular, the Council stated that cannabis does "not constitute a risk to healthy adolescents or adults" of cardiovascular damage, is "less likely to harm lungs than if tobacco is used alone" and that the Council "remains unconvinced that there is a causal relationship between the use of cannabis and the development of any affective disorder (anxiety or depression)."10 Despite these findings, the Home Office continues to assert that "there is a substantial body of scientific and medical evidence to show that controlled drugs, such as cannabis, are harmful and can damage people's mental and physical health, and our wider communities."11

The ACMD's 2008 report also recommended that cannabis remain Class C, which was ignored by Gordon Brown's government, becoming the first since the enactment of the 1971 Misuse of Drugs Act to go against the advice of its scientific panel. The decision led the Government's then chief scientific advisor, Professor David Nutt, to publicly accuse ministers of "devaluing and distorting" the scientific evidence over illicit drugs; remarks for which he was sacked by then Home Secretary Alan Johnson.[12]

2.2.1 Illegitimate aims – restriction of safe and effective treatment

In many ways, it is the Act itself that causes harm to public health and safety. Grown cannabis and cannabis preparations have been used medicinally for several thousand years for hundreds of conditions.[13] Although not a harmless substance, the harms to physical and mental health are lower than all other controlled drugs within the Act and the harms to society are primarily related to the prohibition (and thus criminalisation) via the Act itself. Furthermore, the potential harms to public health and society of cannabis are far less than non-controlled drugs such as alcohol and tobacco. [14]

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[7] ACMD (2002), *The classification of cannabis under the Misuse of Drugs Act 1971*, https://www.gov.uk/government/publications/the-classification-of-cannabis-under-the-misuse-of-drugs-act-1971-2002
[8] ibid
[9] ACMD (2008), *Cannabis Classification and Public Health (2008)*, https://www.gov.uk/government/publications/acmd-cannabis-classification-and-public-health-2008
[10] *ibid*
[11] Response to Ince law firm from the Home Office (4th February 2021)
[12] Travis, A. (2009), 'Chief drug advisor David Nutt sacked over cannabis stance', *Guardian*, 30.10.09, https://www.theguardian.com/politics/2009/oct/30/david-nutt-drugs-adviser-sacked
[13] Abazia, D.T. & Bridgeman, B.B. (2017), 'Medicinal Cannabis: History, Pharmacology, And Implications for the Acute Care Setting', *Pharmacy and Therapeutics*, 2017 Mar; 42(3): 180–188, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5312634/
[14] ACMD (2008), *Cannabis Classification and Public Health (2008)*

Every human has an endo-cannabinoid system (ECS), which is essential to maintaining health and wellbeing, and only whole plant cannabis and cannabis preparations have the ability to maintain the ECS. Cannabis also has the potential to dramatically increase the health index of the population by preventing and treating a range of medical conditions.[15]

As a result, criminalisation of the personal cultivation and possession of a relatively harmless medicinal plant for medicinal reasons restricts both personal autonomy – by restricting medical decision making – and physical integrity, by denying treatment for ill health or preventing ill health. As a result, the classification and scheduling of cannabis within the Act does not meet the threshold for justified curtailment of human rights on the grounds of public health and safety.

2.3 Legitimate aims – economic well-being

Another possible exception allowing a public authority to restrict this right is on the grounds of protecting "the economic well-being of the country." However, the current scheduling and classification of cannabis does more to harm the economic well-being of the country – not to mention individuals – than it prevents.

According to a 2020 review by Dame Carol Black, illegal drugs cost the UK around £20 billion per year, with drug-related crime comprising the majority of total costs. Within this overall crime cost, criminal justice services (CJS) cost £733 million and drug-related enforcement costs amounted to £680 million.[16] Policing approaches focus primarily on the restriction of supply and enforcement, a resource intensive approach that Dame Black's review suggests "can sometimes have unintended consequences such as increasing levels of drug-related violence and the negative effects of involving individuals in the criminal justice system."[17] Conversely, chronically under-funded treatment services have been further diminished by government cutbacks, with around £600 million spent on treatment annually, representing about three per cent of the estimated £20 billon costs of illegal drugs. Further, preference for enforcement over treatment means that around a quarter of all prisoners have been detained for offences related to their drug use, rather than being involved in supply. According to the review, "the crimes (mostly acquisitive) relating to drug use are therefore generating a huge pressure on the prison system."[18]

Despite the expenditure of considerable financial and other resources, the UK continues to perform poorly by most measures. Between 2012 and 2018 deaths involving heroin more than doubled, while there was a five-fold increase involving cocaine – in fact, drug deaths in the UK have increased so much that they are thought to be a significant contributor to an overall decrease in life expectancy in the country, following decades of growth.[19] The review also concludes that "Government interventions to restrict supply have had limited success" and that "even if these organisations were sufficiently resourced it is not clear that they would be able to bring about a sustained reduction in drug supply."

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[15] Crocq, M. (2020), 'History of cannabis and the endocannabinoid system', *Dialogues in Clinical Neuroscience*, 2020 Sep; 22(3): 223–228, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7605027/

[16] Home Office (2020), *Independent review of drugs by Professor Dame Carol Black*, https://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black

[17] *ibid*

[18] *ibid*

[19] *Ibid*

While the prohibitionist and enforcement-led approach to all drugs has been broadly ineffective, the continued criminalisation of cannabis – a relatively safe and widely used drug in the UK – places significant unnecessary cost on society, as well as individuals. A 2016 report by the free-market Adam Smith Institute thinktank found that there were 1,363 people in prison for cannabis-related offences in England and Wales, at a cost to the taxpayer of more than £50 million per year.[20] However, for the estimated 2.6 million cannabis users in the UK, of which at least 1.8 million (69%) are medicinal, the personal economic consequences stemming from the criminalisation of cannabis can be severe. It is well documented that a criminal record – and even a caution, the most common penalty for cannabis possession – severely reduces employment prospects and are connected to higher unemployment and family disruption; further restricted access to essential medicine can also prevent people from being able to work.[21]

2.3.1 Illegitimate aims – prohibiting legitimate markets, lost revenue and organised crime

Perhaps one of the most obviously self-defeating aspects of the UK's current cannabis regulations is that – instead of massive public expenditure for limited or even counter-productive outcomes – a switch to a regulated market has the potential generate considerable sums for the treasury.[22] A regulated market also ensures product safety, while a flourishing and creative private sector is able to push out illicit channels largely controlled by organised crime. According to the Adam Smith Institute, "only regulation addresses all of these issues: ensuring that the product is safe in strength and purity, removing criminal gangs from the equation as far as possible, raising revenue for the Treasury through point-of-sale taxation and best protecting public health." In the US, states such as Colorado – which have a fully legal and regulated cannabis market – have created specific programmes that benefit from cannabis tax revenue. One of its most notable successes – the Building Excellent Schools Today (BEST) grant programme has awarded more than $3.5 billion to help repair or replace aging schools in the state.[23]

Under the current regime, the government spends considerable amounts of public funds in pursuit of a policy that has little scientific basis, is largely ineffective and suppresses a potentially well-regulated and profitable industry with significant revenue generating potential. The lack of a well-regulated market also creates the space and opportunity for criminal gangs to exploit the demand, as well pushing low-level, otherwise law-abiding individuals into criminal association.

3.4 Legitimate Aims - Conclusion

In light of the aims articulated within the MDA itself, and supported by numerous international conventions based on prohibitionist principles, the above assessment concludes that the legitimate

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[20] Starling, B. (2016), *The Tide Effect: How the world is changing its mind on cannabis legislation*, The Adam Smith Institute, https://www.adamsmith.org/store/the-tide-effect

[21] Beckford, M. (2012), 'Police cautions lead to a 100-year criminal record that can wreck prospects of getting a job or going to university, *Mail on Sunday*, 03.11.12, https://www.dailymail.co.uk/news/article-2227522/Police-cautions-lead-100-year-criminal-record-wreck-prospects-getting-job-going-university.html

[22] Starling, B. (2016), *The Tide Effect: How the world is changing its mind on cannabis legislation*

[23] Koen, A. (2022), 'Where Colorado spends marijuana taxes', *KOAA News 5*, 27.05.22, https://www.koaa.com/news/deep-dive/where-colorado-spends-marijuana-taxes

aims of the Act (protecting health and public safety via the classification within MDA 1971 and the scheduling within MDR 2001) has failed, with often disastrous consequences to the public health, society and the economy. Prohibitionist and enforcement-based drug policy has increased organised crime and created an unacceptable drain on public resources for the past 52 years, while the adult use of controlled drugs has increased from 1% to 34%. In particular, the continued Schedule 1, Class B status of cannabis is a disproportionate measure when lawful access of the same substance with the same potential for harm is only available via private healthcare to those who can afford it.

The Home Secretary in place when the decision was taken reclassify cannabis to B – who also commissioned the 2008 report – has since expressed regret that politics and morality were allowed to overrule scientific evidence. Speaking in 2012 – four years after the decision to reclassify – Smith said "knowing what I know now, I would resist the temptation to resort to the law to tackle the harm from cannabis. Education, treatment and information, if we can get the message through, are perhaps a lot more effective."[24]

More recently, there has been a growing number of politicians from across the political spectrum who have begun speaking much more frankly and critically of the UK's approach to drug policy under the MDA. During a parliamentary debate on the Act in 2021, a number of politicians spoke openly about the failure of UK drugs policy. Senior Conservative MP Crispin Blunt perhaps summarised the issue most effectively, saying*:*

> *If the House had known then what we know now, passing that Act would have been an appalling betrayal of its duty to the public interest. In the UK we have invested countless billions in the approach put into law by the MDA, with what success? Illegal drugs are today cheaper, and more available, potent and widely used, than ever. Most of all, victims of drug policy-related crimes are off the scale.*[25]

As the voices calling for a reformed, sensible and evidence-led approach to drugs policy grow louder and broader, it is well past time that that UK undertakes a root and branch review of its more than half century-old approach to drug regulation. First and foremost, should be the scheduling and classification of cannabis, a relatively and medicinally efficacious drug whose criminalisation represents a wholly disproportionate response, often does more harm than good and, in some cases, is in violation of fundamental protections under the Human Rights Act (1998).

3.0 Assessment – Rational connection

As discussed above, according to Lord Reed, any test of proportionality must seek to determine "whether the measure is rationally connected to the objective." In other words, a rational connection must exist between the legitimate aim and the specific elements of the policy which are being challenged. We must therefore examine whether the decision to continue to place cannabis as a Class B substance of MDA and Schedule 1 of MDR and the associated criminal penalties, and

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[24] Ward, V. (2012), 'Jacqui Smith admits cannabis reclassification was wrong', *Telegraph*, 20.11.2012, https://www.telegraph.co.uk/news/politics/9688040/Jacqui-Smith-admits-cannabis-reclassification-was-wrong.html

[25] UK Parliament (2021),'Misuse of Drugs Act: Volume 697: debated on Thursday 17 June 2021 – Hansard: https://hansard.parliament.uk/Commons/2021-06-17/debates/A1B14B26-EBB7-415F-9AA8-1620726307C5/MisuseOfDrugsAct

Schedule 2 of the Misuse of Drugs Regulations, with stringent guidelines which prevent access to the majority who need it, and thereby generally prohibit its medical use, can be said to protect health and public safety.

3.1 MDA & Classification

Substances that are controlled under the Misuse of Drugs Act (1971) are grouped into one of three (A, B or C) classes on the basis of their harmfulness.

At the time the Misuse of Drugs Act was introduced, cannabis preparations (apart from cannabinol and certain derivatives of cannabinol) were placed in Class B. In 2002 the ACMD recommended that all cannabis products be reclassified to Class C. The Home Secretary accepted the Council's advice and the legislative changes came into force on 29 January 2004.

MDA (1971) Drug Classification

Class A*: The most harmful – includes: cocaine, diamorphine (heroin), 3,4-methylenedioxymethamphetamine (ecstasy), lysergic acid diethylamide (LSD) and methamphetamine.*

Class B*: An intermediate category – includes: amphetamine, barbiturates, codeine and ketamine*

Class C*: Least harmful – includes: benzodiazepines, anabolic steroids, gamma-hydroxybutyrate (GHB) and Tramadol.*

In 2005 the Council, at the request of the Home Secretary, reconsidered the classification of cannabis products but advised that they should remain Class C. In July 2007, the Home Secretary requested, in the light of "real public concern about the potential mental health effects of cannabis use, in particular the use of stronger forms of the drug, commonly known as skunk", that the Council re-assess the classification of cannabis. The final report in 2008 again advised that cannabis should remain in Class C but this was ignored and cannabis was returned to Class B shortly thereafter.

As discussed earlier, classification is intended to reflect the potential harms to individuals' physical and mental health, as well as harms to society. The statement which is used with monotonous regularity by the Home Office and Ministers is that "there is a substantial body of scientific and medical evidence to show that controlled drugs, such as cannabis, are harmful and can damage people's mental and physical health, and our wider communities." [26] However, as has been demonstrated, no such substantial body of scientific evidence exists; where evidence and advice does exist – including that provided by government advisors – it overwhelmingly points to the relatively low risks associated with cannabis, particularly when compared with other controlled drugs, as well as non-controlled substances such alcohol.

In 2006, the House of Commons Science and Technology Committee published the damning *'Drug Classification: Making a hash of it?'* report, which makes it clear that the MoDA classification system and scale of harm are based on political objectives with no scientific evidence on which to draw in making policy decisions.[27] A withering criticism, the report finds that "Government's proclivity for

[26] Response to Ince law firm from the Home Office (4th February 2021)
[27] House of Commons (2006), *Drug Classification: Making A Hash Of It?*, London: Science and Technology Committee, https://publications.parliament.uk/pa/cm200506/cmselect/cmsctech/1031/1031.pdf

using the classification system…is at odds with the stated objective of classifying drugs on the basis of harm and the Government has not made any attempt to develop an evidence base on which to draw."[28] This statement, from the Government's own Science and Technology Committee, suggests that many within Parliament do not feel there is a legitimate 'rational connection' between the law and the state aims; and, in many ways, is counter-productive to those aims. On this basis, the MDA fails to justify the infringements to places on individual rights.

On 19 January 2006, following his statement on the classification of cannabis, the then Home Secretary Charles Clarke announced that he was initiating a review of the ABC classification system, saying "the more that I have considered these matters, the more concerned I have become about the limitations of our current system. […] I will in the next few weeks publish a consultation paper with suggestions for a review of the drug classification system, on the basis of which I will make proposals in due course."[29] This review did not happen, and the classification system remains the same 17 years later. This again makes clear that in relation to cannabis, the Class B status within MDA has no rational connection to the aims of protecting health and public safety.

3.2 MDR (2001) and Scheduling

The Misuse of Drugs Regulations (2001) places 'controlled drugs' (CD) into schedule classifications based on an assessment of their medicinal or therapeutic usefulness, the need for legitimate access and their potential harm when misused.

The Misuse of Drugs Act (1971) provides that the Secretary of State may not make regulations under the Act except after consultation with the Advisory Council on the Misuse of Drugs (ACMD). The ACMD is an advisory non-departmental public body, sponsored by the Home Office, who makes recommendations to the government on the control of dangerous or otherwise harmful drugs, including classification and scheduling under the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Therefore, the rescheduling of a controlled drug under the Misuse of Drugs Regulations 2001 would not be made without prior

MDR CD Scheduling

Schedule 1*: Covers CDs which have no medicinal or therapeutic value and are mainly used for research purposes under a Home Office licence. Drugs include: Cannabis, fentanyl, methamphetamines, psilocin, LSD and MDMA*

Schedule 2*: Covers CDs which have a medicinal or therapeutic value but are also highly addictive. Due to their potential harm when misused, these are strictly controlled and are subject to special requirements. Drugs include: Cocaine, diamorphine, morphine, methadone and fentanyl for medicinal purpose.*

Schedule 3*: Covers CDs which have a medicinal or therapeutic value but are less addictive than Schedule 2 drugs. Drugs include: amphetamines, tranquilisers and opioid pain medications.*

Schedule 4*: Divided in two parts - Part one includes benzodiazepines; Part two includes anabolic and androgenic steroids, which is subject to lighter regulation with no possession offence. Drugs include: (i) a range of benzodiazepines and (ii) anabolic steroids and androgenic steroids.*

Schedule 5*: Covers weaker preparations of Schedule 2 drugs that present little risk of misuse and can be sold over the counter.*

[28] ibid
[29] ibid

consultation and recommendation from the ACMD."[30]

In order to assess the rational connection of non-prescribed cannabis remaining a Schedule 1 substance and prescribed cannabis now being Schedule 2, it is helpful to compare cannabis with controlled drugs within other schedules. In order demonstrate the disproportionately restrictiveness of cannabis scheduling, we will examine the findings of a National Institute on Drug Abuse (NIDA) report on anabolic steroids, which is in Schedule 4 (ii) of the MDR (and class C of the MDA).

In assessing the side effects and related harms of anabolic steroids, the report found that "a variety of side effects can occur when anabolic steroids are misused, ranging from mild effects to ones that are harmful or even life-threatening. Most are reversible if the user stops taking the drugs. However, others may be permanent or semi-permanent."[31] The report found a range of physical harms resulting from steroid use, including high blood pressure and cardiovascular disease, disrupted hormone production leading 'masculinisation', liver damage, tumours, and "a rare condition called peliosis hepatis, in which blood-filled cysts form in the liver. The cysts can rupture, causing internal bleeding and even death in rare cases."[32] The report also found significant mental health harms, including increased irritability and aggression (sometimes called 'roid rage'), mania and "major depression."[33] In teens, research also has also found that steroid use can increase neuronal spine densities, which "suggests that pubertal steroid exposure could produce long-lasting structural changes in certain brain regions."[34] Steroid use is also associated with the use of other drugs, though can itself be highly addictive, with 32 per cent of people who misuse anabolic steroids become dependent, and that some users may turn to other drugs to alleviate some of the negative side effects of steroids.[35]

In comparison with the potential harms of cannabis stated earlier, it is obvious that steroids placed within Class C of MDA and Schedule 4 (ii) of the MDR are far more harmful to physical and mental health compared to the less severe or conclusive harms of cannabis. Furthermore, grown cannabis is the most commonly prescribed form of medicine, which would suggest that all 'grown' cannabis has medicinal properties.

In conclusion, the rational connection between the legitimate aim of the policies (to protect health and public safety) and the specific elements of the policy (the classification and scheduling of controlled drugs within the MDA/MDR) have failed.

4.0 Assessment – Necessity

According to Lord Reed, any test of proportionality must also seek to determine "whether a less intrusive measure could be used without unacceptably compromising the achievement of the objectives." The necessity test is comparative. It asks whether there is a policy option which achieves the legitimate aim to the same, or reasonably similar, degree as the challenged policy but does so in

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30 Home Office FOI Ref: T7995/16

31 National Institute on Drug Abuse (NIDA) (2018), *Steroids and Other Appearance and Performance Enhancing Drugs (APEDs)*, https://nida.nih.gov/research-topics/anabolic-steroids

32 ibid

33 ibid

34 ibid

35 ibid

a less rights restrictive way. Given the human rights restrictions associated with denying access to cannabis for those who need it, a less rights-restrictive policy would be one that placed cannabis in a classification and schedule, based on the evidence, that would allow for reasonable access. It is therefore important to establish whether there are any options that would both allow for access to medical cannabis but remain as protective of above noted risks to public health as prohibition.

Following the evidential findings of the disproportionality within the first two tests, it is clear that any form of raw 'grown' cannabis or related cannabis preparations whether prescribed or not are in fact medicinal and therapeutic, relatively safe to human health (except for a small minority) and can be grown to similar standards of that which is prescribed. Due to its natural complexity and the complexity and diversity of the endo-cannabinoid system, cannabis cannot fit into the pharmaceutical medical model in relation to standardised clinical trials. In addition, the claimed social harms are largely unevidenced and directly connected to prohibition. Cannabis can therefore not meet the requirements of the current classification or scheduling within the Act and that this causes more harm to public health and society and thus breaches millions of citizens' fundamental human rights and freedoms as per Articles 8, 9 and 14 of the HRA 1998.

When examining the necessity of cannabis prohibition, it is necessary to ask whether cannabis – a relatively non-toxic medicinal plant which arguably outcompetes the safety and efficacy of many pharmaceutical drugs currently available due to the medicinal effects on the ECS, and is far safer than non-controlled drugs such as alcohol or nicotine – should have ever been controlled in the first place? There is a logical argument that cannabis could be de-scheduled from the Act and instead regulated the same as alcohol and nicotine products with far less harms to public health and society and that this would negatively affect the illicit market.

There are, however, a wide range of alternative approaches, less restrictive approaches available within the current model. Returning cannabis to Class C of the MDA in line with the advice from the ACMD in 2008 and placing cannabis within Schedule 5 of the MDR would relate better to the associated potential harms of the personal use and possession of cannabis, would recognise the general medical and therapeutic properties of cannabis and would be excepted from the prohibition on possession and import for personal use (if in the form of a medicinal product) as per the MDR. This would essentially decriminalise personal possession and allow anyone with medical need to purchase cannabis medicinal products without the need for a private prescription.

Furthermore, the reclassification and rescheduling would reduce barriers to allow access to cannabis-based products for medicinal use (CBPM) via GPs and be potentially funded via the NHS. It would also remove barriers to domestic cultivation, production and sale by cannabis pharmacies and this would lead to a regulated and licenced domestic market. This should also allow the CBD industry to sell full spectrum food products containing a maximum of 1% THC in line with other European countries. National education campaigns for the public and access to a range of cultivars including high CBD products would mitigate the harms to vulnerable groups such as those with a predisposition for psychosis / schizophrenia and it would drastically reduce the social harms via the continued criminalisation for unlicensed commercial supply and trafficking.

While the above measures would reduce the breaches of human rights by allowing access to cannabis without fear of criminalisation, allow a level of personal autonomy of health and physical integrity, there would remain a disproportionate infringement in relation to Article 9 and 14 for those who cannot afford to purchase or access cannabis via the NHS. To protect these rights, Sections 6 (cultivation of cannabis) and 8 (d) (smoking of cannabis on private property) from the MDA should be removed from the MDA.

Such changes would drastically reduce the strain on the economy the police and the judicial system, improve the health and wellbeing of the nation, increase access via the medical route, create a thriving industry and return the fundamental rights and freedoms to people concerned with using cannabis.

5.0 Assessment – Fair Balance

According to Lord Reed, any test of proportionality must also seek to determine "whether, balancing the severity of the measure's effects on the rights of the persons to whom it applies against the importance of the objective, to the extent that the measure will contribute to its achievement, the former outweighs the latter." As has been discussed, the disproportionate and unevidenced measures of the current classification and scheduling of cannabis severely and negatively impacts the fundamental rights of millions of citizens, including to their autonomy of health and physical integrity. Furthermore, access to non-psychoactive full spectrum high CBD products breaches the same rights to the small minority of citizens who have been identified as being more vulnerable to the harms of high THC cannabis (those predisposed to psychosis, schizophrenia and those with heart conditions) by removing access to safe and effective (CBD being naturally anti-anxiety, anti-psychotic and known to reduce high blood pressure) products without the harmful side effects of conventional treatments.

Cannabis products are known to be useful in battling dependency of addictive high-risk drugs such as alcohol, nicotine, opioids and other pharmaceutical controlled drugs such as benzodiazepines and anti-depressants. Cannabis products are also known to be safe and effective medicines for a range of common conditions including chronic pain, anxiety, PTSD, depression, ADHD, multiple sclerosis, Parkinson's, epilepsy, gastro-intestinal conditions including Crohn's disease and there is a growing body of anecdotal evidence in the treatment of a range of cancers. This would suggest that incalculable number and variety of individuals could potentially benefit from cannabis, and thus the current prohibition is a serious abuse of process to which the potential harms to the right are incalculable and inexcusable.

Many people are now aware of the legislative changes around the world, many resulting from challenges under international human rights legislation. The millions of British citizens who use cannabis responsibly, without harm to themselves or the community, live in constant fear of criminal prosecution, losing access to essential medicine/nutrition for health, losing their driving licence without any evidence of impairment (Article 6), losing their children via social services involvement, losing their employment whilst being marginalised and stigmatised within society.

The severity of the Act's measures on HRA Article 9 rights is unjustifiable for individuals who responsibly use, possess, cultivate or non-commercially share cannabis under the premise that it may be potentially harmful whilst everyone else can openly misuse dangerous non-controlled drugs such as alcohol and nicotine which equate to 90% of all drug related deaths.[36]

[36] House of Commons, 2006. Drug Classification: Making A Hash of It? London: Science and Technology Committee Available at: https://publications.parliament.uk/pa/cm200506/cmselect/cmsctech/1031/1031.pdf

Finally, the severity of the measures outlined above are clearly discriminatory (Article 14 rights), especially in the current economic climate where citizens are struggling to feed themselves and keep their homes warm. Allowing awful access to cannabis exclusively through private health care is discriminatory to the majority who cannot afford such care.

6.0 Conclusion

It is clear that for several decades, prior SSHD's and the ACMD have consistently failed in their duties to utilise S7, 33 and 31 of the Act in achievement of the legitimate aims and some have even publicly admitted these failings. The classification and scheduling of controlled drugs must be based on scientific evidence and not on political motivations. The defence therefore finds that the placement of cannabis within Class B, Schedule 1 and 2 respectively is found to breach several human rights, and the measures must be viewed as **ultra vires** on the basis that the Misuse of Drugs Act, implicitly, does not empower the Secretary of State in collaboration with the ACMD to create regulations contrary to human rights and so Section 6 of the HRA 1998 should be implemented in the pursuance of justice.

7.0 Recommendations

1. The de-scheduling of cannabis combined with a regulated market would right the many wrongs of the past ideological and unfounded propaganda which ultimately led to the overly restrictive sanctions on cannabis in the UK.
2. Alternatively, returning cannabis to Class C of the MDA in line with the advice from the ACMD in 2008 and placing cannabis within Schedule 5 of the MDR would relate better to the associated potential harms of the personal use, possession and cultivation of cannabis.

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