SHOULD CANNABIS USE BE LEGALIZED?

Cannabis, good drug or bad? The topic of debate internationally for decades by governments, medical professionals, recreational users and more. A renewed debate about the laws prohibiting or permitting cannabis use and supply around the world has been fuelled by the legalisation of supply and use of cannabis for 'recreational' purposes. **Yasin Patel** and **Amy Hazlewood** consider amongst other things, the use of cannabis, the legal history, advantages and disadvantages of legalising it

History suggests that when medical cannabis is permitted this is often the prelude to broader recreational access. A more permissible approach to medical and thereby recreational use of cannabis is garnering increasing scrutiny, and even reaching main stream politics. In the UK the Labour Party have announced that they would establish a royal commission to review independently all drugs legislation and policy to address related issues of public health.

There is increasing media and public discourse on the issue of changing cannabis laws. However, there remains concerns about the public health impact of cannabis use, and general opposition towards decriminalising or legislating for the recreational use of cannabis. Nonetheless, cannabis laws and the medical and scientific research that informs policy-making can be regarded as entering a period of change, the direction of which is still unclear. It is with this background in mind that this article looks at:

- The legal history of cannabis;
- The case studies of Alfie Deacon and Billy Caldwell
- The law in the UK on cannabis
- Benefits of legalising cannabis
- The regulation of cannabis
- The disadvantages of legalising cannabis

The Legal History of Cannabis

Over 30 countries internationally have legalised medical cannabis. In North and South America, medical use has tended to be followed by acceptance of its recreational use. In America 33 states allow medical use, and 11 have legalised the recreational kind. It is widely accepted that this number is likely to increase. Medical use can also be found in Argentina, Colombia, Mexico, Chile, Peru, Jamaica and Uruguay.

Last year the European Parliament passed a (non-binding) vote to improve access to medical cannabis. As the following case studies highlight, in Britain medicinal cannabis is legal but still very hard to get. The crux of the dilemma is that cannabis sits in a curious medical grey area

- neither licensed for most of the uses for which people want it - nor tested to the standards that patients usually expect from medicines.

Case Studies of Alfie Deacon and Billy Caldwell

Hannah Deacon is the mother of Alfie Deacon. Seven-year-old Alfie suffers from epilepsy. He had up to 500 life-threatening seizures a month before he began treatment with a type of cannabis oil that could not be prescribed until November 2018. The change in November 2018 came about because of Hannah Deacon's tireless campaign to access cannabis oil.

Prior to being given cannabis oil, Alfie was on steroids likely to give him psychosis and consign him to a premature death. He still suffered seizures, rarely attended school and could not pursue his hobbies. Although cannabis oil is no cure, it significantly improved his quality of life.

Alfie's mum initially failed to gain access to the cannabis oil she sought for her son.

However, in June 2018, things changed. The debate around the medicinal qualities of cannabis took a new turn.

Charlotte Caldwell, the mother of a severely epileptic boy, Billy Caldwell, arrived at Heathrow airport with six months' worth of cannabis oil. A doctor in Northern Ireland had prescribed cannabis oil for Billy. It was the first time a child had been issued the substance on the National Health Service. The Home Office ordered the doctor to stop prescribing the medicine as it was "unlawful to possess Schedule 1 drugs". This prompted the Caldwell's to go to Canada to obtain the medicine.

Billy's mum returned from Canada with six months' worth of cannabis oil and this was confiscated as the oil contained a psychoactive substance called tetrahydrocannabinol (THC) which is illegal in the UK.

The Home Office came under intense pressure to allow Billy to be prescribed the medicine that had successfully controlled his seizures for 300 days. After it was taken from him, Billy suffered two seizures that other medicines could not control.

This led to a series of events that culminated in both Billy and Alfie being allowed access to cannabis medicines under special Home Office licences. Shortly after, the Home Secretary recognised there is "conclusive evidence of the therapeutic benefit of cannabis" following a review which put the UK on course to join the 22 other EU countries which have legalised medical cannabis.

Medicalising cannabis forces governments to build regulatory structures to control the legal supply to patients. Once this happens, it seems easier for societies to accept the idea of recreational use. The rationale is that legislation would curb the black market and protect people, who are buying it. However, as evidenced in the case studies, patients suffering seems to carry more political weight than such arguments that are put forward by liberalisers.

The decision to allow this treatment marks the first time that cannabis oil containing THC has been legally prescribed in the UK since it was made illegal in 1971. Whist the decision was welcome, it also received criticism.

The interim medical cannabis panel, set up to advise on prescribing cannabis-based medicines, award very few licences. Many doctors are reluctant to prescribe medical cannabis unless patients had tried every single pharmaceutical drug first. In addition to this, NHS guidance states it should only be prescribed when there is clear published evidence of its benefits[1].

The Law in the UK on Cannabis

The UK legislation on cannabis is largely found in the Misuse Drugs Act 1971 (MDA 1971). In order to establish guilt, the prosecution must prove that the substance that the accused was allegedly in possession of is a prohibited substance. The expression 'controlled drug' is defined in s 2(1)(a) of the MDA 1971 as 'any substance or product for the time being specified in Part I, II or III of schedule 2 to this Act'[2].

Schedule 2 of the Act divides controlled drugs into three categories. These are classified according to the degree and type of harm they are considered to cause to both the individual user and wider society. This is determined by the Advisory Council on the Misuse of Drugs (ACMD) who advise the Government on controlled drug classification.

Part 1 of schedule 2 lists class A drugs which are deemed to have the most harmful impact. Part 2 lists class B drugs and Part 3 lists class C drugs. The level of harm caused by the drug is reflected in the sentences for those found guilty of offences involving them.

Each drug listed is identified according to a pharmaceutical description. Further clarification as to the meanings of certain expressions used are found within the interpretive provisions of Pt 4 of Schedule 2, and particularly in the case of 'cannabis', 'cannabis resin and 'prepared opium' under the provisions of s.37 (1) of the MDA 1971 Act.

Cannabis was classed as a class B drug between 1928 and 2004. From 2004 to 2009, it was a class C drug. It then went back to being a class B drug where it remains at the date of writing. The declassification between 2004 to 2009 was designed to enable police forces to concentrate resources on more serious offences. However, Prime Minster Gordon Brown commissioned a review in 2007 on returning cannabis to a class B classification. In January 2009, cannabis was reclassified to a class B drug.

The MDA 1971 afforded those accused of being in possession of a controlled drug defences that had not previously existed in law. The statutory defences available to an accused charged

[1] https://www.england.nhs.uk/wp-content/uploads/2018/10/letter-guidance-on-cannabis-based-products-for-medicinal-use.pdf
[2] See, e.g., R v Hunt [1987] AC 352

with possession under s.5(1) of the Act are found under s.5(4): Lawful Intention and s.28: Lack of Knowledge.

s.5(4): Lawful Intention

Section 5(4) contains a defence which is available in the case of a charge of simple possession under s.5(2) of the Act. It assumes that the accused knew or suspected that the thing which was in their possession was a controlled drug, but having discovered that, took reasonable steps to either destroy it or deliver it to someone lawfully entitled to possess it. In *R v Murphy*[3], the Court of Appeal emphasised that in order for a defence to succeed under s.5(4)(a), a Defendant must show that he did more than leave it to the forces of nature to destroy the drug in question. In *Murphy*, the Defendant had buried cannabis in a hole. The court took the view that although this may have indicated no intention to possess such, the cannabis was ultimately recoverable. Longmore LJ noted that 'destruction requires a great deal more finality about it than what the Defendant did'[4].

s.28: Lack of Knowledge

The provisions of section 28 allow for a defendant to demonstrate sufficient ignorance of an essential part of the prosecution's case so as to exculpate themselves. Broadly speaking, section 28(2) applies in circumstances where a defendant states that they were unaware of the very existence of the 'substance or product' that turns out to be a controlled drug.

The scope of the general defence under s.28(2) is qualified by defences under s.28(3). Section 28(3) applies in circumstances where the defendant was aware of the 'substance or product' but where he states that he did not believe it to be a controlled drug [(3)(b)(i)].

It is important to note that those charged with a conspiracy to commit one of the drugs offences identified in the MDA 1971 cannot benefit from the above provisions[5].

Lawful Possession

Section 7(3) lists various professionals who are exempt from the legal prohibitions contained within the MDA 1971, providing that at the point of possessing and/or supplying controlled drugs, they are acting in their professional capacity. These professionals include, doctors, dentists, vets and pharmacists.

Defence of 'Reasonable Excuse'

'Reasonable excuse' is a statutory defence available. The burden is on the defendant to show that their excuse is one that meets this threshold, and then for the prosecution to prove a lack of reasonable excuse.

Benefits of legalising cannabis

The obvious benefit of legalising cannabis is that it deprives organised crime of its single biggest source of income, while protecting consumers. Further to this, racial disparities in

[3] EWCA Crim 1768
[4] At paragraph 425
[5] R v McGowan [1990] Crim LR 399

prosecutions, the social and judicial costs of criminalising so many users, and the profits and taxes a legal industry might generate are further arguments in favour of legalising cannabis.

However, proposals to legalise cannabis have raised questions about the ways in which cannabis, for non-medical purposes could be regulated in order to mitigate concerns that legalisation may lead to increases in cannabis use and related harms.

Regulating Cannabis

If legalisation is better than prohibition then the next step to consider is regulation. The repeal of prohibition marks the start of complex arguments about how to regulate cannabis. This stage of the debate is most likely to pose the biggest conundrum for legislators. A plethora of difficult questions begin to emerge: which varieties to allow, how to tax it, who should sell it and to whom.

With recourse to legal and medical professionals, politicians would have to decide the limits to set on personal use, growing cannabis, selling cannabis, ways testing its potency, setting safe-driving limits, age restrictions, deciding on advertising and packaging restrictions and respective penalties for each of these issues. These are challenging questions that will force legislators to decide which competing aims they value the most. Politicians would then have to combine all of this (and more) into workable body of law that achieves liberalisation whilst setting boundaries (regulations and laws) for control.

Answers to such questions will lead to a new body of legislation that defines and sets new parameters for the legal (and illegal) use of cannabis going forward – ideally, combining a clear structure to be applied by the Courts with a necessary degree of flexibility to be applicable to the individual facts of each case.

What can be said with more certainty is that the drug's ambiguous legal status as a medicine will persist for years. A long history of prejudice has thwarted research and deprived millions of patients access to therapies that might help them. The work of creating both regulated and approved medicines should be well advanced, but is only just beginning. It may be that only when cannabis is legal for recreational use will a fuller picture emerge of the benefits it offers and the risks it poses.

Disadvantages of legalising Cannabis

Whilst an overdose is probably unlikely, and maybe impossible, addiction is a real possibility. High-strength strains with high doses, or long-term use increase the risk of psychosis and are included in this possibility. In adolescents there is also a risk of impaired brain development. There are also associated respiratory problems that come with regular smoking. Furthermore, legalisation may be seen as encouraging, or permitting use, leading to more using it than otherwise would have done. Perhaps of most concern is the lack of medical research. The illegal status thwarted scientific research into the effect's cannabis can have. Researchers around the world are working to catch up with lost time, however, there is simply not a long-term body research into the drug's effects.

Medical-cannabis schemes may be the middle ground-fudge agreed on by legislators in the short term as scientific research continues. Denmark currently have a four-year medical cannabis pilot programme that commenced in January 2018. The scheme permits doctors to prescribe cannabis to patients. The cultivation, manufacturing and distribution of the drug is carefully monitored, as are the effects on the patients who participate in the pilot.

The advantages of the scheme are already being seen with more doctors prescribing cannabis and take up for the scheme exceeding initial estimates. There are however, disadvantages to such an approach. It may be easier to get access onto the scheme if you live in certain areas, or have a doctor that is more willing to prescribe cannabis. It may be seen as a soft way of tackling drug abuse, and fuelling addiction for a problem that is better addressed by the criminal justice system as opposed to the health care system. Further to this, poorly regulated medical cannabis schemes may allow leakage of the drug to recreational users. Nonetheless it is a start, and is likely to be regarded by those watching Denmark's pilot scheme as a step in the right direction.

Conclusion

The history of cannabis has been chequered. The law in this area is very susceptible to public opinion and is therefore often present on the political agenda. It may be seen as low hanging fruit for politicians who court for the younger vote. And perhaps it becomes more difficult to resist the calls for change when the political class themselves publicly admit that they engaged in recreational use of drugs.

Attitudes towards the drug are undoubtedly softening around the world and the law in this area has entered a stage of unchartered territory. However, caution is required, and to this end, one basic suggestion needs to be understood at this particular moment.

Legislators who would rather impose higher sentences for cannabis may be better served by instead considering versions of legislation that does the least harm. Once this happens, the legal cannabis industry can be scrutinized not in comparison to organised criminals but to the levels of scrutiny and legislation imposed on the other "sin" industries.