Drugs and Human Rights: A constitutional approach

Is it an abuse of human rights to place medically useful drugs into Schedule 1 of the Misuse of Drugs Regulation 2001?

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14/9/2018
Acknowledgements

Toby Seddon. Thank you for your advice and supervision which has been invaluable in shaping both the structure and content of this thesis. Thank you for always encouraging me in the creation of my ideas and honestly feeding back on them throughout. Your supervision has made this process enjoyable and much easier than it would have otherwise been.

Judith Aldridge. Thank you for your detailed and astute feedback which has kept the thesis on track. Thank you for your supervision and particularly for your feedback on my first draft, which has improved the quality of this thesis immeasurably.

Further thanks go to staff in the university, particularly Jackie and Helen for keeping the show on the road and my annual reviewers for giving me great advice and encouragement throughout.

Thank you also to my family and friends. My mum, whose encouragement and support is the only reason I have been able to do this. My dad, whose support towards the end of the thesis was invaluable. My sisters, who are amazing. And my office – Laura, Caroline, Cath and Cara – who have been great sources of fun and support throughout my PhD experience.
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Introduction

The question addressed in this thesis – is prohibiting the medical use of a controlled drug an abuse of human rights? – engages a long history in drug prohibition. Since its outset, the War on Drugs – the international collection of policies adopted to prohibit and prevent the use of some substances for recreational purposes - has had to balance the primary aim of prohibiting recreational drug use with allowing medical access to many of these prohibited drugs. The Single Convention on Narcotic Drugs 1961 – the first treaty in what has now become the international prohibitionist regime – has in its preamble the following assurance:

Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes\(^1\)

This appears first and before the recognition of the danger of addiction to narcotic drugs. Thus, there is acceptance that the prohibition of drugs could impede their medical availability. The recognition of the medical use of prohibited drugs as legitimate can be seen in all international drug conventions including the first, The Opium Convention.\(^2\) Indeed, the international regulation of opium and ketamine has come under intense criticism on the basis that it does not allow for sufficient medical access, in particular for pain relief.\(^3\) Such criticism argues that restrictive policies risk limiting the availability of prohibited drugs with medical utility and may therefore lead to scarcity or unwarranted conservatism in their medical use, harming patients who need them. Thus, there is a conflict to navigate; prohibition creates restrictive policy for drugs with medical uses, but the greater that

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\(^2\) The International Opium Convention (adopted 23 January 1912, entered into force 28 June 1919) 8 LNTS 187 Article 9.

restriction the more likely that “legitimate” medical access will be impeded.

This dichotomy – the desire to prohibit without inhibiting medical use – has come into sharp relief in the case of cannabis. The international prohibitionist regime has, from its inception, categorised cannabis as a dangerous drug with no medical or therapeutic value. This designation was signed up to by most countries in the world, who signed the Single Convention and instituted domestic laws which replicated this. Ever since, campaigners have argued that this designation is incorrect. Around 25 years ago, however, the campaign to legalise medical cannabis started gaining victories, first in California via referendum in 1996, then Canada due to a challenge in the Supreme Court in 2001 and then in many European countries primarily due to votes of legislatures.

Until very recently, the UK had not seriously considered following these, and other, countries and legalising medical cannabis. That is until the cases of Billy Caldwell and Alfie Dingley, two disabled boys who separately, in the summer of 2018 had their medical cannabis products removed from them as their parents attempted to bring them back to the UK with medicine obtained in Canada and the Netherlands, respectively. Following this removal, the boys became very ill and their plight caused a media storm which prompted reaction from the government and a potential easing off on the strict prohibition the UK has maintained on medical cannabis.

It is in this context that my thesis explores this dichotomy, between prohibition and medical access of drugs, but does so in a specific way; through the lens of UK human rights law under the Human Rights Act 1998. It is my contention that applying the prohibitions contained in the UK’s drug laws – contained in the Misuse of Drugs Act 1977 and the Misuse of Drugs Regulation 2001 – to medically useful drugs is an abuse of human rights and therefore unlawful under the Human Rights Act. This argument is established theoretically through analysis of human rights law as well as evidentially in a case study of medical cannabis prohibition in the UK. The case study of cannabis was

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4 Opium Convention (n 2)
6 This is discussed at length in Part three
7 This story is told in detail in Chapter nine
chosen due to the recent history of legalisation in multiple jurisdictions and the evidence as to its medical use and the impact of its medical legalisation. The case study was chosen, and largely completed, prior to the Caldwell and Dingley cases. Thus, a case study which began life as an argument for reform of current, prohibitive laws has become an additional support and argument for a reform that is ongoing. More fundamentally, however, this thesis moves the issue of the prohibition of medically useful drugs away from the realm of politics and toward the realm of justiciable law. This is to say that the human rights argument made here is not merely a political argument aimed at changing minds on the issue, but rather an argument to suggest that it should be, and is, unlawful to place medically useful drugs within the legal regime that prohibits and criminalises their medical use.

The legal regime concerned is Schedule 1 of the Misuse of Drugs Regulations, which contains cannabis, MDMA and LSD, among many others. It is placement of certain drugs within this Schedule, in addition to criminal control under the Misuse of Drugs Act, which I argue is an abuse of the human rights of those that do need or would benefit from them.

The thesis therefore focusses on a specific regulatory choice – the prohibition on the medical use of certain drugs – and whether that falls foul of a specific legal regime – The Human Rights Act in the UK. The Human Rights Act brings into domestic law the rights of the European Convention on Human Rights. Article 8 of the Convention reads as follows:

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.\(^8\)

The protection of private life under Article 8 has been found to protect autonomy and physical integrity.\(^9\) It is under this protection that the prohibition of a medically useful controlled drug could be challenged: criminalising access to a necessary drug requires a person to choose between severe ill health and potential criminal penalty. This impedes both their autonomy, by restricting their medical decision making and their physical integrity, by denying treatment for ill health.

Article 8, however, is a qualified human right as an infringement of it can be justified if it is a proportional response to a public interest. What constitutes a legitimate public interest is dictated by those aims listed in second paragraph (above) of Article 8, most relevant in this instance is the protection of health and public safety.\(^10\) Indeed in Quayle, the key British case on the defensibility of the use of medical cannabis, the protection of health was the legitimate aim raised in defence of the potential human rights abuse mooted (though not decided upon).\(^11\) Thus, there is a potential conflict between the Article 8 right to private life and the public interest in health. How this conflict is litigated forms the bulk of this thesis.

The system developed in the UK courts to resolve this conflict, based in part on the system in the European Court of Human Rights, is *proportionality*. This test will form the central structure of this thesis. This is born of necessity as the question of proportionality must form the central structure of inquiries into qualified human rights. For a human rights challenge to be sustained the possibility of it being rebuffed on the grounds of a public interest consideration must be confronted. Given this I shall explain, in brief, the proportionality test here, to be further elaborated in Chapter three.

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10 Hereafter referred to as Article 8(2).
Proportionality is a test, or rather a series of tests, which seek to elucidate whether, and the extent to which, the appeal to public interest justifies the infringement of human rights. The four stages of the test are: legitimate aim, rational connection, necessity and fair balance. If the state seeks to justify an infringement of human rights on a public interest, they must meet all four of the tests, which mean the following:

The challenged policy must seek a legitimate aim listed in the convention. Additionally, the aim of the policy must be “sufficiently important” to justify an infringement of human rights. This is a threshold test which is easy to overcome; the objective the policy is pursuing must, in principle, capable of justifying an infringement of human rights.

The challenged policy must have a rational connection to the achievement of the legitimate aim. There is no requirement that it solves the issue completely, but it must make a non-trivial contribution to the achievement of the objective. Equally it must add something to other policies which already exist. If the challenged policy achieves the objective, but so too do other policies in place, then the former is not making a contribution as there would be no damage to the achievement of the objective if it was abandoned.

The challenged policy must be necessary. This requires that the challenged policy is no more intrusive than it needs to be to achieve the stated aim. Thus, it must not be possible to achieve it to the same or substantially similar degree without the level of human rights infringement that it causes.

Finally, the achievement of the legitimate aim must be balanced against the harm done to the right. This last stage of the test, referred to as overall balance or fair balance, is a cost/benefit analysis where the benefit is that which the policy achieves in the furtherance of its aim and the cost is the harm that is done to the human right. If the challenged policy itself causes harm to the objective, or indeed benefits the human right, account must be taken of this.

The thesis is broken into three parts:
Part one – Legal framework

Part one contains two chapters. In Chapter one I will explain the Misuse of Drugs legislation and the international conventions on drugs. It will describe the scheduling in the Misuse of Drugs Regulations which governs the medical use of controlled drugs. Here drugs are placed into 1 of 5 schedules and any placed within Schedule 1 are prohibited for medical use. Thus, it is placement of a drug within Schedule 1 of the Misuse of Drugs Regulations that is the source of the potential human rights abuse in discussion. Chapter two, on the Human Rights Act, will explain the nature of a human rights challenge along with a description of the relationship between the Human Rights Act and the European Convention on Human Rights.

Part two – Constitutional Principles

In Part two, I explain and analyse the constitutional principles that underlie human rights adjudication. Chapter three covers proportionality. Thus, on top of the detailed laying out of the four stages of the test, I draw on the recent history of the proportionality test to show its development and its place within the wider Convention framework. A systematic approach is taken to understanding proportionality. I have reviewed all Supreme Court cases which have conducted a proportionality review of qualified human rights. The findings in Chapter three will shape and inform the proportionality review that I conduct in final part of the thesis. Chapter three reveals the detail of what the state must demonstrate in principle in order to justify an infringement of human rights. It is against this that I shall measure and analyse potential justification for the prohibition of medical cannabis.

Chapter four analyses the principle of judicial deference. It is often argued, by government and others, that when human rights adjudication touches upon complicated issues of social or economic policy the courts should defer to the decisions of the elected branches of the state. This

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12 Details of this review can be found in Appendix 1
argument is advanced on two assumptions. First, that the elected branches are better able than the courts to reach correct and informed answers in such areas of policy. Second, that because the elected branches are the more constitutionally appropriate body to deal with these questions, it is inappropriate for the court to do so. In Chapter four, the latter of these arguments is dismissed with reference to the nature of the Human Rights Act regime as a dialogic, weak form of constitutional protection, where such deference is not necessary. As to the former argument, it is accepted that this will sometimes be the case, and where it is, the court should give the appropriate weight to the views of the state. Thus, the objection that a human rights challenge cannot be mounted on the basis of judicial deference is overcome in Chapter four.

Chapter five concludes Part two with an analysis of how previous cases on drugs and human rights have dealt with issues of proportionality and deference. It is demonstrated that on the issue of cannabis and right to medical use, no proportionality analysis has been undertaken in a reported case in the UK as the issue was never resolved in Quayle. Using Quayle, I demonstrate that the approach taken to that challenge – to try and use human rights to expand the common law defence of necessity – was misconceived and that directly challenging, on human rights grounds, the placement of a medically useful drug into Schedule 1 of the Misuse of Drugs Regulations is a much more fruitful avenue to take.

Part three – Case study: Medical Cannabis

In Part three, the issue of medical cannabis is used as a case study to analyse the central question of the thesis; is it a human rights abuse to place a medically useful drug in Schedule 1 of the Misuse of Drugs Regulations, thereby prohibiting its medical use? Chapter six first establishes why medical cannabis prohibition is an infringement of human rights in need of justification. The most obvious evidence for this is that in Quayle, the government argued that the infringement would be justified under Article 8(2), rather than not occur at all. Additionally, the right to physical integrity is explored through analogy with other UK, Canadian and Convention case law on medical cannabis and other
issues such as rights to medication, abortion (in circumstances where it is medically necessary) and assisted dying. In all cases there is was an infringement of Article 8 which required justification.

Chapter seven establishes the empirical evidence base required to answer the questions arising from the proportionality analyses. Five areas are covered: First, whether the legalisation of medical cannabis leads to increased prevalence of cannabis within the population. Prevalence is the most important question for the proportionality analysis, for reasons explained below, and has received the most empirical attention. This section is, therefore, divided into three parts, each representing a different type of study, one focussing merely of legalisation in general, one on specific types of legalisation, such as dispensaries and finally one on different broad models of medical legalisation such as commercialised vs non-commercialised. It is argued that the latter of these provides the most logical approach and consistent results.

Second, whether medical cannabis legalisation leads to diversion. Third, whether it leads to changes in potency. Fourth, whether it leads to increased use of vaporisation or other non-smoked methods. Fifth and finally, whether medical cannabis legalisation leads to increases or decreases in the use of painkillers such as opioids, alcohol and other illicit drugs.

Once the evidence is established in Chapter seven, it is used to evaluate the proportionality of the prohibition of medical cannabis in Chapter eight. Chapter eight therefore, is a proportionality analysis in which I evaluate whether the justification for the prohibition of medical cannabis passes each of the four tests, I find the following:

- The policy is attempting to pursue a legitimate aim of health and potentially public safety, which is, in this case bound to be sufficiently important to justify an infringement of human rights.
- There is a rational connection between prohibition and protecting health as there is some evidence that some forms of legalisation lead to increases in the prevalence of cannabis use and therefore risk increasing harms of cannabis use.
• The prohibition of medical cannabis, however, is not necessary as there are some models of medical legalisation which do not appear to present risks of increased prevalence and therefore prohibition is not needed.

• Similarly, there is not a fair balance between the harm the policy does to the right and the benefit it achieves for the legitimate aim. This is both because what it achieves, in terms of a reduction of prevalence, is minimal – especially when compared to some strict medical models of medical cannabis legalisation – and there are significant benefits to medical cannabis legalisation, such as the benefits to the patients and reductions in opioid use.

In Chapter nine I address the procedure of medical cannabis legalisation and the medical legalisation of Schedule 1 drugs in general. This is to say I analyse the process by which a drug can get moved from Schedule 1 and into a different schedule. This was necessary as the argument is sometimes made that to legalise medical cannabis would be to subvert the legitimate and necessary procedures by which the safety standards of medicines are upheld.

Thus I explain the two procedures through which the government – both in public statements and freedom of information requests to me – has indicated Schedule 1 drugs may be rescheduled; marketing authorisations and changes in the international regulations. Both are insufficient as they are, for different reasons, unresponsive to changes in scientific and medical evidence and as such are unlikely to allow for reform, even where a Schedule one drug has been demonstrated to be medically valuable. It is unsurprising, then, that the government did not arrive at its current position of rescheduling cannabis after following one of these procedures. Rather the current reform was brought about by a political crisis caused by significant media pressure. This, Chapter nine concludes, is not an appropriate or rational way to structure a medical system.

The thesis concludes, therefore, that the medical prohibition of medically useful drugs in general and that the placement of cannabis in Schedule 1 of the Misuse of Drugs Regulations in particular is an abuse of human rights under the Human Rights Act.
Part one – Legal framework

In Part one, I show that the medical use of drugs is prescribed by the Misuse of Drugs Regulations, which was created under the power of the Misuse of Drugs Act to allow legal and regulated access to those drugs that had been controlled. Schedule 1 drugs, however, are the exception to this. These drugs are prohibited for medical use and thus it is a drug’s placement in Schedule 1 that should be challenged on human rights grounds. Further, the placement of the drugs into this section was largely based upon the categorisations of drugs provided in the 60s and 70s by the international prohibitionist regime, and it has not changed since. Significantly, however, none of these international regimes require the absolute prohibition of a drug for medical purposes, nor do they require that those drugs designated for the strictest control are criminalised when being used for medical use – especially if that medical use is, as this thesis argues, a constitutionally protected human right.
Chapter one: Misuse of drugs legislation

The Misuse of Drugs Act 1971 has two primary effects. First, it establishes the Advisory Council on the Misuse of Drugs (ACMD). This body consists of experts in the physical and societal harms of drug misuse as well as the pharmacology of controlled substances.

Second, the Misuse of Drugs Act creates the mechanism by which the possession, import, export and supply of drugs is controlled and punished. At its heart is a classification system which divides drugs into Class A, B and C. The criminal sanction is highest for Class A with a maximum of 7 years for possession and life imprisonment for supply or production. For Class B the sanction is 14 years for supply or production and 5 years for possession. For Class C the penalties are 14 years for supply and production and 2 years for possession.13

Placement into these classifications is intended to represent the dangerousness of the substance, as was noted by James Callaghan MP when the Misuse of Drugs Bill was presented to the House of Commons in 1970:

The object here is to make, so far as possible, a more sensible differentiation between drugs. [The Misuse of Drugs Act] will divide them according to their accepted dangers and harmfulness in the light of current knowledge and it will provide for changes to be made in classification in the light of new scientific knowledge...

We have taken those lists of drugs and attempted to put them into the Bill in the order in which we think they should be classified of harmfulness and danger. This classification can be changed if the Bill has parliamentary support, as I trust and believe it will.14

The scientific basis of the current arrangement, as well as its responsiveness to new scientific evidence with respect to classification is certainly questioned and heavily criticised. Indeed some have claimed that the classification system bares little relation to the evidence of harm, with some of the least

13 Misuse of Drugs Act 1971 s.1 + Schd.4.

It is important to note that the placement of drugs within classifications (and schedules, to which we shall return below) are, to a great extent, based on the perceived harms of various drugs at the time when both national and international controls were first conceived, which is to say in the late 60s and early 70s. Consider the following statement from James Callaghan MP when introducing the Misuse of Drugs Bill for its second reading in 1970:

Class A contains all the internationally controlled narcotics except six which are less strictly controlled under the International Single Convention, cannabis and cannabis resin. It also includes nine hallucinogens regarded by the World Health Organisation Expert Committee as especially dangerous.\footnote{HC deb (No 14) 1453.}

The WHO report to which James Callaghan MP was referring was published in 1969. This report sought to categorise drugs, not then under international control, into four groups (A to D) on the basis both of harm and medical usefulness; the A group were considered to have a ‘liability to abuse constituting an especially serious risk to public health and having very little, if any, therapeutic usefulness’.\footnote{WHO, ‘WHO Expert Committee on Drug Dependence: Sixteenth Report’ (1969) WHO Technical Report Series no.407 <http://apps.who.int/iris/bitstream/10665/40710/1/WHO_TRS_407.pdf> 11.} The report accepted, at the time, that evidence as to harm and usefulness of some drugs was not of consistently high quality when they undertook the review.\footnote{WHO Expert Committee Report (no 17)} This, somewhat shaky, basis for classification was continued when drugs came to be scheduled according to their supposed medical utility.
It is in this context that decisions were being made on the medical use of those drugs which were brought under control. The Misuse of Drugs Regulations 1973 (replaced first in 1985 and then again in 2001) were passed in order to regulate the medical use of drugs classified under the Misuse of Drugs Act. \textsuperscript{19} The purpose of the regulations is to set out the basis on which drugs which would usually be criminalised may be used legitimately, for medical or research purposes. The Misuse of Drugs Regulations are a statutory instrument made under the authority of Section 7 of the Misuse of Drugs Act, by the Secretary of State. Section 7(1) allows the Secretary of State to make regulations exempting drugs from the controls on import, export, supply, possession and cultivation of drugs. Section 7(3) \textit{requires} that the Secretary of State to make regulations under section 7(1) so that it is not unlawful for a medical professional “acting in [their] capacity as such, to prescribe, administer, manufacture, compound or supply a controlled drug”. Section 7(3) also requires that regulations be made so that pharmacist may manufacture, compound or supply and that pharmacists and medical professionals may possess controlled drugs. \textsuperscript{20}

The Misuse of Drugs Regulations has 5 Schedules. \textsuperscript{21} Drugs within Schedule 1 are viewed as having no medical utility. Drugs in Schedules 2-5 therefore are considered to have medical utility. The placement of a drug between Schedules 2 and 4 relates to the level of harm and risk of diversion.

Schedule 5 includes a number of weak preparations of drugs which may be sold over the counter without prescription. \textsuperscript{22} They may be freely imported, exported and possessed. \textsuperscript{23} Practitioners and pharmacists may manufacture them. \textsuperscript{24}

\textsuperscript{19} The Misuse of Drugs Regulations 2001/3998.
\textsuperscript{20} Misuse of Drugs Act (n 13) s.7(1)+(3); Ibid “Medical professional” includes “doctor, dentist, veterinary practitioner or veterinary surgeon” and “pharmacist” includes persons conducting a retail pharmacy business.
\textsuperscript{21} For the sake of clarity international schedules will be labelled with Roman numerals (Schedules I-IV) whereas domestic schedules will be labelled with standard numerals (Schedules 1-5).
\textsuperscript{22} Misuse of Drugs Regulations (No 19) reg.16, reg.7(1).
\textsuperscript{23} Ibid reg.4(1), Schd.5.
\textsuperscript{24} Ibid reg.8(1).
Schedule 4 is divided into two parts. The drugs in the second, when they are in the form of a medical product, are exempted from the prohibition on possession and can be supplied without prescription. They are similarly exempted from the prohibition on importation and exportation. For drugs in first part of Schedule 4, however, a prescription is required. Drugs in both parts of Schedule 4 are subject to controls related to record keeping and destruction of drugs.

Schedule 3 drugs require a prescription to be lawfully possessed. Schedule 3 drugs have controls (additional to those for Schedule 4) relating to the form of prescriptions and marking of bottles. Schedule 2 similarly requires prescription to be given in order that drugs may be possessed lawfully. Schedule 2 provides for the strongest controls possible for drugs which are legally able to be prescribed for medical purposes. Schedule 2 is the largest category within the regulations and includes drugs such as cocaine and heroin.

Schedule 1 drugs, in contrast to the above, may not be used for medical purposes as they are considered to have no, or very limited, medical utility, thus prescribing them is not allowed. All drugs in Schedule 1 are also subject to a designation order under Section 7(4) of the MDA. Under this section the Secretary of State designates that it is in the public interest for a drug to be wholly unlawful, unlawful except when used for research purposes or unlawful in a medical context except where specific authority or licence is given by the state. The designation order on Schedule 1 drugs

25 Ibid reg.4(3)(a), reg.16.
26 Ibid reg.4(2), Schd.4.
27 Ibid reg.10(2).
28 Ibid reg.22, reg.23, reg.26, reg.27.
29 Ibid reg.10(2), reg.16.
30 Ibid reg.18.
31 reg.10(2), reg.16.
32 Rudi Fortson, Misuse of Drugs and Drug Trafficking Offences (Sweet and Maxwell, 6th edition 2011) 69
33 Note the exclusion of Schedule 1 from Misuse of Drugs Regulations regs.7-10, in particular reg.10(2) which allows for the possession of drugs under the direction of a doctor for administration for medical purposes and reg.7 which allows drugs to be administered to a patient by a medical professional; ibid 61; James J H Rucker, ‘Psychedelic drugs should be legally reclassified so that researchers can investigate their therapeutic potential’ (2015) 350 BMJ h2902.
35 Misuse of Drugs Act (n 13) s.7(4)(a).
does not specify which of these three applies.\textsuperscript{36} However, as will be discussed later, there is some, very limited ability to research on Schedule 1 drugs and, on one occasion an expert panel has been set up to provide a very small number of people with medical access to a Schedule 1 drug. Thus it is not true to say that designation of Schedule 1 drugs mandates that this class of drugs is wholly unlawful, though the exceptions are very limited. I shall return to the nature of such exceptions in the final section of the thesis.

Given the above, it is the placement of a medically useful drug within Schedule 1 Misuse of Drugs Regulations, and its designation under Section 7(4) of the Misuse of Drugs Act which is being challenged in this thesis. I am arguing that such placement/designation can be challenged as a breach of the Human Rights Act.\textsuperscript{37}

Similar to the classification system described above, the placement of drugs into Schedule 1 has been driven by international law. Indeed, Schedule 1, with the addition of cannabis, very closely resembles Schedule I of the 1971 Convention with regards to the drugs which are placed under its control. Equally, it appears to closely follow the WHO expert committee reports mentioned earlier. Given this link between domestic and international scheduling, it is necessary to examine the international prohibitionist regime.

International drug laws

Three conventions, signed by the vast majority of UN states including the UK, are now understood to comprise a global drug prohibition regime:\textsuperscript{38} The Single Convention on Narcotic Drugs 1961 (“1961 Convention” of “Single Convention”), Convention on Psychotropic Substances 1971 (“1971

\textsuperscript{36} Designation order (n 34).
\textsuperscript{37} For the sake of brevity, for the remainder of the thesis I will refer only to the placement of drugs within Schedule 1, rather than their placement and designation, the latter of which is to be assumed.

Two important discussions arise from these treaties; the scheduling systems provided for by the treaties and the extent to which, and under what terms, possession of drugs must be criminalised.

**Scheduling**

With regards to the 1961 Convention, Schedule I is the ‘standard regime’ and as such it is by far the largest and the drugs in it are subject to the entire general controls within the convention. Notable substances in this Schedule are cocaine, coca leaf, morphine, heroin, opium, cannabis, cannabis resin and extracts and tinctures of cannabis. The focus of the Single Convention, and one of the key controls it requires of the signatory states, is to keep the use of the drugs in Schedule I and II to medical and scientific uses. The vast majority of the remaining controls are therefore on the industry in these drugs on the assumption that it is being tightly kept within medical and scientific remit. Such controls include requiring government authorisation of participation in any of the stages of the trade; records be kept; prescriptions for supply to individuals and; limiting the amount of narcotics to no higher than that which is needed for medical or scientific purposes.

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39 Single Convention (n 1); Convention on Psychotropic Substances (adopted 11 January 1971, entered into force 16 August 1976) 1019 UNTS 175 (ECOSOC); United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (adopted 25 November 1988, entered into force 11 November 1990) 1582 UNTS 95 (ECOSOC). None of the conventions define the terms narcotic and with regard to the definition of ‘psychotropic’ and to the distinction more generally the United Nations International Drug Control Program (UNDCP), predecessor to the United Nations Office of Drugs and Crime (UNODC), stated in 2000 that, “[t]he international classification into narcotic drugs and psychotropic drugs… has no conceptual basis. The legal definition of many psychotropic substances is entirely applicable to narcotic drugs, and in many cases, the reverse is true” UNDCP, ‘Commentary on the UNDCP Model Drug Abuse Bill 2000’ (May 2000, United Nations International Drug Control Programme) <http://www.unodc.org/pdf/lap_drug-abuse-bill_commentary.pdf> Accessed 22/07/16 para [27].

40 Single Convention (ibid) Art.2(1); UNSG, ‘Commentary on the Single Convention on Narcotic Drugs’ (Prepared in accordance with ECOSOC res 914D (XXIV) (3 August 1962) para [1]) 51. When referencing Schedules in the international regime, roman numerals are used (Schedule I, II etc) this is done merely to better distinguish between them and their domestic counterparts.

41 Single Convention (ibid) Schd.I.

42 Ibid Article 4(c).

43 Ibid Art.30, 34.
Schedule II drugs are subject to the entire Schedule I controls with some limited exceptions.\textsuperscript{44} Drugs are placed in Schedule II if it is believed that they are not themselves capable of producing addiction but may be converted into drugs which are and yet are also widely used in medicine.\textsuperscript{45} Drugs such as Codeine are in Schedule II.\textsuperscript{46}

Schedule III concerns preparations of drugs; a mixture which contains a narcotic drug and something else. The general rule is that a preparation is subject to the same level of control as the substance of which it is a preparation. However if a preparation fulfils the criteria set out in Schedule III, for instance if it contains less than 0.1\% cocaine, then it will be exempted from some of the convention controls.\textsuperscript{47}

Drugs in Schedule I may also be placed in Schedule IV if they are considered particularly liable for abuse and ill effects and such liability is not offset by therapeutic advantages.\textsuperscript{48} Additional to the controls of Schedule I, Schedule 4 drugs are subjected to the following:

A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.\textsuperscript{49}

The phrasing of this section is optional. The commentary on the Convention does note however, that this must be taken in good faith, which is to say that if, for whatever reason, the state party does not

\textsuperscript{44} For details of such exceptions see Ibid.Art.2(2).
\textsuperscript{45} Commentary (n 40) 53, 446, addiction in this case being defined as abuse of narcotics drugs which cause physical dependence or which are used habitually.
\textsuperscript{46} Single Convention (n 1) Schd.II.
\textsuperscript{47} For detail of such exceptions see Ibid Schd.III, Art.2(3-4).
\textsuperscript{48} Ibid Art.3(5).
\textsuperscript{49} Ibid Art.2(5)(b); Art.2(5)(a) requires that a Party shall adopt any special measures “which in its opinion are necessary having regard to the particularly dangerous properties of a drug”.
chose to prohibit Schedule IV drugs when it is of the opinion that it would be the most appropriate means to protect public health, then it would be acting contrary to the Convention.\textsuperscript{50} Drugs in this schedule include cannabis and heroin.\textsuperscript{51}

The 1971 Convention on psychotropic substances is similarly structured with four schedules. The structure of these schedules is however different from that which is found in the 1961 Convention. While most narcotics in the Single Convention were placed into Schedule I and some select drugs were put in the other three Schedules based on special characteristics, the 1971 Convention takes an approach more akin to that taken in the Misuse of Drugs Act. This is to say that Schedules I-IV supposedly represent ever decreasing potentials for harm with Schedule I being the most harmful.

Similarly to the 1961 Convention, drugs within Schedule II-IV of the 1971 Convention are to be restricted to medical and scientific purposes. From this assumption controls and restrictions are placed upon the trade of these drugs such as the need for licenses, prescriptions and record keeping.\textsuperscript{52} In some instances, as is the case with the keeping of records, the control are proportionally harsher the lower the schedule number.\textsuperscript{53} Some of the controls in the Convention are general across all scheduled drugs, such as the need for inspection.\textsuperscript{54}

A number of special measures apply to Schedule I drugs. These tend to amount to more restrictively phrased versions of the controls placed upon Schedule II-IV drugs, such as the need for a ‘special’ license and ‘close’ supervision for anyone dealing in these substances. Most importantly, under Article 7 parties must:

\begin{quote}
Prohibit all use except for scientific and very limited medical purposes by duly authorized persons, in medical or scientific establishments which are directly under the control of their Governments or specifically approved by them.\textsuperscript{55}
\end{quote}

\textsuperscript{50} Commentary (n 40) 65.  
\textsuperscript{51} Single Convention (n 1) Schd.IV  
\textsuperscript{52} Psychotropic Convention (39) Art.8, Art.9 and Art.11.  
\textsuperscript{53} Ibid Art.11(1-5).  
\textsuperscript{54} Ibid Art.15.  
\textsuperscript{55} Ibid Art.7(a) (emphasis added).
This control is much more severe than that which was enacted under the Schedule I/IV of the Single Convention for a number of reasons. First, the restriction to medical and scientific establishments rules out such drugs being prescribed for the patient to possess and use outside of such a facility, i.e. at home. Second, both the establishment (if not under the control of the state) and the person must be authorized by the state to use the drug, the commentary to the Convention argues that given the restrictive nature of Article 7 as a whole, it is unlikely that that ‘person’ could be understood in the juridical sense rather than the natural sense, this is to say that corporations, more specifically pharmaceutical companies or private hospitals, could not be ‘duly authorized’ to use Schedule I drugs, as an institution, for either medical or scientific purposes; individual authorisation would be required.\(^56\)

The third restrictive phrase (‘very limited medical purposes’) is vague. The commentary offers some suggestions. First, it may be reflective of the fact that at the time of the convention being passed Schedule I drugs were viewed as having very limited medical purposes, this is part of the reason that they are in Schedule I; were their therapeutic uses any more extensive than that, they should be in Schedule II. This passage could simply mean, therefore, that Schedule I drugs should only be used for scientific and medical purposes, the latter of which are limited by definition.\(^57\) Conversely, it could be suggesting that Schedule I drugs should not be used in circumstances where non-Schedule I drugs would achieve the desired effect to the same degree. This interpretation works on the assumption that Schedule I drugs are of such a harmful character that using any other drugs would be preferable.\(^58\) Both these interpretations work on the assumptions the Schedule I drugs are very dangerous and of little medical value, if this is demonstrated to be incorrect then the drug in question should be rescheduled, the process which is examined in later chapters.

Schedule I drugs include LSD, MDMA, DMT, psilocybin and mescaline. Schedule II drugs

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\(^{57}\) Ibid 138-140.

\(^{58}\) Ibid.
include amphetamine and methamphetamine. Schedule III drugs include Cathine (one of the active ingredients in khat). Schedule IV is the largest Schedule and includes temazepam, lorazepam and diazepam.

The 1988 Convention attains more relevance in the next section with regards to the duty to criminalise possession. It does not Schedule any new drugs. Focussed on the illicit drugs trade, it categorises into two lists, and places controls on, a number of chemicals which are commonly used in the manufacture of illicit drugs but which also have other legitimate applications in the manufacture of other things.\(^{59}\)

There was, and still is, some debate as to whether the 1961 and 1971 conventions required the criminalisation and penal punishment of possession for personal use.\(^{60}\) While the need to implement criminalisation was never stipulated in either the Single Convention or the 1971 Convention, it was in the 1988 Convention.\(^{61}\) Article 3(2) of the 1988 Convention states that:

\begin{quote}
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.\(^{62}\)
\end{quote}

While the provision is clearly a requirement to criminalise possession for personal use there are three points of interpretation. First, the requirement is to criminalise personal possession ‘contrary to the provisions of the [Conventions]’. This means that there is no requirement to criminalise possession for personal use that is for ‘scientific and medical purposes’ and fulfils all the other control requirements

\(^{59}\) 1988 Convention (n 39) Art.12, Tables I and II


\(^{61}\) Krajewski (ibid) 333.

\(^{62}\) 1988 Convention (n 39) Art.3(2).
of whatever Schedule the specific drug is in.  

Second, the 1988 Convention makes a clear distinction between those offences pursued for the purposes of trafficking drugs and those pursued for personal consumption.  

The latter is afforded some exceptions; the first of these is contained within the provision itself and qualifies the requirement to criminalise as being ‘subject to constitutional principles’. The constitutional saving has been present throughout the three drug conventions. The commentary to the Single Convention suggests that ‘subject to constitutional limitation’ should be interpreted in a very narrow sense. It is directed, so the commentary claims, at federal constitutional states where the power to make penal provisions is vested within a state or province. In such a case the Single Convention requires that the state should obtain the necessary actions by its component devolved bodies to implement the Convention. It was further stated that the secretariat had no knowledge of any other constitutional limitations which would prevent fulfilling the duties expressed the Single Convention.  

There is reason to believe that while this narrow reading of the Single Convention is appropriate, such a reading would not be appropriate for the 1988 Convention. This is because the Single Convention was less clear in its desire to criminalise the possession for personal use of drugs. Constitutional principles, in particularly constitutional rights, will be much more relevant to a convention, like the 1988 Convention, which takes a more punitive stance on the individual.

Indeed, support for the notion that the constitutional saving in the 1988 Convention applies to constitutional rights can be found in the commentary on the 1988 Convention. In a passage relating to a separate use of the ‘subject to constitutional principles’ qualification, it is noted that this phrase was inserted due to the fears from some states that the provision in question, which related to inciting or inducing others to commit an offence under the convention, would be contrary to constitutionally protected rights to free expression. Thus it seems fairly clear that the ‘constitutional principles’

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63 Commentary (60) [3.92].  
64 1988 Convention (n 39) Art.3(1) and Art.3(2); Karjewski (n 60) 335; see generally Fortson (n 32) 33-40.  
65 Commentary (40) 429.  
66 Commentary (60) [3.66] see also [3.91], [3.95].
saving is meant, in the 1988 Convention, to include constitutionally ensured human rights. An acceptable reading of the 1988 Convention would, therefore, be that the 1988 does not require the criminalisation of possession for personal use if criminalisation were to conflict with a constitutionally ensured human right.

As a dualist country, the domestic courts in the UK will not be bound by international law. However, in some previous cases on drugs and human rights the international regime has held significant persuasive power over the judgments. It is significant, therefore, that medical supply, possession and trade in scheduled drugs is permitted and the absolute prohibition of possession for recreational use is only present subject to the constitutional principles of a country, such as human rights. Consequently, no objection raised against the argument of this thesis can be based upon the international regime of prohibition.
Chapter two: Human Rights Act

The Human Rights Act was passed into law in 1998 and came into force in 2000. Through the European Convention on Human Rights, the UK already had international legal obligations to which it was bound and on the basis of which individuals could petition the European Court of Human Rights in Strasbourg.\(^{67}\) Up until the passage of the Human Rights Act, however, the only means of bringing judicial attention to an breach of human rights by the state was to take action against the UK at Strasbourg. This was seen as an untenable position for a number of reasons, including the worryingly high number of cases before the court, the amount of resources it took to bring a case to Strasbourg and the unfairness of not allowing a British citizen to vindicate their rights before a domestic court.\(^{68}\)

Thus the Human Rights Act can be seen as an attempt to ‘bring rights home’ in the sense of giving British citizens an avenue through which they can have their rights adjudicated domestically, by a court. Indeed, the white paper that preceded the bill highlights that the Human Rights Act enables British courts and judges to develop British human rights law and ‘subtly and powerfully [weave it] into our law’.\(^{69}\)

Given the already existing obligations to the Convention, it was deemed appropriate to use it as the basis for the Human Rights Act. The Human Rights Act obliges public authorities and Parliament to abide by Articles 2 to 12 and Article 14 of the Convention along with Articles 1 to 3 of the First Protocol and Article 1 of the Thirteenth Protocol.\(^{70}\) Rights contained in the Convention are either qualified or unqualified. The qualified rights (Articles 8 – 11, particularly) are structured in two parts. For example, and of pertinence to this thesis, Article 8 provides:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

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\(^{67}\) ECHR (n 8) Articles 1, 32, 34 + 46

\(^{68}\) Rights Brought Home: The Human Rights Bill (White Paper Cm 3782 1997) [1.14-1.17].

\(^{69}\) Ibid [1.14].

\(^{70}\) Human Rights Act 1998 s.1 and Schd.1
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 wellbeing 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.  

The first paragraph – Article 8(1) – sets out what is worthy of being brought under the ambit of protection while the second paragraph – Article 8(2) – describes the basis on which a limitation of the first part may be justifiable. The burden of demonstrating that the measure in question comes into the ambit of Article 8(1) is upon the claimant. If this is demonstrated, however, the burden of demonstrating that the measure fulfils the criteria of a valid limitation under Article 8(2) is on the state. Throughout this thesis, when a measure has been demonstrated to come within the ambit of Article 8(1) the term ‘infringed’ shall be used, as in ‘the measure infringes Article 8’. Where the measure has both engaged Article 8(1) and cannot benefit from a justification under Article 8(2) the term ‘breach’ will be used, as in ‘the measure breaches Article 8’. It is only after a breach of a right has been demonstrated that the state can be said to be liable and a remedy under Section 3, 4 or 8 of the Human Rights Act deployed. In the case of unqualified rights (for example the prohibition of torture and slavery) there is no difference between infringement and breach. Due to the lack of a limitation clause, if the right is infringed it is also breached. There is no justifiable limitation of an unqualified right. No such rights are examined in this thesis.

It is the responsibility of the courts to rule on whether an action or policy is in compliance with the Convention. The mechanisms for enforcing compliance, however, are different depending whether it is a public authority or Parliament who are alleged to have breached the Human Rights Act:

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71 ECHR (n8) Article 8.
73 For judicial discuss of this point see R (on the application of L) (FC) v Commissioner of Police of the Metropolis [2009] UKSC 3.
74 see references to ‘courts and tribunals’ in Human Rights Act (n 70) s.2 and to ‘courts’ in s.4(1+2).
Section 6 of the Human Rights Act makes it unlawful for a public authority to act in a way which is incompatible with a Convention right. Public authority includes any person or body whose functions are public in nature as well as courts and tribunals but, significantly, does not include Parliament. Similarly an act by a public authority will not be subject to Section 6 if, as a result of Parliamentary legislation, the authority could not have acted any differently. If an act or policy of a public authority if deemed incompatible under Section 6, Section 8 gives the court the discretion to decree whatever remedy is deemed just and appropriate in order to achieve convention compliance.

Non-compliant Acts of Parliament, on the other hand, are governed by Sections 3 and 4 of the Human Rights Act. Neither of these sections gives the court the power to set aside Acts of Parliament. Indeed, they were tailored to provide for justiciability of human rights without encumbering Parliamentary sovereignty.

Section 3 of the Human Rights Act is an interpretive power which dictates that the courts must, so far as is possible, interpret and give effect to legislation in a way which is Convention-compatible. The case law on Section 3 demonstrates that the ‘unusual and far reaching’ power of the provision allows the court, when making an ‘interpretation’, to defy the intention of Parliamentary when it passed the legislation. Similarly the court is able to interpret into the legislation a convention compatible reading even where the language of the legislation would not reasonably allow such a reading.

Where the court decides to not apply Section 3, a Section 4 declaration of incompatibility is used. This mechanism alerts Parliament to existence of the incompatibility of the provision in

75 Ibid s.6(1).
76 Ibid s.6(2).
77 Ibid s.8(1).
78 Ibid s.3+s.4.
79 Ibid s. 3(2)(b+c)+s.4(6).
80 Rights Brought Home (n 68) [2.13]; HC Deb 21 October 1998, cols 1358.
81 Human Rights Act (n 70) s.3(1).
83 R v A (ibid) 67-68; R v Offen [2001] 1 WLR 253.
question, but it remains up to Parliament whether they should change it.

Three important points arise. First, it is the responsibility of the courts to determine whether or not a public authority or Parliament has acted incompatibly with the Convention. Second, it is only after such a finding has been made that the court may move to consider the application of remedies. Third, legislative incompatibilities or actions of public authorities who are compelled to act in non-compliance due to legislation come under Sections 3 and 4 and can only be remedied through interpretation of the non-compliant legislation or declaration of its non-compatibility. There are no such restrictions for acts of public authorities which are not compelled by legislation as, under Section 6, the courts have discretion over what remedy to apply.
Part two – Constitutional principles

Part two advances the detail and arguments of Part one by analysing the way in which human rights adjudication – described in brief in Chapter two – proceeds and, significantly, the principles on which it is based. Through a structured analysis of Supreme Court case law, I describe and analyse the requirement of the proportionality test in its four stages – legitimate aim, rational connection, necessity and fair balance – and show what each of these requires. Further I argue that judicial deference should not be used as a bar to challenging the placement of a medical useful drug into Schedule 1 because the structure of the Human Rights Act is already sufficiently deferential to the elected branches of government and there is therefore no need, or justification, for extending this deference into judicial decision making.
Chapter three: Proportionality

Any human rights challenge against the placement of a medically useful drug into Schedule 1 of the Misuse of Drugs Regulations would inevitably encounter a proportionality challenge in which the government would argue that the challenged policy is a proportionate means of achieving a public interest, and therefore not a breach of human rights. It is therefore important to understand the proportionality test.

Prior to the enactment of the Human Rights Act, there was no concept of proportionality as a standard of judicial review in British public law on the issue of human rights.\(^8^4\) Thus, as Kentridge noted shortly after its passage, the Human Rights Act created a need for the UK courts to ‘develop (or invent) a coherent and defensible doctrine of proportionality’.\(^8^5\) Brady, writing in 2012, considered there to be a consensus that this had not been achieved.\(^8^6\) Given this history it is not surprising that the UK court’s approach to proportionality has been both variable and in a constant state of development.

The principle of proportionality has developed significantly since 2012. Indeed, it has achieved a much greater level of coherence than that which existed in its inaugural 10 years. The purpose of this chapter is to describe and analyse the current state of the judicial model of proportionality. The chapter, therefore, acts as an essential explanation of the framework to be applied in the final section of this thesis, where the proportionality of the placement of medically useful drugs within Schedule 1 will be analysed through a case study on medical cannabis. My approach to this chapter – described in more detail in Appendix 1 – was a systematic analysis of the rulings on proportionality emanating from human rights judgments in the Supreme Court.\(^8^7\)

The chapter begins with a description of the acceptance of the proportionality test by the courts in the context of the Human Rights Act. Key features of the proportionality test are then

\(^{8^6}\) Alan Brady, *Proportionality and Deference under the UK Human Rights Act* (CUP 2012) 14.
\(^{8^7}\) Appendix 1.
described, with specific reference to the development of the 4-stage proportionality test, the link between the tests applied in UK and Strasbourg courts and the extent to which the four stages of the test are addressed in a systematic way. Following this each stage of the proportionality test – legitimate aim, rational connection, necessity and fair balance – will be described and their requirements analysed.

Acceptance of proportionality in the UK case law

Prior to the enactment of the Human Rights Act, judicial review of administrative actions was dominated by the Wednesbury reasonableness test. This test dictates that the courts will only challenge a decision if it is so unreasonable that no reasonable decision maker would have made it. Wednesbury is thus a test which applies much less scrutiny than the proportionality test. Indeed in Brind, a 1991 case, Lord Ackner declared that ‘unless and until’ the Convention is incorporated into British law there is no basis for a proportionality review, and that even judicial reviews based, as Brind was, on human rights should be decided on the Wednesbury reasonable test.

The application of the Wednesbury reasonableness test to human rights cases attracted the ire of Strasbourg in Grady v UK. The UK domestic courts in Grady conducted a judicial review of the decision by military authorities to discharge two service personnel upon discovery of their homosexuality. Brown LJ, giving the main judgment, noted that the Ministry of Defence admitted that the applicant’s homosexuality did not affect their work and that the claimants were devastated by the dismissal. The reasons advanced by the Ministry of Defence for the policy were that the presence of homosexuals would shake the confidence of recruits under the homosexual age of consent (then 18) and their parents, cause anger, mistrust and unease with the forces which would diminish their

88 Human Rights Act (n 70).
89 Prior to the Human Rights Act there was little to no scope for judicial review of legislative action.
91 R v Secretary of State for the Home Department, Ex parte Brind [1991] 1 AC 696, 763.
92 Smith and Grady v United Kingdom Application Nos. 33985/96 and 33986/96 (3rd section 25 July 2000)
effectiveness and that it was not appropriate to have open homosexuals given the communal living, and gender segregated arrangements of the armed forces.\textsuperscript{94} The court pointed out the lack of factual basis for these concerns and how the many other countries who allow homosexuals have not experienced the disadvantages predicted, concluding overall that the arguments lie in the favour of the claimants.\textsuperscript{95} However as the Wednesbury test was applied rather than proportionality, the court found in favour of the Government.\textsuperscript{96} While Wednesbury cases involving human rights used ‘heightened scrutiny’ of the justifications offered by the government, the court still only considered itself able to find against the government if that justification ‘outrageously defie[d] logic or accepted moral standards’.\textsuperscript{97} It was found that, in this case, it did not. It spite of the lack of evidence, the mere existence of a possibility that the imagined negative effects could occur was enough to find the decision ‘reasonable’ in the Wednesbury sense. Interestingly, Brown LJ strongly implied that if the case was decided on the basis of the proportionality test, the case would have been found differently and that if the application went to Strasbourg, it would likely succeed.\textsuperscript{98}

Brown LJ’s prediction was vindicated when Strasbourg examined the case.\textsuperscript{99} Here it was not only found that the policy was in breach of the claimants rights under Article 8, but also that the application of the Wednesbury reasonable test in the case was unacceptable from the point of view of Article 13; the right to effective remedy.\textsuperscript{100} It was stated 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 effectively excluded any consideration by the domestic courts of the question of whether the interference with the applicants’ rights

\textsuperscript{94} Ibid 530, 531
\textsuperscript{95} Ibid 533.
\textsuperscript{96} Ibid 538.
\textsuperscript{97} Ibid 540.
\textsuperscript{98} Ibid 540-542.
\textsuperscript{99} Smith and Grady (n 92).
\textsuperscript{100} Ibid from [129].
answered a pressing social need or was proportionate to the national security and public order aims pursued.\footnote{Ibid [138].}

This criticism was seemingly accepted after the implementation of the Human Rights Act, by Lord Steyn in \textit{Daly}. Here it was stated that the Wednesbury test, even in its heightened form, was not appropriate for the protection of human rights.\footnote{\textit{Daly v Secretary of State for the Home Department} [2001] UKHL 26, [2001] 2 AC 532 [27].} After \textit{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.\footnote{See for example \textit{Huang v Secretary of State for the Home Department} [2007] UKHL 11, [2007] 2 AC 167 [13].} This principle has recently been reaffirmed in \textit{Carlile}. Here the Court of Appeal had applied a rationality standard in a Human Rights Act challenge and the Supreme Court dismissed such an approach, confirming that proportionality is the correct standard to apply.\footnote{\textit{R (on the application of Lord Carlile QC and others) v Secretary of State for Home Affair} [2014] UKSC 60, [2015] AC 945 [84-89].} It should be noted that recent judicial commentary, particularly in \textit{Pham} has discussed the near convergence of the test for rationality in public law and the test for proportionality in human rights law. This does not, however, throw any doubt on the conclusion that decision under the Human Rights Act are decided under proportionality, rather it demonstrates that the rationality review may not be a rigid as was once imagined.\footnote{\textit{Pham v Secretary of State for the Home Department} [2015] UKSC 19, [2015] 1 WLR 1591 [60] + [108]; see also \textit{Kennedy v Charity Commission} [2014] UKSC 20, [2015] AC 455 [51]; and Paul Craig, ‘The Nature of Reasonableness’ (2013) 66 \textit{Current Legal Problems} 131.}

\textbf{Nature of the proportionality test}

Even though, ever since \textit{Smith} and \textit{Daly}, the proportionality test was accepted as the correct test to apply, the exact nature of the test was less clear. In this section I address three interpretive issues; whether the test has three stages or four, the relationship between the proportionality test under the Convention and the test developed by the Supreme Court, and whether the test should be systematically applied.
The British definition of proportionality, in the UK, finds its roots in a three-stage test used in the Privy Council case of De Freitas:

(i) the legislative objective is sufficiently important to justify limiting a fundamental right; (ii) the measures designed to meet the legislative objective are rationally connected to it; and (iii) the means used to impair the right or freedom are no more than is necessary to accomplish the objective.\textsuperscript{106}

This case hinged on an interpretation of a limitation clause, similarly phrased to those in Articles 8-11 of the Convention, in the constitution of Antigua and Barbuda.\textsuperscript{107} The question in this case was how these limitation clauses should be interpreted. The Privy Council drew on cases from South Africa and Zimbabwe, both of which were based on the famous Canadian proportionality test proclaimed in Oakes. The Oakes test is a four-stage test with an overall balance test added to the three above.\textsuperscript{108} The South African and Zimbabwean restatements of the Oakes test differed from one another in that the latter version excluded the fourth stage of the test completely. The Privy Council, without explaining why or even acknowledging the difference, went with three stage test elaborated in the Zimbabwean jurisprudence.\textsuperscript{109} De Freitas influenced the approach taken to proportionality in such a way that the three stage test was applied throughout much of the early history of the Human Rights Act.\textsuperscript{110}

The exclusion of the fourth stage of the test is not trivial as it is this stage that allows the court to do a broad assessment of the harms the challenged policy visits upon the human rights and whether these are balanced against the benefit that is delivered to the legitimate aim. Without the final stage there is an under-appreciation both of the scale of the rights infringement and the scale of the benefit:

\begin{footnotes}
\textsuperscript{106} de Freitas v Ministry of Agriculture [1999] 1 AC 69, 80.
\textsuperscript{107} Antigua and Barbuda Constitution Order 1981 s.12+13: ‘reasonably justifiable in a democratic society’
\textsuperscript{109} De Freitas (n 106).
\textsuperscript{110} See for example A and others v Secretary of State for the Home Department [2004] UKHL 56, [2005] 2 A.C. 68 [30]; see also Huang (n 103) [19].
\end{footnotes}
a trivial benefit to a legitimate aim could be deemed legal even where there is extreme damage to the right, so long as there are no less intrusive ways of achieving it.

Indeed writing in 2010, Hickman suggested the three stage test was then ‘firmly established’ as the test to be applied to domestic issues involving conventions rights,\(^\text{111}\) a fact which Rivers criticised on the basis that it excluded the ability of British courts to balance.\(^\text{112}\)

In spite of Lord Steyn insistence that the proportionality test requires ‘the reviewing court to assess the balance which the decision maker has struck’ and ‘attention to be directed to the relative weight accorded to interests and considerations’ the three stage test, excluding the balancing stage, was reaffirmed in Daly.\(^\text{113}\) The exclusion of the fourth stage was challenged, however, in Huang. Here Lord Bingham noted that if the de Freitas test had neglected the balancing stage, this should be corrected.\(^\text{114}\) Thus when called upon to clarify the nature of the proportionality test in Bank Mellat Lord Reed, referencing both Huang and Quila expressed the test thus:

(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.\(^\text{115}\)

While Lord Sumption, in the same case, provided a version with a slightly modified (and shorter) stage four, both accepted that their formulations do not differ in substance.\(^\text{116}\) After Huang and especially since Bank Mellat, the Supreme Court has frequently reaffirmed the four stage formulation, to the

\(^{\text{111}}\) Hickman (n 84) 179.
\(^{\text{113}}\) Daly (n 102) [27].
\(^{\text{114}}\) Huang (103) [19].
\(^{\text{115}}\) Bank Mellat v Her Majesty’s Treasury [2013] UKSC 39, [2014] AC 700 [74].
\(^{\text{116}}\) Ibid [20], [74] see also [132].
extent that, before quoting it in *Christian Institute*, Lady Hale referred to it as the ‘standard approach’.

Thus if the UK constitutional system did, at one point, exclude consideration of balancing, it now explicitly does not. Thus, where the “proportionality test” is mentioned and used in this thesis, this refers to the proportionality test elaborated in *Bank Mellat*.

In terms of how the court implements the four stage test it is clear that a systematic approach, where each stage is dealt with sequentially, is ascendant in the Supreme Court. Indeed, many lead judgments in recent cases having taken such an approach, with some judges expressing that there is a duty to do so. Lady Hale in *Carlile* for example, noted that ‘the court has to go through an orderly process of decision-making, answering a series of questions with which we are now all thoroughly familiar’. Further to this, Lord Reed argues that such an approach is normatively important, suggesting in *Bank Mellat*:

[The four stage test’s] attraction as a heuristic tool is that, by breaking down an assessment of proportionality into distinct elements, it can clarify different aspects of such an assessment, and make value judgments more explicit.

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118 Indeed there is good reason to think that even with the 3 stage test, balancing was not completely excluded from consideration. In *Roth*, for example, Brown LJ supplements the typical notion that the necessity test requires that the impairment of the right to be no more than was needed to achieve the objective, with an additional requirement that measure ‘must not impose an excessive burden on the individual concerned’ *


119 *The Christian institute* (n 117) [91]-[94]; *Ali* (n 117) [30]-[55], [68]; *Re JR38* (n 117) [73]; *Beghal* (n 117) [47].

120 *Carlile* (n 104) [89] (emphasis added).

121 *Bank Mellat* (n 115) [74].
I fully agree with this analysis. As an analytical tool, the proportionality test is better utilised when it is clear what facts and arguments weigh against which stage of the test. Lord Kerr, dissenting in Carlile, further argues that it is necessary to ‘maintain separate consideration’ of each of the stages so as to not confuse stage one and four.\textsuperscript{122} Lord Kerr is right on this point, but his argument can be taken further in order to suggest that the separate consideration of the four stages allows for the requirements of each stage to be better understood and analysed.

This is not to say that there is no place of a non-systematic approach, whereby the questions are addressed all at once, at the same time. Indeed, this was the norm prior to Bank Mellat \textsuperscript{123} and has been used in many cases since.\textsuperscript{124} The choice of which approach to take largely rests on what facts and evidence is adduced; if there are different considerations to be taken into account for each stage then the systematic approach makes sense and should be preferred. Whereas if the same evidence and consideration is relevant to all (or multiple) of the stages, a systematic approach risks repetition and needless cross referencing.\textsuperscript{125} That being said, however, even in this approach is it important to delineate which stages of the test fail and succeed and why, so as to keep the value of structure.

As noted above, the situation has only achieved coherence in recent years, in particular since the Bank Mellat decision. Prior to this, there was often no structured, systematic or analytical approach to answering questions of proportionality, with neither three nor four stage tests employed.\textsuperscript{126} Such cases and the development of the structured approach to proportionality are certainly interesting from a historic point of view, but for the purposes of this thesis, the current structured, systematic, four stage test is the approach to be employed.

\textsuperscript{122} Carlile (n 104) [149].
\textsuperscript{123} HH (n 136); Powell (n 136); ZH (n 136); Thompson (n 136); Norris (n 136).
\textsuperscript{124} R (T) (n 117); Nicklinson (n 117) [82], [120], [348 onwards]; Carlile (n 104) [89], [148]-[149] and Lord Sumption’s judgment generally; Gaughran (n 117) [63] and Lord Clarke’s judgment generally.
\textsuperscript{125} Ibid.
\textsuperscript{126} R (on the application of L) (FC) v Commissioner of Police of the Metropolis [2009] UKSC 3; Principal Reporter v K and others (Scotland) [2010] UKSC 56; BH (AP) and another v The Lord Advocate and another (Scotland) [2012] UKSC 24; ANS and another v ML (AP) (Scotland) [2012] UKSC 30; ZH v Secretary of State for the Home Department [2011] UKSC 4; In the matter of J (Children) [2013] UKSC 9; Patel and others v Secretary of State for the Home Department [2013] UKSC 72.
While the approach outlined above has been, since *Bank Mellat*, by far the most common, there are a small number of cases in contemporary proportionality analyses in which the British formulation is not mentioned at all; however, these cases often fall into discrete categories which explain this. For example, a line of cases on homelessness, supported and council housing and the right to home under Article 8 have found that where an applicant has no right under domestic law to remain in possession of a property, a claim made by a claimant that the decision to evict is disproportionate, can usually be dismissed summarily. As such, cases *Pinnock, Powell* and *ZH and CN* all have proportionality findings without mention of *Bank Mellat* proportionality.127

Similarly, cases *Catt* and *Shahid* do not reference the four stage British test.128 This is explained by both cases being decided overwhelmingly by reference to the jurisprudence of the Strasbourg court, rather than domestic considerations. The European Court of Human Rights and British approaches are different. Indeed, Lord Reed notes in *Bank Mellat* that due to the “analytical approach to legal reasoning characteristic of the common law” the British approach is more clearly structured than that of Strasbourg.129 The issues considered in *Catt* and *Shahid* (retention of data and solitary confinement, respectively) were ones that have been dealt with extensively in Strasbourg and led to disagreements between the Supreme Court and the European Court of Human Rights.130 In the context of this thesis, such an approach is unlikely to be taken and need not be considered as the issue of drugs and human rights has received sparing attention at Strasbourg.

That having been said, there are certain cases such as *AR*, a case concerning whether, and if so when, the state should disclose acquittals on background checks, where proportionality was analysed, without reference to either the *Bank Mellat*, or any other, formulation of the test without

129 *Bank Mellat* [n 115] [72].
specific reason why the standard four stage test was not done.\textsuperscript{131} Such cases are an exception, however, and as such this thesis is justified in adopting the \textit{Bank Mellat} approach to proportionality.

Given the salience of the Convention in British human rights law it is important to consider the differences, and interplay, between the system of the Convention and the system under the Human Rights Act. The test used when a state seeks to justify an infringement of human rights in Strasbourg is described in Article 8(2):

\begin{quote}
There shall be no interference by a public authority with the exercise of this right except such as is in \textit{accordance with the law and is necessary in a democratic society in the interests of}...\textsuperscript{132}
\end{quote}

The article then lists a number of legitimate aims, thus constructing a three-stage test whereby a provision, in order to justify its engagement with human rights, must be in accordance with the law, pursuing one of the legitimate aims and be necessary in a democratic society. It is important to note that the British jurisprudence does not simply replace this test with the one stated in \textit{Bank Mellat}, rather it understands the proportionality test to be a more structured way of answering the third question, which is to say that ‘necessary in a democratic society’ is taken to \textit{mean} proportionality in the \textit{Bank Mellat} sense (see diagram).\textsuperscript{133}

\begin{enumerate}
\item \textsuperscript{131} \textit{R (on the application of AR) v Chief Constable of Greater Manchester Police and another} [2018] UKSC 47.
\item \textsuperscript{132} ECHR (n 8) Art.8(2) (emphasis added).
\item \textsuperscript{133} \textit{Carlile} (n 104) [98]; \textit{Re JR38} (n 117) [71]-[72]; \textit{Christian Institute} (n 117) [70]; \textit{Quila} (n 117) [45]; \textit{R(T)} (n 117) [144]; \textit{Goughran} (n 117) [19]-[20], [59].
\end{enumerate}
Thus, under the Human Rights Act, in order for a measure to be justified in spite of its engagement with qualified human rights, it must be both in accordance with the law and pursuing a legitimate aim as well as fulfilling the four stage Bank Mellat test. In this regard, Lord Mance in Northern Ireland Human Rights Commission in described the two tests as ‘overlapping schema’.\textsuperscript{134} I shall not go into much detail as to the requirement that the measure be ‘in accordance with the law’ as it is essentially indisputable that the misuse of drugs laws discussed in this thesis are. It is sufficient to say that this test requires that the provisions in question are sufficiently clear so as to be understandable and predictable (with the help of legal advice) and that there is not scope for them to be arbitrarily applied.\textsuperscript{135}

The question of whether the measure is ‘pursuing a legitimate aim’ is similar to the first stage of the Bank Mellat test, which requires that the objective be sufficiently important. It will become clear in the following section, where this stage is examined, that there is a subtle difference between the two. For current purposes it is necessary to know that the legitimate aim test requires a  

\textsuperscript{134} Northern Ireland Human Rights Commission (n 117) [104]  
\textsuperscript{135} R (on the application of Roberts) v Commissioner of Police of the Metropolis and another [2015] UKSC 79, [2016] 1 WLR 210 [15]-[27].
demonstration of the link between the law or policy which infringes the human right and the list of stated aims in Article 8(2), these are:

[N]ational security, public safety or the economic wellbeing 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.

The depth of such an enquiry in UK case law is variable. In some cases, the link will just be stated to exist as if it were obvious. In Catt the police had retained information regarding the two claimants. In the case of the first claimant, his attendance at rallies which often got violent was catalogued. In the case of the second, information regarding a notice that the she had been presented, by the police, with allegations of harassment by her were kept on record. In addressing the link between this retention of information and the Article 8(2) legitimate aims, Lady Hale noted that ‘no-one doubts’ that the information was collated in pursuance of a legitimate aim, further adding that one such aim ‘certainly’ included ‘for the prevention of disorder and crime’. Similarly in Quila Lady Hale noted that the desire to prevent, delay and deter forced marriage was ‘undoubtedly’ linked with the protection of the rights and freedom of others. In the same case Lord Wilson proclaimed that such a link did exist, without any further exploration of the issue. Thus, while some cases are not so easily resolved on this point, the court will often view the link between the challenged measure and the legitimate aims listed in the Convention as so obvious as to require little or no explanation.

136 See as examples The Christian Institute (n 117) [89]; Ali (n 117) [34], [67]; Catt (n 128) [48]; Carlile (n 104) [96-97]; Nicklinson (n 117) [79], [235], [311]; R (T) (n 117) [141]; HH v Deputy Prosecutor of the Italian Republic [2012] UKSC 25, [2013] 1 AC 338 [30], [120]-[121], [152]; Quila (n 117) [45], [73]; Powell (n 127) [36], [73], [80]; ZH (Tanzania) v Secretary of State for the Home Department [2011] UKSC 4, [2011] 2 AC 166 [17+18], [28]; R (on the application of F) and Thompson v Secretary of State for the Home Department [2010] UKSC 17, [2011] 1 AC 331 [41]; Norris v Government of United States of America [2010] UKSC 9, [2010] 2 AC 487 [87], [105], [128].
137 ECHR (n 8) Article 8.
138 Catt (n 128) [48].
139 Christian Institute (n 117).
The four stages

As described in the previous sections, the proportionality test is a four stage test, which is conducted as a means of answering the third stage of the test laid down in the text of the Convention, which is to say that it is conducted along with considerations of whether the policy in question is in accordance with the law and pursuing a legitimate aim listed in the Convention. For this reason, I address each stage in turn.

Sufficiently important objective / Legitimate aim

“(1) whether the objective of the measure is sufficiently important to justify the limitation of a protected right”

Before we proceed it is necessary to clarify the use of language. Throughout this chapter I shall use the terms ‘legitimate aim test’ and ‘sufficiently important objective test’. These terms are sometimes, both in academia and case law, use interchangeably or, more often, both tests are referred to as the ‘legitimate aim test’. The two tests do however have a slightly different meaning. The legitimate aim test, as above, merely requires a link to be made between one of the listed objectives and the challenged policy. The sufficiently important objective test, on the other hand asks whether the policy is aiming to do something that is sufficiently important, even in theory, to limit human rights. This test will fail a measure which, while it is linked in some way to listed objectives, is of trivial importance and cannot therefore be used to justify the infringement of a human right.

As a matter of pure logic, it seems possible that a challenged policy could pass the legitimate aim test and yet still fail the sufficiently important objective test. The case law, however, suggests that this is very unlikely. Indeed, some judges have viewed them as the same test, while others have viewed them separately. Lord Reed in RE T, for example, considers whether there is a legitimate aim and then,

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140 Bank Mellat (n 115) [74].
upon deciding that there is, moves to consider rational connection, which suggests no distinction between legitimate aim and sufficiently important objective.\textsuperscript{141} Some judgments have, however, analysed whether the aim of the challenged policy is legitimate \textit{and} whether the objective is sufficiently important to justify an engagement with human rights as if they are separate questions.\textsuperscript{142} Lord Kerr, dissenting in \textit{Gaughran}, specifically argues that it would be possible for a policy to pursue an aim listed in the Convention but still be considered to have an insufficiently important objective to pass stage one of the \textit{Bank Mellat} proportionality test. His argument is worth quoting in full:

\begin{quote}
\ldots although, in most cases, the pursuit of such an aim will provide an effective answer to the 
first of the mooted questions. It is, at least hypothetically, possible to conceive of a legitimate 
aim that a contemplated policy or a legislative provision might seek to achieve but, because 
the right that would thereby be infringed is so fundamental, no limitation on it, on the basis 
of the avowed legitimacy of the aim to be pursued, would be defensible.\textsuperscript{143}
\end{quote}

This discussion, Kerr admits and I agree, is somewhat ‘esoteric’, grounded, as it is, in the purely theoretical. Indeed, the hurdle over which the government must jump in order to prove a sufficiently important objective is low. In \textit{Carlile}, a group of MPs and peers had challenged the decision to prevent an Iranian dissident (currently living in France) from coming to the UK and speaking in Parliament. This decision was taken by the Home Office on the basis that to have the dissident speak at Parliament would be a provocation and risk diplomatic ties with Iran as well as risk the welfare of diplomats currently stationed in Iran. On sufficiently important objective, Lady Hale proclaimed that the test was met because it could not be said ‘that preserving our relations with Iran is not even capable of justifying some limitation on freedom of speech’. Thus, the theoretical possibility of the objective

\begin{footnotes}
\textsuperscript{141} R (T) (n 117) [141]-[142]; see also, as one example \textit{Northern Ireland Human Rights Commission} (n 117)

\textsuperscript{142} \textit{Christian Institute} (n 117) [89]-[91]; \textit{Ali} (n 117) [30]-[45] Lady Hale discusses the importance of the measure while also discussing the link between the measure and the ECHR list, it is never assumed that such a link proves the importance of the measure.

\textsuperscript{143} \textit{Gaughran} (n 117) [60].
\end{footnotes}
being capable of justifying an engagement with human rights is enough to pass the test. It is important
to note at this juncture that how important the objective is will be a relevant factor in the fair balance
stage, but stage one is merely a threshold test.\textsuperscript{144} The legitimate aim and sufficiently important
objective can, and will in this thesis, be taken together, as both usually rely on the same facts – i.e. the
discovery and evaluation of the objective of the challenged policy.\textsuperscript{145}

The value of the test is therefore rarely going to be in eliminating insufficiently important
objectives, but rather in identifying what the objective of the policy is. Why this was important is
demonstrated in the cases of \textit{Quila} and \textit{Ali}. Both cases challenged some of the restrictions placed upon
the granting of marriage visas for foreign spouses of British citizens. In \textit{Quila} the rule in question was
the raising of the maximum age, from 18 to 21, which both spouses must attain before the foreign
spouse may be granted access to live in the UK. In \textit{Ali} the challenged rule required that the foreign
spouse passed a pre-entry English test while still in their country of origin as oppose to learn English
once they have arrived and be tested in the UK. Significantly, in both cases the objective of the
measure \textit{was not immigration control}. Rather, in \textit{Quila} the objective was the prevention of forced
marriages and in \textit{Ali} it was ensuring integration of foreign spouses.\textsuperscript{146} In both cases the selection of
the objective proved important.

In \textit{Quila}, tackling forced marriage was accepted as a sufficiently important objective. However,
this choice had the effect that the Home Secretary was tasked with proving that increasing the age
from 18 to 21 was rationally connected to, necessary for and in fair balance with the prevention of
forced marriages. This the Home Secretary did not achieve. Lord Wilson noted that the nexus between
forced marriage and the minimum age of marriage visas was not obvious.\textsuperscript{147} While Lady Hale discussed
that much of the Convention case law on the topic, is concerned with balancing the right to family life
against the need \textit{to control immigration}. Considering that the purpose of the measures in \textit{Quila} was

\begin{itemize}
  \item \textsuperscript{144} Carlson (n 104) [101].
  \item \textsuperscript{145} For brevity sake, I will refer to this joint test as legitimate aim.
  \item \textsuperscript{146} Quila (n 117) [8], [63].
  \item \textsuperscript{147} Ibid [8].
\end{itemize}
not immigration control but rather tackling forced marriages, Lady Hale found that the immigration
dimension can be ignored; the only questions to answer relate to the nexus between forced marriages
and the age at which marriage visas are given. Emphasising this point, Lady Hale noted:

> The Secretary of State cannot at one and the same time say that she is not doing this for the
> purpose of controlling immigration and rely upon jurisprudence which is wholly premised on
> the state's right to control immigration.148

In *Ali* the objective of ‘assist[ing] the partner's integration into British society at an early stage’ was
accepted as sufficiently important.149 However, expert evidence was referenced suggesting that the
quickest and best way to learn the language is through ‘immersion and practice’ in the country and
that the basic level of English that would be necessary in order to pass the pre-entry test would not
be much use in terms of allowing the partner to integrate.150 Thus, the practice of ensuring that
spouses learn English when they arrive in the UK is much more important in the furtherance of
integration than the pre-entry test.151

In both cases it can be seen that had the objective of the policy been immigration control the
proportionality analysis would have been markedly different and more favourably for the Home
Secretary. The objective of the measure, however, is a matter of fact and evidence. This is to say that
it is not open to the Home Secretary (or anyone else defending a measure) to select an objective, at
the outset of the trial, which they feel will be the most favourable to the proportionality analysis.
Often the objective of the measure will be evidentially discoverable without relying on the testimony
of the Government. In *Quila* for example there had been extensive consultation and study, both by,
and for, the Home Secretary, on whether lowering the age of marriage visas would be an effective

148 Ibid [72].
149 *Ali* (n 117) [30] + [40].
150 Ibid [34]- [42].
151 Ibid [32], [44]-[45].
means of tackling forced marriages. Factors such as this would have made the objective of the measure independently discoverable even if a party had attempted to argue it was otherwise.

Thus, while a case will rarely be dismissed on the basis of the insufficiency of its objective, discovering the objective is important for the functioning of the rest of the test.

*Rational connection*

“(2) whether the measure is rationally connected to the objective”

Stage two of the test requires linking the challenged policy to the objective. It is self-evident that the state should not be able to appeal to the necessity of meeting an objective in order to justify a measure which, in fact, does nothing to further it. This stage of the test, therefore, requires arguments to be adduced as to whether the challenged policy does, or could, serve to help the objective.

The challenged policy does not have to singularly and completely solve the objective to which it is purposed. Rather, it must make, or be capable of making, some contribution to the objective in question. In *Ali*, for example, Lady Hale set the bar fairly low, suggesting that the measure passed the rational connection test because ‘it cannot be said that it makes no contribution towards [the objective] at all.’ Similarly, Lord Sumption in *Bank Mellat*, suggested that the policy of freezing the assets of one Iranian bank was rationally connected to the policy of attempting to stultify Iranian arms sales because it ‘may well have added something to Iran’s practical problem in financing transactions associated with those programmes’. This was in spite of the fact that the policy did not cover a whole range of Iranian banks which might have also been involved.

Furthermore, Lord Reed cites a number of authorities in *Bank Mellat* which suggest that the rational connection test is one which can be fulfilled on the basis of reason and logic and does not

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152 Quila (n 117) [25]-[27].
153 It is important to note that in neither case did the Home Secretary attempt to argue that the objective was immigration control.
154 Bank Mellat (n 115) [74].
155 Ali (n 117) [46].
156 Bank Mellat (n 115) [27] (emphasis added).
157 Ibid [23].
require the government to adduce evidence as to the connection. Thus, demonstration of a logical reason that the challenged policy would contribute to the objective is sufficient to pass the test. The key passage explaining this position is from the Canadian case of Lavigne:

The *Oakes* inquiry into ‘rational connection’ between objectives and means to attain them requires nothing more than showing that the legitimate and important goals of the legislature are logically furthered by the means government has chosen to adopt.¹⁵⁸

This conception of the rational connection test leaves an unsolved question; what if a rational connection can be demonstrated to be plausible and logical, but a significant amount of evidence tells against it existing? To put it another way, even if the rational connection does not need to be satisfied using empirical evidence, can an otherwise satisfactory rational connection be defeated using with reference to contradictory evidence. While to my knowledge, this specific point has never been tested, it seems unavoidably the case that if the claimant can disprove a rational connection evidentially, then one cannot be assumed to exist, regardless of how logically sound it appears. Proving such a negative claim, i.e. that there is no connection between the policy and the objective, however, would inevitably be very difficult. There are, however a number of other ways in which a challenged policy can fail the rational connection test.

A rational connection will be challenged if the policy is not directed at the people it is claimed to be directed at. Thus, in *Tigere* a policy of only giving student loans to those who had indefinite leave to remain was challenged. The challenged policy was justified, by the government, as pursuing the legitimate aim of only giving limited finances to ‘settled students’ i.e. those who were most likely to remain in the UK and therefore accrue (both for themselves and the country) the benefits of higher education.¹⁵⁹ The claimant was the child of an immigrant who had overstayed their visa but was

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unaware of this fact until she came to apply for the funding. The court ruled that the claimant, as a person who had grown up in the UK and would almost certainly, on human rights grounds, not be removed ought to be included in the ambit of ‘settled student’ and the lack of inclusion and consideration of inclusion of students in position similar to the claimant, was problematic to rational connection. This is to say that the aim of benefiting ‘settled students’ could not be rationally connected to a policy which excluded a tranche of students who could readily be defined as such. Thus, it seems that creating a policy that is too narrow to fulfil the goal will potentially be injurious to a claim that there is rational connection between the policy and the aim.

The approach taken in Tigere could, at first, appear to contradict the statements above. Indeed, if all a policy must do to be rationally connected to the aim is achieve something towards it then the policy adopted here should surely fit. Limiting it only to those with indefinite leave to remain does do something to achieve the legitimate aim of restricting funds to only those who are most likely to benefit the exchequer through increased productivity. The apparent contradiction may be resolved by understanding what is being meant by ‘the policy’. The rational connection test is not judging the policy in general, but rather the element of the policy that is being challenged. Thus, there must be a rational connection between the policy of excluding people such as the claimant and the legitimate aim, not merely the between the higher education funding regime in general and the aim.\textsuperscript{160}

The government in Tigere offered a further justification. It was argued that for good administration to take place, the government needed to construct a “bright line” rule against which administrators could judge applications, rather than having to individually assess each and every candidate subjectively to judge whether not funding them was a breach of their rights. The Court rejected this, noting that while good and easy administration was a legitimate aim, and constructing a “bright line” rule was a way of achieving that, the choice of which bright line rule to use still had to pass the rational connection test.\textsuperscript{161} Simply put, while the Secretary of State was justified in choosing

\textsuperscript{160} Ibid
\textsuperscript{161} Tigere (n 159) [35], [64].
a bright line rule which could be administrated objectively, that was no saving for the fact that, as discussed above, the rule which was chosen, was not rationally connected to the legitimate aim. Indeed, a different and proportionate, “bright line” rule was available, as will be discussed in the necessity section.162

A further way in which the rational connection test may be failed was shown in Brewster. Here, the claimant challenged a decision to deny her the pension of her partner who died suddenly. They were unmarried but had been cohabiting for 10 years. The challenged provision did allow for pensions to be given to surviving cohabiting couples but only if that pension holder nominated their partner, which the deceased partner had not done.163 The requirement of the nomination was challenged on the basis that it was discriminatory under Article 14 of the Convention (in conjunction with Protocol 1 Article 1) as the nomination requirement did not apply to married couples. The objective of the challenged measure was to make sure that the cohabitation was genuine and legitimate. The court noted however, that this aim was already achieved by the other requirements of the policy, which were that the claimant must evidentially demonstrate at least two years of cohabitation and must demonstrate other things such as financial (inter)dependence. Given that the objective was already achieved by existing policy requirements which were not infringing upon human rights, there could not be a rational connection.164 Thus a policy, or part of a policy, which infringes a person’s human rights must add something to the achievement of the aim taking into account the other regulations and requirements that exist.

A much more searching and rigorous approach to rational connection has been consistently supported by Lord Kerr’s, the most significant elaboration of which was made in dissent in Gaughran. This case concerned the indefinite retention of the DNA profile of a man who had been drink driving, arrested, charged and prosecuted, yet not given a custodial sentence. His DNA was taken lawfully.

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162 Ibid.
163 In the matter of an application by Denise Brewster for Judicial Review (Northern Ireland) [2017] UKSC 8, [2017] 1 WLR 519 [41-43].
164 Ibid.
Under PACE rules, fingerprints and DNA profiles may be kept indefinitely if they were collected for recorded offenses (these are offences which are punishable by imprisonment plus a number of other specified offences) unless the person was under 18 at the time of the crime; the crime did not attract a custodial sentence; it was not a “qualifying offence” and; the convicted person did not have previous convictions for recordable offences. In such a case the length of retention might be shorter. The claimant in this case was an adult at the time of the offense so indefinite retention was applied. The claimant argued that such retention breached his Article 8 right to privacy. Having accepted that such rights were engaged the Police Service of Northern Ireland and the Secretary of State argued that the retention of the data was justified as it aided the prevention and detection of crime. Lord Kerr accepted this as a legitimate and sufficiently important objective but questioned the rational connection. Lord Kerr not only suggests that the connection between the policy and the objective must be evidence-based but is also rather searching in what precisely it is that he requires the government to evidentially demonstrate:

It is not enough that retaining these items on a permanent basis might, in some vague or unspecified way, help in the detection of crime in the future. It is necessary to show that in a real, tangible sense, keeping DNA profiles, fingerprints and photographs indefinitely will assist in counteracting or detecting future crime.

In this regard he notes that there would need to be proof of the rates of reoffending specifically among adults who had been convicted of recordable offenses. This was not provided. All that was provided, Lord Kerr laments, was evidence demonstrating that 90% of those given custodial sentences reoffended within two years. As Lord Kerr notes, this does not justify indefinite retention. Further, crimes and offenders met with custodial sentences after often going to be significantly more serious

165 Goughran (n 117) [12].
166 Ibid [18]-[20].
167 Ibid [65].
than some who have merely been convicted of recordable offences, some of which, Lord Kerr notes, are minor or even trivial.\textsuperscript{168} Significantly, however the rational connection test was passed for the majority in \textit{Gaughran} who found that there was proportionality, suggesting that Lord Kerr’s more searching approach to rational connection does not represent an approach of the Court.

In summary, therefore, the rational connection test requires that the element of the policy which is being challenged specifically, rather than the wider policy in general, must further the objective that is being used to justify it. Equally, the policy cannot replicate the achievements of the already existing policy arena, it must add to it. However, these demonstrations need only to be logical or rational, rather than necessarily evidential. It should be further noted that even if, as Lord Neuberger in \textit{Nicklinson} states a ‘somewhat tenuous’ connection is viewed to be sufficient to pass the low bar of the rational connection stage of the test, that it was tenuous would be relevant, and detrimental to the challenged policy, in the later stages.\textsuperscript{169}

\textit{Necessity}

\begin{quote}
“(3) whether a less intrusive measure could have been used without unacceptably compromising the achievement of the objective”\textsuperscript{170}
\end{quote}

In the final two stages of the test the challenged policy receives the greatest degree of scrutiny. The key principle of the necessity test is whether there is an alternative way of achieving the objective that does not infringe on the policy as much as the challenged policy, or at all. If such an alternative approach does exist, then the rights infringement of the challenged policy cannot be necessary, as it is possible to achieve what it achieves in a less infringing way.

This test, applied too forcefully would in practice be almost impossible to pass, thus Lord Reed noted in \textit{Bank Mellat}, citing Blackmun J in the US case of \textit{Illinois State Board of Elections}, that a judge

\begin{itemize}
\item \textsuperscript{168} Ibid [70].
\item \textsuperscript{169} \textit{Nicklinson} (n 117) [85], incidentally this case also included Lord Kerr dissenting, one such basis for his dissent was his assertion that the rational connection needed to be evidenced based [351].
\item \textsuperscript{170} \textit{Bank Mellat} (n 115) [74].
\end{itemize}
would be ‘unimaginative indeed if he could not come up with something a little less drastic or a little less restrictive in almost any situation, and thereby enable himself to vote to strike legislation down’.\textsuperscript{171}

Thus the test must be directed at discovering a method which is appreciably less rights intrusive while fulfilling the objective to a similar degree. It is important also that the test requires the achievement of the objective to not be unacceptably compromised, rather than be fulfilled to precisely the same degree.\textsuperscript{172} In this regard the less rights intrusive means might still be acceptable, in terms of the test, even if the objective is achieved to a slightly lower, yet still acceptable degree. Indeed, Hickman notes that were this not the case, the necessity test would be almost redundant, given how difficult it would be to find an alternative means that would be exactly as effective as the challenged measure.\textsuperscript{173}

A further problem emerges with a literal rendition of the test. Given that the burden of proving proportionality rests with the state, the necessity test could require the government to prove a negative if it forced them to conclusively prove that there are no less injurious alternative means. This interpretation, however, has been argued against in \textit{Beghal} by Lords Neuberger and Dyson who noted of the requirements of the necessity stage, that it was not the case that:

\begin{quote}
[T]he executive must produce positive evidence to show that the means which it has adopted to meet the objective in question is no more than is required. In some cases, it would be tantamount to proving a negative, which is often hard and sometimes impossible.\textsuperscript{174}
\end{quote}

From this proposition emerges the assumption, argued in some judgments, that it should be the claimant’s responsibility to put forward and prove a less infringing policy and demonstrate that it would work. Indeed, this was the view of Lords Neuberger and Wilson in \textit{Nicklinson}. This case

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{171} \textit{Illinois State Board of Elections v Socialist Workers Party} (1979) 440 US 173, 188–189
\item\textsuperscript{172} As distinct from the approach proffered by Barak (n 72).
\item\textsuperscript{173} Hickman (n 84) 181.
\item\textsuperscript{174} \textit{Beghal} (n 117) [76].
\end{itemize}
\end{footnotesize}
concerned assisted dying. The claimants argued that the criminalisation of assisted dying was a disproportionate interference with their rights to privacy under Article 8. The claimants were three men, all of whom were severely paralysed for various reasons and could only communicate through either small movement in their hands or through the arduous use of a blink machine. Their conditions are incurable, and all wished for assistance in ending their lives, a feat which they, for obvious reasons, could not achieve unaided, save for self-starvation, a method which is undignified and painful. They describe their lives as ‘dull, miserable, demeaning, undignified and intolerable’. With regards to their challenge, their argument is simple; the criminalisation of assisted dying creates a situation whereby they are forced to suffer such indignity and as such that law infringes their right to private life.

One of the counterarguments of the Government was that the engagement with Article 8 was justified on the legitimate objective of safeguarding the lives of others, in particular those who would, were assisted dying not absolutely prohibited, be pressured into committing suicide.

Thus, in regard to the question of necessity the issue was the following; are there any less rights-intrusive means of safeguarding such people other than an absolute ban? In answering this question Lord Neuberger explains mechanism by which lifting the ban of assisted dying might endanger the vulnerable. First, people in a similar medical situation to the claimants, who did not share their desire to die, would either be pressured into killing themselves or feel they are under some duty to die. Alternatively, the change in the law could send a similar, more general message to weak and vulnerable people who would therefore be at greater risk of committing suicide, or seeking assistance in doing so.

Neuberger was sufficiently satisfied by ‘expert experienced and professional opinion’ that the above risks exist and are not ‘fanciful or unrealistic’. From this position he required that, in order

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175 Nicklinson (n 117) [3]-[14].
176 Ibid.
177 Ibid [86].
178 Ibid [88].
for the absolute ban on assisted suicide to fail the necessity stage, it must be demonstrated, presumably by the claimants, that

there [i]s a physically and administratively feasible and robust system whereby Applicants could be assisted to kill themselves, and that the reasonable concerns [as to such risks] were sufficiently met.¹⁷⁹

Thus, in Lord Neuberger’s estimation, once the existence of the risk that the challenged law seeks to address is sufficiently demonstrated, it is for the claimants to demonstrate that their suggested alternative would address such a risk. Similarly, Lord Wilson notes a finding of disproportionality cannot be made unless the court can be satisfied that the exception to the law can be operated ‘in such a way as to generate an acceptably small risk’ of vulnerable people being pressured to commit suicide.¹⁸⁰

A different conclusion was reached on necessity in this case by the dissenting Lord Kerr and Lady Hale. Lord Kerr argues that it should be possible for a provision to be deemed disproportionate without a fully formed alternative being articulated.¹⁸¹ He suggests that it is for the government to demonstrate that the protection of the vulnerable can ‘only’ be achieved by drawing the provision as widely as it has been drawn’.¹⁸² Kerr does not require that the government empirically demonstrate this to be the case, given how difficult such a task may be. He does, however, note that some ‘tenable’ basis for providing why a blanket ban is necessary should be required if empirical evidence is not available. Thus, where Lords Neuberger and Wilson rested the onus on the claimants, Kerr has placed it on the Government, or at least Lord Kerr requires more from the government in order to be satisfied that a risk to vulnerable people is present in the absence of an absolute ban. Lord Kerr is supported in his submissions by Lady Hale who states that it is the rights interference, created by the criminalisation

¹⁷⁹ Ibid [120].
¹⁸⁰ Ibid [201].
¹⁸¹ Ibid [354].
¹⁸² Ibid [352] (emphasis provided by Lord Kerr).
of assisted suicide, not the exception that needs justification.\textsuperscript{183} Again, this subverts the burden of proof imagined by Lords Neuberger and Wilson. Both Lord Kerr and Lady Hale, then, did not accept that sufficient evidence had been produced as to the risk of creating an exception to the ban. This was largely due to two reasons. First, as Lord Kerr pointed out, assisted suicide has been allowed in various forms in some countries of Europe and some states in America and there has been no evidence of the risks imagined in justification of the absolute ban being realised in any of these jurisdictions.\textsuperscript{184} Indeed Neuberger does acknowledge the lack of such evidence but is cautious about drawing too much from it, noting that it is a small number of jurisdictions in which assisted suicide has been legal for only a short period. Thus, he notes, the evidence falls ‘some way short’ of establishing that there is ‘no risk’.\textsuperscript{185} This is to suggest, or at least imply, that if the evidence from other jurisdictions was more robust he too might have looked more favourably on the claimants’ case.

Second, Lady Hale goes to some length in describing how a court or tribunal could go about granting permission for assisted in dying to people in the situation of the claimants, suggesting the framework for a four stage procedure to go about separating, and therefore protecting, the vulnerable and weak who do not harbour a genuine desire to kill themselves. She notes that such a task is similar to judicial tasks which are performed in similar areas of law in the UK.\textsuperscript{186} Indeed, Lords Neuberger and Wilson consider the viability of a suggested alternative system as decisive, so on this point the justices are in agreement. The disagreement stems from the extent to which its viability requires proof. It should also be noted that the alternative means elaborated by Lady Hale were not a significant feature of the case made by the claimants, she explains; ‘the sort of process which I have suggested above was scarcely touched upon, let alone explored, in evidence or argument’.\textsuperscript{187} Had it been it is possible that it would have provided Lords Wilson and Neuberger with the demonstration of the alternative means they sought.

\textsuperscript{183} Ibid [320].
\textsuperscript{184} Ibid [356].
\textsuperscript{185} Ibid [88].
\textsuperscript{186} Ibid [314].
\textsuperscript{187} Ibid [318].
In summary of *Nicklinson*, therefore, while the Justices are divided on the extent to which various proposition must be proven, and by whom, they do appear united in the types of evidence that could be utilised to find against the government at the necessity stage. First, examples of other jurisdiction that have employed alternative, less injurious means, and have yet not experienced the negative consequences, the risk of which the government uses to justify the challenged law. Second, the existence of a demonstrably viably suggested alternative approach will either be helpful (per Lord Kerr and Lady Hale) or necessary (per Lords Wilson and Neuberger), particularly if its existence forms a key part of the argumentation and evidence in the case. Such a process will benefit if similarity to already existing systems within the British legal system can be shown.

Further, *Tigere* supports the notion that if the alternative policy can be mapped on to a regulation, law or policy which already exists, it will have more chance of being accepted as a demonstration that a less intrusive measure is available. In that case, it was argued that rather than using indefinitely leave to remain as the basis on which to assess whether funding is given, the decision makers could use paragraph 276ADE (1) of the immigration rules, which are used to assess whether to grant leave to remain on the basis of private life.\(^{188}\) This would still provide a ‘bright-line’ immigration rule which would include the applicants but, being that the rules require the claimant to have been living in the UK for half of their life, would still be limiting the funds to those who were likely to continue to be resident in the UK, and thus the achievement of the objective would not be unacceptably compromised.\(^{189}\)

A further reason for which a measure may fail the necessity test is if it is either under-inclusive or over-inclusive. The latter of these is more obvious so I shall address it first. In *Quila*, banning all marriage visas when one partner was less than 21 years old in order to tackle forced marriages meant that the vast majority of the marriages within the prohibited group were not forced. Such over inclusiveness failed the necessity test for a two reasons. First, as Lady Hale noted, there are other ways

\(^{188}\) *Tigere* (n 159) [38].

\(^{189}\) Ibid [38], [64].
to achieve the objective of preventing forced marriages.\textsuperscript{190} In this regard it is suggested that forced marriages are a problem that can be tackled without taking the rather extreme measures taken by the Home Secretary and are thus not necessary. Second, it was noted by Lord Wilson that the Home Secretary had not demonstrated that the policy of raising the marriage age of visas would actually have the desired effect and that the deterrent effect of the Home Secretary’s policy was ‘debateable’.\textsuperscript{191} Indeed, as Lady Hale noted, there were reasons to believe that it might not work, or may even have negative effects on the objectives.\textsuperscript{192} It should be clear that a policy which, by design, targets many more people than those necessary to meet the objective, which has not been demonstrated to work, cannot be considered necessary.

A less obvious case is that of under-inclusive provisions. These are provisions which are tackling a problem yet, for whatever reason, chose to only tackle one element or cause of that problem. The key case here is \textit{A and others}. This case concerned a law which permitted the detention of non-nationals if the Home Secretary considered them a threat to national security. The law did not permit such detention of British nationals and, as it was an immigration measure, it allowed the detained to be freed if they were leaving the UK. The proportionality test was being employed in this case to consider whether the UK had a right to derogate from the Convention under Article 15, which requires the measure to be necessary (in the proportionality sense) in order to confront an emergency threatening the life of the nation. This law was found to be failing the necessity test on the basis that if such a measure was not strictly necessary for British nationals who were similarly suspected by the Home Secretary, then it could not be necessary for non-British nationals, given that both pose a qualitatively similar threat.\textsuperscript{193} This thinking was followed by some of the justices in \textit{Bank Mellat} case, where the targeting of only one Iranian bank was seen as demonstrative of the fact that such targeting was not strictly necessary.\textsuperscript{194}

\textsuperscript{190} \textit{Quila} (n 117) [77].
\textsuperscript{191} Ibid [50], [58].
\textsuperscript{192} Ibid [75], [76].
\textsuperscript{193} \textit{A and others} (n 110) [132].
\textsuperscript{194} \textit{Bank Mellat} (n 115) [25].
Thus, in summary, factors which may be taken into account when deciding upon necessity are: whether there are examples (the more long standing and numerous the better) of other jurisdictions where the objective is achieved in a different less intrusive way; whether there is a demonstrably viable alternative mechanism, preferably though not necessarily one already extant within the UK legal system; and whether the policy is either under-inclusive or over-inclusive in such a way as is unjustifiable.

*Fair balance*

“(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.” 195

The first observation to make with regards to the final stage of the proportionality analysis is that it is different from the first.196 The first stage, the sufficiently important objective test, analyses whether the objective of the measure is *in principle* capable of justifying a human rights infringement. The fourth stage, on the other hand, asks whether what is achieved by the challenged policy in furtherance of the objective outweighs the harm done to the right.

This conceptual difference is important because there are clearly various degrees to which a measure can achieve an objective and harm a right. The question of whether the importance of the right to online privacy outweighs the risk of terrorism, for example, is too general and non-specific to be capable of a confident answer. The court, in the fair balance stage, therefore, sets about analysing how important the right in question is, how severe the infringement on the right is, how important the objective is and the extent to which the objective is furthered by the challenged policy or law. If, continuing our example, the challenged policy allowed for the surveillance of all emails and instant messages online by a government institution, this would require a much more significant

195 Ibid [74].
196 Ibid [76].
demonstration of benefit, than a policy which allows the police to only read the emails of convicted terrorists. Conversely, if the government could demonstrate that the challenged policy has foiled dozens of terrorist plots, it could likely justify much larger infringement into rights to privacy than a policy for which no such demonstration could be made.

Thus, in *Shahid* for example it was noted that the longer that solitary confinement went on for, the greater the demonstration of benefit to an objective must be.197 This is to say that the more harm that is done to the right, the greater the benefit to the objective must be in order to justify it. The reverse is also true. Thus, in *Norris* it was ruled that extradition is so important to the prevention of disorder and crime that human rights claims against an extradition on the grounds of Article 8 would have to demonstrate very severe harm in order to be successful.198

Some interests are viewed to be so important that they are given a large degree of presumptive weight. For example, it has been found that the public interest in extradition of those accused of crimes in other countries is so high, that to avoid extradition on human rights grounds will happen only in ‘exceptional circumstances’.199 Even in such cases, however, a balancing exercise must be conducted. This is to say that, even if the presumptive weight of a public interest is very high, the judge is not free to conclude the case on that basis alone, the individual circumstances must be balanced in each individual case.200

The fair balance test has been described as and criticised for being a test which involves incommensurability as often the harm to the right and the achievement to the objective are values without basis of objective comparison; how does one ‘compare’ internet privacy with risk of terrorism? In this regard some of the metaphors deployed in descriptions of the fair balancing test are not helpful, for example suggesting that the harm to the right and benefit to the objective can be placed on either side of a ‘scale’ or ‘equation’ implies that they are measured in the same way, which

197 *Shahid* (n 128) [76].
198 *Norris* (n 136) [52], [96], [105].
199 *HH* (n 136) [103].
200 *Norris* (n 136).
Given this, the fair balance test requires some element of subjective value assessment. While this is unavoidable, the fair balance stage attempts to, in Lord Reed’s words, ‘make the value judgements more explicit’ and elaborate precisely what is being ‘balanced’ against what. The functioning of the fair balance stage of the test is best explored through example, thus what follows are a number of cases where the proportionality decision hinged upon the fair balance stage.

In Ali, the relevant facts of which are described above, it was noted that the requirement that a foreign spouse learn English once they have arrived and are tested on this after five years of residency, already contributed greatly to the objective of integration. Given this, the requirement (which was the subject of the challenge) that spouses learn English prior to entry did not add a great deal to the achievement of the objective, this was especially so given that the level of language required to pass the pre-entry test was not particularly useful in term of integration. This ‘modest benefit’ of the policy was, by Lady Hale, contrasted against the very substantial practical problems that arose where spouses did not have access to training and test centres near them in their country of origin. That the policy achieved very little led to its failure at the fair balance stage. There is an important nuance to this decision in that the benefit is judged against the less restrictive alternative, rather than nothing. Thus, if there is another, already existing, or suggested, policy that achieves the objective to a certain degree, the value of the challenged policy will be judged on the basis of how much it adds to this, rather than judged in a vacuum.

The reverse is also true. The harm to the right is judged in comparison to the extent to which the right can still be achieved while the policy is in place. Thus, it is not assumed that a policy which infringes a right does so absolutely. A clear example of this is Carlile, the relevant facts of which are described above. Here the banning of the Iranian campaigner from the UK was deemed to be a less severe infringement on the right to free speech of those who invited her because there were various

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other means by which the Parliamentarians could speak to her. Thus, as Lord Sumption points out, the infringement was not preventing a valuable political conversation, but rather hindering it. The communication was made less effective, rather than halted all together. This fact made the harm to the right ‘less weighty’ than it would have otherwise been.\(^\text{202}\)

Thus, if the harm done to the right is not severe, this will weigh in favour of the challenged policy. This was so in *Beghal*, where under challenge was a law allowing authorities at border ports to, without objective grounds for suspicion, question passengers on issues related to detection of terrorism. The passengers were thus detained for the time it took to ask the questions. Such detention was viewed as a ‘slight’ infringement of the right of liberty, which was deemed to tell in favour of the proportionality of the provision.\(^\text{203}\) Lord Kerr dissented, but not on the basis that he rejected the notion that a slight infringement is easier to justify but rather he disagreed with the characterisation of this infringement as slight.\(^\text{204}\)

Even more damaging to a claimants challenge than the infringement being ‘slight’ is a measure which is beneficial to the people whose rights it is accused of harming. Such a case is *RE: JR38*. Here a boy of 14 was pictured by police in connection with continued and escalating community violence and rioting in Derry, Northern Ireland. This case principally involved the sharing of pictures by the police to two news publications. These pictures showed the claimant, underage at the time, being involved in criminal rioting in public.\(^\text{205}\) The publication of these photographs was an attempt to identify the young people involved in order to restore public order, stem the violence and, significantly, to divert those young people identified away from community violence related activity. This latter aim was bolstered by a presumption in favour of diversion over prosecution in order to avoid the stigmatisation and criminalisation of the identified young people.\(^\text{206}\) Significant also is the fact that identification and

\(^{202}\) *Carlile* (n 104) [74], [106].

\(^{203}\) *Beghal* No.33 (n 117) [79].

\(^{204}\) Ibid [126]-[127].

\(^{205}\) *Re JR38* (n 117) [4]-[10].

\(^{206}\) Ibid [24].
other lines of inquiry had been attempted through a number of means before publication was considered and implemented.\textsuperscript{207}

The claimant argued that his Article 8 rights to privacy were infringed through the sharing of these images. Lord Kerr (with whom Lords Toulson, Hodge and Wilson agreed on this point)\textsuperscript{208} noted in regards to whether a fair balance had been struck that the actions taken by the police were likely to have, in the long term, helped the claimant by diverting him away from sectarianism and violence.\textsuperscript{209} The latter claim was bolstered by the fact that of the 37 young people identified only five were prosecuted in spite of there being sufficient evidence to charge all of them with criminal offences.\textsuperscript{210} Thus the benefit the claimant receives from the challenged policy is also a consideration to be taken into account in deciding the fair balance, not merely the benefit to the greater society.

The corollary of this principle must also be true. This is to say, that if the challenged measure in question has a negative impact on the public interest it is supposedly furthering, this will tell against it. The case of Quila offers an example of this. The basic facts are explained above however some further elaboration is required. The theory behind why the raising of the minimum age of marriage visas might prevent forced marriage is that many forced marriages occur in that age bracket and obtaining a marriage visa (and therefore rights to entry into the UK) was one of 13 identified motivations for forced marriage. Thus, by raising the age at which a marriage to a British citizen will grant a foreign spouse a visa, the Home Office hoped that they would delay some forced marriages. This delay would lead to the forced participant in the marriage being three years older at the time of the marriage and therefore possessing greater emotional and personal faculties to fight off, report or otherwise challenge the marriage. The evidence base of this theory was debatable, which told against the proportionality of the measure in and of itself. What further went against the measure was that

\textsuperscript{207} Ibid [14]-[21].
\textsuperscript{208} There was disagreement on whether or not Article 8 was engaged at all. Lords Kerr and Wilson thought it was. Lords Toulson, Hodge and Clarke thought it wasn’t. Toulson (with whom Hodge agreed), however, accepted that if Article 8 was engaged Lord Kerr (with whom Wilson agreed) was right about the question of proportionality [103].
\textsuperscript{209} Re JR38 (n 117) [79].
\textsuperscript{210} Ibid [26].
there was potential that, if this policy did not work as intended, it could cause a great deal more harm than good. The principal route by which this might happen is described by Lady Hale:

A young woman may be sent abroad and forced to marry against her will and kept there until she can sponsor her husband to come here. During this time she may be raped many times, bear children she does not want to have and be deprived of the education and life which she would otherwise have had here. Even if she is allowed to come home, she will not be able to escape from the marriage. She will be obliged to stay married so that she can sponsor her husband to come here.\(^\text{211}\)

Similarly, if it is difficult to see how the policy achieves the legitimate aim it will be impossible for it to pass the final stage of the test. This was shown in the case of *Northern Ireland Human Rights Commission* which centred on criminalisation of abortion in Northern Ireland. Here, the legitimate aim was the protection of morals by virtue of the protection of the life of the unborn baby. It was ruled that criminalising abortion in the case of fatal foetal abnormality cannot achieve a fair balance because there is no real sense in which the legitimate aim is achieved, as the unborn child is bound to die in any case.\(^\text{212}\) More fundamentally, it was found that the prohibition on abortion in a wider variety of cases could not achieve a fair balance because women in need of an abortion, in the vast majority of cases, procured one in Britain. It might be questioned why, given this, the abortion laws didn’t fail at the rational connection stage. However, as there were various different types of abortion claims involved in the case (rape, incest, fatal and non-fatal foetal abnormality) some for which the criminalisation was more defensible in proportionality terms than the others; judges viewed it as expedient to address all of them in the final stage of the analysis.\(^\text{213}\) The key point the take from this example, therefore, is that even if a challenged policy, which does not achieve its aim to any significant degree, somehow passes the rational connection test, it will likely fail the fair balance test.

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\(^\text{211}\) Quila (n 117) [76].

\(^\text{212}\) Northern Ireland Human Rights Commission (n 117) [126].

\(^\text{213}\) Ibid [279].
In summary, therefore, the fair balance inquiry is one which examines and elaborates, evidentially, the extent to which the challenged policy harms the right and achieves the legitimate objective. The harm is then weighed against the achievement. The fair balance test may also act as a refuge for arguments made in the first two stages of the test. In this regard the extent of the evidential connection between the objective and the policy as well as the importance of the objective will be relevant factors in the decision making. Finally, as *RE: JR38* and *Quila* demonstrate, the fair balance inquiry is wider than merely looking at the specific route through which the challenged measure has harmed the right in question or benefited the objective; it’s other positive, intended consequences as well as its negative, unintended consequences will be factored relevant to the balance.
Chapter four: Deference

In many human rights cases, including ones involving drugs, the government will claim that the court should not find against it as to do so would run against the principle of judicial deference. Deference describes the respect that courts pay to the elected branches of government (executive and legislature). Giving deference – sometimes phrased as giving weight, allowing a discretionary area of judgment or affording due respect – denotes the process of the court affording preferential treatment to the testimony, findings and actions of the primary decision maker – Parliament or a public authority – in a human rights adjudication.

Deference is not a singular doctrine; there are various levels and types of deference. For example, deference can range from complete submission, by the court, to merely treating the views of the primary decision maker with respect. Equally, sometimes the court will defer to the primary decision maker on their factual assessment of an issue whereas other times they will defer to their assessment of the normative importance of various rights and interests. It is important to note, therefore, that to refer to the ‘principle of deference’ is to refer to a broad category of judicial behaviours.

In this chapter I argue that deference should be used as an epistemic tool to aid the judiciary in reaching the correct answer to the questions arising out of the proportionality test. It should not, however, be viewed as a constitutional tool designed to correctly calibrate the relationship between the courts and elected branches of government or as a means by which the court demonstrate respect for the democratic credentials of the elected branches. Such calibration and respect is provided for by

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214 The utility of the term ‘deference’ has been questioned both in the courts and academically due to the implication of servility that the term suggests. However given that it is the most widely used term to express the principle in discussion here it shall be used.

215 In the field of drugs see R v Taylor (Paul) [2001] EWCA Crim 2263; [2002] 1 Cr App R 37 The literature on deference is vast, the key starting points on the topic should be Brady (n 86); Hickman (n 84) Chapter five; Aileen Kavanagh, Constitutional Review under the UK Human Rights Act (CUP 2009) Part two.

216 There will not always be ‘correct’ to questions of rights, in the sense of there being one answer which is objectively true in opposition to all others which are not. This is particularly true with regards to interpretation of rights and the overall balancing of principles (stage 4 of the proportionality test). There will however, be many questions arising out of the proportionality test which are of an empirical nature and thus have answers which can be characterised as correct or not.
the structure of both the proportionality test and the Human Rights Act.

Deference can be divided into two separate forms, each with reference to a separate concern. The first is a concern that the court is not capable of answering, with any degree of certainty, some of the questions which arise out of the proportionality analysis. It is right, therefore, for the courts to defer, to some extent, to the findings of a primary decision maker with more expertise or capacity to answer the specific question. Deference in this sense is a judicial admission that a primary decision maker is more likely to have reached the correct answer in that given instance. As Kavanagh notes deference is a ‘rational response to uncertainty’. Deference that emanates from the concern over uncertainty, and is therefore positioned as a means of arriving at the correct answer, I shall refer to as ‘epistemic deference’.

The second concern is that a fulsome application of the proportionality test will lead to the court usurping or otherwise trespassing upon the role of the elected branches. The concern here is that the court, an unelected body, would take on a legislative role if they were to apply the proportionality test too forcefully. Deference emanating from this concern can be seen as ‘constitutional’, positioned, as it is, as a safeguard of principles of legislative supremacy and separation of powers. I argue that epistemic deference is a rational judicial practice whereas constitutional deference, in the context of the Human Rights Act, is not.

This chapter will proceed as follows. First, I shall argue that constitutional deference is unnecessary due to the inherent nature of the Human Rights Act, in particular the primacy the Human Rights Act grants to Parliament. Second, I contextualise the UK human rights system as a dialogic model of constitutional adjudication, explaining why such a system is effective in protecting human rights and why constitutional deference potentially undermines such effectiveness. Following this,

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218 This distinction between constitutional and epistemic deference has been made elsewhere, see in particular Alison Young, ‘In Defence of Due Deference’ (2009) 72(4) Modern Law Review 554, 564; Jeffry Jowell, ‘Judicial Deference and Human Rights: A Question of Competence’ in Paul Craig and Richard Rawlings (eds), Law and Administration in Europe (OUP 2003) 80; Carlile (n 104) [22].
raise constitutional objections to constitutional deference based upon impartiality, the rule of law and the constitutional assignment of responsibility. Finally, I shall argue that while constitutional deference is not acceptable, epistemic deference is. Epistemic deference is, however, justified only when combined with the non-doctrinalist view of deference, whereby deference is applied in a deeply contextual and fact specific way and is viewed as simply an extension of the normal process of rational judicial decision making.

**Constitutional deference and the Human Rights Act**

A need to defer, on democratic grounds, to the elected branches has been declared in much human rights case law. Take for example this statement by Lord Hope in the pre-Human Rights Act case of *Kebeline*:

> In some circumstances it will be appropriate for the courts to recognise that there is an area of judgment within which the judiciary will defer, on democratic grounds, to the considered opinion of the elected body or person whose act or decision is said to be incompatible with the Convention[^219]

This position is not an outlier in human rights cases and has been confirmed in a number of post-Human Rights Act cases[^220]. Indeed Lord Bingham noted, while arguing in favour of deference in *Pretty*, that the House of Lords are not a legislative body[^221]. Further, in *Lychniak*, he noted that the settled will of democratic assemblies is due a degree of deference[^222]. This drive for constitutional deference is explained by Brady thus:

[^219]: R (Kebeline) v DPP [2000] 2 AC 326, 381.
[^221]: Pretty (n 9) [2].
“the court [under the Human Rights Act] will need to be cognisant of the dangers of intruding too heavily, lest they become the final arbiters of all political conflicts.”

The concerns of Brady and their Lordships are misplaced, or at least overstated: Under the Human Rights Act the courts cannot become final arbiters of anything; the final decision is always left to Parliament. This is most obviously so with declarations of incompatibility under Section 4 of the Human Rights Act. These have no effect upon the parties in the case and no effect upon the law; there is no sense in which the application of Section 4 could be described as the courts acting a final arbiter. Indeed, Brady accepts this point and goes as far as to suggest that deference should be lowered when Section 4 is applied.

The concern that a non-deferring court could become final arbiter of political conflicts might be better placed for applications of Sections 3 and 6 of the Human Rights Act. Both sections do provide the court with the power to change the decision of the primary decision maker and have a direct effect upon the parties of the case. Further consideration of these provisions, however, reveals the concern is still misplaced:

Even though the court has the power to overturn the decisions of public bodies and strike down secondary legislation under Section 6 (in combination with Section 8), there are exceptions to this. Most prominently, for the purposes of Section 6, Parliament is not considered a public body and Acts of Parliament do not, therefore, fall within the jurisdiction of Section 6. Section 6 will also not be applicable (and Sections 3 and 4 will be) where an act of a public body is necessitated by an Act of Parliament. Thus, if the court overturns a decision of a public body, it is within the power of Parliament to pass legislation which necessitates such a decision and thus removes it from the purview of Section 6. Such a piece of legislation would likely be declared incompatible, but as has been made clear above, this does not obligate Parliament to do anything. Thus, as with the use of Section 4, Parliament

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223 Brady (n 86) 19-20.
224 Human Rights Act (n 70) s.4.
225 Brady (n 86) 120.
remains the final arbiter of political conflicts within the human rights field.

With regard to Section 3 of the Human Rights Act, the power should not be understated. It allows to court to read into the law an interpretation that Parliament did not intend and that the language of the statute would not, on sensible construction, allow.\textsuperscript{226} Indeed, as Tucker states ‘[the Human Rights Act] requires the courts to treat Parliamentary decisions that implicate human rights as weighty... but never as authoritative’.\textsuperscript{227} Brady frames Section 3 in proportionality terms arguing that under Section 3 the court enquires as to whether there are any measures which achieve the states interest in a less rights intrusive way and if there are, they are applied. Therefore, Section 3 is a complete denial, Brady argues, of the discretion the elected branches have to choose between proportional options.\textsuperscript{228} This analysis is true only to the extent that Parliament is willing to yield to the judicial interpretation selected under Section 3, which it is under no legal obligation to do. Parliament is fully within its rights and powers to enact a piece of legislation which chooses another of the proportionate options, or even chooses the dismissed, or any other, disproportionate one.\textsuperscript{229} If a proportionate option is chosen the courts will have no power to interfere. If a disproportionate option is selected and is passed as a fundamental feature of the piece of legislation\textsuperscript{230} the courts will have to declare it incompatible, at which point Parliament is under no obligation to change the law. Again, Parliament, and therefore the elected branches retain their place as final arbiter.

There are further bulwarks against the judicial overuse of Section 3 already built into its application. If the non-compatible provision is a ‘fundamental feature’ of the legislation or if the resolution of the breach of human rights is an innately political decision better suited to the legislature,

\textsuperscript{226} Ghaidan (n 82) [30+35]; R v A (n 82) 67-68; Lambert (n 82); Offen (n 83); see previous chapter for full explanation.
\textsuperscript{228} Brady (n 86) 119.
\textsuperscript{229} Ibid 119, this is a factor which Brady accepts, but seemingly views as unimportant.
\textsuperscript{230} Ghaidan (n 82) [33-34].
the court will decide to use Section 4 instead.231 Indeed, in setting these limits Lord Nicholls was concerned with making sure the use of Section 3 did not cross constitutional boundaries.232 Thus the risk of the court foreclosing the range of proportional options available to the elected branches would be remote even if the court did have the final say, which it does not.

A prime example of this is Bellinger. This case involved the marriage of a transgender woman to a man. Under Section 11(c) of the Matrimonial Causes Act a marriage was void unless the parties were ‘respectively male and female’.233 Previous case law found that under the meaning of this act the gender of the parties was to be represented by their biological gender at birth.234 The court viewed this provision as incompatible with Bellinger’s Article 8 rights to privacy. Given previous Section 3 case law, there would be little lexical difficulty in remedying this incompatibility by ‘interpreting’ gender in a way which included transgender people. The court, however, decided that the case raised questions of social policy and administrative feasibility. This fact drove the court to declare the legislative measure incompatible under Section 4 of the Human Rights Act rather than modify it under Section 3, as to do the latter would be an unacceptable trespass onto the legislative realm of Parliament.235 Thus, the courts are already taking account of the same constitutional factors that may be used to justify constitutional deference, yet they are doing so at the stage of remedy rather than proportionality. The fear of ‘judicial legislation’ should be assuaged, to some degree, by the reticence of the court to use Section 3 in such cases.

In this vein, Young posits concern that the arguments advanced for using Section 4 instead of Section 3 – such as legislation having wide ramifications or addressing points of social policy – are the same as those advanced for using constitutional deference when deciding if a breach of the

231 Ghaidan (n 82) [33-34]; see also Alison Young, ‘Ghaidan v Godin-Mendoza: Avoiding the Deference Trap’ [2005] Public Law 23, 29.
232 Ghaidan [Ibid] [33]
235 Bellinger (n 234233) [37]; See also Re: S (Minor) (Care Order: Implementation of Care Plan) [2002] UKHL 10, [2002] 2 AC 291 [43]+[44] for the courts reluctance to use s.3 where there are resource allocation ramifications.
convention has occurred. Young argues that such factors should only be taken into account when deciding whether or not to find a breach: To defer twice, for the same reason, in the same case is to risk failing to live up to the constitutional duties of rights protection.236 I agree with Young’s analysis as to the risks involved in deferring at the proportionality stage for the same, democratic, reasons as choosing Section 4 over Section 3. We part company however on the conclusion as to the point at which it is best to take these factors into account. Young’s analysis is rejected for two reasons. First, as Gearty notes, Bellinger is an

‘acknowledge[ment] that there are some rights issues (often on points of great ethical importance on which many views are held) which judges are equipped to identify but not to resolve.’237

Just because the court is incapable of resolving the human rights issue, does not mean it is incapable of identifying it. Indeed, the relative legitimacies of the bodies involved should have no bearing on the conclusion of whether a right has been infringed, rather it should have bearing on how (and who) is best to resolve it. Indeed, addressing the issue of which body is legitimately able to solve a problem is most obviously a consideration for the remedy stage; the stage at which a solution is decided. This approach allows for a full exposition of the issue during the substantive evaluation of the human right, yet still gives Parliament the complete discretion on whether to act and if so, how. A constitutional compromise, through deference, at the rights stage is therefore not only potentially unnecessary in such circumstances, but might also be a compromise too soon in the adjudicatory process.

Second, taking into account the legitimacy of each body to resolve the human rights issues is potentially legislated for by Section 3 or 4. Given that Section 4 exists and that Section 3 only allows interpretation where ‘possible’ it is clear that the Human Rights Act envisioned the court deciding

236 Young (n 231) 30-33, it should be noted that constitutional factors are not completely excluded from consideration at the remedy stage of human right adjudication in Young’s proposal, yet they are heavily limited.
when it was appropriate to change a provision through interpretation and when it was best to defer the resolution of the problem to Parliament. Conversely, while the text of the Convention does imply, through the ‘necessary in a democratic society’ clause, the need for proportionality in deciding whether limitation upon rights are justified, nothing in either the text of the Human Rights Act or the Convention imply deference, for constitutional reasons, during the rights stage of adjudication.

The ascendancy of Parliament within the structure of the Human Rights Act is not an accident. When drafted, it was specifically designed to create judiciable human rights while maintaining Parliamentary sovereignty.238 Thus the need for judges to create a doctrine of deference in order to maintain separation of powers or the supremacy of Parliament is misplaced as all the heavy lifting in defence of these constitutional concerns was been done in the drafting of the Human Rights Act itself.

None of this analysis is to deny the fact that the Human Rights Act makes it significantly harder for the elected branches to make a decision in the realm of public policy which is, in the view of the courts, injurious to human rights. This increased difficulty should be seen, however, in the context of the democratic dialogue model of constitutional adjudication that was created with the passage of the Human Rights Act.

Democratic dialogue

A democratic dialogue model of constitutional adjudication was first attributed to the Canadian Charter of Fundamental Rights239 and defined by Hogg and Bushell as a model in which judicial decisions are open to ‘reversal, modification and avoidance’ by the legislature.240 This forces the legislature to consider seriously the finding of the courts on issues of human rights, but ultimately allows it to retain the power to overrule. Dialogic models of constitutional law are therefore ‘weak form’ judicial review and the methods of human rights protections are more subtle than in systems of

239 Constitution Act (Canadian Charter of Rights and Freedoms) 1982
judicial supremacy. This is not to say that they are not effective. Indeed, dialogue can be seen to positively affect human rights in at least two ways.

First, they alert the legislature to what Dixon refers to as ‘legislative blind spots’. These can be seen as inadvertent breaches of human rights that derive from, Dixon argues, three distinct forms of legislative blindness. First, blind spots of application where the legislature fail to appreciate how individual laws they pass might affect rights when applied in specific circumstances. Second, blind spots of perspective where the legislature fails to reach out to minority voices, or voices that do not traditionally vote for them and as a result fail to appreciate their perspective. Third, blind spots of accommodation where the legislature fails to appreciate or realise, due to lack of time or expertise, that their objective can be achieved in large part with less rights interference. In each of these instances a dialogic model alerts the legislature to a human rights failing that they had not considered and forces them to address it.

Second, dialogue is instrumental in positively affecting human rights even where the legislative incursion was not the result of a ‘blind spot’ but was deliberate. Yap argues that:

Under a dialogic model of judicial review, the judiciary serves as an interlocutor of rights in a constitutional democracy by allowing legislators to have their way if they so choose, but the lawmakers must openly deliberate and take political responsibility for their courses of action.

The Human Rights Act functions in this way. As noted above, Sections 3, 4, 6 and 8 of the Human Rights Act all ultimately allow for legislative override. All sections will, however, alert Parliament and Government to ‘blind spots’ by finding against the law. This is especially the case with a Section 4 declaration of incompatibility as the court must alert the Crown to the challenge. But it is

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242 Ibid.
244 See further Alison Young, Parliamentary Sovereignty and the Human Rights Act (Hart 2008) Chapter five
245 The Human Right Acts (n 70) s.5
additionally true for Sections 3 and 6 (in combination with Section 8), as they force Parliament to confront the issue of a human rights incursion head on if they wish to retain it by taking the proactive step of changing the law and thus Parliament is left with the obligation of bringing forward, and receiving a legislative majority for, a reversal of the law or decision of the court. The dialogues provided for by the sections are therefore slightly different but in each case it amounts to the court presenting their view of the human rights issue and awaiting assent by omission in the case of Sections 3 and 6 or by action under Section 4.

Indeed, Parliament usually agrees, or it might be more accurate to say they don’t actively disagree,246 with the finding of the court. In the vast majority of cases the parliament has either modified the law after a declaration of incompatibility and has left interpretation chosen by the courts under Section 3 untouched.247 As the non-implementation of the Smith v Scott declaration of incompatibility on prisoner votes shows,248 however, Parliament is willing to act as a final arbiter of political conflicts if it feels strongly enough.249 Indeed, Hickman considers the UK model under the Human Rights Act to be effective due the persuasive power of Section 4 declarations and to the fact that Section 3 requires Parliament to take the initiative and pass overruling legislation if it wishes to breach human rights. This ‘strong’ form of dialogue allows the court to be more than just a pressure group in the political process, allowing it to still fulfil role of insulating fundamental human rights principles from majoritarian assault while also allowing room for interaction between the branches of

246 ‘Agree’ is used in the institutional sense. This is to say that Parliament act in such a way as to not change or go against the original finding of the court. This should in no way be taken to mean that individual members (or parties) of Parliament agree with each and every one of the courts human rights rulings. They do not.
247 For declarations of incompatibility see Human Rights Joint Committee, ‘Seventh Report: Human Rights Judgments’ (4 March 2015) [4.1+4.13] here it is shown that all but one of the declarations made have been followed; for the response to interpretations by the court see Christopher Crawford, ‘Dialogue and Rights-Compatible Interpretations under Section 3 of the Human Rights Act 1998’ (2014) 25(1) King’s Law Journal 34, Crawford studied all 59 interpretive changes made by the court prior to 2013. 40 had received no parliamentary attention at all, in 7 the process of reform was already underway at the time of the change, in 9 cases parliament adopted the judicial interpretation into legislation, in 1 parliament have re-legislated the same wording that was the subject of the ruling, in 1 case the original provision has been repealed and finally, in only 1 instance has the been a repudiation, in the follow up legislation, of the interpretation of the court.
249 HC Deb 10 February 2011, vol 523, cols 584.
government and the eventual, albeit rare, legislative override.\textsuperscript{250}

As Young notes, deference and democratic dialogue are both methods combatting the criticism that human rights enforcement damages democracy.\textsuperscript{251} Such criticism might argue, for example, that it is wrong for a non-elected, non-accountable judicial body to make final and supreme decisions on human rights when the scope of those rights and their application are contestable in nature and the issues involved are political.\textsuperscript{252} Given that they are addressing the same issue it is necessary to evaluate whether both democratic dialogue and constitutional deference are needed. I argue that they are not:

To combine the two mechanisms risks undermining the protection of human rights altogether; democratic dialogue is only useful in addressing human rights problems to the extent that the court is willing to raise human rights problems to the legislature. As argued above, democratic dialogue is premised on the ability of the court to force the legislature to revaluate its incursions upon human rights, while ultimately accepting Parliament’s final decision. If the court decides to rule in favour of the primary decision maker as a result of their democratic credentials, then no dialogue has been entered into. As Yap argues ‘judicial deference deprives the political process of the insights that the judiciary can provide to the polity’s shared understandings of rights’\textsuperscript{253}. Such deprivation leaves human rights without even the persuasive protection that is offered to them by the Human Rights Act.

Furthermore, it is possible that the incursions, by the elected branches, into the human rights were as a result of ‘blind spots’ amongst the original decision makers. In this context the elected

\begin{footnotes}
\item[251] Young (n 244) 117.
\item[253] Yap (n 243) 543, it should be noted that Yap refers to ‘ex ante’ deference in this passage. This is to distinguish from post ante deference. This dichotomy is used in Canada to describe, respectively, the deference paid to the legislature in an initial human rights decision and the deference paid to the legislature once a law has been struck down by the courts and re-enacted by the legislature. Given that the Human Rights Act provides no power to strike down legislation it is only ‘ex ante’ deference that is ever applied in the UK.
\end{footnotes}
branches might, having been alerted to the fault within the law by a finding of the court, accept that their original approach was in error. Indeed, the fact that most Section 3 and 4 decisions are not overturned implies that this is at least partly true. Deference in this context would deny the elected branches the opportunity to have presented to them considerations that might change their original decision.

Thus, if the courts decide to defer to the primary decision maker solely for constitutional reasons, they are actively failing to participate the dialogue that is at the heart of the model of human rights adjudication necessitated by the Human Rights Act. Indeed, Clayton argues that the existence of a dialogic model provides for a principled justification for strict scrutiny in human rights adjudication because under such a system there is no risk of judicial supremacism.254

This criticism of deference combined with dialogue was made toward the majority in the Nicklinson Judgment. Here, the majority ruled that they were not prepared to consider a declaration of incompatibility. The reasons for this were various, but primarily based on the fact that assisted dying is a complex social and moral issue on which there is no consensus in society and it is therefore for parliament to decide.255 Of relevance also, to some of the judges, was the fact that Parliament was, at the time, considering the private members bill on the issue.256 This reasoning is questioned by Wicks, who argues it is wrong for three reasons. First, the Section 4 power was granted to the courts by Parliament in the Human Rights Act, which specifically allows them to make such a declaration. Second, the point of a declaration is to notify Parliament of the court’s views, but it does not usurp the role of Parliament; it passes the issue to Parliament. Finally, a declaration can be ignored by Parliament, thus the making of it can never replace the role of Parliament.257 For reasons stated above, I agree with this criticism and view the constitutional approach to deference, exemplified by the

254 Clayton (n 220) 46-47.
256 Nicklinson (n 117) [343].
257 Wicks (n 255) 152 – 154, see also Nicklinson (n 117) [343].
majority in *Nicklinson*, to be unsustainable.

**Constitutional principles against deference**

Far from protecting constitutional principles, Allen argues that deference may denigrate them. Allen opposes the use of factors, within human rights adjudication, which are external to the discovery of whether a human rights breach has occurred. Specifically, he argues that if deference forces the court to choose the testimony of the primary decision maker over the claimant for reasons of democracy, rather than for reasons of rational decision making, then it is abdicating its responsibility to remain impartial.258 Indeed, constitutional deference can be understood as attaching some degree of heightened preference to the testimony of the primary decision maker based solely upon its democratic credentials. It is therefore necessarily true that the level of cogency, reason and evidence that the state will have to submit to the court in a human rights adjudication in order to win a case will be *lower* than that which the claimant, disadvantaged by their lack of elected position, must submit in order to achieve the same result. This situation is especially striking given that within the proportionality test the burden of proving the justifiability of a human rights infringement is on the state. As Allan argues, to have presumptive weight upon *anything* submitted by the executive and legislature simply because it is submitted by them is a subversion of the promise of judicial enforcement of rights provided by the Human Rights Act. It is also, and more fundamentally, a subversion of the principle of rule of law given that it presumes that the same action will be differentially treated depending upon which arm of the state is responsible for it.259 Lord Steyn, writing extra-judicially, has similarly argued that for the courts to desist from making decisions, on the grounds of separation of powers or other constitutional principles would be to surrender their

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responsibility under the rule of law.\textsuperscript{260}

To preference the views of parties to a case in proportion to their electoral representativeness, is objectionable also on grounds of rationality: In some, perhaps many, cases the degree to which a body is accountable to the population will be a non-sequitur to the likelihood that they have the correct answer to a given question. Thus, to take constitutional factors into account regardless of their epistemic relevance would be to decrease the probability that the correct answer is being reached.

Beatson et al further note that it is not justifiable to provide for different legal tests depending on the democratic accountability of the primary decision maker. Indeed there is no expression of the idea that the legal test changes in proportion to the level of democratic accountability in the Human Rights Act or the Convention.\textsuperscript{261} Affording deference on the basis of democratic accountability would create such a provision with no legal or rational basis.

It should be noted that Allan criticises what I am calling epistemic deference as well as constitutional deference. This is to say that he also views the expertise, experience and capacity of the decision maker as ‘external’ to adjudication of rights; the relative competence of the primary decision maker has no bearing, he argues, on whether the human right has, in fact, been infringed. Hickman correctly accepts this conclusion but does not consider it to preclude the use of epistemic deference.\textsuperscript{262} The argument in favour of epistemic deference is not that the experience and expertise of a primary decision maker is relevant to whether it infringed human rights. Rather it is relevant to how likely it is that their experience and expertise has led the primary decision maker to be better placed to answer a question.\textsuperscript{263} In this regard there are two related questions that the court must answer: “Has a human rights abuse taken place?” and “what person or body is most likely to have the correct answers to various questions, the answering of which is necessary in order to know whether


\textsuperscript{261} Jack Beatson et al, Human Rights: Judicial Protection in the United Kingdom (Sweet and Maxwell 2008) 283.

\textsuperscript{262} Hickman (n 84) 142.

\textsuperscript{263} Ibid.
a human rights abuse has taken place?” – Epistemic factors for deference are relevant in answering the second question. Constitutional factors for deference are relevant in answering neither.

While it is the case, as shown above, that constitutional deference has been used by the courts, it is also the case that the judiciary have made some statements of disagreement with the underlying assumptions of the arguments in favour of constitutional deference. Most prominently Lord Bingham took issue with the accusation, made by the attorney general, that judicial decision making was undemocratic. Rather, Lord Bingham argued in A v SSHD, judicial decision making is the cornerstone of rule of law, and in the case of challenges to primary decision makers on human rights issues, it is specifically mandated by the Human Rights Act. 264 This point was similarly made by Jowell, who argues that the Human Rights Act:

‘clearly signall[ed] the expectation that human rights will be respected by all branches of government and the conferment of the power of judicial review over statutes means that there is no longer a ‘monopoly of legitimacy to those principles to… decisions endorsed by the electorate’. 265

This, Jowell argues, has subverted the constitutional order in such a way that it is now the courts that are presumed to be the body entrusted with deciding (if not resolving) questions of rights as a matter of law. It is therefore not appropriate to talk of deference as a constitutional matter because Parliament – through the Human Rights Act – has decided which body is constitutionally the most appropriate to adjudicate human rights, and that body is the courts. 266

Though they do not amount to explicit repudiation, the findings in Huang appear to suggest

264 A and Others (n 110) [42].
265 Jeffrey Jowell, ‘Judicial deference: servility, civility or institutional capacity?’ [2003] Public Law 592, 597; this point is also made in Beatson et al (n 261) 277; it is also a key argument of Lord Kerr in Carlile (n 104) [152] who, in dissent, argues against constitutional deference. See also Mark Elliot, ‘Human rights, proportionality and the judicial function: R (Carlile) v Home Secretary in the Supreme Court’ (Private Law For Everyone, 3 Nov 2014) <https://publiclawforeveryone.com/2014/11/13/human-rights-proportionality-and-the-judicial-function-r-carlile-v-home-secretary-in-the-supreme-court/> accessed 03/05/16.
266 Jowell (n 218) 73-75.
scepticism within the House of Lords for constitutional deference. Lord Bingham, representing a unanimous decision, rejected the notion that because the immigration rules had the ‘imprimatur of democratic approval’ they should be taken as striking the correct proportionality balance. This was followed by a comparison between housing law and immigration law. The former, Lord Bingham argued, had been the result of a democratic process which had taken into account all the relevant parties after long deliberations; this could not be said for the latter. While the assertion made by the court that the housing legislation involved such deep consideration is disputed, that the debate was characterised in this way does demonstrate that the court’s concern with the democratic processes rests more with its likelihood in reaching the correct answer through deliberation and less with its ‘democratic imprimatur’.

Before I move to discuss epistemic deference, it is important to briefly consider the implications if my above argument on constitutional deference are not accepted. Would the issue of the medical use of drugs and human rights be an issue on which the court would defer constitutionally? The jurisprudence on this point is ambiguous. Quayle, discussed below, suggested it would be and cases such as Nicklinson (on assisted dying) and Carlile (on free speech and relations with Iran) both deploy large a degree of deference. Many cases, all of which could be considered to be about issues at least as social, moral and complex as the above did not. For example, Quila (on forced marriage and immigration), Ali (on English language requirements in immigration), Brewster (on the rights available to married and non-married couples after death) and Northern Ireland Human Rights Commission (on abortion) all included little, if any, deference for constitutional reasons. It is difficult to predict, therefore, whether and how much deference would be applied in a challenge to the placement of medically useful drugs into Schedule 1. It is sufficient to say however, that even if

267 Huang (n 103) [17].
268 Ibid.
my arguments on constitutional deference are not accepted, this is no guarantee that constitutional deference would be applied at all, or very forcefully, to the question in discussion in this thesis.

**Epistemic deference: supporting a contextual approach**

The preceding analysis has shown that it is unacceptable for the court to modify their view or refuse to engage in adjudication on the basis of constitutional concerns. The issue will often not, however, be as clear cut as this. Indeed, there will be many instances in which the court are uncertain of the answers to questions arising out of the proportionality test and will therefore provide for epistemic deference.

Epistemic deference, therefore, bases deference not on reticence over constitutional positions of the branches of government but rather on the inevitable uncertainty which the courts face when evaluating complex human rights issues. In this regard it can be viewed as a method of rational decision making though which the courts attempt to reach a conclusion that is most likely to be correct. The fact that, as argued above, the courts have constitutional authority over human rights under the Human Rights Act and that constitutional deference is a potentially dangerous addition to democratic dialogue, does not mean the court should be blind to the ‘limits of their own institutional competences’. This principle is affirmed by Lord Sumption in *Carlile*, who noted

> It does not follow from the court’s constitutional competence to adjudicate on an alleged infringement of human rights that it must be regarded as factually competent to disagree with the decision-maker in every case or that it should decline to recognise its own institutional limitations.\(^\text{271}\)

The court need not pay heed to the democratic credentials of the primary decision maker in order to defer, or give weight, to their judgment in situations where the primary decision maker has a greater

\(^{270}\) Jowell (n 218) 80.

\(^{271}\) *Carlile* (n 104) [32].
level of experience and expertise than the court and applies that experience and expertise to the
decision on hand. Young notes that epistemic deference is necessary when rights, or questions relating
to the adjudication of rights, are contestable. Thus, if the correct answer is not obvious and there is
uncertainty, an enquiry into which body or person is most likely to have arrived at the correct answer
is a rational endeavour.

Before we proceed it is important to clarify one point. As noted in the introduction, deference
can range from complete submission to merely showing respect for the decision of the primary
decision maker. This distinction decides what course of action is taken after it is accepted that there
is a valid reason for deference (in our case, once it has been accepted that the primary decision maker
has applied its superior expertise and experience to the resolution of the issue). Under submissive
derference the courts enquiry will end at that point and it will accept that the primary decision maker
has the correct answer. However, under respectful deference the court will still come to its own view
but will attach a significant amount of the weight to the findings of the primary decision maker.
Indeed, in applying this distinction to Human Rights Act adjudication, Young argues that submissive
forms of deference are systems of non-justiciability in that they preclude the courts from evaluating
the facts for themselves. For this reason deference as submission should be avoided. As has been
repeatedly noted by the courts, it is for them to ultimately decide whether something is or is not a
breach of the Convention. To defer this question to the primary decision maker is not an acceptable
course of action. When ‘epistemic defence’ is supported in the section it should always be understood
to mean deference as respect, not deference as submission.

What is being argued for, then, is an approach whereby the courts use the relative experience
and expertise of the primary decision maker in order to decide what weight to attach to their

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272 Young (n 218) 576-577.
273 The distinction was originally described by David Dyzenhaus, ‘The Politics of Deference: Judicial Review and
274 Young (n 218) 561.
275 See for example Carlile (n 104) [57 + 67]; Belfast City Council v Miss Behavin’ Ltd [2007] UKHL 19, [2007] 1
WLR 1420 at [13], [24], [31], [44] + [97].
testimony. Hickman notes that deference understood in this way is not a distinct principle of public law but rather an extension of the normal process of judicial decision making. As Beatson et al note, the attaching of weight to submissions of primary decision makers is not a task unique to human rights adjudication. In Eisai Ltd v National Institute of Clinical Excellence (NICE), for example, Dobbs J noted that the court would ‘giv[e] such weight to the expertise [of NICE] as the court thinks appropriate’.

In order to stake out exactly how epistemic deference as respect ought to be applied by the courts it is necessary to delve into a long running debate between those that support a freestanding doctrine of ‘due deference’ and those that do not. For the sake of ease, I shall respectively refer to them as ‘doctrinalists’ and ‘non-doctrinalists’.

The distinction can be applied thus: doctrinalists view deference as a free-standing principle of public law that is separate from the proportionality test. They consider it possible and necessary to enunciate in the abstract a collection of factors the presence of which in a case will lead a judge to defer to the primary decision maker. The non-doctrinalists on the other hand view deference as built into the proportionality analysis, as a normal judicial reasoning process and therefore favour an approach where the level of deference is decided on a case by case basis, with reference to the specific institutional capacity of the primary decision maker in the context of the case.

Kavanagh, of the doctrinalist camp, suggests that minimal deference should be applied to all decisions of the elected branches. She argues that the testimony of the primary decision maker should have some presumptive weight simply by virtue of the court showing respect to the other branches of government. Kavanagh further argues that substantial deference, which is a stronger

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276 Hickman (n 84) 135.
277 Beatson et al (n 261) 268.
278 Eisai Ltd v National Institute of Clinical Excellence (NICE) [2007] EWHC 1941 (Admin); (2007) 10 CCL Rep 638 [42]; see also the remarks Richards LJ at appeal [2008] EWCA Civ 438, (2008) 11 CCL Rep 385 [60], which favoured the giving of weight to, while still finding against, NICE demonstrating both that the courts give weight, or deference, in other context and that such a judicial exercise is not tantamount to submission.
280 Kavanagh (n 217) 191-192.
presumption in favour of the elected branches, be given when one of three factors are present; greater competence, greater legitimacy, greater expertise. Once these factors exist, substantial deference is applied. In Roth, the doctrinalist position got its best judicial airing in the dissenting judgment of Laws LJ. Laws suggested that there are four principles of deference: First, an act of Parliament is given greater deference than a decision of the executive or secondary legislation. Second, there is more deference for adjudication of qualified rights rather than unqualified ones. Third, more deference should be provided for issues which fall outside the constitutional responsibility of the courts. Finally, more deference should be provided for issues within the expertise of the elected branches.

While doctrinalist approaches differ in what reasons they give for defence, they all agree with the principle that certain general criteria (greater expertise, institutional capacity etc.) can be preordained as necessarily requiring deference when present. This approach is problematic as it might not always be that the existence of these criteria will lead to the primary decision maker having a better chance of reaching the correct answer. In order to develop a rational approach, it must be analysed if the factor for which deference is being given has been utilised in the given case, and how. In this regard it is not the attempt to set out factors which might lead to deference ahead of time that problematic per se. Indeed, thinking about what would count as a good or bad reason for deference is a useful enterprise. Rather, as will be explained below, objection is levelled at the view that it is possible to lay out such factors with a sufficient degree of precision that whenever those factors are present deference will be justified.

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281 Kavanagh (n 215) 181-182.
282 Roth (n 118) 83-87.
283 It is disputable whether supporters of due deference do actually think this. Indeed, both Young and Kavanagh have built into their models of due deference a view that the doctrine can be applied contextually. Hickman has questioned whether a doctrine of due deference which does not attempt to lay out such prescriptive criteria, with precision enough for them to be applied, can meaningfully be described as a doctrine ‘worth its salt’, Hickman (no 84) 138; Kavanagh (n 215) 201; Young (n 218) 574. Interesting though this debate is, what matters for the purposes of this thesis is the conclusion that the correct approach to deference is a fundamentally contextual application of it; whether this is possible while still supporting certain versions of the due deference doctrine is of no consequence.
This criticism is most prominently aired by Hickman. Hickman notes that while there are certainly both good and bad reasons for attaching weight to the testimony of a party in a case, this should not lead to the conclusion that it is a valuable enterprise to distil these reasons into a freestanding doctrine. He objects to this on the basis that setting factors for deference in abstract prior to a case will inevitably lead to generalisations being crystallised into rules. 284 What is meant by this is best illustrated by an example. It might be the case that greater access to expert advice usually leads to a decision maker having a better chance of being correct on a given issue, but it will not always be the case; the advice might be wrong, unclear or ambiguous, the advice might not have been followed or might have been misinterpreted by the primary decision maker, it might also be the case that access to advice does not always translate to advice being given in every case. This example illustrates two problems with the doctrinalist approach. First, creating a due deference doctrine that contains notions such as ‘access to advice should lead to weight being given to the primary decision maker’ will inevitably lead to weight being given in circumstances where greater access to advice has played no positive role in the decision making process. Second, the various reasons why a general statement on deference that might usually be true, is not true in a given case are too numerous and context specific to be built into a freestanding doctrine of deference.

It is similarly important that the level of deference is not simply based upon the abstract institutional factors of the primary decision maker but rather hinges upon the relative expertise and knowledge of the court and the primary decision maker. 285 Given this it should be clear that the deference to be afforded to a primary decision maker will depend on the judicial body conducting the adjudication. For example, a family court or immigration tribunal will probably have significantly less reason to give epistemic deference than other courts would. Equally, it is inevitable that the same court and the same primary decision maker might have different relative competences in two separate cases depending on the nature of the case. Indeed, the two cases could even be on broadly the same

284 Hickman (n 84) 137.
285 Brady (n 86) 117.
issue yet in one the primary decision maker could have marshalled the resources of the entire department into consultation, investigation, empirical study and expert testimony whereas in the other the claimant's rights were infringed with no deliberation or thought. Similar divergence might occur in the courts access to the claimant's case if in one case there is a detailed submission of the detriment to the human rights of the claimant and cross examined expert evidence whereas in another no such detailed evidence was available.\textsuperscript{286} In this context it is irresponsible to make general statements about the court being required to give a specific level of deference to any given institution as any such general statement risks uniform application of deference to non-uniform scenarios.

The important point of the preceding analysis, and the repudiation of the doctrinalist approach in general, is that the factors that inform the amount of weight to be justifiably given to a primary decision maker (or anyone else) are both innumerable and intrinsically context specific. As Allan notes, the non-doctrinalist position is to take these factors into account when they are relevant to the factual and legal claims made by the parties of the case. The doctrinalist position, on the other hand, by setting out factors which necessarily lead to deference when present, would inevitably lead to consideration of these factors even when they are not relevant to the truth or validity of the claims being made by the parties.\textsuperscript{287}

It is important, then, to not generalise reasons for giving weight to a decision of the primary decision maker but rather afford weight on a case by case basis. Equally, however, it is important to not generalise within a case. This is to say that while one question arising out of the proportionality test might warrant weight to be given to the primary decision maker, such as an evaluation of the effect of the measure on the public interest, other questions will not be so deserving of deference, such as an assessment of the harm done to the right of the individual.\textsuperscript{288} In this regard the correct approach to deference is contextual as between cases and between difference issues within one case.

\textsuperscript{286} Hickman (n 84) 138.
\textsuperscript{287} Allan (no 259) 99.
\textsuperscript{288} Hickman (n 84) 133-134.
This approach can be seen in \textit{Huang}, a case which has been lauded by some as supporting the non-doctrinalist position.\footnote{Ibid 130-144; Allan (n 259) 100; Brady (n 86) 26-27.} This case concerned a decision of the Home Secretary to refuse the claimants’ applications to remain in the UK as they did not qualify under the immigration rules. The claimants argued that their Article 8 family rights would be breached by such a removal. The government argued that deference should be given to the assessment of the Home Secretary. The court however found that while it was right to attach weight to the Home Secretary’s assessment of the public interest in asylum policy, it was the Immigration Appeal Tribunal that was more deserving of weight on the issue of what effect the removal would have upon the claimant’s rights.\footnote{\textit{Huang} (n 103) [15-16].} This is a clear example of the court giving weight to the assessment of whichever body is best able to answer the specific question.

Further, it must be questioned whether it is acceptable to give weight to the assessment of the primary decision maker with regard to fourth stage of the proportionality test. This is the stage at which the court decides whether a balance has been struck between the right of the individual and the interest of the public. Hickman notes that it is often not appropriate for the court to give weight to the balance struck by the primary decision maker, but rather only appropriate to give weight to the considerations that inform that balance when they are relevant to the performance of the primary decision maker’s capacity, such as the public interest.\footnote{Hickman (n 84) 135.} In this connection, Jowell notes that there are some questions, such as whether the public interest is under threat and whether the fulfilment of the human rights in question will endanger the public interest, where the primary decision maker will often be better placed than the court to make a decision. However a question for which the primary decision maker will never be better placed to answer, he argues, is the overall balance.\footnote{Jowell (n 218) 81.} Indeed once all the factors relating to the overall balance (such as the level of detriment to the right, the importance of the public interest etc.) have been calculated, the question of whether there is overall...
balance is a question of law, not policy or empirical fact, and is therefore squarely within the province of the judiciary.\textsuperscript{293} This is true even if the considerations which are inputted into to overall balance are political and uncertain. In such a scenario the court can, and probably will, give weight to the primary decision maker and others as to what are the appropriate considerations to load into the overall balance. But the overall balance itself will usually be the courts to make. Once all the facts have been properly understood and accepted, the overall balance stage amounts to the balancing of two competing constitutional principles (human rights and public interest). Thus, it is difficult to envisage a primary decision maker, or any other party, who is more capable than the courts in fulfilling this task.\textsuperscript{294} This sentiment is expressed well by Sedley LJ in \textit{Szuluk}, a case involving the confidentiality of correspondence between a prisoner and his doctor:

\begin{quote}
The court will ordinarily accept from the executive the evaluation of the risk of serious abuse of outside mail because the prison service knows far more about it than the court does, and because it involves no immediate issue of law. The court's task is to consider whether, in the light of it, a sufficiently pressing need is demonstrated to justify what will otherwise be the denial of a fundamental right. Once the facts are established, to abstain from adjudicating on them is not deference but abdication.\textsuperscript{295}
\end{quote}

Here we can see two important features. First the court attaches weight, for epistemic reasons, on the factual assessment of the risk that outside mail poses to security. Second, once the factual assessment has been accepted, the constitutional question of how best to weigh that risk against the fundamental right in question is seen as best answered by the courts. This approach is to be preferred.

This position has received powerful support in the dissenting judgment from Lord Kerr SCJ in \textit{Carlile}. He admitted that the Home Secretary is much more competent that the court in understand

\textsuperscript{293} Beatson et al (n 261) 272.
\textsuperscript{294} See \textit{Carlile} (n 104) [34].
\textsuperscript{295} \textit{R (on the application of Szuluk) v Governor of Full Sutton Prison} [2004] EWCA Civ 1426, [2005] 2 Prison LR 42 [26]; Ibid [67]+[68].
the potential risks to national security that would be taken were the right in question not infringed. He strongly rejected, however, the notion that this required, or allowed, the court to simply accept the assessment of the importance of the right, or the existence of an overall balance. These tasks, Kerr argues, are a matter a constitutional interpretation and therefore squarely within the competence of the courts, the Home Secretary’s access to greater information with regards to national security does not denigrate the superiority of the courts in the task of constitutional interpretation.296

A necessary corollary of the above conclusion follows: If it is accepted that deference should not be constitutional, but epistemic and that epistemic deference should be afforded in proportion to the likelihood a given testimony or opinion is correct, the state, either government or parliament, is not the only body that should be afforded deference. Deference in this sense rationally and logically should extend to any expert or experienced testimony that is most likely to be true; as with any case before the court. Thus, by rationalising, as Hickman does, deference as a normal element of the judicial decision making process, one allows for the possibility that an expert testimony would and should receive more deference than the opinion and findings of the primary decision maker, if it is better placed to arrive at a correct answer to a given question. While in any given case it might be true that the primary decision maker ought to, and in fact does, know more than the court, an expert (or experts) furnished with a body of research and information might know significantly more than both. Thus, if the above theory of deference is subscribed to, it is they to whom the court should defer – in the sense of giving weight to their testimony – not themselves or the primary decision maker.

Given this, the salience and importance of undertaking empirically based human rights case studies such as those done in Part three of this thesis becomes apparent. If human rights adjudications are to be examined epistemically, in the sense of weight being given to those who are more likely to have to correct answer, it is incumbent upon human rights researchers to examine human rights questions with this in mind and try to provide the thoroughly detailed analysis suitable for use in

296 Carlile (Ibid) [155]-[160].
potential adjudications. An example of the utility of this approach can be seen from the expert testimony relied upon in *Quila*. While this case involved an issue of complex social policy (forced marriage and immigration) the judgment, rather than deferring solely to the government, attached weight also to a report from the National Centre for Social Research, testimony from experts in domestic violence and forced marriage such as Southall Black Sisters and Karma Nirvana, as well as an academic report. The negative peer review of the latter was also discussed in the case. Indeed, the court even chided the government for not adducing any evidence of certain of its claims. 297 Thus, the court is prepared, when necessary, to engage in reasonably complex empirical discussions and not solely rely on, or defer to, the primary decision makers. This is further demonstrated by the case of *UNISON* which, while it does not involve the Human Rights Act, concerns the common law right to access to justice which, on this point at least, is sufficiently analogous. Here, a challenge was being made to the introduction of high fees for employment tribunals on the basis that they impeded access to justice. In analysing the question of affordability, the court considered the various financial complexities of the fees along with the Rowntree Foundation’s economic analysis of the minimum income required to attain an acceptable standard of living. 298 Commenting on the case Elliot stated that:

> it is striking that the Court was prepared to engage in detailed consideration of relevant statistical and financial information, so as to build up a comprehensive picture of the real-world impact of the Fees Order. 299

Thus, it is demonstrated that the court, rather than merely deferring to the assessment of the primary decision maker is willing and able to engage with detailed empirical evidence in order to rule on proportionality. Engaging with and providing such detailed empirical evidence is the aim of the final

297 *Quila* (n 117) [23]-[24], [55], [81].
298 *R (on the application of UNISON) v Lord Chancellor* [2017] UKSC 51, [2017] 3 WLR 409, [50]-[55].
part of this thesis.
Chapter five: Proportionality and deference in Quayle

Having examined, and argued for, the appropriate uses of both proportionality and deference in human rights adjudication in the preceding two chapters, the final chapter of Part two examines Quayle – the key case of drugs and human rights in the UK. It is shown that while this case mentions the medical use of cannabis and Article 8, it does not decide on this matter, and leaves such a decision to the future. The reason for this failure to make a finding is explained, along with proposals for how to structure a human rights claim on this issue in the future to avoid a similar failure.

The Quayle case has been considered, both academically and judicially, to be a case which decided against and potentially forecloses the option of an Article 8 challenge to drug prohibition based on medical use.300 I do not accept this interpretation of the case. Indeed, Walsh notes that this reading is not accurate, suggesting that the issue was not fully considered due to a perceived lack of evidence in the Court of Appeal.301 Walsh is correct in saying that the Quayle case did not conduct a proportionality analysis and therefore did not actually make a definitive finding as to the human rights compatibility of the application of drug prohibition to medical users. I would add to Walsh’s explanation, however, that not only did the Court of Appeal not have the evidence to make the ruling, it, for reasons explained below, did not have the legal authority to do so.

Quayle was a joint appeal of five criminal cases.302 In all five cases the defendants had been charged with possession, supply or importation of cannabis. All argued that the cannabis was ultimately being used for palliative purposes for conditions ranging from HIV/AIDS to chronic pain. The defendants attempted to have the common law defence of necessity put to the jury in their respective cases. In four of the appeals the defence of necessity was not allowed to be put to the jury, the defendants were either found or plead guilty and appealed the decision not to allow the defence to


302 Quayle (n 11) [2]-[6].
be used. In the fifth case the defence was put to the jury and the AG referred to the Court of Appeal the question of whether necessity could be used as a defence in the case of importation of cannabis for medical purposes.

The case therefore primarily concerned the question of whether the common law defence of necessity should be applied to instances where the defendant had used cannabis for medical purposes. The Court of Appeal first found that the common law defence of necessity was restrictively applied and would only be applicable where the factor bringing about the necessity was an external agency that was capable of objective assessment; the ailments of the claimants did not, the court claimed, fit within this purview. It further ruled that it was not possible to extend the common law defence of necessity as the legislative scheme (including the Misuse of Drugs Act, Misuse of Drugs Regulations and Section 170(2) of the Customs and Excise Management Act 1979) had provided not only clear instruction that cannabis should be criminal but also clear instruction as to how to provide for its medical use. Thus, to extend the common law defence of necessity in this way would be to contradict the clear effect and purpose of legislation.

It was noted that common law was effective up until ‘Parliament can legislate to draw a line or map out a new path’. Thus in creating a legislative scheme that did not allow for a medical defence in these circumstances and providing a specific mechanism for addressing medical use of illegal drugs, Parliament had drawn a line over which the common law could not cross in the way desired by the applicants.

It is important to note that the issue of the compatibility of the drug laws with human rights was not central to the case; no declaration of incompatibility was sought. Human rights were used to buttress the claim that the common law must be expanded. Council for the claimants explicitly stated that he viewed a declaration as unnecessary as, if the legislative scheme was viewed as a breach of human rights, the court would be under a legal obligation to extend the common law defence of

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303 Ibid [47]; citing (among other) R v Shayler [2001] 1 WLR 2206 [66].
304 Quayle (Ibid) [56].
necessity.\textsuperscript{306} It will be explained below that nothing in the Human Rights Act provides such a duty of common law expansion and that the decision to not seek a declaration led to there being no legal basis on which to scrutinise the compliance of the legislative system of drug prohibition with human rights. Indeed, due to this decision taken by council for the claimants, the compatibility of the legislative scheme with the convention was never actually ruled upon, the court only explicitly found that:

\begin{quote}
We see no basis in Article 8 for altering our conclusions regarding the scope and the inapplicability of the common law defence of necessity by extraneous circumstances in the context of the present appeals and reference.\textsuperscript{307}
\end{quote}

What finding the court did make on compatibility was restricted to:

\begin{quote}
On the material before us, so far as it is appropriate for us to express any view, we would not feel justified in concluding that the present legislative policy and scheme conflict with the Convention.\textsuperscript{308}
\end{quote}

This latter passage was said in the context of the previous paragraph in which the judge stated that in order to make a conclusion as to compatibility, the court would first need to give consideration to medical and scientific evidence, competing interests, arguments and deference; something which it was not in a position to do in this case.\textsuperscript{309} Given this, it should be clear that the Court of Appeal made no definitive ruling on the general compatibility of the legislative drug scheme with Article 8 in the matter of medical usage. This is to say that no proportionality analysis was attempted, let alone completed. We turn now to the reasons, specifically, why the Court of Appeal could not indulge in such a ruling.

As noted above, the decision was taken to focus on the common law defence of necessity.

\textsuperscript{306} Quayle (Ibid) [32].
\textsuperscript{307} Ibid [67] emphasis added.
\textsuperscript{308} Ibid [69] emphasis added.
\textsuperscript{309} Ibid [68].
Human rights were used to argue that if the common law defence of necessity was not extended, the claimant’s Article 8 Convention rights would be infringed. This approach is problematic as there is no legal basis, within the Human Rights Act, for the application of extending the common law as a remedy for incompatibility in this case:

As noted earlier, the Human Rights Act provides for two remedial systems. This first is provided by Sections 3 and 4. These are applied to legislative incompatibilities and provide the power to interpret legislation in a compliant way or else declare it incompatible. 310 The second system is provided by Section 6 which makes it unlawful for a public authority to be in breach of the convention and, through Section 8, gives the courts wide latitude in remedying that breach. 311 Significantly Section 6 does not apply to acts of Parliament or acts where, as a result of primary legislation, the public authority could not have acted another way. 312

This is significant as it is only through Section 6 that the extension of common law remedy could be applied: While Section 3 is interpretive in nature, it applies only to the interpretation of primary and secondary legislation, not common law; 313 Section 4 offers only declaratory relief and nothing else. Thus, in order to attain success, the alleged infringement suffered in Quayle would have to have been inflicted by a public authority and not by legislation. Indeed, this was the argument that the claimants made, suggesting that the court’s decision to allow for the application of the common law defence of necessity was the source of the infringement. Given that the court is a public authority, this argument might appear to be capable of engaging Section 6. Indeed in the case on which the claimants relied, Venables, the court did extend the common law in order to not have the court, a public authority, fall foul of Section 6. 314

A key factor distinguishes Quayle from Venables, however, is that in Quayle the infringement

310 Human Rights Act (n 70) s.3+4.
311 Ibid s.8.
312 Ibid s.6(2)(a).
313 Ibid s.3.
was a result of a clear legislative scheme whereas in *Venables*, it was not. In *Quayle* the court could not extend the common law because doing so would go against the clear purpose and effect of the legislation, something which, as a general matter of common law, has consistently been deemed unacceptable. This factor has the effect of disallowing the extension of the common law, as a general matter, but also disallowing the engagement of Section 6, which cannot apply if the court (i.e. the public authority) had no option other than to refuse to extend the common law as a result of primary legislation. Indeed this distinguishing factor was specifically noted by Mance LJ, in *Quayle*, where he stated that *Venables* concerned the balancing of two competing rights under the Convention, whereas the case at hand concerned the conflict between a legislative scheme and a Convention right.

Due to the above, it is clear that the only remedies to be attained were from Sections 3 and 4. As already noted, the remedy which the claimants had applied for was not available under Section 3 or 4 and in any case the claimants specifically declined any declaration of incompatibility. With regards to this failure to argue for a declaration Mance LJ states that:

> We have not had put directly before us under section 5 of the 1998 Act any issue as to the compatibility or otherwise of any aspect of the United Kingdom’s current drug legislation with the European Convention on Human Rights. *We have not been put in a position procedurally in which we could determine any such issue*. Nor has it been suggested that the legislation can be read down or qualified.

Given the specific direction taken in this case, Sections 3, 4, 6 and 8 were all closed to the court. It is not surprising therefore that Mance LJ deemed it inappropriate to conduct a compatibility analysis.

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315 *Quayle* (n 11) [64].
316 *McLoughlin* (n 305) 430.
317 *Quayle* (n 11) [64].
318 Ibid [32].
319 Ibid [66], Mance refers here to Section 5 when referring to declarations, which are legislated for under Section 4, this is because Section 5 requires that the crown be allowed to intervene if a declaration is being considered. Mance is still referring to Section 4 declarations of incompatibility in this passage. (emphasis added).
Although, as previously noted, the option of such an analysis was specifically left open for the future, granted with a tone of scepticism as to its potential success.\textsuperscript{320}

Given the above any human rights challenge made against the prohibition of a medically useful drug should be one which can make use of Sections 3, 4, 6 and 8 of the Human Rights Act. This can be done in the following way. First, the challenge should be directed against the placement of that specific drug in Schedule 1. While the Misuse of Drugs Act does direct the Secretary of State to provide regulations for medical use, it is silent on which drugs should be allowed and which should not. Thus, it could not be argued that the public authority (i.e. the Secretary of State) was necessitated to regulate how they have because the regulatory act being challenged (the placement of a drug in Schedule 1) was not specifically directed by the Act. Thus Section 6 applies. Indeed, it is confirmed by, among other cases, \textit{Javed} that the content of secondary legislation is judicially reviewable even where it undergoes the affirmative procedure.\textsuperscript{321} Thus the Secretary of State (i.e. the public authority), rather than Parliament, is responsible for the regulation’s content. If the placement of a certain drug within Schedule 1 is found to breach human rights, it would likely be viewed as \textit{ultra vires} on the basis that the Misuse of Drugs Act, implicitly, does not empower the Secretary of State to create regulations contrary to human rights. If this is not the case, and this analysis is wrong, our hypothetical human rights challenge against the prohibition of a medically useful drug should seek, as an alternative, a declaration of the incompatibility under Section 4. Given this, and unlike in \textit{Quayle}, there would be a legal basis for a proportionality enquiry and eventual finding of a breach.

\hyperlink{320}{\textsuperscript{320}} \textit{Ibid} [68]

\hyperlink{321}{\textsuperscript{321}} \textit{R (on the application of Javed and others) v Secretary of State for the Home Department and Another} [2001] EWCA Civ 789, [2002] Q.B. 129, 155.
Part three – Case study: Medical cannabis

Part three is a case study of medical cannabis. The issue of whether the prohibition of cannabis for medical purposes is a human rights abuse is chosen as cannabis is the Schedule 1 drug which has been legalised for medical purposes in the most jurisdictions and this legalisation has attracted a large degree of study and attention, on which this case study will draw. These developments make the choice of medical cannabis for a case study ideal because substantial evidence has therefore been generated on its medical utility, and the effects of its legal availability on various indicators of public harm.

‘Medical cannabis’ is used here to describe both raw cannabis used for medical purposes and cannabis based medical products, such as oils, oral tablets, sprays and tinctures. When referring to the legalisation of medical cannabis in this chapter I am referring to moving this variety of cannabis based medicine, out of Schedule 1 of the Misuse of Drugs Regulations. Currently, some medical products containing cannabidiol (CBD) are medically available as CBD is not in Schedule 1. Whereas as those containing Tetrahydrocannabinol (TCH) or other cannabinoids are, with a very small number of limited exceptions, not available as they are. THC is associated with both the ‘high’ of cannabis and many of its medicinal and negative effects.\textsuperscript{322} CBD is associated with some of the medicinal effects but with neither the high or the negative effects and appears to be somewhat protective of those negative effects.\textsuperscript{323}

Upon completing this research and writing up this case study the government announced measures for and a review into its approach to medical cannabis. These policy options are still emerging, and a full account of the recent reforms will be given in Chapter nine on the procedure of


\textsuperscript{323} Vast amounts have been written on this issue for an overview see McLaren (n 522) 1100; Raymond J M Niesink and Margriet W van Laar, ‘Does cannabidiol protect against adverse psychological effects of THC’ (2013) 4 Front Psychiatry 130.
rescheduling drugs. This case study provides, then, an alternative argument for reform than those used in the debate so far, providing a specifically legal, human rights argument for why the approach prior to reform was unsustainable under the Human Rights Act and why movement of cannabis out of Schedule 1 is a legal requirement.

Chapter six establishes why it should be considered a human rights infringement in need of an Article 8(2) justification to prohibit the medical use of illegal drugs. This is established through reference to analogous case law both in the UK, Canada and under the Convention.

Chapter seven lays out the detail of the empirical research into the effects of medical cannabis legalisation on prevalence of cannabis, diversion of medical cannabis into illicit markets, the potency of cannabis, the ways cannabis is taken, and the use of other substances such as opioids, alcohol and other drugs. In Chapter eight I address the legal arguments of the case of prohibition of medical cannabis. Here, the justification for the prohibition of medical cannabis – that it protects health – is tested against the four stages of the proportionality test outlined in Chapter three.

Following this case study is analysis, in Chapter nine, of procedural arguments against the legalisation of medical cannabis (and other Schedule 1 drugs). These arguments are not built into a fully-fledged proportionality analysis, because, as will be shown, it is not clear what the argument or procedure being relied on is.

In examining the legal case against medical cannabis prohibition, empirical evidence will be drawn upon from different jurisdictions which have legalised medical cannabis. It is necessary, therefore, to explain the different models of legalisation which have occurred in different countries. While many different countries have legalised medical cannabis, this section analyses the four separate approaches that appear in the empirical literature namely Israel, the Netherlands, the US and Canada.\(^{324}\)

\(^{324}\) Details on Israel's provisions are briefer than the others as many of its regulations are not translated into English.
Different examples of legalisation

In Israel, the provision of medical cannabis is regulated by the Dangerous Drugs Ordinance 1973 in conjunction with the 2014 Procedure 106. This allows for cannabis, which is otherwise criminalised, to be used for some specified indications (cancer, pain, HIV). Medical cannabis provision is controlled by the Medical Cannabis Unit, a government body. This body works under the principle that medical cannabis should be treated, as much as possible, like any other medication, with the requisite safeguards that would be expected of a dangerous, narcotic medication. Thus, cannabis is a prescription only medication available at pharmacies which may only be prescribed once all other recognised treatments have been employed. Further, in order to be prescribed cannabis, one must hold a permit which is granted by the Medical Cannabis Unit on the recommendation of a specialist physician. The decision of the Medical Cannabis Unit may be appealed. Permits will have a specified dose and any change in dose requires a reapplication to the Medical Cannabis Unit. Thus, Israel provides for the strictest regulations of the four countries, with two gatekeepers to the system – specialist doctor and a government body – as well as limits on the amount that can be prescribed and the conditions for which prescriptions can be made.

The approach to medical legalisation in the Netherlands most closely resembles a standard prescription model for prescription only medications. Since 2003, cannabis has been available, on prescription, from pharmacies. The growing and production of cannabis is tightly controlled to make sure that quality is consistent. There are only five varieties of medical cannabis produced in the Netherlands, three of which are available in pharmacies. Each variety has specified levels of TCH and

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325 Jacob Ablin et al, ‘Medical use of cannabis products: Lessons to be learned from Israel and Canada’ (2016) 30(1) Der Schmerz 3, 4.
326 State of Israel Ministry of Health, ‘Medical Cannabis Unit’ (Ministry of Health) <https://www.health.gov.il/English/MinistryUnits/HealthDivision/cannabis/Pages/default.aspx> accessed 29/03/18.
327 Ablin (n 325) 4.
328 Ibid.
CBD which has allowed the Government to release guidance for doctors and patients on which cannabis strains are most suitable for certain afflictions:330

- Bedrocan (19% THC; <1% CBD)
- Bedrobinol (12% THC; <1% CBD)
- Bediol (6% THC; 7.5% CBD)

For example, they advise that because evidence suggests that higher levels of CBD is useful for treating pain and spasm from MS and inflammatory conditions, for such conditions patients will be prescribed Bediol. Those with “Tourette syndrome, therapy-resistant glaucoma and symptoms like weight loss, nausea and vomiting”, however, require higher THC so will be put on to Bedrocan and Bedrobinol. Significantly, those with chronic neural pain conditions are often started on the low THC, high CBD Bediol and then a higher THC option is substituted if this did not work.331

The guidance also suggests a variety of non-smoking administration methods (vaporisation and tea, primarily), smoking the cannabis is strongly discouraged.332 The variety and method of administration will be decided by the doctor in consultation with the patient. There is detailed information about type of cannabis, dose, how to use and how to approach (with consultation from a doctor) increasing the dose if necessary.333

The Netherlands government guidance does provide a list of conditions for which cannabis is recommended including, primarily, the conditions already mentioned. This list, however, is not exhaustive and doctors can prescribe for other conditions if they consider that to be the best treatment option. Significantly, in all cases the doctor may only prescribe cannabis if standard medications are not working or the side-effects are too severe.334 In this regard cannabis is a medicine

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331 Ibid.
332 Ibid 6.
334 Ibid 5.
of last resort in the Netherlands.

In the initial years after legalisation, around 6 per 100,000 new patients were prescribed cannabis each year, though this number halved in the subsequent years. The number of people receiving a medical cannabis prescription in any given year ranged from 5-8 per 100,000.\textsuperscript{335}

While a much more detailed treatment will be given to the US below, it is necessary to introduce some basic features of the American model(s). Some states have legalised medical cannabis and some have not and amongst those that have, different policy options have been chosen and different policies have been taken at the federal level. The key starting point is that cannabis is still and has consistently been since 1970 a Schedule 1 drug in the US. This, in simple terms, is a combination of Class A and Schedule 1 in the UK; severest penalties are attached to it and it is not recognised as having a medical value and is therefore illegal.\textsuperscript{336} However, given the federal structure of the US, many – 30 plus Washington DC at time of writing – have taken an opposing position and legalised cannabis for medical use.\textsuperscript{337} Thus there exists a conflict between state and federal law which has manifested itself in a number of ways. First, as cannabis is a Schedule 1 drug, doctors are not able to formally ‘prescribe’ cannabis in the normal sense, which is one reason for the emersion of dispensaries and other distribution mechanisms, to which we will return later.\textsuperscript{338}

Second, the federal enforcement of cannabis prohibition in states which have legalised has been variable. Prior to 2009 the federal authorities would still raid and prosecute suppliers and users of cannabis, even if it was for medical purposes and in accordance with state law.\textsuperscript{339} There were even

\begin{itemize}
\item \textsuperscript{335} Ibid.
\item \textsuperscript{336} Controlled Substances Act 1970.
\end{itemize}
threats to take administrative action against state officials who were involved in cannabis provision as well as doctors who recommended it. This latter point was repudiated by the Supreme Court on free speech grounds. In 2009, the Ogden memo, delivered by the then Deputy Attorney General, was published, in which it was stated the federal government will not focus prosecution resources on pursuing those medical users or their caregivers who are engaging in compliance with the law of the state in which they reside, signalling a significant reduction in the risk of prosecution. This position was seemingly tempered, or at least clarified, by the Cole memo, delivered by Ogden’s successor. This stated that the Ogden memo was never supposed to shield large scale commercial cannabis ventures from federal prosecution and that those who cultivated, sold and distributed cannabis for medical purposes in medical cannabis states, were still liable for prosecution. This position was further clarified in the second Cole Memo in 2013. Here, the Deputy Attorney General suggested that while large commercial ventures in medical cannabis may still be targeted, the need to target them will be alleviated if the state provides for a sufficiently well controlled regulatory system. Thus we see, over time, the medical cannabis states being treated differently by the federal government, with different levels of certainty as to the security of medical cannabis operations. The effects of these memos will be returned to later.

Aside from differential federal enforcement overtime, there are also different models of regulations between states. The modern spate of medical legalisation began in 1996 when, through referendum, California decided that patients with doctor recommendation and their ‘caregivers’ may

legally cultivate and possess cannabis for medical purposes.\textsuperscript{345} As would later be seen, the protection of caregivers lead to the emergence of dispensaries, in some cases out of previously existing Cannabis Buyer’s Clubs which were largely used by those suffering from HIV/AIDS.\textsuperscript{346} Here, those that ran such enterprises would designate themselves caregivers to all those that purchased cannabis from them. Although this model initially attracted a negative ruling from the Californian Supreme Court, which ruled that such dispensaries were not protected by the law, several municipalities began to regulate for dispensaries. This led to a locally regulated model in California where the protection of dispensaries was largely down to municipal regulations.\textsuperscript{347} This was clarified somewhat by 2003 when Senate Bill 420 allowed for patients and caregivers to collectively and cooperatively cultivate cannabis.\textsuperscript{348} However, as stated, even prior to this, individual municipalities were drawing up regulations for dispensaries.\textsuperscript{349}

Over the 20 years following the liberalisation of medical cannabis in California, 29 other states and Washington DC followed. Some states, in particular those which legalised soon after California, such as Oregon and Washington, adopted a similarly deregulated approach, just legalising possession and cultivation for patients and their caregivers and therefore allowing patient collectives to emerge de facto.\textsuperscript{350} Following this, however, a more regulated approach took hold, often specifically legislating for dispensaries and not allowing home cultivation or caregivers.\textsuperscript{351} Almost all states which have legalised require patients to register in order to be afforded protection and/or engage with the dispensaries.\textsuperscript{352}

\textsuperscript{345} Proposition 215 Compassionate Use Act 1996 (11362.5 H&S).
\textsuperscript{347} Ibid 342.
\textsuperscript{348} An act to add Article 2.5 (commencing with Section 11362.7) to Chapter six of Division 10 of the Health and Safety Code 2003 SB 420.
\textsuperscript{349} Reiman (n 346) 342-343
\textsuperscript{350} Ibid 347; Smart (n 338) 83
\textsuperscript{351} Reiman (ibid).
What can be seen, therefore, is a system which contains many different iterations of medical
legalisation which varies on a number of points; whether dispensaries are formally legalised and
regulated, whether home cultivation is allowed and whether caregivers are allowed to provide for
patients and if so whether there is a limit on the that number of patients.

These, and other, differences in the models, state-by-state, have created vastly different levels
of registration. According to ProCon, who have aggregated all the data on registration, the average
registration rate is 806 per 100,000. With a wide range from 10-1980 per 100,000.353

Canada initially began the legalisation of medical cannabis at the behest of the courts who, in Parker,
rulled that denying access to medical cannabis was a human rights abuse.354 Following this Canada
created the Medical Marihuana Access Regulations 2001 which legally protected those who gained
authorisation for cannabis use from the state. Such authorisation was based, in part, on doctor
recommendation and allowed the patient to grow cannabis themselves, acquire it from the state or
from designated growers.355 This system attracted low number of participants in its early years. For
example, in 2004 there were a total of 747 authorised users. This number was kept low partly due to
the application procedures which in January – September 2004 granted just 47 of the 299 applications
for medical cannabis access.356 This number steadily increased to the still fairly low level, by American
rather than Dutch standards, of around 1400 successful applications by 2007.357 In spite of this,
however, the Courts in Canada still considered, again on human rights grounds, there to be insufficient
levels of access to cannabis for patients that needed it, leading to a change in approach by the
Canadian government.358

353 ProCon, ‘Number of Legal Medical Marijuana Patients’ (ProCon.org 3 March 2016)
354 R v Parker [2000] CanLII 5762 (ON CA) <http://canlii.ca/t/1fb95> accessed 2016-02-01 para [35]
355 Benedikt Fischer, Sharan Kuganesan and Robin Room, ‘Medical Marijuana programs: Implications for
356 Philippe Lucas, ‘Moral regulation and the presumption of guilt in Health Canada’s medical cannabis policy
357 Lynne Belle-isle & Andrew Hathaway, ‘Barriers to access to medical cannabis for Canadians living with
This led to the Marihuana for Medical Purposes Regulations 2013 which changed the authorisation system through central government with a model closer to the doctor’s recommendation model of America. Here a patient must get authorisation from a doctor who is prepared to say that they have a medical symptom (there is no prescriptive list) which would benefit from medical cannabis.\textsuperscript{359} The doctor may also set the amount the patient may use each day and the length of time for which the patient is authorised to use.\textsuperscript{360} Furthermore, the government then licenced growers and sellers of cannabis, and regulated prices. This created a regulated, commercial market in medical cannabis.\textsuperscript{361} This market runs alongside a system of largely unsanctioned dispensary/collective operations that have proliferated.\textsuperscript{362} These regulations were recently further updated into the Access to Cannabis for Medical Purposes Regulations 2016.\textsuperscript{363} The 2016 regulations bring back the ability of people to apply to be licenced growers of cannabis either for themselves or for someone who has designated them their producer while keeping the commercial element of the 2013 regulations.\textsuperscript{364}

This new system, post 2013, had seen a sharp increase in the numbers of people being authorised to use medical cannabis, with the number at the end of January-March 2018 quarter being 296,702 or roughly 818 per 100,000. This number appears to be rapidly increasing as the previous three quarters were 201,398 (April-June 2017), 235,621 (July-September 2017), 269,502 (October-December 2017).\textsuperscript{365}

\textsuperscript{359} Fischer et al (n 355) 16
\textsuperscript{360} Access to Cannabis for Medical Purposes Regulations (SOR/2016-230) Section 8(1) (ACMPR) while this is reference for the 2016 regulations the government clarified that this part was unchanged from the 2013 regulations, see Health Canada, ‘Understanding the New Access to Cannabis for Medical Purposes Regulations’ (August 2016, Government of Canada) <https://www.canada.ca/en/health-canada/services/publications/drugs-health-products/understanding-new-access-to-cannabis-for-medical-purposes-regulations.html> Accessed 30/07/17.
\textsuperscript{361} Ibid.
\textsuperscript{362} Ibid.
\textsuperscript{363} Ibid.
\textsuperscript{364} Ibid Part two.
Given the high numbers of authorised users, commercial involvement and relative ease of access, both in terms of getting ‘prescribed’ as needing cannabis and purchasing it from dispensaries and licenced sellers, Canada has arguably adopted a commercialisation model of medical cannabis like that seen in Colorado and California in the US. Indeed, even though in both the Canadian and commercialised US systems the doctor is the gatekeeper, systems in these countries are qualitatively different from the Dutch prescription model for at least three reasons. First, the Dutch system has only five strains of cannabis which are allowed for medical use, only three of which are available at pharmacies, whereas the Canadian system has allowed for significantly more strains (354) and therefore involved a much larger number of commercial entities (36). There is no unified record of the number of strains available in the US, to my knowledge, but given the piecemeal and lax style of regulation it is fair to assume there are many. Second, cannabis, in the Canadian and commercialised US systems is not a drug of last resort and there is no significant control over the strain of cannabis that is taken. Conversely, the Dutch system, by trying the patient initially on less potent, safer strains before moving them on to stronger forms, has made a more serious attempt to bring cannabis into the traditional prescription model. Third, both the US and Canadian models have allowed for the proliferation of for-profit cannabis recommendation services from specialist practices.

In this regards there is something of a division between medicalised, strict regulations seen in Israel, the Netherlands and some US states and commercialised regulations, or lack thereof, seen in Canada and US states such as California. This distinction is one to which we will return in Chapter seven.

Accessed 30/07/17.
Chapter six: Establishing the human rights claim

Both internationally and in the UK, human rights claims have been made against the prohibition of medically useful drugs. In this chapter I describe the legal basis for these claims, examining how and why certain elements of drug prohibition infringe human rights. This chapter will examine whether certain elements of drug laws infringe Article 8(1) on the Convention and therefore require proportional justification under Article 8(2).

The argument can be structured in the following way: A person has a medical condition, respite from which can be achieved through use of a currently illegal drug. The illegal status of the drug forces the sufferer to choose between breaking the law and treating their condition; forcing such a choice is an infringement of human rights.

Such an argument has been attempted in the UK based on both Article 3 and Article 8. Article 3 arguments were made in Altham. Here the claimant had been involved in a car accident resulting in a hip replacement which left him with constant chronic pain in his lower body. It was his contention that the level of his suffering amounted to degrading treatment and that this suffering was the responsibility of the state as by not allowing the defence of necessity to be used in cases of medical usage of illegal drugs, the UK was forcing sufferers to choose between enduring extreme pain and being guilty of an offence punishable by prison. This argument was unsuccessful. In order to engage Article 3, it was found, the state would need to be responsible, in some way, for inflicting the suffering or subjecting the claimant to the ill-treatment. This was not the case in this instance. In view of the fact that the state had no hand the accident the court ruled that to apply the unqualified right of Article 3 in this case would be an over-extension. Further the truth of the notion that he had no other choice than to take cannabis was doubted, by highlighting that the claimant is now using another drug.

368 R v Altham (n300) [10].
369 Ibid [26]; see also Lord Brown in R (Limbuela) v Secretary of State for the Home Department [2006] 1 AC 396 [92]: “The real issue in all these cases is whether the state is properly to be regarded as responsible for the harm inflicted".

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ketamine, which has been legally prescribed to him.\(^\text{370}\)

The attempted, and somewhat hopeful, use of Article 3 in \textit{Altham} was likely due to the fact that the claimant considered Article 8 avenues closed after the \textit{Quayle} case.\(^\text{371}\) For reasons explained in Chapter five, this view is not correct and Article 8 can and should be applied to the prohibition on the use of medical cannabis:

The Convention has long accepted that ‘private life’ in Article 8 includes the protection of physical and psychological integrity as well as personal autonomy.\(^\text{372}\) Deciding to use drugs for medical purposes is undoubtedly an autonomous decision which, when access to those drugs is the only, or best, option for treatment, relates to a person’s physical and psychological integrity. Thus, acceptance of these principles under ‘private life’ will be a necessary foundation on which to build a challenge. In that connection the House of Lords, in \textit{Pretty}, accepted protection of physical and psychological integrity and personal autonomy as elements of ‘private life’ under the Human Rights Act.\(^\text{373}\)

Application of these principles to the restriction of medically useful drugs can be seen in the Strasbourg case \textit{Hristozov v Bulgaria}. Here all ten applicants had cancer and had either exhausted all conventional treatments or been told that they would not work.\(^\text{374}\) They all approached a private medical facility believing it to have an experimental cancer drug which could potentially be of use in treating their condition. This drug had yet to be authorised by Bulgaria and Bulgarian authorities stated that it was not possible to allow the use of a drug which had not begun clinical trials or been authorised. They also ruled out allowing its use on compassionate grounds.\(^\text{375}\) The applicants argued that the manner in which people chose to live, even if that had harmful consequences was an element of ‘private life’ under the meaning of Article 8.\(^\text{376}\) The court agreed, arguing that the ‘limitation on the

\(^{370}\) Altham (Ibid) [26].
\(^{371}\) Ibid [9].
\(^{372}\) \textit{X and Y} (n 9) [61].
\(^{373}\) \textit{Pretty} (n 9) [23].
\(^{374}\) \textit{Hristozov and others v Bulgaria Application Nos.47039/11 and 358/12 (4th section 13 November 2012).}
\(^{375}\) Ibid [7]-[14].
\(^{376}\) Ibid [104].
applicants capacity to choose, in consultation with their doctors, the way in which they should be medically treated with a view to possibly prolonging their lives’ was clearly an Article 8 issue, thus it created an infringement in need of justification. It was found that notions of personal autonomy and quality of life underpin the notion of private life.\textsuperscript{377} Strasbourg ultimately found that no violation had occurred as the balance struck by the authorities between the harm to the individual and the benefit to society was within its very wide margin of appreciation.\textsuperscript{378} This latter point is of no relevance to this chapter however; the purpose of this example is to demonstrate that restricting the access to a medicinally useful drug should be properly understood as engaging Article 8(1) of the Convention.

The UK courts have not dealt with a human rights case like\textit{ Hristozov} so the precise approach to this question is not known. The issue of access to experimental medical treatment was addressed in\textit{ Simms}, involving parent’s attempts to access experimental treatment for two children. However, and the only reference made to Article 8 rights was in relation to the family rights of the patients.\textsuperscript{379} Thus there is no specific indication, in the UK, of whether restricting access to treatment should be considered a breach of the Article 8 right to private life. It has been made clear by the court that certain specific failures to fund treatments, such as gender reassignment treatment, do not engage Article 8.\textsuperscript{380} This however is a separate issue from the question at hand as it concerns the potential for positive obligations to fund certain treatment rather than the negative obligations not to punish or regulate specific treatments.

Given the lack of UK jurisprudence on the specific question of the application of Article 8 to cases where medically useful drugs, such as cannabis, have been criminalised it is instructive to assess a thorough examination of the issue by the Canadian courts.\textit{ Parker} concerned a man suffering from severe and potentially life-threatening epilepsy. He discovered that taking cannabis significantly

\textsuperscript{377} Ibid [116].
\textsuperscript{378} Ibid [118]-[127], as has been repeated on numerous occasions by the supreme court, the notion of Margin of Appreciation does not apply in domestic human rights litigation.
\textsuperscript{379}\textit{Simms v Simms} [2002] EWHC 2734 (Fam); [2003] Fam 83.
\textsuperscript{380}\textit{AC v Berkshire West Primary Care Trust} [2010] EWHC 1162 (Admin); [2010] Eq LR 49 [37].
reduced his instances of seizures. Cannabis had a significantly positive impact on his condition and there was no alternative to him taking it.\textsuperscript{381} The authorities however, discovered his growing and consuming of cannabis and charged him on crimes of possession and cultivation. He appealed to the Ontario Court of Appeal arguing that this action fundamentally breached rights provided in the Canadian Charter of fundamental rights.\textsuperscript{382}

There are some relevant differences between the human rights principles applied in this case and the ones that would potentially be applied under Article 8. First it should be noted that Canada does not have a ‘private life’ provision that could be viewed as analogous to Article 8. As a result, \textit{Parker} was decided upon the basis of Section 7 of the Canadian Charter, which reads:

\begin{quote}
Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.\textsuperscript{383}
\end{quote}

This provision is most similarly drafted to Article 5(1) of the Convention, the only difference being the inclusion of ‘life’ and limitation being justified on the basis for ‘fundamental justice’ rather than an exhaustive list of exceptions. The reason that \textit{Parker} is relevant to the current discussion, however, is that the principles that give rise to inclusion of the medical use of illegal drugs under Article 8, namely, personal autonomy and protection from interference with physical and psychological integrity, are included under Section 7 of the Canadian Charter.\textsuperscript{384} The question as to why these principles are included under Section 7 of the Canadian charter but fall under Article 8 rather than Article 5 of the Convention are no doubt very interesting, but ultimately of no relevance to this thesis. It is sufficient to understand that while the wording of the original provision is different the key principles being applied are the same.

The court ultimately found in favour of Parker. It reached this conclusion on two relevant

\begin{footnotes}
\item[381] \textit{Parker} (n 354) [35]
\item[382] Ibid.
\item[383] Constitution Act (n 239) s. 7.
\item[384] \textit{Parker} (n 354) [77].
\end{footnotes}
considerations. First, the view was taken that a person has the right to make decisions of fundamental personal importance, the right to choose the medication with which one attempts to alleviate a serious, or life-threatening condition is, undoubtedly, one such decision. Analogous principles can be found in Hristozov. Indeed, UK courts have found that Article 8 protects against undue ‘interference with the way in which an individual leads his life’. For this right to be at all meaningful it must be engaged when the state removes from an individual the choice over the way in which they will treat a medical ailment. Particularly if their choice of treatment is medically viable and even more so when it is the best, or only, treatment available.

Secondly, the court in Parker viewed there to be a right to psychological and physical integrity. This right was engaged if and when the state, particularly through criminal sanctions, restricts access to a ‘medical treatment for a condition representing a danger to life or health’. Actions by the state which removed a person’s control over such integrity were viewed as also injurious to autonomy. As well as the aforementioned protection of physical and psychological integrity, Article 8 has been considered to be underpinned by notions of quality of life. The state, in restricting, under threat of criminal sanction, access to medically useful drugs for ill people is acting against notions of physical integrity and quality of life. The demand, put in its simplest form, made of sufferers is to remain sick or risk going to prison. Given this, in certain circumstances the blanket prohibition of medically useful drugs should engage Article 8(1) in the sense of providing for an infringement that must be justified under Article 8(2).

The case of Quayle is the most prominent case in the UK to deal with the issue of medical uses of illegal drugs. As explored more fully in Chapter five, however, the Quayle case did not specifically address the compatibility of criminalising medical use of cannabis, rather it noted, that such a ruling would require a proportionality examination but given the confines of the case, it was not able to

385 Ibid [92].
386 Pretty (n 9) [61].
387 Parker (n 354) [93].
388 Ibid [96].
389 Hristozov (n 374) [116]; Pretty (n 9) [65].
deliver one. Given this it is difficult to pronounce on what the UK courts’ position is in relation to whether criminalising the medical use of cannabis engages Article 8. That the judge reflected on the need for a proportionality analysis to resolve the question implies that he considered the first hurdle, that the legislation infringes Article 8, already passed. There is no need for a proportionality test if there is no infringement with the right in question.

The only other hurdle to jump for an infringement to be established is the evidential demonstration that medical cannabis actually works; if medical cannabis is not effective in treating ailments, its prohibition cannot be a human rights abuse. I will not dwell upon this point, however, as, from a legal point of view the government and courts have already accepted that there are some scenarios in which cannabis is not only useful, but preferable in the treatment of particular, and some serious, conditions. Further, this material is considered in more detail later in the thesis:

The most recent of review of the evidence is the 2017 joint review by the US National Academies of Science, Engineering and Medicine. Using their previous 1982 and 1999 reviews as a starting point they searched for good quality, post 1999, systematic reviews to cover 11 features of cannabis and health. They then searched for all the primary research on each of the 11 points after the most recent systematic review. If there was no systematic review, they used all primary research after 1999.390 The review found there to be “conclusive” evidence that cannabinoids are effective in the treatment of nausea and vomiting associated with chemotherapy, and “substantial” evidence that cannabis is medically useful in treating chronic pain, and that cannabinoids are effective treatment for spasticity in patients with MS. Further there is “limited” evidence of usefulness in treating Tourette’s, dementia, glaucoma and wasting associated with HIV. For the other of the 11 health conditions there was insufficient evidence to make a judgement either way.391

391 Ibid 85.
Thus, while the effects of cannabis were often modest,\textsuperscript{392} there is good medical evidence that it is useful for the treatment of some afflictions which broadly coheres with the compelling, yet anecdotal, submissions in \textit{Quayle}.\textsuperscript{393}
Chapter seven: The Evidence

Most of the questions that arise from the proportionality analysis to be conducted in Chapter eight are empirical in nature. Given this, it is essential to explore the empirical evidence base for these questions. What follows in this chapter, therefore, is an analysis of the empirical evidence broken into four distinct consequences of medical cannabis legalisation; changes in prevalence, diversion of medical cannabis, changes in the forms of cannabis, and cannabis substitution. The first of these – prevalence – has received the most academic attention and is split into three distinct categories. First are studies which test the effect on prevalence of legalising medical cannabis. The second test the effect of different specific policies which fall under the banner of ‘legalisation’ for example the impact of allowing dispensaries or of allowing home growing. The third collection of studies test broader categories of regulatory models against each other, for example medical vs nonmedical forms of legalisation. These three stages represent something of an evolution in the way medical cannabis policy is studied and it will be argued that the latter category is the most beneficial way in which to test the question.

Prevalence – legalisation

The question of prevalence has attracted substantial empirical study, the majority of which has occurred in the US. In principle, the US provides a useful context in which to empirically test this question as there are several good and consistent datasets on drug use and states have legalised at different times and some not at all. This allows for comparison between medical cannabis states and non-medical cannabis states, between different forms of medical cannabis regulation and, most importantly, difference-in-differences analyses of the change pre and post-medical legalisation compared to the change in non-medical cannabis states. On the other hand, the heterogeneity of approaches between states has caused difficulty in interpreting the data. While this will be fully drawn out later, currently we explore the attempts to understand the impact of medical cannabis by

comparing states which have legalised with those that have not. In this chapter and the remaining thesis ‘legalised’ is used, for brevity sake, as shorthand of the legalisation of medical cannabis, rather than its usual more general use, meaning legalisation of the recreational market. If I am referring to recreational legalisation I will do so explicitly.

One crucial caveat must be attached to the research on prevalence; the survey datasets, such as the National Survey of Drug Use and Health (NSDUH) that are often used to quantify prevalence in the US do not distinguish between cannabis use by patients and non-patients. Thus, unless every prospective medical cannabis user was a current cannabis user at the time of legalisation, you would expect some level of increase in use to be seen, just as a new medical drug coming on to the market would see an increase in use when it enters circulation. Thus, it cannot be assumed that all increases in prevalence of cannabis use are entirely nonmedical, recreation, illegal or illicit. Equally, however, it cannot be assumed that all medical cannabis users were not cannabis users prior to their initiation of medical cannabis. More research is needed to disaggregate recreational and medical use of cannabis.

Initially, it is important to acknowledge that the prevalence of cannabis use is higher in US states which have legalised cannabis. Wall et al, for example, found that for the period of 2002–2008 the 16 states which had legalised medical cannabis by 2011 had higher average adolescent use (8.68%) when compared to the 34 states which had not (6.94%).395 This chimes with the research of Martins et al, which found that, for all age groups, including adolescents, the prevalence of cannabis was greater both in states which had legalised medical cannabis and in those that would go on to when compared to those which had not and would not.396

In theorising a causal link between the legalisation of medical cannabis, two main mechanisms

have been proposed. First, diversion of medical cannabis into the recreational stock could increase availability and/or decrease the price.\textsuperscript{397} Second, the proliferation of medical cannabis may increase the acceptability of it, leading to fewer people viewing cannabis as a dangerous substance.\textsuperscript{398} There are therefore higher rates of cannabis use in medical cannabis states and plausible ways in which legalisation may lead to increase used. What follows are attempts to empirically demonstrate this link.

The studies attempting to establish causation are broadly broken into those which address adolescents, adults and adolescents, and just adults. Negative results on the link between medical legalisation and increased \textit{adolescent} use have been consistent, across different datasets and methodologies.\textsuperscript{399}

Lynne-Landsman, Livingston and Wagener, for example, used the Youth Risk Behaviour Survey (YRBS) and analysed data from four states, Montana (MT), Rhode Island (RI), Michigan (MI), and Delaware (DE). The study sought to test whether legalisation of medical cannabis influenced either past 30 day or lifetime usage of cannabis.\textsuperscript{400} These states would all eventually go on to legalise medical cannabis but did so at different times (MT in 2004, RI in 2006, MI in 2008 and DE in 2011). The study

\begin{itemize}
\item On diversion see subsection below; on decreased price see Mark Anderson, Benjamin Hansen and Daniel Rees, ‘Medical Marijuana Laws, Traffic Fatalities, and Alcohol Consumption’ (2013) 56 \textit{The Journal of Law & Economics} 333, 340-1.
\item Martins et al (n 396) 28-29.
\item Sarah D Lynne-Landsman, Melvin D Livingston and Alexander C Wagenaar, ‘Effects of State Medical Marijuana Laws on Adolescent Marijuana Use’ (2013) 103(8) \textit{American Journal of Public Health} 1500, 1502.
\end{itemize}
period was from 2003 to 2009 split into six varying and overlapping time periods; 2003-2005, 2005-2007, 2007-2009, 2003-2007, 2005-2009 and 2003-2009. In each of these time periods those states which legalised medical cannabis within the period were compared to those which had not yet legalised.\textsuperscript{401} Thus there were ten comparison groups tested on two factors (past 30 day use and lifetime use) leading to 20 comparisons in total. For each, a difference in differences analysis was conducted. Of all 20 comparisons, only one showed a statistically significant result; medical legalisation was associated with higher lifetime cannabis use in Montana when compared to Delaware in the 2003-2009 period. However, as there were 20 test comparisons one positive results would be expected from chance alone.\textsuperscript{402} They also studied for intensity of cannabis use among a restricted sample of just the cannabis users, again using the same ten comparisons and again based on two questions; yes/no to daily cannabis use and yes/no to weekly cannabis use. Again, of the 20 comparisons only one produced a statistically significant result; for the period of 2003-2009 Montana (the medical cannabis state) showed a decrease in daily cannabis use when compared to Delaware (the non-medical cannabis state).\textsuperscript{403} Thus there was no demonstration of a statistically significant relationship between the legalisation of medical cannabis and adolescent prevalence.

Choo et al also used the YRBS data, but in a different way. Rather than making multiple comparisons between the same four states, they paired ten geographically similar legalised and non-legalised states together. A difference in differences analysis was conducted between the comparison pairs with the primary measure of any cannabis use in the last 30 days (yes/no).\textsuperscript{404} Subpopulation analyses were conducted; comparing individual grades (9\textsuperscript{th}, 10\textsuperscript{th}, 11\textsuperscript{th} and 12\textsuperscript{th}) thus created five comparisons in each pair (state overall + each of the grades). In addition, a comparison of all the legalised states against all the non-legalised states, again both overall and by grade, provided for a total of 30 comparisons. They found that in no instance was the legalisation of medical cannabis

\textsuperscript{401} Ibid 1502-3.
\textsuperscript{402} Ibid 1504.
\textsuperscript{403} Ibid 1503-1504.
associated with an increased probability of cannabis use. In two pairs there was, however, a decrease in the probability of cannabis use after legalisation of medical cannabis; Utah-Nevada and Idaho-Montana. The sub analyses by grade further find that in Utah-Nevada, the effect can primarily be seen in grades ten and 12 and that grade nine in the New York – Vermont comparison showed a decrease, even though no such decrease was seen overall in that pair. No effect was showed in the combined, all-states comparison.\textsuperscript{405} To the extent that this study reveals anything at all (again there are a low number of positive results in a total of 30 comparisons) it shows a decrease in adolescent prevalence after medical legalisation.

Hasin et al used the Monitoring the Future (MTF) dataset of adolescents (8\textsuperscript{th}, 10\textsuperscript{th} and 12\textsuperscript{th} graders) in 48 contiguous states and Washington DC from 1991-2014. They combined the medical cannabis states and tested ‘whether the risk of marijuana use changed after a medical marijuana law was passed compared with the risk before the law passed, controlling for the contemporaneous risk of use overall in other states.’\textsuperscript{406} They found that the risk of adolescent cannabis use, aggregating across all grades, did not change after the legalisation of medical cannabis. Among 8\textsuperscript{th} graders, however, the risk of cannabis use decreased, to a statistically significant degree, after legalisation.\textsuperscript{407} No significant change was found in 10\textsuperscript{th} and 12\textsuperscript{th} graders. This result held when testing for both past 30 day and past year use. Similarly, ‘[r]ecoding the year of passage to model delayed effects did not change the findings’.\textsuperscript{408}

In Keyes et al the same team of researchers followed up on the findings from Hasin et al. Again, using the MTF dataset, Keyes et al tested whether there was an increase in cannabis prevalence associated with medical cannabis legalisation, but also how this effect, if any, is mediated by changes in attitudes towards cannabis harm. Perceived harmfulness increased post-legalisation to a

\textsuperscript{405} Ibid 162.
\textsuperscript{406} Hasin (n 396) 604.
\textsuperscript{407} Ibid 605.
\textsuperscript{408} Ibid 606.
statistically significant degree amongst 8th graders, but not amongst 10th and 12th graders.\textsuperscript{409} Although there was a countrywide decrease in adolescent perception of cannabis harm, due to this increase in 8th grader perceived harmfulness, legalised states had ‘a lower overall decrease in perceived harmfulness than adolescents in states without [medical cannabis legalisation]’.\textsuperscript{410} Furthermore, while a decrease in use was seen in both groups post legalisation, among 8th graders the decrease in cannabis use was, to a statistically significant degree, greater among those that did perceive cannabis to be harmful versus those that did not.\textsuperscript{411} These results provide evidence for the link between perceived harmfulness and use. However, the consequence, in the case of 8th graders, appears to have gone in the opposite direction than to that which was predicted. This is to say that medical legalisation is associated with an increased perceived harmfulness and therefore a decrease in use.

Johnson, Hodgkin and Harris analyse the YRBS data from 1991-2011, testing for past 30 day use of cannabis and past 30 day heavy cannabis use.\textsuperscript{412} Only 11 states had data for pre and post legalisation within the study period, so these were analysed with all other states (both those without legalisation and those which legalised after the study period) used as controls. They found small but significant decreased odds of any cannabis use associated with medical cannabis legalisation and no significant effect on heavy cannabis use.\textsuperscript{413}

One study has found an association between the legalisation of medical cannabis and increased adolescent use.\textsuperscript{414} Stolzenberg, D’Alessio and Dariano analyse data from the NSDUH 2002-2011 on cannabis use of 12-17 year olds separated into five measurement periods (2002-2003, 2004-2005, 2006-2007, 2008-2009, and 2010-2011). In each of these periods, they present the data for all the 16 states which had legalised cannabis at some point before the end of the study period (see graph on next page). Significantly, for each of these periods, the before and after for the same states is not

\textsuperscript{409} Keyes (n 399) 2190.
\textsuperscript{410} Ibid 2192.
\textsuperscript{411} Ibid 2191.
\textsuperscript{412} Johnson (n 399) 2.
\textsuperscript{413} Ibid 3.
being compared. For example, the eight states which legalised prior to the 2002 period are always in the ‘after law’ bar but never in the ‘before law’. A state will remain in the ‘before law’ bar until the period in which it legalised, at which point it will be placed in the ‘after law’ bar, hence why there is no ‘before law’ bar by the end of the study period. Thus, Stolzenberg et al found that for the periods of 2004-5, 2006-7 and 2008-9 the mean use of cannabis was lower in states which had not yet legalised compared to those which had. Stolzenberg et al conclude from this that the legalisation of cannabis leads to an increase in adolescent cannabis use.\(^{415}\)

Wall et al, however, argue that this conclusion does not follow from the data presented. They consider it problematic that the analysis of Stolzenberg et al does not compare the mean cannabis prevalence of the same states before and after legalisation.\(^{416}\) This is specifically problematic, they claim, as the states which legalised earlier in the study period (Vermont, Montana and Rhode Island) already had high prevalence rates even before legalisation:

Therefore, creating means of post-[legalisation] marijuana use by combining these states with the states that [legalised] later leads to an artificial appearance that marijuana use increased post-[legalisation] because the means are increased through inclusion of states that were higher even before they [legalised].\(^{417}\)

\(^{415}\) Ibid 85.


\(^{417}\) Ibid 11.
Wall et al went on to compare the mean prevalence of cannabis pre and post legalisation in the states which legalised and found that in five of the eight, cannabis use decreased after legalisation while it increased in the other three. The change in overall prevalence in the eight states was -0.1%, thus indicating no evidence that medical cannabis legalisation increased cannabis use among adolescents.

While the above studies focussed entirely on adolescents some have covered both adolescents and adults. Harper, Strumpf and Kaufman replicated the Wall et al finding that states with legalised medical cannabis have higher prevalence than those without it and went on to analyse whether cannabis use had increased as a result of legalisation of medical cannabis. Also using the NSDUH, and employing a difference in differences analysis, they studied both adolescent and adult prevalence. Medical legalisation was not associated with an increase in cannabis use for any age group. The legalisation of medical cannabis was found, like the above studies, to be associated with a very small decreased chance of adolescent cannabis use.

Martins et al examined whether the perceived availability of cannabis was impacted by medical legalisation. They used NSDUH data 2004–2013. The data were analysed based upon whether states legalised medical cannabis. They found that perceived availability of cannabis was higher in states that had, and would go on to, legalise cannabis. However, they also found that legalisation of medical cannabis did not have a statistically significant effect on the perceived availability among 12-17 year olds or 18-25 year olds, but did increase the perception of availability among those 26 and over. This finding is consistent with the fact that legalisation was associated with an increase use of cannabis among the over 26 but not among the 12-17 or 18-25 age groups. Thus we see that there is a link between perceived availability and increased prevalence, but that this is not seen among the young, as was predicted by some, but among the older (26+).

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418 Ibid.
419 Wall et al questions other assumptions made in Stolzenberg’s data from ibid 11-13.
Wen, Hockenberry and Cummings use the NSDUH dataset 2004-2012 to test for cannabis use outcomes in 10 states for which there was pre and post data in the study period. They employed a difference in difference analysis with states which had legalised by 2004 and states which had not legalised by 2012 used as controls, the differences in those states being compared to the test states.⁴²² Among the younger group there was an increase in last year initiation, but no increase in past month usage, suggesting that medical cannabis legalisation may cause young people to experiment, but then not continue with use. Among the older group, however, implementation of legalisation increases probability of using cannabis in the past month by 1.32 percentage points. Similarly, there is a 0.58 percentage point increase in daily/almost daily use. However, the latter figure is under .8%, which is the average number of people registered in medical cannabis programmes in the US.⁴²³ As registered patients are more likely to use daily, this seems to follow from that. Conversely to the younger age group, there is no change in initiation among the over 20s.⁴²⁴

Some studies have not relied on survey data but on other datasets, such as arrests and hospital visits, these data largely focus on adults. Gorman and Huber, for example, tested for the effect that legalising medical cannabis had on the amount of people who tested positive for cannabis among arrestees and emergency department patients. Data for arrestees were gathered from the Arrestee Drug Abuse Monitoring system 1987-2003. 23 of the cities in this system had sufficient data to use in the study, of which five were in states with legalised medical cannabis.⁴²⁵ Data for emergency department patients were gathered from the Drug Abuse Warning Network 1994-2002. They employed a time series analysis, comparing the pre-law trend in positive test results to the post law trend. No statistically significant results were found for either of the datasets.⁴²⁶ The areas covered by

⁴²² Hefei Wen, Jason M Hockenberry and Janet R Cummings, 'The effect of medical marijuana laws on adolescent and adult use of marijuana, alcohol, and other substances’ (2015) 42 Journal of Health Economics 64, 68-69, Models using either one of these groups of states alone were also ran, with no significant difference.
⁴²³ Ibid.
⁴²⁴ Ibid 71 – 73.
⁴²⁶ Ibid 163-4.
this study, being cities from only four states and the fact that it was only testing at risk groups (arrestees and emergency patients) reduce the generalisability of the results.

Chu similarly tested for proxies for drug prevalence; namely, increased drug possession arrests and increased drug treatment. For drug possession arrests Chu used the Universal Crime Reports dataset 1988-2008, which covers a total of 751 cities with up to date data.\textsuperscript{427} Chu found that legalisation of medical cannabis on average ‘resulted in a 20.1% increase in the arrest rate [for cannabis offences], a 22.4% increase in the ratio of marijuana arrests to all arrests, and a 14.5% increase in the ratio of marijuana arrests to all drug arrests among adult males.’\textsuperscript{428} Treatment admissions data were gathered from the Substance Abuse and Mental Health Services Administration’s Treatment Episode Dataset (TEDS) 1992-2008.\textsuperscript{429} Data cover all substance abuse treatment facilities that receive public funding. Chu excluded criminal justice referrals from the data and tested for the ratio of cannabis treatment referrals to other drug referrals.\textsuperscript{430} Chu finds that medical cannabis legalisation increases the ratio of adult drug referrals that are primary cannabis referrals (in the sense that cannabis is the primary problematic drug referred to) by between 13.7–14.1%.\textsuperscript{431} The ratio of cannabis referrals when compared to other drugs was already very low (8%), indicating, perhaps, its much lower danger profile and / or popularity when compared to other drugs such as heroin and cocaine (together make up 30% of referrals) and alcohol (50% of referrals).\textsuperscript{432} Equally, when the absolute number is small, even a statistically significant increase of around 14% does not necessarily mean a large increase in absolute terms. That being said, the increase in arrests and treatment referrals, in combination, leads Chu to conclude that there is likely an increase in adult

\textsuperscript{428} Ibid 49, Chu analysed and controlled the effect that varying law enforcement may have on the results as well as the potential for California and Colorado to have disproportionate effects on the results.
\textsuperscript{429} Ibid 53.
\textsuperscript{430} Ibid, this is done, respectively, to control for changes in law enforcement and control for the fact that some states switch between testing all patients in publically funded facilities and only publically funded patients in publically funded facilities, thus creating artificial changes in the absolute cannabis referral figures.
\textsuperscript{431} Ibid 55, again controlling for the effects of Colorado and California.
\textsuperscript{432} Ibid 54.
use associated with medical cannabis legalisation.433

Shi continues this analysis by studying hospitalisations related to cannabis dependence or abuse.434 Shi uses the State Inpatient Database 1997-2014 which covers 97% of all hospital discharges in the 27 participating states, nine of which had legalised in the study period.435 Again, the difference in the pre and post legalisation rates of hospitalisation were studied, controlling for the change in rates in contemporaneous non-legalising states.436 In contrast to Chu, however, Shi found there to be no statistically significant increase in cannabis dependence or abuse hospitalisation associated with the legalisation on medical cannabis.437

Masten and Guenzburger use the Fatality Analysis Reporting System (FARS) in order to analyse whether legalisation resulted in increased cannabinoid positivity after fatal driving accidents. This is a good proxy for prevalence (among adult age drivers) as cannabinoids stay in the system and are detected in tests for a long period of time, up to a month. Thus, cannabinoid positivity doesn’t imply intoxication, rather use of cannabis in the last month. Masten and Guenzburger conduct a time series analysis on 12 states which had legalised during the time period; excluding two due to lack of data. Data from the 37 non-treatment states were used to identify and control for any nationwide trends which might otherwise be confused as an effect of legalisation.438 Only 3 of the 12 states showed an increase attributable to legalisation – California, Hawaii and Washington.439 These were step increases, rather than upwards trends in that there was an initial rise in positivity which then held flat, rather than an ever increasing trend. This indicates, the authors argue, that legalisation “may have

434 Yuyan Shi, ‘Medical marijuana policies and hospitalizations related to marijuana and opioid pain reliever’ (2017) 173 Drug and Alcohol Dependence 144, Shi also studies the substitution effect of medical cannabis and opioid hospitalisations, to which we shall return in the final section.
435 Ibid 145.
436 Ibid 146.
437 Ibid.
439 Ibid 43.
indeed provided marijuana access to a stable population of patients as intended, without increasing
the numbers of new users over time”.  

Hasin et al study both prevalence and cannabis use disorders by focusing on 3 cross sectional
and second, the second and third and the first and third are analysed and compared to each other
and/or the analogous changes in the non-legalised states.  

Between the first and third, and therefore
over the whole period, the change in both prevalence and cannabis use disorders was significantly
higher in legalised states than non-legalised ones. Between the first and second, and the second and
third periods, prevalence increased to a greater degree in legalising states than in non-legalised states.
Increases in cannabis use disorders were, however, not statistically significant. This suggests that
there is in fact an increase in cannabis use associated with legalisation. Though if there is an increase
in prevalence, but not cannabis use disorders this could be indicative of new initiators being less risky,
lower intensity users, though more data is needed to demonstrate this.

In summary, it appears that there is little evidence that the legalisation of medical cannabis
leads to increased adolescent use. There is some evidence, though it is far from conclusive, that at
least in some of the younger age groups, the legalisation of medical cannabis decreases use. There are
several reasons why this might be so. For instance, rather than making it appear safer, the
medicalisation of a drug may make it appears less attractive for recreational use as it is viewed as
something that sick people need, rather than something healthy people enjoy. Conversely, it might be
the case that the legalisation of medical cannabis is usually accompanied by a more public debate
about the harms of cannabis, or may lead parents to be more vigilant about drug use, fearing that it
has become more accessible. More study is needed on this point.

The picture with regard to adult cannabis prevalence is a more mixed. There are both positive

\[440\] Ibid 46.

\[441\] Deborah Hasin et al, ‘US Adult Illicit Cannabis Use, Cannabis Use Disorder, and Medical Marijuana Laws’
(2017) 74(6) JAMA Psychiatry 559, 580.

\[442\] Ibid 528.

\[443\] Keyes (n 399).
and negative results depending on the dataset that is analysed. Also, some, though not all, of the positive results can be plausibly explained as merely representing the increase in medical users, rather than an increase in general prevalence. Given this ambiguity in the data, some researchers have attempted a different method of studying this question.

**Prevalence – different policies**

Some authors, Pacula in particular, criticised some of the analyses into medical cannabis legalisation on the basis that it did not account for the heterogeneity between states which have legalised medical cannabis. Indeed, as Pacula et al note, medical cannabis policies which allow for greater legal access points would likely have a larger effect on recreational use than those which are limited.\(^{444}\) Thus, for example, one would expect policies which allow dispensaries to have a greater impact on use than those which do not. In light of this criticism, many of the above and other studies also examined the effect that dispensaries and other policy options have on prevalence.

Freisthler and Gruenewald explore this idea in a cross-sectional study, analysing whether the physical availability of medical cannabis, through dispensaries and delivery services, is related to cannabis use prevalence.\(^{445}\) They analyse 50 Californian cities comparing self-reported cannabis use in phone surveys with density of cannabis dispensaries and delivery services. The physical availability of medical cannabis through dispensaries and delivery services was positively related to cannabis prevalence.\(^{446}\)

Shi similarly analyses the issue of dispensaries, but focuses on their proximity, rather than density, this time focussing on adolescents.\(^{447}\) Shi employs the MTF dataset using two binary measures of whether there was a dispensary within five and 25 miles of a school.\(^{448}\) Overall, and conversely to

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\(^{444}\) Pacula et al (n 352) 8.
\(^{445}\) Freisthler and Gruenewald (n 514).
\(^{446}\) Ibid 247.
\(^{448}\) Ibid 2.
Freisthler and Gruenewald, the proximity of dispensaries, at either the five or 25-mile range, were not associated with increased cannabis use in general. However, there was evidence that the availability of a dispensary within five miles was associated with last year use of cannabis among 8th graders while availability between a five and 25 mile area was associated with last year cannabis use among 10th graders. No association was found with 12th graders.\footnote{Ibid 3.} This provides a potential, though very weak, association between some groups of adolescents and some forms of use.

Being cross-sectional, these studies do not test causation. The Pacula et al study, however, does. This study uses the TEDS dataset to study the number of primary cannabis treatment referrals and the NLSY dataset to study prevalence. Employing a difference in differences analysis they find that medical cannabis \textit{legalisation} is associated with a reduction in cannabis treatment referrals and has no association with increased use in the NLYS.\footnote{Ibid 19.} They go on, however to study the effects of three different forms of legalised policy; the requirement for a patient registry, allowing home cultivation and legally protecting dispensaries.\footnote{Shi (n 447) 10-11, a state is defined as allowing home cultivation if it offers legal protection for either patients or designated caregivers to grow cannabis. A state is defined as requiring patient registry if being on the registry is compulsory to gain legal protection; this excludes both states which do not have a registry and those which have one but entry onto it is voluntary. A state is considered to be dispensary state if it offers explicit legal protection to dispensaries, if there is no cap on both the number of patients a caregiver can ‘care’ for and the amount of cannabis they can give them or there is an official law which acknowledges dispensaries without condemning them. The latter two were included so as the catch de facto dispensaries which have often emerged without explicit legal permission.} They find that the implementation of dispensaries is associated with a 28% increase in the number of non-criminal justice, primary cannabis treatment referrals (16% when including criminal justice referrals).\footnote{Ibid.} States with mandatory registries have 18% lower rates of non-criminal justice cannabis referrals.\footnote{Ibid 19, though given the small number of states with no registry, this should be treated with caution.} The effect of home cultivation was not statistically significant.\footnote{Ibid 19 - 20.} In the NLSY data there is a positive association between the legal protection of dispensaries and increased prevalence (any use in the past 30 days) and no statistically significant effect on either heavy use or number of days used in the past 30.\footnote{Ibid 20, 22.} Allowing home cultivation lead to
a 1.8 percentage point increase in the probably of cannabis use and a 1 percentage point increase in heavy use. This appeared to show, therefore that while legalisation does not increase prevalence, legal protection of dispensaries does.

Unlike Pacula, however, many studies found there to be no effect of dispensaries and variable impacts of other policies. The Hasin et al (methodology described above) study, which found that there was no increased risk of cannabis use associated with medical cannabis legalisation though there was a decrease risk of 8th grade use, also studied for the effect of dispensaries. In this measure there was a three-level variable; no cannabis legalisation, legalisation without dispensaries and legalisation with dispensaries. In the latter variable was included those states which allowed de-facto dispensaries through large or no caregiver limits.\textsuperscript{456} Contrary to Pacula, however, no discernible difference was noted with the protection of dispensaries as oppose to mere legalisation.\textsuperscript{457}

Johnson, Hodgkin and Harris (methodology described above) found there to be a small decrease in the odds of cannabis use after legalisation. On testing a variety of different policies, they found some positive results. Interestingly, this did not include dispensaries, irrespective of whether they were active (as oppose to merely being allowed, but not yet operational) or ‘for-profit’. Equally no significant effect was found from allowing home cultivation, limiting the number of plants allowed under home cultivation and caregiver patient limits.\textsuperscript{458} Of the 12 variables they tested, only two revealed positive and significant results in the adjusted models; possession limits and requiring a registry. Last 30-day use of cannabis was higher in states with higher possessions limits when compared both to those states with lower limits and those which had not legalised medical cannabis.\textsuperscript{459} Voluntary as opposed to mandatory patient registration was associated with higher past

\textsuperscript{456} Hasin (n 396) 603.
\textsuperscript{457} Ibid 606.
\textsuperscript{458} Johnson (n 399) 3-4, this list is not extensive, to see all 12 heterogeneous policies variables tested see pages 2 and 3.
\textsuperscript{459} Ibid 4, higher possession limits are defined as those allowing 2.5oz or more.
30-day use and past 30-day heavy use.\textsuperscript{460}

Wen, Hockenberry and Cummings (methodology described above) similarly studies four different types of legalisation policy; dispensaries, patient registry, home cultivation and allowing non-specific pain conditions in the list of cannabis treatable conditions.\textsuperscript{461} Of these, only allowing non-specific pain lead to a significant effect, which was to increase cannabis use. They hypothesise that this may be because it broadens out the base of people eligible for medical cannabis or indeed may allow for people to enter the system by feigning a pain condition, as such conditions are difficult to objectively verify.\textsuperscript{462} Significantly, Wen et al only code a state as allowing dispensaries after the date at which dispensaries actually become effective, rather than the date they become legal.\textsuperscript{463}

Two further studies tested the effects of dispensaries (as opposed to mere legalisation) and found there to be no effect. Shi (methodology described above) found there to be no effect on cannabis hospitalisation of medical cannabis legalisation. It was further found that medical cannabis dispensaries alone did not have any independent effect of hospitalisations either.\textsuperscript{464}

Similarly Keyes et al (methodology described above) added sensitivity analyses for dispensaries in their study of the effect of legalisation. In this case the same three level variable was used as in Hasin; no legalisation, legalisation with dispensary (either implicit or explicit), legalisation without dispensary.\textsuperscript{465} Keyes et al found that in the group being tested, the use of cannabis decreased in both legalised stated with dispensaries and those without them, thus showing no discernible effect of dispensaries.\textsuperscript{466}

One of the potential problems with studying the effects of different, individual legalisation policies, in particular dispensaries, is that these policies variation do not form discrete categories. For

\textsuperscript{460} Ibid, this result should, however, be treated with caution as of the 11 states in the study only one, California, had a voluntary, rather than mandatory, registry.
\textsuperscript{461} Wen, Hockenberry and Cummings (n 422) 68-69.
\textsuperscript{462} Ibid 74.
\textsuperscript{463} Ibid.
\textsuperscript{464} Shi (n 434) 146.
\textsuperscript{465} Keyes (n 399) 2190.
\textsuperscript{466} Ibid 2192, 2193.
example, coding for ‘dispensaries’ is confused by the fact that many states do not specifically legislate for dispensaries, but de facto dispensaries emerge anyway in the vacuum of deregulation or ambiguous caregiver rules. As Hunt notes, for example, both Wen et al and Pacula et al test for dispensaries but in Wen’s study California is treated as a dispensary state from 1996 because California legalised medical cannabis and did not specifically outlaw dispensaries. Pacula on the other hand only codes California as a dispensary state in 2003, when they explicated legislated for them. More fundamentally, as will be explained below, the actual operation of dispensaries may be significantly different in two states that are both coded as a dispensary states, if they have different possession limits, for example or different rules on where and how many dispensaries there can be. In this regard different policy choices can compound and complicate any attempt to compare states with and without a given policy. Given this it is unsurprising that the above studies have produced somewhat ambiguous results, with many different policies implicated a potential increase in cannabis use, while many studies contradict Pacula’s initial finding that dispensaries have a discernible impact.

**Prevalence - different models**

Given these issues with testing for individual policy choices, another approach is to categorise legalisation policy into groups more capable of comparison. The value of this approach is demonstrated by two Coloradoan studies, which rather than examining the effect of legalising medical cannabis or of individual policy choices such as dispensaries, focussed on the commercialisation of medical cannabis in Colorado. This refers to a combination of factors which in 2009 led to medical cannabis becoming commercially available, relatively easy to acquire and deregulated in such a way that saw a massive explosion of provision of medical cannabis dispensaries. Thus there is a comparison being made between non-commercialised legalisation policy (pre-2009) and commercialised legalisation policy (post 2009). This is a better test of Pacula’s original hypothesis as

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467 Hunt and Miles (n 394).

that posited a link between an increase in the supply and ease of acquiring cannabis, which is captured by the concept of commercialisation.

Salomonsen-Sautel et al used data from Fatality Analysis Reporting System (FARS) 1994-2011 to examine the trends in cannabis positive fatal car accidents pre and post commercialisation compared with the control group of all non-legalised states.\(^{469}\) It was found that, in Colorado, there was a negative trend in the pre-commercialisation period and a positive trend in the post-commercialisation period, thus leading to a statistically significant positive change in the trend, post-commercialisation. The 34 control states did not see a statistically significant change in the trend of positive results post-commercialisation and thus, when compared to the change in Colorado the increase in positive results is statistically significant.\(^{470}\) In short – commercialisation is associated with an increase in positive cannabis results in fatal accidents in Colorado.

Schuermeyer et al similarly analysed commercialisation by comparing Colorado to non-legalised states, but focused on cannabis use and cannabis attitudes. Utilising NSDUH 2003-2011 they find a significant decrease in the percentage of Coloradoans who perceived there to be a “great risk” from smoking cannabis 1-2 times per week and a significant increase in the number of people who considered cannabis easy to obtain.\(^{471}\) With regards to use, there was a significant increase in past year use among the 18-25 age group (but not under 18 group or over 25). There were no significant changes in any age group for heavy past month use (defined as more than 20 occasions of use).\(^{472}\) When compared to non-legalised states Colorado had more liberalised attitudes towards cannabis (perceived less risk, ease in obtaining) and greater use to begin with.\(^{473}\) It was also found, however, that there was trend deviation between Colorado and the non-legalised states possibly indicating that there was an association between the commercialisation of medical cannabis in Colorado and

\(^{469}\) Ibid 139.
\(^{470}\) Ibid 140.
\(^{472}\) Ibid 148.
\(^{473}\) Ibid 153.
increased permissive attitudes towards it and increased use.\textsuperscript{474} While these studies suffer from being specific to Colorado, they do suggest that a commercial model of medical cannabis regulation may lead to increased use and therefore harm.

These studies are limited by their concentration on one state. Thus, two further approaches which seek to categorise different approaches to legalisation are instructive. One – Williams et al – categories medical cannabis models on whether they are medicalised or non-medicalised; the second – Smart – on whether they were lax or strict supply regulations. Both studies then relate this categorisation to the level of registration into the medical cannabis programme.

Beginning with the first, on medicalisation, Williams et al, from a list of American practices and regulations laid out seven features that would usually typify ‘traditional medical care and pharmaceutical regulation’.\textsuperscript{475} These are; doctor-patient relationship; manufacturing and dispensing licences; testing and labelling; unsmoked medication; 30-day supply limits; prescription drug monitoring programme and; physician training.

They then track how many medical cannabis states adhere to these seven principles in their provision of medical cannabis, providing each state with a score of one-seven (one point scored for each principle).\textsuperscript{476} The average score was 1.96. Eight states did not meet any of the criteria and six states only met one, in every instance this was the bone fide doctor-patient relationship.\textsuperscript{477} This left only ten states with a score higher than one, only one of which (New York) met all the criteria.\textsuperscript{478}

It appears therefore that the US medical cannabis system is, to a significant degree, nonmedical in its regulation and distribution. Williams et al further find that medicalised programmes (defined as those with a score of two or more) had one-twentieth the enrolment rate of the

\textsuperscript{474} Ibid 153.
\textsuperscript{475} Arthur Williams et al, ‘Older, Less Regulated Medical Marijuana Programs Have Much Greater Enrollment Rates Than Newer ‘Medicalized’ Programs’ (2016) 35(3) Health Affairs 480, 481.
\textsuperscript{476} Ibid 485-486.
\textsuperscript{477} Ibid, see also Appendix A <http://content.healthaffairs.org/content/suppl/2016/02/29/35.3.480.DC1/2015-0528_Williams_Appendix.pdf> Accessed 03/08/2017
\textsuperscript{478} Ibid 485-486.
nonmedical programmes (58 per 100,000 v 1,030 per 100,000). Thus, 99.4% of medical cannabis users in the US are participants in nonmedical models. If we proceed on the assumption that the afflictions which are treated by cannabis are similarly prevalent in both medicalised and nonmedical states – there is no reason to believe that MS, HIV or neuropathic pain is more common in New York than California, for example – the higher enrolment rate in nonmedical programmes has two potential explanations. Either the medical states are being restrictive and preventing legitimate users from engaging in the programme, or the nonmedical states are letting recreational users participate in the programme. Of course, the answer could be and probably is somewhere in the middle and I have no basis on which to make firm conclusions. With the dispensation of other medicines, however, the ‘medical’ (prescription) model is standard practice, as is assumed to be the best method of getting medicines to those that need it.

In any case, given that diversion is common, as demonstrated in the next section, increasing the number of registered patient 20-fold would likely lead to an increase in the supply of cannabis. It is possible, therefore, that, to the extent that medical cannabis legalisation is associated with increased prevalence, it is non-medical policies and consequent high enrolment rates that are potentially the cause of it.

This conclusion is supported by Smart, who conducts an economic analysis of the medical cannabis market in the US. Smart similarly finds that less strict regulatory models are associated with high registration. Smarts analysis however is significantly more complex. Initially Smart analyses how enrolment rates were impacted by different policy options. These include; whether or not state licenced dispensaries were legalised; the laxness of caregiver restrictions (unlimited caregiver allowance vs limited caregiver allowance vs no caregivers allowed); whether chronic pain was a qualifying condition; possession limits and; registration fees. Smart argues that states can be divided into those with lax and strict supply restrictions. Lax supply restrictions are high, or no, possession

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479 Ibid 486, significantly, this is not the same as saying that 99.4% of medical cannabis patients are nonmedical. 480 As Smart is focussed on enrolment rate, she does not include the states where registers are not kept or are not mandatory.
limits; high and unlimited caregiver allowances leading to de facto, unregulated dispensaries; easy recommendations; loose restrictions on suppliers (dispensaries and caregivers). These lax models are associated with greater enrolment rates.\textsuperscript{481}

Smart further analyses the effect that the Ogden and Cole memos have on enrolment rates. Finding that across legalised states enrolment rates were relatively low up until the 2009 Ogden memo, which eased off federal prosecution of medical cannabis providers in states which had legalised and following which enrolment rates began to raise significantly. This rise was seen until the Cole 2011 memo, which suggested resurgence in federal prosecutions, at which point the rate at which enrolments increased slowed. The rate at which enrolments increased began to rise again after the second Cole memo, which liberalised the federal approach again.\textsuperscript{482} There was however significant variation in the effect that the memos had between states. Significantly, states with lax regulations were significantly more reactive to the memos than those with stricter regulations. This is to say that there was a precipitous increase in registration in lax states after the Ogden memo, followed by a similarly precipitous decrease following first Cole memo.\textsuperscript{483} However in states with either strict supply restrictions or otherwise strict, state regulation, such as controlling the number of dispensaries or the amount of cannabis available, there is a slight increase after Ogden but neither of the Cole memos has much effect on the registration rates.\textsuperscript{484} Indeed between the Ogden and Cole memos states with strict regulations saw an additional 0.2% of adults register whereas in lax states registrations rates jump by 2% (which is statistically significant).\textsuperscript{485} Thus states with lasher regulations are both more likely to have high enrolment rates and be more responsive to federal enforcement.

This analysis can be suggestive of the fact that removing the prospect of criminal prosecution can be associated with commercialisation and extremely high rates of enrolment, but only, it seems,

\textsuperscript{481} Smart (n 338) 20.
\textsuperscript{482} Ibid 17.
\textsuperscript{483} Ibid 68.
\textsuperscript{484} Ibid 69.
\textsuperscript{485} Ibid 71; see also Brian J Fairman, ‘Trends in registered medical marijuana participation across 13 US states and District of Columbia’ (2016) 159 Drug and Alcohol Dependence 72.
when lax regulations allow for a proliferation of a profitable market. Where there are strict limits on caregivers and well controlled supply and possession limits, the removal of the threat of prosecution does not lead to a precipitous rise in the size of the market.

Thus, we can see that both lax and nonmedical policies lead to significantly greater levels of participation. Significant similarities can be seen in Williams’ definition of nonmedical and Smart’s definition of lax regulations. For example, loose (or non-existent in the case of caregivers) supply restrictions on producers and suppliers and possession/supply limits for consumers/patients.\textsuperscript{486}

Merely seeing a rise in patient registration is insufficient to understand whether certain policies increase general population prevalence. Usefully therefore, Smart extends this analysis by examining whether the increase in registration rates impacts either adolescent or adult use of cannabis. Smart uses NSDUH for both past month and past year use of cannabis and analyses whether the level of registration is significantly related to the prevalence of cannabis use.\textsuperscript{487} Smart finds that the estimated effect of an additional 1% of the population being registered as medical cannabis patients predicts a significant 6% increase in the share of 12-17 year olds reporting past-month marijuana use, a 7-8% increase for 18-25-year olds, and a 20% increase for older adults. The effects on past-year initiation are similar but smaller in magnitude, indicating a 1-5% increase in the share of 12-17 year-olds reporting past-year initiation, a 6% increase for 18-25 year olds, and a 12-18% increase for adults over age 25.\textsuperscript{488}

Emphasising this result is a further finding by Smart that, similar to the above studies, that mere legalisation of medical cannabis has no statistically significant effect on prevalence of adult use and a negative effect on adolescent use when state-specific trends are taken into account. The above effect of registration rate increases holds even when such trends are accounted for.\textsuperscript{489}

While it is impossible to meaningfully compare the rates of medical cannabis use by country

\textsuperscript{486} Ibid 19/20; Williams (n 475) Exhibit 1.
\textsuperscript{487} Smart (Ibid) 75.
\textsuperscript{488} Ibid 76.
\textsuperscript{489} Ibid 79.
as each country has such different contexts, it seems to be the case that a one percentage point increase in the number of medical cannabis users is, relatively speaking, extremely high. Indeed, this as represents a 1,000 per 100,000 increase, which is above the whole population of medical cannabis users in Canada and 1 to 2 orders of magnitude higher than that which is seen in the Netherlands and medicalised US states.490

This vein of research has similarly been used by Abouk and Adams. Noting the link between heavy cannabis use and heart problems, they hypothesise that legalising medical cannabis will lead to an increase of cardiac related mortality on the assumption that such legalisation will increase use. Significantly, they divide states into “lax” and “strict” models of medical cannabis regulation, using a previous categorisation by Ullman based on numbers of cardholders and the ease with which one can acquire medical cannabis.491 Using a difference in differences method they find that legalisation of medical cannabis is indeed associated with statistically significant rises in cardiac related mortality; 2.3% for men and 1.3% for women. This increase is only seen, however, in “lax” states whereas results from the “strict” states are statistically insignificant.492 Abouk and Adams noted that the Ullman categorisations are substantially similar to the Williams medical/nonmedical model, with only 3 states changing. When the latter were used in place of the former, results were similar. Significantly, the statistically significant results were in the 45-64 and 65+ age groups as oppose to 18-44.493

Given all the above, there is no good evidence to suggest that increases in prevalence can be associated with legalisation in general or any given specific policy within legalisation. Rather increases in prevalence only follow the adoption of lax, nonmedical models of legalisation. Thus, increases in prevalence are not a necessary consequence of legalisation, but rather an artefact of models allowing too many users to engage with the programme and thus allowing for diversion.

490 See pages 101-106 of this thesis.
492 Abouk and Adams (Ibid) 4.
493 Ibid.
Diversion

Diversion describes the process whereby medical substances are redirected from legal stocks and uses to illegal ones, primarily from licensed medical stocks into unlicensed medical or recreational markets. As there is not yet widely available medical cannabis in the UK, diversion of other medicines can be examined. At the end of 2016 the ACMD completed a review of diversion in the UK. Here it was found that the primary drugs which are diverted are opioids and benzodiazepines, primarily found in Schedule 2 Misuse of Drugs Regulation. The reasons people used diverted drugs vary from medical reasons to recreation but also, though this is less common, as study aides, or “smart drugs”.

The ACMD found that ‘the major source of supply is by prescription prior to diversion’, this means that a drug is prescribed legitimately to a patient, then passed on to someone else. It is usually the case that a drug is ‘diverted’ in the sense that it was prescribed to a person and that person either kept using it after the medical need has elapsed or sold/gave it on to somebody, usually a friend or family member. For example, in a survey of 7360 people in the UK 98% of the 369 people who stated they misused tramadol said that they had either been prescribed it themselves or got it from a friend. This chimes with the American perspective as described by Babor, who cites evidence that the primary source of diverted drugs is friends and family. A caveat to place on this, however, is that just because a person received drugs from a friend or relative does not necessarily mean that, that person got the drug on prescription. It is further worth noting that internet sales of diverted drugs are becoming an increasing concern and that the ACMD reports an example of prescription only

495 Ibid 2.2.9.
496 Ibid 2.2.12-19.
497 Ibid 3.1; 3.2.13.
498 Adam Winstock, Rohan Borschmann and James Bell, ‘The non-medical use of tramadol in the UK: findings from a large community sample’ (2014) 68(9) International Journal on Clinical Practice 1147. 64% prescribed to them; 34% obtained it from a friend; 3% bought it from a dealer and 2.7 from the internet (Ps were able to choose more than one option).
medications being diverted in large quantities into illegal markets by wholesalers. The scale of diversion in the UK is, however, very difficult to quantify. While there is a common perception among stakeholders that the practice is increasing, most of the data is anecdotal and there are no suitable monitoring systems to make an assessment.

US research has provided evidence of medical cannabis diversion occurring. For example, Nussbaum surveyed discharged patients from a Colorado inpatient psychiatric facility. Of the 552 participants, 24.1% reported that someone with a medical cannabis card had shared cannabis with them or sold it to them. While 24 of the 60 medical cannabis card holders said that they had shared or sold their cannabis. Thurstone, Lieberman and Schmiege studied 80 adolescents in outpatient substance treatment in Colorado, 39 of whom said they had obtained cannabis from someone with a medical cannabis licence. Salomonsen-Sautel conducted a Colorado based study of 164 outpatients in substance treatment (up to 31 could have been participants in Thurstone et al’s study). 73.8% of participants said they used someone else medical cannabis.

A caveat to these studies is that the perception by users that cannabis is medical may not be accurate. For example, dealers may market cannabis as ‘medical’, to imply greater quality or potency. A study by Lankenau et al remedies this limitation. This study, conducted in California, compared the usage and source of cannabis using participants, both with and without cannabis cards. All participants were relatively regular users of cannabis (4+ times a month, though most significantly more). Of the 156 without medical cannabis cards, 80.1% reported their primary source

500 ACMD (n 494) 3.2.6.  
501 Ibid 4.2.2-3  
503 Ibid 171.  
506 Ibid 697.  
507 Ibid 697.  
of cannabis as a friend with a card getting it for them from a dispensary and 53.6% reported this as their *only* source. Further, 15.4% of those without cards, bought directly from the dispensary.509

‘About one-quarter’ of those with and without medical cannabis cards reported having sold cannabis which was obtained from a dispensary on to another person.510

Diversion has been identified also in studies specifically of young people. In a large survey sample of 10,658 8th-12th grade students who reported at least one means of obtaining cannabis in the past 30 days, the Arizona Criminal Justice Commission found that 11.6% had obtained cannabis from a person with a medical cannabis card.511 Similarly, Boyd, Veliz and McCabe studied the MTF 2014 dataset, consisting of a sample of 4,394 12th grade students from across the US. They found that 6.1% reported using cannabis that had been prescribed to someone else.512 Interestingly, it is this group – those to whom cannabis had been diverted – that reported higher percentages of all the examined risk behaviours such as using cannabis regularly, using other substances and ‘being hooked’ on cannabis. This being a cross sectional analysis, however, no causation can be inferred.513

Diversion will not only take place where a patient has passed cannabis on to another, but also when people attempt to enrol in the medical cannabis programme for recreational reasons, rather than medical ones. The vast majority of studies which survey medical cannabis users, internationally, have samples disproportionately male and young to middle aged.514 Further, Reinarman et al’s study

509 Ibid 183.
510 Ibid.
511 Bach Harrison, ‘Arizona Youth Survey: State Report’ (Arizona Criminal Justice Commission 2012) <http://www.azcjc.gov/acjc.web/sac/AYSReports/2012/AYS%202012%20Report%20Final%2012%2031%202012.pdf> accessed 22/03/17, 43, respondents were permitted to provide more than 1 answer to the question, thus the total does not equal 100%.
513 Ibid 243-244.
finds, for example, that the ‘great majority’ of the 1,746 Californian medical cannabis patients studied, had used cannabis recreationally prior to obtaining an assessment for medical use; however 41.2% of the participants said that they were not using it recreationally immediately prior to initiating medical use.\textsuperscript{515} Such demographics – disproportionately young, male and former recreational users – might be what one would expect if there were at least some people engaging in the programme for recreational reasons. This however is clearly not evidence of diversion through enrolment by recreational users, and more research is needed on this question.

This picture is also muddied as use can be viewed as both recreational and medical by users themselves. Piper et al surveyed 1,531 participants recruited from dispensaries in Maine and Vermont. Participants were asked to express their use of cannabis on an 11-point continuum from 0% medical/100% recreational to 100% medical/0% recreational. The mean score was 84.7% medical.\textsuperscript{516}

In vaping studies, Shauer et al found of the ~300 in the sample who were current cannabis users, 10.5% were medicinal only, 53.4% were recreational only and 36.1% were both.\textsuperscript{517} In Malouf, of the 96 surveyed, ten used for medical purposes, 38 for recreational purposes and 48 for both.\textsuperscript{518}

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\textsuperscript{515} Reinarman (Ibid) 131, see also Nussbaum (Ibid) 169.

\textsuperscript{516} Piper (n 514) 569.

\textsuperscript{517} Gillian L Schauer et al, ‘Toking, Vaping, and Eating for Health or Fun’ (2016) 50(1) American Journal of Preventive Medicine 1, 3.

\textsuperscript{518} John M Malouf, Sally E Rooke & Jan Copeland, 'Experiences of Marijuana-Vaporizer Users' (2014) 35(2) Substance Abuse 127, 128.
Roy-Byrne et al also study the question by surveying 868 primary care patients who had used at least one illegal or non-prescribed drug. Participants were divided into medical cannabis (131), recreational cannabis (525) or other drugs (212) users. Study participants were evaluated four times over a year at three, six, nine and 12 months. 17% of the original recreational users described themselves as medical after one year while 42% of the original medical users described themselves as recreational users after one year.\textsuperscript{519} While participants might have become well or unwell over the study periods, this shift is likely caused at least to some extent, by some viewing their recreational use and medical use as interchangeable.\textsuperscript{520}

Similarly, Sznitman conducted an online study of cannabis users in Israel. The 1,479 participants were split into three groups; recreational users (41.6%), licensed medical users (5.6%) and unlicensed users defining their use as medical (38.1%). These were compared on various factors. In general, various things separated the three groups, but more separated the unlicensed and licensed users than the unlicensed and recreational users. Thus, Sznitman argues that in Israel there is a meaningful difference between the use patterns of licenced medical users and others (recreational users and unlicensed medical users) in the patterns of use. Prominently, licenced users are more likely to take cannabis more often, alone and before midday but report being stoned for less amount of time. Sznitman argues that this use profile is more analogous to medical use than recreational use. This division may imply that, in Israel at least, medical cannabis users are legitimately medically using, and are distinct from recreational users or claimed medical users.\textsuperscript{521}

Given this evidence of medical cannabis diversion and the more general phenomena of the diversion of recreationally desirable medicines, as well as the blurry line that is drawn by users between recreational and medical use of cannabis it is a fair assumption that the legalisation of

\textsuperscript{519} Peter Roy-Byrne et al, ‘Are Medical Marijuana Users Different from Recreational Users? The View from Primary Care’ (2015) 24 The American Journal on Addictions 599.
\textsuperscript{520} Ibid 601, 604.
\textsuperscript{521} Sharon R Sznitman, 'Do recreational cannabis users, unlicensed and licensed medical cannabis users form distinct groups?' (2017) 42 International Journal of Drug Policy 15.
medical cannabis would lead to a potential for diversion. More research is required into diversion in other counties with medical cannabis to get a fuller picture.

**Potency**

Potency of cannabis is primarily concerned with the percentage of its strongest cannabinoid, delta-9-tetrahydrocannabinol (THC).\(^{522}\) TCH is associated with both the ‘high’ of cannabis and many of its medicinal and negative effects.\(^{523}\) In addition, the presence of cannabidiol (CBD) is associated with some of the medicinal effects but with neither the high or the negative effects and appears to be somewhat protective of those negative effects.\(^{524}\) High potency cannabis such as skunk (which typically includes very high percentages of THC and no, or negligible amounts, of CBD), in comparison to other, less potent varieties, has been associated with psychosis and dependency in UK studies.\(^{525}\) In spite of the potential harm of THC, there is therapeutic rationale for combining the two (and other) cannabinoids.\(^{526}\) Given this, it is important to examine what effect, if any, medical cannabis legalisation has on the potency and balance of cannabis.

Mammen et al examined the THC/CBD ratios of the 277 licenced cannabis products in Canada. 180 were found to have a higher ratio of THC than CBD, of these 105 had higher than 15% TCH, considered to be high potency, and 163 had only trace levels of CBD. A further 30 products had no CBD in at all, of these 16 had above 15% TCH.\(^ {527}\) This indicates that medical cannabis has the potential to be very potent, but it is important to understand whether medical cannabis legalisation causes

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\(^{524}\) Vast amounts have been written on this issue for an overview see McLaren (n 522) 1100; Raymond J M Niesink and Margriet W van Laar, ‘Does cannabidiol protect against adverse psychological effects of THC’ (2013) 4 *Front Psychiatry* 130.


\(^{527}\) Mamman (n 366) 731.
cannabis to be more potent.

Sevigny, Pacula and Heaton studied data from 39,157 marijuana samples from the 51 US jurisdictions from 1990 to 2010. This sample is a law enforcement seizure sample and only includes herbal cannabis not hashish, which tends to be less potent. They found no statistically significant impact of medical cannabis legalisation on potency. The rise in potency does reach statistical significance (+1%) when testing whether a state permits cannabis retail dispensaries. Sevigny et al also find that the increase in potency that was detected was mediated through a relative increase in the share of the market held by high-potency sinsemilla cannabis, indicating that higher quality, and therefore stronger, strains of cannabis are being diverted from the medical stocks into the illegal market. Thus, legalisation of medical cannabis has no significant impact on potency, but dispensaries seem to have a significant, but small impact.

Given how potent medical cannabis is, this may appear surprising, but the potency of recreational cannabis has been consistently rising, both in countries with medical cannabis legalisation, like the Netherlands and those without it, like the UK. It is therefore unlikely that the relative potency of medical cannabis will be much greater, in the UK at least, than that which already exists in the recreational market. More studies on the effect of medical cannabis legalisation on potency would be required to fully answer this question.

Most importantly, however, when legalising medical cannabis, one could choose to heavily regulate its potency. While this has not occurred in the US or Canada, it has in the Netherlands where

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529 Ibid 313.
530 Ibid 314.
531 Ibid 314.
532 Ibid 314.
534 Freeman and Winstock (n 525) 3182.
only five types of medical cannabis are available and each as a regulated level of THC and CBD. As noted earlier, all but one of these types of medical cannabis are at the lower end of the potency scale. Thus, an increase in potency is not a necessary consequence of the legalisation of medical cannabis.

**Vaping and other non-smoked forms of cannabis**

Another metric of importance is whether cannabis is smoked or not. Non-smoked forms of use are less harmful as they do not involve the inhalation of burned cannabis and thus involve little, if any, inhalation of ‘carbon monoxide, tar and other toxins’. 535

The aforementioned Lankenau et al research also reported on the form of cannabis used and how it was taken. While the clear majority of those without medical cannabis cards reported using the traditional flower/bud form of cannabis and reported some form of smoking, 48.1% reported using edibles and 34% reported vaporization. 536 Those with medical cannabis cards reported much higher use of non-smoked methods; 51.9% used vaporisation while 66.2% used edibles. 537 However, as 85.7% used pipes, bowls and joints, smoked methods were the more popular. 538 This perception is supported by the aforementioned Reinarman et al survey in which 86.1% of participants used smoked cannabis while only 24.4% and 21.8% reported oral use and vaporisation, respectively. 539 Cranford et al, who surveyed 1,485 users presenting at Michigan dispensaries, found similar results. Here, 90.8% reported smoking whereas 44% and 39% reported eating/drinking and vaporising cannabis, respectively. Significantly, of those that vape, only 5.9% do so exclusively, while 87.3% smoke as well. 540

Lucas and Walsh, however, surveyed 301 patients of a Canadian medical cannabis producer and found a majority had tried non-smoked forms of cannabis (86% vaporizers and 76%

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535 Lankenau (n 508) 186.
536 Ibid 185.
537 Ibid.
538 Ibid.
539 Reinarman (n 514) 132.
Further a majority (~53%) collectively reported their primary methods as non-smoked, with 38% vaporization 14% edibles and 1% topicals (a kind of ointment). Smoked methods accounted for around 48% with joints at 25%, bongs 12% and pipes 11%. The increase in use of non-smoked methods may be explained, the authors claim, by the involvement of a doctor in the process who suggests it.

In another Canadian study in 2015, Shiplo et al found non-smoked methods were the preference of the majority of medical cannabis users. Here 364 current medical cannabis users were recruited from patient lists of nine legal produces. Of these, more (28.3%) reported vaporization as their preferred method than smoking a joint (23.1%). In total, more people (42.9%) reported a non-smoked method than a smoked method (37.6%).

Piper et al, in the US, methods described above, also found a majority preferring non-smoked methods. While smoking joints was the most popular single method of delivery at 48.5%, with vaporizer at 22.3%, edibles 14.3%, tincture 10.8%, concentrates 3.4% and topicals 0.7% a majority (~51.5%) of the preferences were non-smoked.

Given the relatively recent and emerging status of vaporisation as a popular mechanism, we may see a greater prevalence of it over time. The same is potentially true of edibles, clearly not in the sense of it being a new technology, but rather a significant issue with edible products is dose control given how difficult equal dispersal of active elements is through cooked products. As the medical cannabis market continues to function in a legal sphere, it is possible that we will see advancements in better, safer modes of delivery. Equally, the longer cannabis is in the legal medical market, there will be greater opportunity for the creation of more conventional medical forms such as pills, inhalers and sprays.

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541 Lucas and Walsh (n 514) 31 – respondent did not all answer every question and could give multiple answers to this one.
542 Ibid – numbers are rounded up, hence the total of 101%.
543 Ibid 34.
Borodovsky et al surveys a convenience sample, using Facebook, of 2,838 people who had ever used cannabis. Using logistic and linear regressions, data outcomes were analysed based on whether the participants were in a legalised state, how long the state had legalised medical cannabis (no legalisation, 0-5 years, 6-10 and >10 since legalisation) and the density of dispensaries (no legalisation, legalisation but no dispensaries, <1 and >1 dispensary per 100K). Individuals in states with legalised medical cannabis were more likely to have ever vaped (53.8% v 68.6%) or used edibles (68% v 77.6%). Further, of those that had ever tried smoking (>99%), those in non-legalised states were more likely to report smoking as their preferred method of delivery than those in legalised states (84.3 % v 78.9 %). In addition to this, the likelihood of both vaping and edibles is higher after long periods of legalisation have elapsed (>10 years) as opposed to shorter periods (0-5 and 6-10 years). Similarly, states with the highest density of dispensaries have the highest rates of ever trying vaping or edibles and when compared to those states with no dispensaries, states with the highest density of dispensaries had significantly higher chances of ever having vaped or used edibles.545

Similarly, Sznitman, methods described above, finds licensed medical users are more likely than unlicensed and recreational users to vaporize.546 Sznitman further finds that licenced medical cannabis users more likely than others to consume cannabis more frequently, before midday and alone. These items are normally associated with cannabis dependence under the DSM, but in the case of the Sznitman participants, these users had lower rates of cannabis use problems than some of those that did not exhibit these patterns of use. Thus, as would be predicted, those with legal and easy access to cannabis, alternative methods of delivery and medical advice, are more likely to use safer methods and less likely to use more harmful ones.

These studies are non-representative convenience samples and do not therefore tell us specific numbers in any given population. Equally, they are from varying cannabis markets so cannot

combined to form a meaningful picture of exact numbers. Rather, they are a demonstration of the fact that medical cannabis markets do contain and can inculcate some level of non-smoked methods of delivery. Further, most of these studies find individuals are using both smoked and non-smoked methods. The introduction or initiation of a less harmful drug, or drug delivery system does not necessarily imply abstinence from the more harmful one.

**Substitution**

Substitution describes the process of replacing the consumption of one drug with the consumption of another; in this case replacing the consumption of medication, alcohol or illicit drugs with the consumption of cannabis. Evidence of substitution comes primarily from two sources; self-report data from surveys in which medical cannabis users report substitution and quantitative empirical analysis of the effects of medical cannabis legalisation on datasets on drug use, overdose or fatal accidents.

Reiman in 2007 surveyed 130 participants in seven cannabis facilities in San Francisco Bay. 74% of participants reported substituting cannabis for prescription drugs while a smaller but still substantial number reported substituting for alcohol (50%) and illegal drugs (47%). The primary reasons given for substitution were fewer side effects from cannabis and better symptom management, when compared with the substituted substances.\(^\text{547}\)

With an increased sample size, Reiman further studied this issue in 2009. Participants were recruited from a San Francisco medical cannabis collective. 65.8% of participants reported cannabis as a substitute for prescription drugs, 40% for alcohol and 26% for illicit drugs (26%).\(^\text{548}\) The same reasons for substitution were given as the previous study with 85% of participants noting that cannabis has less adverse side effects than prescription medication.\(^\text{549}\)

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\(^\text{547}\) Ibid 42.
\(^\text{548}\) Ibid.
\(^\text{549}\) Ibid.
Two studies conducted similar surveys, but in cannabis practices rather than dispensaries/collectives. These are clinics which charge $100-125 to receive a doctor’s assessment of whether a person would benefit from being allowed access to cannabis. This does not necessarily imply that the participants were not current medical cannabis users as they could be seeking reauthorisation as many clinics only offer one-year authorisations. In the first study, Reinarman et al surveys 1,746 consecutive participants from nine Californian practices.\(^{(550)}\) 50.9% of the participants reported that they had substituted cannabis for prescription drugs and 13% for alcohol.\(^{(551)}\) 73% of the participants reported having previously tried prescription drugs.

Second, Nunberg et al achieved almost identical results but with different methods.\(^{(552)}\) Data was taken from 1,655 participants in nine cannabis speciality MediCann clinics throughout California. Rather than surveying them directly, data was taken from their medical charts and doctor’s notes of interviews. 50.8% of the participants reported (to their doctors in the initial assessment, not to Nunberg et al) substituting cannabis for prescription medicine while 13.2% reported substituting for alcohol.\(^{(553)}\) Further, 47.6% were taking prescription meds at the time of the evaluation, while 79% had taken prescription in the past. 48% of participants had either tried prescription opioid in the past or were still on them at the time of evaluation.\(^{(554)}\) The precision of the data from Reinarman and Nunberg suggests that the reporting to doctors and surveyors is similar.

Two further US studies utilised more varied surveys. Boehnke, Litinas and Clauw surveyed 374 patients at a Michigan cannabis dispensary between 2013 and 2015. Of these, 184 used cannabis for chronic pain control.\(^{(555)}\) When comparing before and after cannabis initiations there were large reductions in the use of opioids from 65% of participants to 18%, anti-inflammatory drugs from 62% to 21% and antidepressants from 39% to 14%.\(^{(556)}\) The 65% of participants who used opioids were asked

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\(^{(550)}\) Reinarman (n 514).
\(^{(551)}\) Ibid 131.
\(^{(552)}\) Nunberg (514).
\(^{(553)}\) Ibid 7.
\(^{(554)}\) Ibid 10.
\(^{(555)}\) Boehnke, Litinas, and Clauw (n 514) 741.
\(^{(556)}\) Ibid 742, 743, for a full breakdown of all the reductions in different drugs see table 4.
to express their reduction or increase in opioid use as a percentage. The average reduction was 64%. Thus, there is a large average reduction in the number of opioids used and a large number of people abstaining completely following medical cannabis initiation. Participants were also asked to rank the “degree to which side effects of medication affect daily function” before and after using medical cannabis on a scale of one (no effect) to ten (significant effect). The average score reduced by 3.72 from 6.51 to 2.79 when comparing before and after medical cannabis initiation.\textsuperscript{557}

Zaller et al surveyed 200 people in dispensaries in Rhode Island, 100 each in an urban and rural dispensary.\textsuperscript{558} Again, a significant substitution effect was found as 42\% of participants reported substituting cannabis for either alcohol or illicit drugs and 55\% reported substituting for prescription drugs.\textsuperscript{559} Of this latter group, 91.5\% reported fewer side-effects from cannabis. Interestingly, however, 73\% of participants noted that they still required pain treatment additional to their use of cannabis.\textsuperscript{560} Thus it appears that in some cases cannabis allows a patient to reduce, rather than eliminate, the use of opioids. However, as Zaller notes in discussion:

Studies have shown that co-administration of vaporized cannabis with morphine or oxycodone acts synergistically to relieve pain without affecting opioid plasma levels (Abrams et al. 2011). Thus, the addition of cannabis to pain management may be a safe alternative to exclusive opiate based therapy.

A reduction in opioid use, even if it is not total, will likely lead to a lower risk of harm and overdose. Though given the fine balance and difficulty with mixing medications, this emphasises the salience of involvement by a prescribing doctor.

This theme of potential reduction, as oppose to abstinence is picked up by Piper et al who surveyed 1,531 participants recruited from dispensaries in Maine and Vermont. Data is taken from

\textsuperscript{557} Ibid.
\textsuperscript{558} Zaller (n 514).
\textsuperscript{559} Ibid 21.
\textsuperscript{560} Ibid.
those who are still taking prescription drugs. Of the 215 still taking opioids, 76.7% reported reducing their opioid use ‘slightly’ or ‘a lot’, similarly high numbers were reported from those who still took but substituted anxiety (71.8%), migraine (66.7%) and sleep (65.2%) medications with smaller numbers for alcohol (42%) and antidepressants (37.6%). Further, participants were asked to express the relief they got from cannabis on an 11 point scale from ‘0%, no relief at all’ to ‘100%, complete relief’. Averages across different types of pain ranged from 72% to 77.9%.

A stream of studies from Canada corroborates some of the US results. Lucas et al surveyed 404 randomly selected participants in four Canadian dispensaries. As explained earlier, while such dispensaries are largely tolerated, they’re outside the protection offered by the Access to Cannabis for Medical Purposes Regulations. 75.5% of participants report substituting cannabis for some other substance with prescription drugs being the most commonly substituted drug (67.8%), followed by alcohol (>41%) and illicit substances (36.1%). The primary reasons given for the substitution were that cannabis has fewer side effects (39.6%), is better at managing the symptoms (53.9%) and leads to less withdrawal (67.7%). Interestingly those who reported substituting cannabis for alcohol are statistically more likely to be alcohol users than the participants who did not report this. This emphasises that substitution does not necessarily imply abstinence from the substituted substance. Rather, a person may no longer drink when in pain as cannabis is a better reliever of that pain, but still drink recreationally. Indeed, one would expect this in alcohol substitution, given the high population prevalence of recreational alcohol use. Further this type of substitution may not show up in data sets which study prevalence measures such as last year, last month or even last week alcohol use, but may be detected by intensity measures such as number of drinks/units consumed weekly.

In 2016 Lucas et al again surveyed medical cannabis users in Canada, this time using the

561 Ibid.
562 Ibid 471.
563 Lucas et al (n 514).
564 Ibid 439, the figure for alcohol is written in the study as “over 41%”.
565 Ibid.
Cannabis Access for Medical Purposes Survey of 473 participants completed online or in hard copy at dispensaries. The survey analyses whether cannabis substitution differs over different conditions and symptoms. The majority (87%) of participants reported substituting cannabis for one or more of the 3 classes of substances; prescription drugs (80%), alcohol (52%) and illicit substances (33%). While a plurality (37%) of these substituted for only one class of drug a significant number substituted for 2 (26%) and 3 (25%), respectively. Predictably, those who use medical cannabis to treat pain related conditions and symptoms were more likely to substitute for prescription medications then those with other conditions.

Most recently, Lucas and Walsh conducted a survey of 271 participants from Tilray, a licensed cannabis vendor in Canada who funded the study and for whom one of the authors, Phillippe Lucas, works. Like all other surveys above, a majority (71%) of the participants reported substituting cannabis for something else, 63% for prescription medications, 25% for alcohol, and 12% for tobacco. The substitution for illicit drugs was much smaller than most other studies at 3%. The most common prescription drug substituted for were opioids (32%) followed by benzodiazepines (16%) and antidepressants (14%). Again, the most common reasons for switching to cannabis were fewer adverse side effects (39%), cannabis being safer (27%) and better symptom management (16%).

The results of these surveys are consistent, showing a substitution effect of cannabis for prescription medication, alcohol and other illicit substances, ranked in that order, with prescription medication being the strongest. Similarly, the surveys show that the prescription drugs most substituted for are pain medication, particularly opioids, about which there are serious public health concerns. These results must be treated with caution as these studies are self-selected and conducted in cannabis selling establishments. Thus, there is a need to corroborate these finding with quantitative analyses of the effects of medical cannabis legalisation on datasets of opioid and alcohol harm.

Using death certificate records from the Centres for Disease Control and Prevention,
Bachhuber et al examines the link between legalisation and opioid overdose. They select all deaths coded as fatal drug overdose and opioid analgesic from 1999 to 2010, thus testing for illicit or licit, intentional or accidental overdoses.\(^{569}\) There were ten states which legalised during the study period, for which a time series regression was used.\(^{570}\) Data was further analysed based on the time elapsed since the law changed, giving estimates for each year after implementation. Medical cannabis legalisation was associated with a mean 24.8% lower annual rate of overdose, resulting by 2010 in an estimated 1,729 fewer opioid deaths than would have been forecasted had the laws not been implemented. This effect strengthened over time; from one to six years following the law the estimated reductions in annual rate of overdose were; \(-19.9\%\), \(-25.2\%\), \(-23.6\%\), \(-20.2\%\), \(-33.7\%\) \(-33.3\%\).\(^{571}\) These results hold statistical significance both when intentional deaths are excluded and when heroin deaths are included. Equally, there was no association between overdose and cannabis laws one or two years prior to the change in law, strengthening the attribution of this change in overdose rates to the change in law.\(^{572}\)

Shi et al’s methodology is described above in relation to cannabis hospitalisation. They further study opioid hospitalisation. They find that the implementation of medical cannabis law is associated with a 23% reduction in hospitalisations related to opioid abuse and dependence and a 13% reduction in overdose hospitalizations.\(^{573}\) This effect was strongest a year after implementation, though still significant thereafter and was not seen in the years prior to implementation.\(^{574}\)

Powell, Jacobson and Pacula address two measures of opioid harm; admissions and overdose death. On admissions they examine pain reliever addiction admission using the TEDS from 1999-


\(^{570}\) Ibid.

\(^{571}\) Ibid 1670.

\(^{572}\) Ibid 1671.

\(^{573}\) Shi (n 434) 146.

\(^{574}\) Ibid.
For opioid related deaths they use National Vital Statistics System – a census of US deaths – from 1999-2013. The data include overdoses of any intent. For both datasets a difference in differences analysis is conducted using non-legalised states as controls, complemented by an analysis of both lagged effects and pre-existing trends. They find that legalisation with operational and legal dispensaries led to a 25% reduction in overdose death. However, when testing simply for legalisation, there is no statistically significant effect. Similarly, for opioid and heroin admissions the reduction attributable to legalisation is not statistically significant, while the additional 38% reduction following legalisation with operational and legal dispensaries, is.

Powell et al also analyse the levels of legal distribution of opioid using the Drug Enforcement Administration’s (DEA) Automation of Reports and Consolidated Orders System (ARCOS) – which tracks legal distribution of controlled drugs between manufacture and retail – from 2000 -2013. When measuring ‘morphine equivalent doses of the 8 most commonly abused opioid analgesics’ they find, no statistically significant effects of legalisation of dispensaries on the distribution of these drugs.

Kim et al analyse opioid positivity in car accidents using the FARS dataset 1999 – 2013. First, when comparing the odds of opioid positivity before and after legalisation in states, 21-40 year olds were found to have statistically significant lower odds of opioid positivity after legalisation. This is the only age group where a significant result was found. This was tested in differences in differences analyses in four specific states. While all four showed reduced opioid positivity post legalisation, none were statistically significant. Thus, while the effect can be seen in the whole population of legalised

576 Ibid.
577 Ibid 33.
578 Ibid 35.
579 Ibid 31.
580 Ibid.
581 Ibid 36.
583 Ibid.
584 Ibid 2035.
states, it was not in those four.

If these reductions in overdose and misuse in medical cannabis states are real, a potential cause of this could be people being prescribed opioids at a lower rate. Bradford and Bradford sourced data from 2010 – 2013 from Medicare Part D, which forms the prescription service of the Medicare programme. Data was gathered on off and on-label medications that were used to treat nine conditions for which medical cannabis was used (anxiety, depression, glaucoma, nausea, pain, psychosis, seizures, sleep disorders and spasticity).\textsuperscript{585} Bradford and Bradford employed a difference in differences analysis for pre and post legalisation for each of the nine conditions. For all but two conditions, glaucoma and spasticity, they found that the implementation of effective medical cannabis legalisation led to a statistically significant decrease in the mean daily dose prescribed per physician per year. This ranges from a reduction of 1,826 in the case of pain to 265 in the case of depression.\textsuperscript{586} This result is expected from the above research findings of a stronger substitution effect for opioids and other pain medications rather than for depression. Indeed, the reduction in the prescribing of pain medication is much greater than the medications for any other condition.\textsuperscript{587} A study by Kim et al supports the notion that the reduction in opioids is as a result of lower medical use as oppose to nonmedical use. Here the NSDUH was utilised from 2004 – 2013 to test whether the legalisation of medical cannabis along with the provision of effective access lead to increases in the nonmedical use of prescription opioids. Utilising a multilevel linear regression, there was no association between nonmedical use of opioids and the legalisation measure among the 12-17 and 18-25 age groups. There was a reduction in the 26+ group, but this was not statistically significant.\textsuperscript{588}

These studies collectively provide good evidence for the protective effects of medical cannabis legalisation, in some form, on opioid related harm. Unlike the other studies however Powell et al do

\textsuperscript{585} Ashley C Bradford and W David Bradford, 'Medical Marijuana Laws Reduce Prescription Medication Use In Medicare Part D' (2016) 35(7) Health Affairs 1230.
\textsuperscript{586} Ibid 1234.
\textsuperscript{587} Ibid.
not find an effect of medical legalisation alone – save for an estimated significance after three years in the first-time delay model – but do find an effect for dispensaries. The use of different datasets and study periods may explain the discrepancy; for instance, the Treatment Episodes Dataset previously found (in the Pacula et al study, described above) that dispensaries lead to an increase in cannabis use but legalisation alone did not, if cannabis and opioids are a substitute then this is consistent (within this dataset) with the finding that dispensaries lead to a reduction in opioid admissions, but legalisation alone does not.

Having analysed opioids, we move to alcohol substitution, about which there is less research. There is significant and contradictory evidence on whether, in general, alcohol and cannabis are complements or substitutes. This ambiguity is, unfortunately, extended into the research on medical cannabis legalisation.

In a thorough examination of the issue, Anderson, Hansen and Rees use the FARS dataset 1990 – 2010 and test for two types of alcohol positivity in fatal accidents; any positive blood alcohol concentration (“BAC > 0”) and blood alcohol concentration above .10 (“BAC > .10”). Whether traffic fatalities fell because of legalisation was tested through a difference in differences model. Post-legalisation average traffic fatality rates fall faster in legalised states as oppose to non-legalised states. The effect is estimated as a 10.4% reduction in the traffic fatality rate associated with medical cannabis legalisation. This analysis was repeated with the BAC > 0, BAC > .10 and ‘no alcohol’ measures to test whether the effect is different depending on alcohol positivity. The reduction in traffic accidents not involving alcohol was statistically insignificant. Conversely, there were statistically significant reductions of 13.2% in traffic fatalities involving any alcohol positivity associated and 15.5% in fatalities where at least one driver had a BAC above .10. Thus, the reduction in traffic fatalities associated with medical cannabis legalisation comes disproportionately from traffic accidents

589 Meenakshi Sabina Subbaraman, ‘Can Cannabis be Considered a Substitute Medication for Alcohol?’ (2014) 49(3) Alcohol and Alcoholism 292.
590 Anderson et al (n 397) 342.
591 Ibid 345.
involving alcohol. Further, legalisation was associated with a statistically insignificant decrease in traffic fatalities during weekdays but a statistically significant 10.7% decrease on weekends. Similarly, there is a statistically insignificant decrease during daytime whereas the decrease of 11% during the night is statistically significant.\(^5\) Thus the decrease in traffic fatalities occurs more when one would expect it to, if it were mediated by alcohol consumption; weekends and evenings.

Thus, Anderson et al appear to have demonstrated that the traffic fatalities reduce after medical cannabis legalisation and that this is likely mediated, at least partially, through reductions in alcohol related accidents. To add weight to this conclusion the Behavioural Risk Factor Surveillance System dataset 1993 – 2010 is analysed to show legalisation is associated with reduction in many categories of drinking across different ages. Most prominently among 20-29 year olds there is a 5.3% reduced probability of consuming any alcohol in the last month, 19.6% reduction in the probability of consuming more than 60 drinks and a 10.6% reduction in the number of drinks consumed. Equally there is a “sharp” reduction in measures for any binge drinking in the last month in 18-19 years olds (9.4%) and 40–49 year olds (8.8%) and a 7.4% reduction in the probability of at least two binges in the last month for 20-29 age groups.\(^5\) The final piece of evidence adduced by Anderson et al is from alcohol sales, data for which is supplied by the Brewers Almanac from 1990 – 2010. Here legalisation is associated with a statistically significant 5% reduction in beer sales, but there is no statistically significant reduction for wine and spirit sales.\(^5\) Anderson et al provide good demonstration that medical cannabis is a substitute for alcohol and legalisation of the former leads to a reduction in use of the latter and therefore traffic accidents related to it.

Wen, Hockenberry and Cummings, methods described earlier inject a note of doubt on the conclusion made in Anderson.\(^5\) They find that in the over 20 age group, medical legalisation is not associated with increases in the number of drinks but is associated with an increase in the number of

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\(^5\) Ibid 350.
\(^5\) Ibid 355 – 357.
\(^5\) Ibid 357.
\(^5\) Wen (n 422) methods were described earlier discussing cannabis prevalence; the same methods are used for alcohol.
binge drinking days by 0.16, or 10%. Complementarity is further demonstrated by there being a 22% increase in the probability of both cannabis and binge drinking in the past month and an 18% increase in the probability of cannabis use while drinking. No significant change is seen in the under-21 age group.  

Given this conflict and ambiguity in the data, it is not possible to conclude on whether alcohol is a substitute or complement to medical cannabis.

Very little research has been done on whether the legalisation of medical cannabis leads to increases in other illegal drugs. Chu however, replicating his above study finds that with an increase of 8-10.6% in the ratio of cannabis arrests, following legalisation, there is a concomitant 12.2-15.3% decrease in the ratios of heroin and cocaine arrests – the data group heroin and cocaine together as one. Though, unlike the cannabis results, there are not statistically significant when city specific trends are accounted for. On the treatment data, a 5.9% increase in treatment admissions is found for any cannabis treatment, with an 8.6–9.5% increase in primary admissions. For cocaine the results were never significant. For heroin, however, there is a decrease in any treatment admission of between 10.2–20.2% and a decrease in primary treatments by 13.1-23.9%. These estimates increase when criminal justice referrals are excluded, though for cocaine they remain statistically insignificant. These results are potentially indicative of the fact that medical cannabis is a substitute for heroin, though more research on this question is needed.

596 Ibid 72.
597 Chu (n 433) 496.
598 Ibid 507.
Chapter eight: The proportionality test

Chapter six demonstrated that there is an infringement of human rights in need of justification. This chapter will explore the proportionality of that justification. Consistent with the constitutional, human rights approach taken in this thesis, this discussion will be presented within the framework of the proportionality analysis used in human rights cases. Thus the four questions raised in the Bank Mellat proportionality test and outlined in Chapter three form the structure of this chapter, these are: does the prohibition of medical cannabis pursue a legitimate aim which is sufficiently important to justify an infringement on human rights; is there a rational connection between the prohibition of medical cannabis and the objective of the measure; is prohibition no more restrictive than necessary in order to achieve the objective and; is there, overall, a fair balance between the achievement of the objective and the harm done to the right? In answering these questions, the conclusions from the available evidence – explained in the previous chapter – will be referenced throughout.

Legitimate aim

The proportionality analysis requires two initial inputs; the challenged policy and the aim of that policy. The proportionality of the measure is judged against its aim. The first of these inputs, the challenged policy, is the placement of cannabis into Schedule 1 of the Misuse of Drugs Regulation, despite its medical value. As this is a thesis and not a case in which the government have submitted a policy objective, the potential objectives which justify this policy must be inferred. There are, however, some bases on which we can proceed. First, the aim of the policy, in order to be justified, must pursue one of the stated aims mentioned in the Convention. Second, previous case law on attempts by the UK to justify the human rights infringing effect of prohibiting a drug have relied on ‘health and public safety’ as a justification. This was so in Taylor, which concerned the religious use of cannabis and Article 9 (which includes a qualification clause similar to that in Article 8). Having accepted that the prohibition on cannabis limited Taylor’s right to manifest his religion, the government justified this limitation on the basis that the ‘unqualified ban on the possession of cannabis, with intent to supply,
is necessary to combat public health and public safety dangers arising from such drugs\textsuperscript{599}. Similarly in Andrews, also about the religious use of cannabis, this time challenging the prohibition on its importation under Section 170(2) of the Customs and Excise Management Act 1979, the justification for the infringement was deemed to be based upon ‘public health’.\textsuperscript{600} Unfortunately, in both these cases the treatment of the proportionality discussion is both brief and not directly relevant to medical use of drugs. Thus, given that Quayle, as previously argued, also offers no guidance on this matter, the UK case law offers little indication of what the objective of the prohibition on medical cannabis is, in any more detail than the proposition that the state views the prohibition of cannabis as pursuing the objective of public safety and health. This is supported by the scope of the, recently announced, review into medical cannabis, which states that “[the review] will provide an assessment based on the balance of harms and public health needs.”\textsuperscript{601}

A further confirmation of what the aim of prohibiting medical cannabis (or at least prohibition more generally) is, can be found in the introductory text of the Misuse of Drugs Act, under which authority the Misuse of Drugs Regulations are enacted, which states that it is “[a]n Act to make new provision with respect to dangerous or otherwise harmful drugs and related matters.”\textsuperscript{602} These sentiments chime with the overall purpose of the international prohibitionist regime which is, in the preambles to the drug conventions, described as tackling ‘addiction’ and ‘the social and economic danger’ of drugs and being concerned with ‘the health and welfare of mankind’ and ‘the public health and social problems resulting from the abuse of certain psychotropic substances’.\textsuperscript{603}

Given this, we are provided a fairly safe assertion that prohibition of medical cannabis is

\textsuperscript{599} Taylor (n 215) (emphasis added – the case concerned possession with the intent to supply, but the principle of justification is the same).
\textsuperscript{600} R v Andrews [2004] EWCA Crim 947 [21].
\textsuperscript{602} Misuse of Drugs Act (n 13)
\textsuperscript{603} Single Convention (n 1) preamble; Convention on Psychotropic Substances (n 39) preamble.
pursuing the aims of public safety and health.\textsuperscript{604} The question then becomes by what mechanisms would the legalisation of medical cannabis lead to increase public health harms. Many commentators have linked the policy of legalising medical cannabis with increased recreational use of cannabis, particularly in adolescents, and consequent public health harms.\textsuperscript{605}

The veracity of these claims is addressed in the rational connection section. For present purposes it will be useful to explore in more detail the nexus between drugs policies and resultant harms. A good starting point in this regard is the MacCoun and Reuter’s analysis of what contributes to the total harm of drugs:

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\text{Total drug-related harm} = \text{Harmfulness (average harm per dose)} \times \text{Prevalence (number of users)} \times \text{Intensity (number of doses per user).}\textsuperscript{606}
\]

Any policy which would increase one or more of the three factors without decreasing the others would increase total drug harm. Equally, any policy which would decrease one or more of the three factors without increasing the others would decrease total drug harm. As MacCoun and Reuter point out, while these three goals – reducing harmfulness, prevalence and intensity – are not mutually exclusive, they will come in to conflict from time to time.\textsuperscript{607} It could be the case, for example, that legalising MDMA would cause an increase in prevalence/intensity due to increased availability but decrease harmfulness through regulation of adulterants and dose sizes.\textsuperscript{608}

It is also possible that a policy may both add to and detract from the same factor. For instance, a policy which increases cannabis use may decrease opioid or alcohol use. How positive this is viewed

\textsuperscript{604} Mark Anderson and Benjamin Hansen, ‘Medical Marijuana Laws and Teen Marijuana Use’ (2015) 17(2) American Law and Economics Review 495, 496.
\textsuperscript{607} Ibid.
\textsuperscript{608} This is an illustrative example; I am not expressing a view on whether it is true.
to be will depend on the variance, if any, that the different drugs have with regards to the other two arms of the equation (i.e. is the intensity and harmfulness of the substituted drug greater or lesser than that which replaced it?)

Similarly, harmfulness should be seen in as broad a way as possible, including more than the merely physiological harms that the taking of a drug causes for the users, such as harms relating to safety, criminal justice and government expenditure. As far as the proportionality test is concerned, any harm that could be identified under a legitimate aim listed in the Convention could be included in the analysis. Indeed, the source of the harm of the drug may not always be the taking of it, but instead the enforcement of its prohibition. Equally it would be wrong to assume that the only effect of a drug is harm; there are also benefits. The most obvious of these benefits is that which is taken from the experience of drug use by the user, be that pleasure or social bonding (in the case of recreational users) or treatment (in the case of medical users).

Drug use should be viewed, therefore, as a balance of harms and benefits. The likelihood of the harms outweighing the benefits is greater when drug use is related to addiction, binge using and other problematic substance use behaviours. Instructive, therefore, is the United Nations Office of Drugs and Crime, who have consistently estimated that the percentage of drugs users who have drug use problems is around 11%.

This therefore leads to another detail to add to the harm formula; all prevalence is likely not equal. As MacCoun and Reuter hypothesize, those that would take a drug in a system of legalisation but not one of prohibition are likely to be more cautious users, thus the average user in legalisation is likely to be safer, even if more people are users. Indeed, the Normalisation Thesis posited that drug use becoming normalised in society, and more people therefore using drugs,

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610 ECHR (n 8) Article 8, ‘economic well-being of the country’ and the ‘prevention of disorder or crime’ are also possibilities, though these do not appear to be used of justifications in the drugs and human rights case law.
611 MacCoun and Reuter (n 606) 64.
613 MacCoun and Reuter (n 606) 64.
'would be associated with a shift in the recruitment of substance users from risky, deviant segments to non-risky, well-adjusted segments of the youth population'. This is a prediction that Sznitman et al tested and confirmed. Thus if a given policy increases prevalence, it is important to, if possible, identify what types of users this includes; if they are safer and less intense users, this will require a different weighing exercise than if they were heavy, risk taking users.

Given the above, the prohibition on medical cannabis can be related to health and public safety to the extent that it is aimed at reducing harm per dose of cannabis, reducing the number of users or reducing the amount that users use, or is associated with reduced use of more harmful substances. Indeed, in legal terms, given the extremely low bar that is set for the legitimate aim arm of the test, a policy which is aimed at doing any of these things would have a sufficiently important objective in the Bank Mellat sense. The question then becomes, therefore, in what sense does the prohibition of medical cannabis reduce total drug harm? It is that question that is addressed by the rational connection inquiry.

**Rational connection**

As stated earlier, a rational connection must exist between the legitimate aim and the specific element of the policy which is challenged. Thus, we must examine whether the decision to place cannabis into Schedule 1 of the Misuse of Drugs Regulations, and thereby prohibit its medical use, can be said to protect health and public safety. Analogy here can be drawn to Nicklinson where an absolute prohibition (in that case assisted dying) was called into question. There, as here, there needs to be an examination of the risk of lifting that prohibition and thus consider evidence of the harms, or not, of legalisation. To do this it must be shown that the legalisation of medical cannabis in some way harms health. As noted above, there is a link made between increases in prevalence and increases in harms.

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This runs on the assumption that as some harm accrues from cannabis use, increases in use will, as a matter of logic, represent an increase in harm. Given the significant and largely consistent negative results on the link between legalisation and the risk of increased adolescent use of cannabis, the rational connection between prohibition and protecting children from increased cannabis related harms is weak. While there was a demonstration of diversion to children and this provides a plausible, logical reason why legalisation might include adolescent use, there was no demonstration of increase prevalence, harmfulness or intensity when testing for legalisation alone and even some evidence of a decrease in prevalence. The one credible exception for this is the Wen et al study, which did show an increase in the experimentation with cannabis, but no uptake in regular or continued use; while this effect should be further tested and monitored, from the perspective of total drug harm, it barely registers. Thus, the notion that medical cannabis legalisation alone harms children, at least given current knowledge, does not appear to be supported. Pacula et al did find there to be an increase in youth use associated with dispensaries. But this conflicted with a number of other studies, which did not. Smart’s lax vs strict model analysis does show an increase in adolescent use, but it is by far the smallest effect size and only occurs in the lax model of regulation.

Thus, while the evidence that legalisation of medical cannabis causes increases in the use of cannabis among children is weak, the above analysis does not go so far as to disprove it entirely, especially given that there appear to be some forms of legalisation which do run that risk. This is especially true given the demonstration of significant levels of diversion to adolescents. Thus, given the low bar that the rational connection test erects, it cannot be stated with certainty that the measure would not overcome it here, though it certainly would not do so convincingly. The weakness of the evidence on adolescent prevalence is referenced specifically for two reasons. First, as noted above, much of the literature and fear surrounding the legalisation of medical cannabis was focused on adolescents and the prospects of their increased use. Second, there is medical evidence that the harms associated with cannabis are more acute and various when the drug is taken by younger
Thus, the prohibition of medical cannabis would be more likely to be viewed as proportional if there was a plausible risk of increased adolescent use from legalisation. This is to say that the strength of the justification of prohibiting medical cannabis would have been made much stronger, had it been able to identify a risk to children. This is not to say, however, that an increase in adult use is not legally significant. For adult use, while the evidence is mixed, there is a plausible risk that the legalisation of medical cannabis, in some of its policy variations, is liable to increase adult prevalence, and therefore potentially overall drug harm, to some degree. This is true both when evidence tests of legalisation, dispensaries and other models, and commercialisation. As a clear matter of logic, if the finding is that legalisation, or at least some forms of it, might be associated with these negative outcomes, then the continuation of a state of non-legalisation, or prohibition, is clearly a way of eliminating that specific risk. That there is some empirical evidence of the risk of increased adult use when legalising medical cannabis is likely enough, therefore, to pass this stage of the test. Two caveats are required here. First, the evidence of increases in prevalence as a result of some form of legalisation is mixed in almost all instances, thus while some evidence of increases is present, the risk cannot be viewed, in proportionality terms, as especially high.

Second, the rational connection test, as a threshold test, is concerned in this context only with the establishment of a risk that the challenged policy logically combats. The harms of the challenged policy itself, the additional benefits that might be gained from its discontinuation and the nuances between different forms of legalisation are all fodder for final two stages of the test. To which we shall return.

On the other metrics of potential harm, intensity and harmfulness, the evidence shows very little, if any, risk of legalisation, in any form. As noted, one study shows a small rise in potency associated with

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617 This is not to say that the risk of increase prevalence, in general, is eliminated by prohibition, it clearly is not.
dispensaries. However, the risk of increased potency relies on potency of medical cannabis being higher than that of recreational cannabis, which is not a necessary feature of legislation. This contrasts with the increase in prevalence, the potential for which is necessarily created by increasing the supply of cannabis. Legalising medical cannabis is, by definition, increasing availability of cannabis whereas it is not, by definition, increasing the potency of cannabis. Further, the evidence is mostly silent of the question of intensity, i.e. whether legalisation of medical cannabis leads users to use more than they otherwise would have done.

Given this, the justification for prohibition appears to rest on the association between medical legalisation, increased prevalence and resulting harm.

**Necessity**

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 a less rights-restrictive way. Given the human rights restriction in question is denying access to medical cannabis to those who need it, a less rights-restrictive policy would be any that would, as oppose to current prohibition, allow for some access. Thus, our inquiry is whether there are any options that, on the balance of probability, would, or do, both allow for access to medical cannabis but remain as protective of above noted risks to public health as prohibition. It is my contention that such options are available and therefore the justification for prohibiting medical cannabis must fail at this point. This argument is advanced in the following way:

- Legalisation of medical cannabis comes is many different regulatory forms.
- The harms, such as they are, in the American system stem primarily from the lax and non-medical nature of the ‘medical’ cannabis programmes that promulgate there.
- A tightly controlled, medical model would significantly reduce the risk of increased prevalence, making absolute prohibition unnecessary.
An analysis of the likely regulatory framework for medical cannabis in the UK – Schedule 2 of the Misuse of Drugs Regulations – reveals it to be a tightly controlled, medical model.

This section, therefore, builds on the hypothesis that there are some approaches to legalisation that are much more likely than others to lead to increases in prevalence. Indeed, one would expect the vast array of different regulatory options that exist when legalising medical cannabis to have different effects.

The research on prevalence was far from conclusive. Both when testing solely for legalisation and when testing for different types of legalisation policy, the results were mixed. When analysing data based on whether the model in general was strict and medical or lax and nonmedical, the data appear to show the increases in the prevalence and harm are concentrated in the latter models, mediated through the size of the medical cannabis markets, as represented by registration rates. The evidence suggests, therefore, that legalisation, in general, can sometimes be associated with an increase in prevalence, but that this increase is largely concentrated in places where a nonmedical, lax model of regulation proliferates. From this we can glean several policy levers to attempt to pull in order to reduce the harm of medical cannabis legalisation. This is primarily to be achieved, the evidence suggests, by creating medicalised models with strict supply regulations for medical cannabis. Such models could include low possession limits; regulation of suppliers, both through requiring labelling, testing and monitoring and not allowing caregivers; a robust system for deciding who may get access to medical cannabis, which includes a continuing relationship between doctor and patient, preferably under a Dutch-prescription model, and a requirement of the level of specificity when allowing cannabis use for “chronic pain”; and finally a prohibition on the sale of smoked cannabis for medical purposes, which would also preclude home cultivation.

This combination of policies, as oppose to the lax, commercialised regulatory legalisation creates benefits: It would control and limit the number of patients which in turn keeps the medical market smaller and avoids increases in prevalence through diversion. Indeed, many of the stricter controls, such as supply limits, possession limits and continuing relationships with doctors will combat diversion.
either by lessening the degree to which people can pass legitimately prescribed cannabis to others and/or by limiting the number of recreational users involved in the medical model.

Thus, a model resembling this, evidence-based model should form the basis of comparison against which the prohibition of medical cannabis is judged. Given the analysis that increases in prevalence, such as they are, resulting from legalisation can be traced almost entirely to lax, nonmedical models it is difficult to see, or at least difficult to evidentially demonstrate that prohibition is necessary in order to protect against the risks of increased prevalence.

As stated in Chapter three, the suggested alternative in the necessity stage will stand a better chance of being accepted if it maps onto a policy or regulation that already exists. It is of relevance, then, that Schedule 2 of the Misuse of Drugs Regulations, into which cannabis would be moved upon medical legalisation, provides many of the strict, medicalised features that are associated with low participant rates and therefore no increases in prevalence. The Misuse of Drugs Regulations requires, for example, a prescription for any scheduled drug. This in turn creates the requirement for a doctor patient relationship, and by virtue of Regulation 15(1)(f-g) requires a specification of the dose, the total amount to be supplied and the intervals between which it supplied may be given, which in practice acts as a possession limit. This model does not allow home cultivation, and therefore does not allow “caregivers”. It similarly requires accurate labelling and therefore dosing.

Furthermore, and just as importantly, stricter, more controlled, medical models will allow for the creation and medical proliferation of non-smoked cannabis with a more favourable CBD/THC ratio than the recreational stock. If medical cannabis is less “potent” in the sense of having a higher CBD/THC ratio and supplied through vaporisation (for example) then it will have two benefits. First, it will protect the patient against the negative effects of long-term use of high potency cannabis and of inhaling burned substances. Second, if such cannabis is diverted, it will likely be safer than the cannabis found in the illegal, recreational market, and can thus minimise the harm of that diversion. The

618 Tigere (n 159) [38], [64]; Nicklinson (n 117) [314]-[318].
619 Misuse of Drugs Regulations (n 19) Regulation 15.
620 Ibid Regulation 18.
proliferation of safer cannabis will be addressed in more detail in the next section. However, for current purposes it is sufficient to note that the availability of this option and the regulatory model of Schedule 2 of the Misuse of Drugs Regulations provide sufficient safeguards to protect against the potential harms of ending the prohibition of medical cannabis while offering access for patients, and thus being less intrusive in the proportionality sense.

The justification for absolute prohibition therefore fails at the necessity stage.

**Fair balance**

The conclusion in the preceding section – that the justification for the prohibition of cannabis fails at the necessity stage – is the most defensible given current evidence. Given this, such prohibition breaches the Human Rights Act irrespective of how it performs at the fair balance strange. We must allow, however, for the possibility that the conclusion at the necessity stage is wrong. Indeed, given the messy nature of the empirical data and the lack of good empirical work from outside the US, there is certainly a possibility for research to emerge showing that tightly controlled, medical models with relatively low enrolment rates still lead to increased recreational use through diversion. Or that some other mechanism that connects legalisation and harm is found.

Given this, it is important to proceed through to the conclusion of the proportionality test and analyse whether there is an overall fair balance between the benefits and the harms of absolute prohibition of cannabis.

What ‘fair balance’ requires, as a test, is the analysis of whether the harm the policy does to the human right is balanced against the benefit it achieves to the legitimate aim. As already noted, however, a wider range of harms and benefits are also considered at this stage, so long as they are relevant to the rights or legitimate interests in question. As the previous sections of focused on the potential harm of medical cannabis legalisation (and therefore the benefits of prohibition), this section will look at the benefits of the medical cannabis legalisation (and therefore the harms of prohibition). These come in broadly three categories; medical and other benefits to medical cannabis users, proliferation of safer forms of cannabis and substitution.
Benefit and harm to the medical cannabis user

The primary, or at least most obvious, benefit of medical cannabis is to the patients who use it. I begin with an exemplification of the benefits of medical cannabis by looking at the claimants in Quayle. Mr Quayle was an amputee who suffered severe pain which kept him awake for an average four hours during the night. Doctors and professionals in the case recognised that his pain was relieved by cannabis, that cannabis may be better than other prescription medications and that it helped him with his sleep. He could not, he claimed, use diazepam or temazepam as they ‘knocked him out’ and this was injurious to his ability to look after his children. All these facts were accepted by the government, who were defending his prosecution against an appeal. Mr Wales - joint claimant with My Quayle - had a litany of serious injuries and ailments. Because of these he suffered from chronic pain, for which he was originally prescribed and subsequently became addicted to, dihydrocodeine – an opiate. He started using cannabis in order to relieve his pain while trying to rid his addiction. Cannabis also allowed him to retain his appetite, which opiates did not. Again, in this case, these medical facts were attested by the claimant’s personal doctors, other medical and research professionals as well as accepted by the government, who (at least in the appeal stages) argued against the case on legal principle, rather than on fact.621

These two instances mirror, in their severity at least, the Billy Caldwell and related cases discussed in the introduction and covered in more depth in the next chapter and the case of Parker all of which involved making cannabis inaccessible to people with life threatening epilepsy. In all such cases we have a strong demonstration of benefit to the individual user; more effective pain relieve for severe, debilitating pain or more effective treatment for an extremely debilitating and life threatening condition, with the additional benefit of better and more manageable side effects (less drowsiness, retention of appetite, less addictive). The criminal law as it stands gives such patients the choice of either not taking cannabis and suffering severely and unnecessarily and potentially dying or taking

621 Quayle (n 11).
cannabis and risking criminal legal consequences which will severely disrupt already difficult lives. Legalisation of medical cannabis would therefore provide great medical and personal benefit to such people if they would otherwise be unable to take the cannabis. If, on the other hand, they can access the cannabis illegally, legalisation will provide two equally significant benefits. First, it (at least under the strict medical model supported here) provides them with safer, more consistent and precisely dosed cannabis that can be obtained through legitimate and safe means, as opposed to the potentially unsafe, or at least unreliable, criminal suppliers from which they currently source it. Second, it removes from them the threat or reality of criminal sanctions, which can cause severe anxiety, and if conviction is achieved will provide a criminal record, potentially prison and all associated life difficulties that come with this.

These examples represent cases toward the strongest end of the claims of medical cannabis users. This is to say that not all those people who conceptualise their own cannabis use as medical will be provided with this level of benefit by cannabis legalisation. Indeed, given the legal tests in the US and Canada, which allow recommendation to be given out to a person if they have any condition that could benefit from medical cannabis, this is inevitably the case. Thus, while it is important to keep in mind the extraordinary benefit that they receive, we should not imagine that every medical cannabis user is Mr Quayle. This, however, does not imply that the benefit received by these ‘weaker’ cases is trivial or insignificant. Paracetamol, for example, rarely dramatically improves people’s lives. But it will still provide a significant benefit to sufferers of headaches, and its prohibition – especially if it were the only thing that worked for a person – would be a legally relevant incursion into their lives.

As cannabis appears to be useful in the treatment of several different conditions, the population size of the potential beneficiaries is difficult to estimate. Indeed, as there is no clear information on what proportion of HIV, cancer, epilepsy and MS patients could benefit from the use of cannabis.

Given this, claims – such as those often made in Canada of a one million strong population of
medical cannabis users – must be properly contextualised. These one million will fall somewhere on a spectrum from the serious and life-threatening circumstances of the Quayle defendants all the way to those whose use of cannabis is recreational at one moment and medical the next. This is not to suggest that the latter is not worthy of human rights protection, rather that the former provides a much more obvious case in which the harm/benefit analyses built into the fair balance test falls on their side. Further, it is not obviously the case that a person receiving both medical value and pleasure from a drug should be seen negatively.

The above noted benefits of cannabis accepted, the harm of cannabis to medical users should not be overlooked. Indeed, various studies have shown that medical cannabis users are regular, often daily, users. This coheres with the medical profile of cannabis as a symptom reliever of chronic problems.

Further, as Sznitman showed, registered medical cannabis users, while having higher instances of behaviours which usually predict addictions (regular, daytime use ect.) have lower instances of cannabis dependency. This raises the prospect that cannabis harm is experienced differently by licensed/supervised medical users when compared to recreational or unlicensed users. More research is needed on this question. However, in individual cases, as with other medicines, the side effects of the treatment can and should be monitored both by the patient themselves and their prescribing doctors; if in their estimation cannabis is of medical value this appears to be a judgement to which courts should give significant weight.

Given the above, the discussion of the relationship between prevalence and harm must be properly contextualised: While it is logically true that if cannabis use produces problem x (respiratory problems, heart disease, mental health issues etc.) in a given percentage of users, then increasing the overall number of users will, all other things being equal, increase the overall numbers of people

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622 Lucas (n 514) 327; Belle-Isle and Hathaway (357).
623 For example Benedikt Fischer et al, 'Medical marijuana programs — Why might they matter for public health and why should we better understand their impacts?' (2015) 2 Preventive Medicine Reports 53, 54; Richmond (n 514) 2; Roy-Byrne et al (519) 601.
624 Sznitman (n 521) 18
suffering from that problem. It is also the case that many, and potentially most, of the increases in harm will be offset by the significant benefits outlined above.

**Safer forms of cannabis**

As a general proposition, cannabis will be safer if it ‘well balanced’ in the sense of having no more THC than is necessary and having higher levels of CBD. Similarly, if cannabis is not combusted and smoked, its use will be less associated with lung and respiratory problems.

The research on whether such forms of cannabis have promulgated as a result of legalisation is mixed. On potency, there is very little study of the question, but Canada, for example, has very potent medical cannabis and there is some indication of a small increase as a result of dispensaries in the US. On vaporisation, legal medical users are much more likely than illicit users to use non-smoked methods, though most usually use smoked methods as well. Whether a majority prefer smoked or non-smoked methods more depends on the location of the study.

The key point here, however, is vaporisation and ‘well balanced’ cannabis can be pushed through regulatory choice. In Canada and the US, market forces have largely been left free to dictate the form of cannabis that is used by medical cannabis patients; with the proliferation of dispensaries, home cultivation and other relatively free market policy options there has been no serious attempt made to affect the type of the cannabis that is allowed for medical purposes. While it is encouraging that many medical users in these places are choosing to switch to the safer, non-smoked options, given that cannabis is being proffered as a medicine, it is questionable whether this should be left to a free choice. In the Netherlands, non-smoked methods of vaporisation and tea are heavily pushed and smoking strongly dissuaded. Vaporisation and smoking both use the same base product – raw cannabis plant – the only difference being that one is directly burned and then smoked while the other is merely heated to a sufficient temperature for vapours to be released and inhaled. Thus, it may not yet be feasible to provide medical raw cannabis (remembering the value of the various different cannabinoids in cannabis, as opposed to isolated individual ones) in a form that can only be vaporised
and is impossible to smoke. Though the emergence of oils, tinctures, sprays, liquids and oral medical cannabis products, many of which need not be inhaled at all, are certainly promising in this regard. Further, the involvement of the doctor throughout the process and the clear and consistent nudging of patients away from smoked methods would seem likely to push more patients into safer methods of use.

A further promising avenue of harm reduction through vaporization is its potential to prevent the co-use of a cannabis and tobacco among medical users. Often, smokers of cannabis use tobacco at the same time as the latter helps with the combustion of the former. Without the need for combustion, vaporisation may reduce tobacco use, a clear benefit in proportionality terms.625 Clearly, much more research needs to be done to substantiate the claim that vaporisation reduces co-use of cannabis and tobacco, that being said; the mechanism by which it might is certainly plausible. And other, non-smoked mechanisms will, by definition, not involve tobacco, such as sprays and oils.

Potency is easier to control through regulation. The tightly controlled medical cannabis market of the Netherlands demonstrates that this is possible and that the patient can be provided with cannabis of a known THC/CBD ratio. Importantly, a patient can be prescribed low potency cannabis to begin with and can be titrated to higher doses of THC if that is deemed necessary. This is only possible if a medical, doctor/prescription model of medical cannabis distribution is adopted. Given the retail model that has been adopted in Canada and the US it is unsurprising that very potent forms of cannabis proliferate there. If patients purchase cannabis recommendations from specifically purposed clinicians and are then allowed to freely buy various forms of cannabis from retailers, tight controls on potency are much harder. Also, without clear medical guidance a patient may not know whether they are likely to need potent cannabis. The increasing potency of cannabis in both illegal and legal but loosely regulated markets suggests that free markets in cannabis trend towards higher

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625 Malouff et al (n 518) 128 in a very small online (and non-representative) survey of both medical and recreational users from the US, Australia, Canada, the UK and elsewhere, found that while 15 out of 96 participants reported the co-use of cannabis and tobacco when smoking, only 2 out of 96 used tobacco when vaporising.
potency. A medical market which demands products be sold at certain ratios and involves clinicians prescribing specific ratios to patients, can quell this trend. Significantly, such a regulated medical market in cannabis would contain safer cannabis than both lax legalised models and prohibition, which provides for an essentially ‘free’, in the sense of being devoid of regulations on standards, illegal market.

In terms of total drug harm, if there is a significant increase in prevalence as a result of medical legalisation (which, as I have argued above, there needn’t be) there is potential for the harms of this to be offset if the cannabis being produced in, and diverted from, the medical market is of a safer quality than that which would otherwise exist in the recreational market. From a proportionality perspective, it would be better if a system were devised that limited diversion and did not result in increased prevalence, as was described in the necessity section. The controlling of the medical market so as to produce safer cannabis, however, benefits patients and acts as another potential blockade against harm to the diverted users. Indeed, if either of these groups had previously been using less safe form of cannabis prior to legalisation, then the lower harmfulness of medical cannabis will reduce the total drug harm, or at least partially offset the increase in total drug harm from increased prevalence and intensity. Conversely, these safer forms of medical cannabis may not be popular with recreational users if they want high THC, smoked cannabis, thus tempering the fear of increased prevalence through diversion.

The fine-grained effects of tightly controlling cannabis quality in medical markets needs more research before conclusions are drawn. However, it can be said with some certainty that the effect that medical cannabis legalisation can have is heavily dependent on regulatory choice. A provision which controls the potency and delivery mechanism of medical cannabis is much more likely to have beneficial effects than one which doesn’t.

Substitution
The final way in which the legalisation of medical cannabis may provide benefit to public health is through substitution. Studies on substitution appear to show that legalisation of medical cannabis reduces the use of pain medications, particularly opioids, thus reducing opioid related harm. Indeed, the Wen, Hockenberry and Cummings study into prevalence suggested that including pain, or at least non-specific pain, as a condition for which cannabis can be recommended was a factor in increasing the participation in the cannabis market and leading to a relative increase in prevalence.

Thus, it could be the case that significant numbers of pain suffer will engage with the medical cannabis market and in doing so eschew, at least to some degree, the use of opioids. In this regard the increase in prevalence of cannabis should not be thought of as necessarily leading to net harm, but likely leading to benefit, not only as it relieves a medical ill, but as it reduces the use of opioids. Indeed, this direct transference from opioids to cannabis is implied by the fact that the Treatment Episodes Dataset records an increase in cannabis referrals as a result of dispensaries (as demonstrated by Pacula et al\textsuperscript{626}) and records a concomitant reduction in opioid referrals (as shown by Powell et al\textsuperscript{627}). Thus, the increased drug harms from a greater prevalence in cannabis may be offset by the benefit in the reduction of opioid use and harm. More research is required to elucidate and quantify the extent to which such harm is offset. However, as cannabis has a lower addiction and abuse profile than opioids, is generally considered to be less harmful and is a smaller public health concern, even if recreational users engage with the medical cannabis system, the reduction in the need for opioids could still accrue net benefit.

Though a targeted, strict medical model of medical cannabis, with informed physicians and careful application could reap the benefits of the reduction in opioid harms – by transferring pain patients from opioids to cannabis – while still minimising the number of recreational cannabis users who engage with the system. Indeed, a prescription model in the style of the Netherlands is much more likely to achieve this than the US model which appears easy to divert from.

\textsuperscript{626} Pacula et al (n 352).
\textsuperscript{627} Powell et al (n 575).
As a matter of proportionality, substitution of prescription medications will not always be good. Prescriptions are given on the belief that patients benefit from taking the amount prescribed at the dose and with the regularity instructed. If medical cannabis legalisation leads to a reduction in patients listening to medical advice from doctors, this may cause a level of harm which, at least partially, offsets the benefit from fewer opioid abuses and overdoses. As Piper et al note, however, the prescription drugs where the substitution effect is most pronounced are those classes of drugs which are prescribed to be taken when required, such as pain and sleep medication. A substitution effect here is not concerning as there is no interference with the regular and planned prescription schedule set by medical professionals. Drugs such as anti-depressants which tend not to be prescribed on an as-needed basis see a much weaker substitution effect from cannabis. Further, and more fundamentally, if cannabis is merely added to the list of medications a doctor may have recourse to, rather than sold separately and commercially (admittedly on doctor’s recommendation), this issue does not arise. This again emphasises the necessity of a prescribing doctor to be involved throughout the process of medical cannabis provision, rather than just at the beginning to give recommendation.

Summary and conclusion on proportionality

Given in the previous section I judged that the risk of increased prevalence that may follow medical cannabis legalisation could be mostly avoided by creating a sufficiently strict model of medical cannabis regulation, the conclusion at the fair balance stage is in some senses predetermined: If a policy is not necessary (in proportionality terms), there cannot be a fair balance between it and the harm done to the right, because, when judged against its less restrictive alternative, the benefit of prohibition is nugatory.

If it is found, however, that even strict, medical cannabis models of legalisation lead to increased prevalence, it is necessary to have a sense of the benefits that legalisation provides, so that they may be weighed up against that harm. Given the above, there are significant potential benefits

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628 Piper et al (n 514) 573.
to legalisation – both to the individual, and wider society, through safer forms of cannabis and substitution. Therefore, even if prohibition of medical cannabis did provide the benefit of keeping a lid of prevalence – which, when compared to strict medical models of medical cannabis legalisation, it does not appear to – this benefit would have to be balanced against the harm that is done by blocking the benefits analysed in this section. The most defensible conclusion therefore is that the harm done by the absolute ban on medical cannabis – though blocking the potential benefits legalisation has to offer – is sufficiently large to outweigh the benefits achieved to the legitimate aim of protecting against increased prevalence, even if those benefits are greater than that which was concluded in the necessity section.

Two caveats must be acknowledged. First, a lot of the above cited evidence in the previous chapter is not conclusive and occasionally points in more than one direction. There is clearly room for the general picture, on diversion, prevalence or substitution to change, or for discoveries to be made which change the balance. Indeed, throughout I have pointed out where greater research is needed to make firmer conclusion. Thus, this conclusion is mine based on the balance of the available evidence and is subject to change.

Second, as previously stated, the incommensurability problem is present. There are differences in how one may view the plight, or not, of those who claim to need medical cannabis, and what weight should be attached to them. Similarly, the importance of the right to autonomy and personal integrity that I have attached this claim might be viewed by some as less serious than I am viewing it and therefore the weighting I have attached might be disputed. As I noted earlier, the fair balance stage of the proportionality test, by necessity, collapses into subjective value judgment at some point. This is an unavoidable limitation. That being said, it is difficult, given the evidence, to make a data driven case that there is a risk of increased prevalence, intensity or harmfulness associated with a tightly controlled, strict, medical cannabis programme. This is not to say that no such risk exists, or that the preceding analyses has disproven such a risk, only that such a risk is not present in the evidence. Without a demonstration of such a risk, there is very little ‘benefit’ to pin on absolute
prohibition as compared to such a model of legalisation. If such a risk is demonstrated then my argument is weakened significantly, but as it has not yet been, the justification for the prohibition of medical cannabis does not meet the proportionality test and the placement of cannabis into Schedule 1 of the Misuse of Drugs Regulations is therefore an unlawful breach of the Human Rights Act.
Chapter nine: Procedural arguments

Aside from the arguments around the potential harms of medical cannabis legalisation, procedural arguments have been made for the continuing prohibition of medical cannabis. These arguments, broadly speaking, opine that it is illegitimate to reschedule Schedule 1 drugs without following the usual process, as this process ensures the safety of drug. Therefore, so the argument goes, cannabis should not be rescheduled as to do so would undermine, or divert from, the legitimate process that is already in place to recognise and regulate controlled drugs. Answering on behalf of the government, Sarah Newton MP, Minister of State for the Home Office said in Parliament in 2016:

It is important that all medicines containing controlled drugs are thoroughly trialled to ensure they meet rigorous standards so that doctors and patients are sure of their efficacy and safety. To do otherwise for cannabis would amount to a circumvention of the clearly established and necessary regime for approving medicines in the UK.\textsuperscript{629}

A further question in 2017 was answered thus:

Cannabis, in its raw form, has no recognised medicinal benefits in the UK.

There is a clear regime in place, administered by the Medicines and Healthcare products Regulatory Agency (MHRA), to enable medicines (including those containing controlled drugs such as cannabis) to be developed, licensed and made available for medicinal use to patients in the UK.\textsuperscript{630}

The status of this procedural argument is unclear because it is not clear what the procedure, or ‘regime’, to which the minister refers, is. Upon encountering these procedural arguments, I conducted freedom of information requests into the procedure of rescheduling a Schedule 1 drug. As I shall explain, the procedure communicated to me, based largely on marketing authorisations, was

\textsuperscript{629} HC Deb 15 November 2016, Written question 52408.
\textsuperscript{630} HC Deb 20 September 2017, Written question 8282.
not followed in the fallout to the Billy Caldwell case. Equally, there were suggestions (now largely moot, one would imagine) that the government will review its approach to medical cannabis following a review at the UN level, which again does not cohere to the approach laid out in the freedom of information request responses. It appears therefore that the procedure explained to me is merely one of a yet undefined number of procedures that can lead to the rescheduling of medical cannabis.

This chapter, therefore, will describe and criticise these three procedural approaches. I will explain why each are flawed and cannot reasonably form the basis of an argument against rescheduling.

**Freedom of Information requests and marketing authorisations**

The responsibility for rescheduling drugs from Schedule 1 to the other schedules of the Misuse of Drugs Regulations is held by the Home Secretary who is under a legislative requirement to consult the ACMD. In response to a question about the circumstances under which the Home Secretary would reschedule, the Home Office confirmed:

> the rescheduling of a controlled drug under the Misuse of Drugs Regulations 2001 would not be made without prior consultation and recommendation from the ACMD.

This appears to suggest that the Home Office will not reschedule unless the ACMD recommends that it does. Given this, I sent a further freedom of information request to the ACMD asking for their policy for reviewing Schedule 1 drugs, to which they responded:

> The ACMD may decide to conduct a review of a substance in Schedule 1 if there is new evidence that the substance has a legitimate medical use and acquired a marketing authorisation through the MHRA (Medicines & Healthcare Products Regulatory Agency). The ACMD may also consider if the said substance has a legitimate medicinal use in another

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631 Misuse of Drugs Act (n 13) s.1.
632 see appendix 2 (emphasis added)
country. The ACMD would undertake such reviews either through its own volition or upon request from the Home Office.633

It is not clear from this response to the freedom of information request whether these two conditions – new evidence of medical utility and a marketing authorisation – would still have to be met if the Home Office were to request the ACMD conduct a review or whether a request from the Home Office, even absent these conditions, would be sufficient to trigger a review. It seems clear from the subsequent events, discussed later, that the latter is true. That being said, it is still necessary to examine the acquisition of a marketing authorisation, and how likely this eventuality would be.

Marketing authorisations are licenses required in order to place medicines on to the market. These licenses are required as the Medicines Act 1968 prohibits the sale, supply, export, import, manufacture or assembly of any medicinal product without a license, with exceptions for doctors and dentists.634 Further, the Human Medicines Regulations 2012 state that a person may not sell or supply, or offer to sell or supply a medical product without a marketing authorisation or other form of authorisation.635 Failure to comply with these requirements is a criminal offence. The requirement for a marketing authorisation does not apply to pharmacists or hospitals acting on the direction of a prescription made by an appropriate practitioner.636 Thus, as Merrills and Fisher note, the marketing authorisation is required for the drug ‘manufacturer or the person to whose order the product is manufactured’,637 the possession of a marketing authorisation thus immunising such persons from an offence under the Human Medicines Regulations.

A marketing authorisation does not immunise a person from offences under the Misuse of Drugs legislation, however. Where a drug has been given a marketing authorisation but is still in

633 See Appendix 3
634 Medicines Act 1968 s.7(2)+(3), s.8(2) and s.9.
635 Human Medicines Regulations 2012/1916 Regulation 46; the other forms of authorisation are not relevant to this thesis.
636 Ibid regulation 4.
Schedule 1 it will remain criminal to possess, supply, import, export (etc) that drug unless under the purview of a specific Home Office licence. Thus, a marketing authorisation and removal from Schedule 1 is necessary in order to legalise the sale and supply of a drug for medical purposes by a company or person. Moving a drug from Schedule 1 to Schedule 2 gives a practitioner or pharmacist the right to supply the drug (on prescription) to a person who may legally possess the drug. However, if a drug is in Schedule 2 but still without a marketing authorisation it would still be illegal for a pharmaceutical manufacturer to produce/market the drug. All that would be changed, necessarily, is that a doctor could prescribe the drug to a person and therefore give them a right to possess it for medical use.

Given this, the statements delivered to Parliament, quoted above, are not accurate; rescheduling a drug, under current Home Office guidance, would not circumvent the regime for trailing medicines in the UK, for two reasons. First, the rescheduling of cannabis does not automatically create a right for anyone to produce cannabis; producers of cannabis would still require a marketing authorisation. Thus, it is possible to have a Schedule 2 drug which is not available because no-one has been granted, or has applied for, a marketing authorisation: the issue of availability is separate from the issue of rescheduling. The marketing authorisation process, which protects all patients/consumers taking medical drugs controlled or otherwise, would still apply to cannabis were it (or any other Schedule 1 drug) to be rescheduled. Second, as explained below, the actual process of rescheduling, itself, through the Home Office and ACMD, includes an analysis of peer-reviewed empirical evidence. Thus, it appears that requiring a marketing authorisation prior to the initiation of an ACMD review adds little to the protection of health, as the review itself ensures an adequate evidence base before offering a recommendation.

This marginal, or potentially non-existent, benefit to health can be contrasted with the extraordinarily large burden it places on those seeking marketing authorisation. First, the cost of an

638 Misuse of Drugs Regulations (n 19) Regulation 7 and Regulation 16(1).
639 Human Medicines Regulations (n 635) Regulation 46 and Regulation 4.
application is £92,753.\textsuperscript{640} Second, the application must, understandably, include significant details on such things as the manufacturing process, trials and expert evidence.\textsuperscript{641} No suggestion is being made here or anywhere in this thesis that these are unreasonable requirements to expect a company to meet prior to giving them permission to market a medicine. Indeed, such detailed provision is undoubtedly sensible. What is being questioned here is whether or not it is reasonable for the ACMD to appropriate the attainment of these conditions \textit{by a private company} as necessary prerequisites for even contemplating a review into the medical utility of Schedule 1 drugs; why is it necessary to demand a company has obtained a marketing authorisation prior to conducting a review into the scheduling of a drug? 

In making this distinction clearer it is necessary to point out what a marketing authorisation will give a company in the case of a non-Schedule 1 drug as oppose to a Schedule 1 drug. In the former case the attainment of a marketing authorisation grants a company the right to sell the drug for which they have received authorisation. In the case of a marketing authorisation for a Schedule 1 drug, on the other hand, attainment of a marketing authorisation will not provide this. As noted above, if a drug has a marketing authorisation but remains a designated, Schedule 1 drug it will still be illegal to possess, supply, produce (etc) the drug. Thus, what a marketing authorisation in the case of a Schedule 1 drug gives a company is the chance to have that drug \textit{possibly} become the subject of an ACMD review; this review \textit{may} recommend that the drug be rescheduled, a recommendation which the Home Secretary is perfectly at liberty to ignore. Indeed, as the reclassification of drugs under the Misuse of Drugs Act shows, the Home Secretary has been more than willing to ignore suggestions of the ACMD for political reasons.\textsuperscript{642}

Given this context it seems doubtful whether a company would risk incurring £92,753 cost, as


\textsuperscript{641} Human Medicines Regulations (n 635) 50(1).

\textsuperscript{642} From the vast literature of criticism see as examples Nutt, King and Phillips (n 15) 1564; David Nutt et al (n 15) 1051; Walsh, (n 301) 84; \textit{Drug classification: Making a hash of it?} (n 15) [94-95]; Levitt, Nason and Hallsworth (n 15).
well as the significant time and financial costs of the application when the ultimate viability of the product is still subject to a review of the ACMD and a political decision of the Home Secretary. This is compounded by the additional problem that all of the Schedule 1 drugs in consideration here are not patentable as they, having been around for a great number of years, will not fulfil the novelty requirement or, being non-novel plants, are not capable of being patented. Indeed many Schedule 1 drugs were patented many years ago and those patents have since run out.

The Schedule 1 status of drugs also impedes the requirement that there is adequate national and/or international evidence of the medical utility of a drug. In particular, the mere fact that a drug is placed within Schedule 1 makes carrying out research significantly more difficult for a number of reasons.

First, as stated above, any person who is to do research on a Schedule 1 drug is required to have a specific Home Office license. Only a very limited number of such licenses are given out. Writing in 2015, Rucker claimed that only four hospitals in the UK had such licenses. Nutt, King and Nichols, writing in 2013, claimed there to be only three such licenses held by hospitals in the UK, a fact made even starker, they claim, by the fact that, due to their placement in Schedule 2, all hospitals have the right to hold cocaine and heroin, two drugs significantly more dangerous than those which are placed in Schedule 1.

I conducted a freedom of information request to the Home Office, which revealed that the number of licenses given to anybody (not limited to hospitals) for clinical trials and/or in vivo studies on Schedule 1 drugs in the year August 2015 – August 2016 was seven. The licenses require yearly renewal and do not necessarily grant their holder the right to do such research with all Schedule 1 drugs.

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643 Patents Act 1977 s.2.
645 James J H Rucker, ‘Psychedelic drugs should be legally reclassified so that researchers can investigate their therapeutic potential’ (2015) 350(2902) British Medical Journal.
647 Appendix 4.
Second, practical problems arise from cost of the licenses themselves, which range from £580 to £4,700. Significant though these costs are, they are not the only financial hurdle faced by those who would seek to research Schedule 1 drugs. For example, Rucker argues that due to the international regulatory regime there is only one manufacturer producing psilocybin at a sufficiently high quality, and they quoted ‘a prohibitive £100,000 for 1 g (50 doses)’. Further, as noted by Sessa and Nutt, the need for licenses at every point in the process, including distribution and production, as well as record checks and pharmacy safes further escalates the price. All this cost is compounded by the fact that, as Rucker claims, the stigma attached to Schedule 1 drugs makes funders less willing to grant money to such research projects. Given this, the research requirement for rescheduling a Schedule 1 drugs is made significantly more difficult by giving a drug that designation. This was at least partially acknowledged by the ACMD in their interim findings of a review into the barriers to research into Schedule 1 drugs. Recognising that Schedule 1 provides an impediment to research and that the risk of diversion from medical research is low, they recommended, among other things, a research schedule, into which Schedule 1 drugs could be put while they were undergoing trials, so that many of the restrictions no longer apply. The Home Office have yet to reply to this. Similarly, the 2018 Chief Medical Officer Review into the medical benefits of cannabis suggested that one of the reasons for the paucity of evidence as to the medical utility of cannabis for certain indications is that the Schedule 1 status of cannabis prevents clinical trials from taking place.

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649 Rucker (n 645).
Given these significant barriers, it is unsurprising that in response to another Freedom of Information request in August 2016 the ACMD noted that it “has not yet undertaken a review to reschedule a substance from Schedule 1 to any other schedule”.\textsuperscript{653} Further, in answer to a written question in the House of Commons in November 2017, the minister for the Home Office Nick Hurd MP noted:

No licences have been granted to companies to investigate the use of medicinal or ‘herbal’ cannabis in its raw form and nor has the Home Office commissioned any reports into medical cannabis.\textsuperscript{654}

This position has changed with the current review into the cannabis-derived medicinal products, which is explored later in the chapter. However, it is notable that the initiation of that review was not a result of the procedure laid out above, nor was it a response to emerging medical or scientific data. It is clear from the above however, that the marketing authorisation procedure risks inertia in its response to emerging evidence of the medical value of Schedule 1 drugs. Given this, it is thankful, though for reasons explained below, not exculpatory, that it appears that reviews can be triggered by more than just marketing authorisations, in particular by changes in the international regulatory picture and, as demonstrated by the case of Billy Caldawell, by media pressure.

**Changes in the international regime**

The Government have recently noted that there is to be an international, UN review into cannabis for medical use:

The World Health Organization’s Expert Committee on Drug Dependence has committed to reviewing the scheduling of cannabis under the United Nation’s 1961 Convention. This is due to consider the therapeutic use, as well as dependence and the potential to abuse constituent

\textsuperscript{653} Appendix 3.
\textsuperscript{654} HC Deb 14 November 2017, Written question 111651.
parts of cannabis. This is due in 2019 and we will await the outcome of this report before considering the next steps.655

It is not clear what the government intended to do in response to this review if, for example, the review suggested the legalisation of medical cannabis. Given that a review has happened anyway, this point is moot. That being said, if this statement implies that they would consider rescheduling in response to international rescheduling and thus departing from the marketing authorisation route this would clearly, given the above, be welcome. Indeed, a much earlier statement by George Howarth MP, Parliamentary Private Secretary to the Home Secretary in 1997 stated:

[Rescheduling]... would depend upon the therapeutic benefits of a medicinal form of the drug being satisfactorily demonstrated in the United Kingdom, or the United Nations Commission on Narcotic Drugs reducing the international controls on the drug.656

Thus, there appears to be a long-standing procedure, or convention, to change or review scheduling when faced with international changes. An analysis of the rescheduling system of the UN bodies, however, demonstrates why reliance on them exacerbates, rather counteracts inertia within the system:

The 1961 and 1971 International drugs conventions (described earlier) created mechanisms for making changes to the scheduling in reaction to new evidence. Both involve the World Health Organisation (WHO) and the Committee on Narcotic Drugs (CND). The Single Convention requires the WHO or a party to the Convention to initiate the process of changing the scheduling by notifying the Secretary General and supplying and relevant information.657 The Secretary General then transmits the notification and any relevant information to the state parties, the WHO (if initiated by a party) and to the CND.658 It is then for the WHO to pronounce on whether the drug should, in its opinion, be

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655 HC Deb 07 March 2018, Written Question 130113.
656 HC Deb 17 December 1997, vol 303, c172W;
657 Single Convention (n 1) Article 3(1).
658 Ibid Article 3(2).
added in, moved between or removed from the Schedules. The CND can either accept this conclusion or not act.\footnote{Ibid Article 3(3-6).} Any party of the Convention can request that the ECOSOC review the decision. The ECOSOC, whose decision is final, may alter, confirm or reverse the decision.\footnote{Ibid Article 3(8).} The process for 1971 Convention differs only in that the CND is free to modify the Schedules in a way which was not suggested by the WHO, an option foreclosed in the 1961 Convention.\footnote{Psychotropic Convention (n 39) Article 2.} Further, in the 1971 Convention decisions of the CND must be taken by two thirds majority.\footnote{Ibid Article 17(2).}

As Corte notes, such a review mechanism is fairly unique among international conventions as it vests authority in an international body (the CND) to create and modify binding international legal commitments.\footnote{Cristian Gimenez Corte, 'The Forms of International Institutional Law: An Historical Analysis of the scheduling Decisions of Narcotic Drugs and Psychotropic Substances taken by the United Nations' Commission on Narcotics Drugs' (2010) 7 International Organizations Law Review 171, 181-182.} Such a system was viewed as necessary in order to inject flexibility. There are, however, reasons to question the flexibility of the international regime of drug prohibition.

First, both the CND and the ECOSOC are, inevitably given the nature of the above stated power, political bodies. As decision making and appeal granting authority is vested in them there is always the possibility that the scientific/medical impetus for rescheduling would be blocked for reasons of politics. Indeed, as Brewley-Taylor notes, there is a relatively large prohibitionist bloc within the UN which has long been led by America. Not only can this bloc vote down any attempt to reschedule a drug, it can apply financial and political force upon states not in this bloc.\footnote{David Bewley-Taylor, ‘Challenging the UN drug control conventions: problems and possibilities’ (2003) 14 International Journal of Drug Policy 171, 174; Brewley-Taylor (n 38) 311-312.}

Second, even without the political blocking of rescheduling in the CND and ECOSOC there is reason to believe that the WHO’s mechanism for reviewing drugs is not sufficient either. Danenberg et al studied the process of international substances review from 1912-2013 and found that 28 drugs had not been reviewed since their inclusion in the Conventions. Some (cannabis resin, opium and
heroin) had not been reviewed since their original inclusion in 1912. Other drugs of significance also had not been reviewed for long periods of time; LSD, Mescaline, Psilocybin had not been reviewed since 1969 and MDMA since 1985. In this regard Danenberg et al suggest that such a situation “seriously undermines and delegitimizes international control” of such substances as the historic assessment does not represent the current scientific opinion. Thus, while after a significant delay, the UN system is coming to review cannabis, relying on it to be the impetus for rescheduling is not a guarantor against the otherwise inflexible and unresponsive domestic system of rescheduling.

Billy Caldwell and others

In June of 2018 a 12-year-old boy, Billy Caldwell, was taken to Canada by his mother, Charlotte Caldwell, in order to obtain cannabis oil to treat his epileptic seizures. This treatment was effective and greatly reduced the number of seizures that Billy had in any given day. Upon returning to the UK, Billy’s cannabis oil was confiscated by the Home Office. The confiscation led to Billy’s condition deteriorating and him being hospitalised. Around the same time a similar case, that of Alfie Dingley, occurred. Alfie, who is six, was travelling back from the Netherlands, where he had acquired medical cannabis and similarly, upon his return, it was confiscated and as a result he fell seriously ill.

Initially, the Home Office responded by denying access to cannabis oil, with a statement similar those with which this chapter began:

[I]t is important that medicines are thoroughly tested to ensure they meet rigorous standards before being placed on the market, so that doctors and patients are assured of their efficacy, quality and safety

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665 E Danenberg et al, ‘Modernizing methodology for the WHO assessment of substances for the international drug control conventions’ (2013) 131 Drug and Alcohol Dependence 175, Table 1.
666 Ibid 179.
Noting further that as it is in Schedule 1, it cannot be “prescribed, administered or supplied to the public” and may only be used for research purposes. Due to significant and consistent media pressure, however, this position changed. Initially, and as a transitional measure, the Home Office started granting licences, allowed under the Designation order under section 7(4) of the Misuse of Drugs Act. In doing so, they conflicted with their previous statement that such licences could only be given out for research purposes. These licences are expensive – over £3,000 – and are accompanied by a significant administrative burden on patients and their parents. For instance, Billy Caldwell could only be administered the cannabis oil at a hospital, which was a four hour round trip for him and his mother. For a drug which is required twice a day, this is clearly unsustainable.

The Home Secretary therefore commissioned a two stage review into the rescheduling of medical cannabis. Part one was conducted by Professor Dame Sally Davies, the Chief Medical Officer (CMO) and concerned the medical and therapeutic benefits of cannabis and cannabis medicinal products. Part two, conducted by the ACMD is to cover the harms and public health benefits of rescheduling cannabis and/or cannabis based medical products.

Part one was completed on the 3rd of July and recommended that all cannabis based medical products moved out of Schedule 1; this includes organic / herbal cannabis, cannabinoids and ‘compounds with chemical structures similar to cannabinoids’. Davies’ report was based on the review done by the National Academies, described above, and found there to be conclusive or substantial evidence of the efficacy of cannabis in the treatment of pain, nausea and vomiting and

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668 Ibid
670 Controlled drugs (n 648).
672 Home Office launches review into medical use of cannabis (n 601).
spasticity, as well as moderate and limited evidence for utility in treating a large number of other conditions.

It is significant that the involvement of the Chief Medical Officer featured nowhere in the responses to the freedom of information requests discussed earlier. This is suggestive of one of two things. Either the Home Office policy, which previously required only the consultation and recommendation of the ACMD, has changed or the inclusion of the Chief Medical Officer in this instance was ad hoc. In either case, the Home Office should be more transparent with what is required, and when what is required changes, this should be publicly communicated.

Part two of the review is ongoing but has registered interim findings. It agreed with the submission of Part one that cannabis is medically effective in some forms for some conditions. It therefore recommended that ‘Cannabis-derived medicinal products... of appropriate medical standard’ 674 be moved out of Schedule 1, this includes cannabis, cannabis resin and cannabiol derivatives. It further recommends that the Department of Health and Social Care (DHSC) and MHRA should provide an appropriate definition of the ‘cannabis-derived medicinal products’. The advice is worded like this as both the Chief Medical Officer and the ACMD feared that using ‘grown or street cannabis... of unknown composition’ will increase the likelihood of harm from the use of medical cannabis. 675 Additionally to these controls the ACMD recommends that the DHSC and MHRA should also develop additional frameworks to prevent inappropriate prescribing and diversion. It should be clear from the previous chapter that I view the concerns of diversion and increased harm as real, but surmountable. While it is promising that the ACMD and the CMO have alighted on the same concerns as I have in this case study, it is yet to be seen how DHSC and MHRA address these concerns and

675 Ibid.
whether they do so proportionately. As there is no further information in this regard, however, I move to discuss the implications that this series of events has on the procedural arguments discussed above:

The procedure, such as it is, that led to this review does not follow that which has been laid out before; it did not involve a marketing authorisation, or the UN and it does involve the Chief Medical Officer. The only common element of the three procedures outlined above is the necessary involvement of the ACMD and their review of the medical value of cannabis. As this is a statutory duty, this is unsurprising. This procedure alone, however, cannot be the basis for the argument that this chapter began by evaluating; that it is not safe to reschedule a drug without following the standard procedure. If all that is meant by ‘procedure’ in this argument is the involvement of the ACMD then the government cannot rationally appeal to this procedure as a reason to not reschedule as they have the discretion to initiate it. As the Billy Caldwell case made clear, the government has the discretion to initiate a review into the rescheduling of a drug in Schedule 1. Thus, appealing the procedure is not a defence of inertia; when it is government who have one of the triggers that can begin the procedure of reform, it cannot feign an inability to act because of that procedure.

Conversely, this procedural argument could have been referring to a different procedure, perhaps marketing authorisation, over which the government does not have immediate control. Two problems would emerge in this case. First, as already explained, the procedures that are currently extant – marketing authorisation and international review – are insufficient to respond to changing medical and scientific information. Second, and perhaps more fundamentally, that these, or other, procedures were not followed in the response to the Billy Caldwell case demonstrate that they are not necessary: a procedure cannot be viewed as necessary for the protection of citizens in any real sense, and certainly not in the proportionality sense, if it can be abandoned in response to bad press and the resultant minor political crisis. Thus, the case of Billy Caldwell and the fallout from it demonstrates that it is possible for the government to initiate the rescheduling procedure and as such it cannot appeal to that procedure to justify not acting.

More fundamentally, the difficulty, and general lack of clarity, in the procedure is worrying.
That the marketing authorisation and the UN route are so difficult to achieve, a prospective patient is left with the route taken in the Billy Caldwell case. This issue with this is, however, that the Caldwell case represents a lack of, rather than a clear, procedure. Here the government took in initiative in response to a political crisis brought about by sympathetic cases in the media. This level of discretion and reliance on media pressure is not a rational or fair way to structure a framework for medical treatment, which is ultimately what the Misuse of Drugs Regulations are. There should be a system, which can be triggered more easily, quickly and independently in response to emerging scientific information and medical need. If there is not such a system, the misuse of drugs regime will continue to be in breach of the Human Rights Act, as described in Chapter eight.
Conclusion

This thesis has demonstrated that it is possible to mount a human rights case against the prohibition and criminalisation of the medical use of a controlled drug. Concluding on this point was advanced through several stages. First, primarily in Chapter one, the specific source of the potential human rights abuse was identified as the criminalisation of drugs in the Misuse of Drugs Act in combination with the scheduling of a drug into Schedule 1 of the Misuse of Drugs Regulations, which unlike other schedules, does not allow for the medical provision, possession, sale or supply or supply of drugs. The point was furthered in Chapter five in which it was shown that the failing in Quayle, the key case in which a human rights argument was raised, was not directly challenging the placement of cannabis into Schedule 1. Making such a direct challenge has the benefit of engaging Section 6 of the Human Rights Act, as scheduling decisions are made by the Secretary of State and therefore engage the public body requirement of the provision. This is true so long as it is not found that the Secretary of State was forced to act in such a way by the primary legislation. While this possibility is not likely, any challenge against the prohibition of medically useful drugs should, in such an eventuality, challenge the compatibility of the Misuse of Drugs Act itself, something which the claimants in Quayle specifically failed to do.

Second, the nature of the human rights legal test was described and analysed. In Chapter two the Human Rights Act was described, and its provisions outlined. Specifically noting that the challenge at issue in this thesis would be based on a qualified human right and therefore any infringement that was demonstrated could potentially be justified by the government. Chapter three, therefore, analysed the mechanism by which such a justification would be judged – the proportionality test. This allows the government to justify an infringement, if their justification passes all four of the constituent tests – legitimate aim, rational connection, necessity and fair balance. This analysis was based on a
structured review of Supreme Court cases which had conducted a proportionality analysis, making it at present the most authoritative and up to date elucidation of the judicial test for proportionality in human rights cases in the UK. This analysis forms the basis of the case study on medical cannabis in the final part.

Third, Chapter four, on deference argued against the use of constitutional deference in human rights adjudication as the things that such deference attempts to protect – Parliamentary supremacy and separation of powers – are already protected by the dialogic, weak from of review provided by the Human Rights Act. Conversely, it is reasonable to defer or give weight to the testimony of the elected branches in cases where they are most likely to have the correct answer to a question, either through expertise or having done research or consultation. However, this logic extends to all other parties and evidence to the case; if there is expert testimony that is more likely than both the court and the elected branch to be correct, then that too should be given weight appropriate to its expertise and/or research. Deference, then, is conceptualised as part of the normal judicial process of apportioning weight based on testimonial value. This in turn provides a further motivation for the approach taken in this thesis; if deference in human rights adjudication is to be based on expertise and research, where possible it is incumbent upon academia to provide empirically focussed answers to human rights questions, presented in a legal framework. This is what this thesis does in Part three.

Finally, this thesis moves to an empirical exploration of the human rights case against the prohibition of medically useful illegal drugs using the case study of medical cannabis. First, in Chapter six, I explain, with reference to analogous UK, Convention and Canadian case law why it should be considered an infringement of human rights in need of justification to deny and criminalise access to a medically useful drug, particularly given the seriousness of the conditions for which cannabis can be used as a treatment.

Second, the empirical examination of this justification was completed with a review of available empirical evidence of the effect of legalising medical cannabis, in Chapter seven. The findings of Chapter seven were used to inform the conclusion of Chapter eight in which it is shown that it is
not possible to mount a justification of the prohibition of cannabis that proportionally appeals to a legitimate aim in Article 8(2) of the Convention. The justification fails on the basis that while there is some risk of medical cannabis legalisation leading to increases in prevalence and therefore harm, the empirical evidence points toward this risk being situated only within nonmedical, lax models of cannabis regulation with no demonstration that medical, strict models suffer from the same problem. Thus, the absolute prohibition of medical cannabis is not necessary for the protection from harm. Furthermore, the legalisation of medical cannabis has the potential, given the correct regulatory choices, to be beneficial to public health and safety both by reducing opioid abuse and overdose and by providing for and proliferating safer, non-smoked forms of cannabis. This benefit, in addition the extraordinary benefit that would be accrued by those in significant need of medical cannabis would render a justification based on health disproportionate even if it was necessary in the proportionality sense, which it is not.

Further, procedural arguments against the case made in this thesis are deconstructed in Chapter nine. Here the procedures, the necessity of which some government ministers have appealed to in order to not reschedule cannabis drugs are analysed and disputed. First, the requirement of marketing authorisation before a review into rescheduling can proceed seriously encumbers the possibility of there ever being a review, without adding anything, additionally to the pre-existing requirements that are present for an ACMD review, to the protection of health and public safety. Furthermore, the mere placement of a drug into Schedule 1 encumbers research into it and therefore damages the potential ability to research treatment options for serious illnesses. International rescheduling, in response to which the government has shown willingness to act, does not save the system as it too is fundamentally inert. This is exemplified by the fact that it took the international regime 105 years to review the evidence on medical cannabis.

Given the above, in this thesis I make two conclusions. First, it is possible to successfully challenge the placement of a medically useful drug into Schedule 1 of the Misuse of Drugs Regulations
using the Human Rights Act. Second, that in the case of cannabis, such a challenge should, on currently available evidence, be successful.

**Further Research**

This thesis in general and Part three in particular has focussed on the issue of medical cannabis because it is the most medicinally popular, well researched and most internationally regulated Schedule 1 drug. There are, however, other Schedule 1 drugs for which the argument could apply as forcefully, if not more so. Psilocybin, the psychoactive component of magic mushrooms, for example has been trailed for the treatment of otherwise treatment resistant depression, while MDMA appears to have an application as an adjunct to psychotherapy for people with Post Traumatic Stress Disorder.\(^{676}\) The Multidisciplinary Association for Psychedelic Study has a useful list of studies into the medical value of various psychedelics.\(^{677}\) However, given the developmental stage of much of this evidence there are no long and consistent examples of the medical use of any such drugs. Thus, there is not the bank of evidence to draw on as there was for medical cannabis. Thus, a detailed proportionality analysis is not possible. There are, however, some reasons to suspect that if psychedelics are to be demonstrated to be medically useful; their prohibition would similarly be disproportionate.

First and most importantly, the way psychedelic medicines are administrated is different from cannabis, as are the ailments for which they are supplied. MDMA for example, is being trialled as an adjunct to psychotherapy. Thus, a patient would go into hospital or a clinic and be given a dose, subjected to the therapy and then leave without ever having been in possession of the medically supplied drug. Similarly, psilocybin treatment effects appear to be long lasting, though not necessarily permanent. Thus, a patient will be administered the drug in a supported setting irregularly. In both

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\(^{677}\) MAPS, ‘Other Psychedelic Research’ (MAPS) [http://www.maps.org/research/other-research](http://www.maps.org/research/other-research) accessed 31/03/18.
cases, there would be no need to prescribe the drug as there is no requirement for regular, unsupported taking of it. This is unlike cannabis, which is taken largely as a palliative drug for conditions like pain or epilepsy, and therefore is needed to be consumed regularly and at home. Therefore, treatments like this are unlikely to lead to diversion which, as previously stated, occurs primarily after the prescription stage of the market.

Second, the conditions for which psychedelics are said to be useful are much more limited than cannabis, which has various claimed benefits. Thus it will be more difficult for recreational users to engage with the medical system, as has likely happened in some of the less strict medical cannabis markets. Third, psychedelics are significantly less popular than cannabis and have a lower addiction profile than other recreationally desirable medications such as opiates. Thus, there will be less of a demand for accessible recreational psychedelics.

For these reasons it seems an appropriately regulated and controlled medical market in psychedelics would have even less to worry about it terms of harm than is the case with cannabis. As the risks of harm are lower and thus the benefit of prohibition less, the chances of successfully defending the prohibition on the medical use of psychedelics are slim. This hypothesis relies on several assumptions. First, psychedelics are medically useful. Second, their utility is limited to a small number of conditions. Finally, the utility of psychedelics extends only to supervised administration rather than prescription. If any of these assumptions proves to be false, then the proportionality analyses may not be easier than it was for cannabis.

The significant chance of medical viability of psychedelics lends further significance to the arguments of this thesis, particularly those of Chapter nine, criticising the process by which Schedule 1 drugs are rescheduled. While it is tempting to take solace in the fact that medical cannabis appears to be on the road to at least some form of medical legalisation, the procedural problems outlined remain. The rescheduling of medical cannabis was dictated and caused by events, which became a

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political crisis with, at least, two severely disabled children as prominent victims. This is by no means a firm blue print for reform. Indeed, it is perfectly plausible that the value MDMA, for example, is demonstrated scientifically but it either does not have the sympathetic victims of its continuing prohibition or, for whatever reason, such victims do not catch the media’s attention enough to create a similar political crisis, which leads to reform. Equally it could create a media storm like that created around medical cannabis, but the government could be in a better position to weather it. In such circumstances, the above described inertia of the domestic and international rescheduling procedures would likely keep this medicine from those patients who could benefit from it, in some cases significantly, even if not as dramatically as Billy Caldwell. In such circumstances, the human rights framework described here would be a valuable tool in challenging such prohibition.

Another area of research and enquiry which is raised, but not fully addressed by this thesis is the use of empirical research, data and statistics in public law adjudication. Indeed, the level of complexity of the preceding empirical research may cause some issues for a court. This thesis has worked on the assumption that the type of case study that was attempted in Part three is suitable, in some form, for transposition into the judicial setting of the human rights adjudication. The undertaking of this kind of empirical enquiry in a judicial setting, however, would likely not be compatible with strong approaches to deference, for example or traditional notions of separation of powers and judicial competences. There is reason, however, to believe that the courts would be willing to undertake such an enquiry. First, in Quayle Mance LJ stated that a ruling on this issue would not be straight forward and would necessarily involve:

evaluation of the medical and scientific evidence, a weighing of the competing arguments for and against the immediate change recommended by the Select Committee and the Runciman
Committee, a greater understanding of the nature and progress of the tests of cannabis which have taken and are taking place... 

Thus, there is recognition that this issue would require an evaluation of significant amounts of data and evidence. More recently, we have seen the Supreme Court undertake similarly complex evidential enquiries. In *Quila*, for example, the court uses data to attempt to analyse the proportion of marriages between British citizens and foreign nationals between 18 and 20 are forced. They then go on to note that such an exercise is flawed due to the issues with the dataset, demonstrating a willingness to engage with the empirical data and methodology. Further in *UNISON*, the Supreme Court used empirical research to quantify the fall in tribunal applications following the implementation of tribunal fees. They then went on analyse whether the fees were affordable with reference to an economic analysis by the Rowntree Foundation. These analyses predicted the required income needed in order to sustain families of a different sizes and incomes. The court calculated, based on this prediction and the fee remittance system, whether such families would be able to afford the fees and still live an acceptable standard of life according to the Rowntree Foundation. The court also engaged with the government’s criticisms of the underlying assumptions of the Rowntree Foundation’s analysis. It is this level of empirical and financial detail that Elliott (quoted above) referred to as ‘striking’.

These examples are given to demonstrate that the court is increasingly willing to engage in what some might think overly-complex empirical enquiries. This is essential as human rights issues raises necessarily empirical questions (“does legalising medical cannabis harm health?”, “does reducing the age of marriage visas help the fight against forced marriage?” or “are tribunal fees affordable?” etc). Given that the courts are legally required to answer human rights issues substantively and that the best evidence for these enquiries are economic and data analyses, approaching these questions in this way is unavoidable. The empirical data in *UNISON* were clear and

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679 *Quayle* (n 11) [68]
680 *Quila* (n 117) [23]-[24], [55], [81].
681 *UNISON* (n 298) [50]-[55].
682 Elliott (n 299).
in *Quila*, the failures of the Government were more fundamental and thus the case didn’t entirely rest on the data. Given this, the question of how the court deals with a case which hinges upon more equivocal or complicated empirical evidence than that seen in UNISON has yet to be answered. Will the courts wade into the deep waters of statistical significance and probability? It seems inevitable that they must, and public law academia needs to begin to think about how they should.

*Significance and originality*

The significance of this thesis is twofold. First, it answers, in a more fulsome way than has ever been attempted before, an interesting and important legal question: is the prohibition of a medically useful drug an abuse of human rights? While this question has been raised and considered before,\(^{683}\) it has not been analysed so thoroughly. Indeed, this has required a fusion of technical constitutional law with empirical drug policy studies. Given the constitutional nature of human rights and the empirical nature of the questions raised, this is certainly a rare, but necessary, fusion.

Second, in this thesis I, to my knowledge, adopt an original approach to answering a human rights question, embarking on a detailed and empirically based analysis following the framework of judicial human rights test. In this regard this thesis highlights and demonstrates the importance of understanding and using empirical data and research in the answering of legal questions. This is particularly important for human rights and public law due to the centrality of proportionality. Indeed, while proportionality in principle was accepted soon after the Human Rights Act came into force in 2000, it is only since *Bank Mellat* in 2013 that the principle has been solidified and a common understanding repeated.\(^{684}\) Further, in *Pham* the Supreme Court accepted that proportionality rather than Wednesbury unreasonableness may be used in other substantive review cases outside of human rights and legitimate expectations (which, up until then had been the only other situation in which it was deployed).\(^{685}\) This is significant as proportionality subjects the decisions of government to a more

\(^{683}\) Walsh (n 301); Bone and Seddon (n 300).

\(^{684}\) *Bank Mellat* (n 115).

\(^{685}\) *Pham* (n 105) [98], [119].
searching substantive review (i.e. a review of the outcome, rather than the procedure of a decision) than any previous standard of review. Wednesbury only requires that the court review whether a decision so outrageously defies logic and moral standard that no reasonable person could have made it. In such a formulation, there is little scope for fine grained empirical analysis as if a decision fails this test, it will usually be immediately evident. This is not so for proportionality. Under the necessity test, for example, the court is required to essentially conduct a comparative policy analysis while under fair balance a harm/benefit analysis is required. Thus, as the court increasingly reviews the outcome of government decisions, including legislation, based on proportionality, they will increasingly encounter complex empirical questions such as those raised in this thesis. This thesis, therefore, offers something of a framework as to how to analyse such questions academically, structuring the empirical enquiries within the framework of proportionality.

Third, the arguments in this thesis are important as they add weight to current momentum building in the UK towards medical cannabis reform. Public law in general and human rights in particular, has not featured at all in the current arguments for reform. This is not a merely rhetorical point. I am not suggesting here that the human rights argument is more convincing in rhetorical terms than that which has already been employed in this case. Rather I am suggesting, and this thesis argues, that the reforms that are currently being hoped for in this climate are a legal requirement. If the placement of cannabis (and any other medically useful drug) into Schedule 1 is an abuse of human rights, it is unlawful. Thus, the government, unless it was to seek parliamentary approval for its position, would not be able to maintain the prohibition of medical cannabis. This fact remains relevant even if the government allows some form of medical cannabis, but access to it is too limited or cumbersome. This is demonstrated by the Canadian experience: While after Parker, the Canadian government was required to legalise medical cannabis, it did so in such a way that was viewed as unacceptably limited by campaigners and patients and their representatives, who brought a further

human rights case in 2007, the result of which required that medical cannabis access be widened to include more people.\(^{687}\) In the context of proportionality, the impact of widening the market would have to be balanced against the increased risk of prevalence and diversion. However, the point remains that once it is found that the denial, through criminalisation, of a medically useful drug is a human rights abuse; this provides further leverage and options for reform, once the current political crisis surrounding Billy Caldwell dies down, as it inevitably will.

To put this claim more starkly, if the arguments of this thesis are correct, and the placement of medically use drugs into Schedule 1 of the Misuse of Drugs Regulations is an abuse of human rights, the provision of medical cannabis becomes a legal requirement; the choice and discretion of the government would be limited. This overcomes the problems, outlined in Chapter nine, of an inert system of rescheduling, and proponents for reform will be able to press the case judicially, rather than merely politically. Thus, the arguments in this thesis are significant as they suggest that the medical care of people such as Billy Caldwell and Mr Quayle should not be, and as a matter of law are not, in the political discretion of the government.

\(^{687}\) \textit{R v Long} (2007) 88 O.R. (3d) 143
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Appendixes

Appendix 1 – Case Review Methodology

Stage 1: Search the whole text of official judgments of each Supreme Court case (total of 620) (found here: https://www.supremecourt.uk/decided-cases/) for the phrase “human rights” (using the Control F function). Discount all cases which do not include “human rights”.

Stage two: Search the remaining cases on the basis of whether they evaluated the proportionality of a qualified human right (Article 8-11). This was done through using search terms such as “proportiona*”, “rational connection”, “legitimate aim”, “Article 8/9/10/11” as well as summaries, introductions and conclusions of the cases. When convinced that the case examines the proportionality of an infringement of a qualified human right, it is included. When convinced that it does not, it is discounted. Cases were discounted on the following grounds (non-exhaustive):

- They did not consider proportionality in any sense
- Were about Articles 2-7 of the ECHR and therefore did not consider proportionality in the sense meant in this thesis
- They conducted a proportionality examination in a different area of law, for example EU, legitimate expectations or discrimination
- Usually, cases falling under Protocol 1, Article 1 of the ECHR while they do use the standard 4 stage test, do in different ways and to different standards and so, when this is true they are discounted.
- They solely hinged upon whether a challenged policy was “in accordance with the law”.

Stage three: Read the selected cases and analyse the approach to proportionality. If during this stage it became clear that a case does not examine proportionality as described above, it is discounted.

688 See RECOVERY OF MEDICAL COSTS FOR ASBESTOS DISEASES (WALES) BILL: Reference by the Counsel General for Wales [2015] UKSC 3
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Table displays the number of cases and their neutral case citations number that proceeded to each stage. Entries in the left hand column were those that were read and analysed for the proportionality chapter of the thesis.
Appendix 2 – Home Office correspondence

My request:

“Good morning,

I am a postgraduate researcher at the University of Manchester School of Law. I am doing research into the scheduling and classification of drugs under the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulation 2001 and would be very grateful if you would be able to clarify a Home Office policy for me. In 1997, in answer to a question in the House of Common, George Howarth MP answered the following with regards to the Home Office Policy on moving a drug from Schedule 1 to Schedule 2 of the Misuse of Drugs Regulations 1985 (now replaced by the Misuse of Drugs Regulation 2001):

“Reclassification from Schedule 1 to Schedule 2 would depend upon the therapeutic benefits of a medicinal form of the drug being satisfactorily demonstrated in the United Kingdom, or the United Nations Commission on Narcotic Drugs reducing the international controls on the drug.” (HC Deb 17 December 1997 vol 303 c172W. Quote can be found at http://hansard.millbanksystems.com/written_answers/1997/dec/17/misuse-of-drugs-act#S6CV0303P0_19971217_CWA_27)

I would be most grateful if you could inform me of whether this remains Home Office policy in regards to rescheduling of drugs in the Misuse of Drugs Regulations 2001. I would be extremely thankful for any further information as to the Home Office policy on rescheduling that might be available also.

Thank you for your time,

Kenneth Ingram

Postgraduate Researcher and Teaching Assistant
School of Law
01612750200
kenneth.ingram@postrag.manchester.ac.uk”

Home Office Response:

“
Mr Kenneth Ingram

kenneth.ingram@postgrad.manchester.ac.uk

Reference: T7995/16

Dear Mr Ingram,

Thank you for your e-mail of 19 July about the classification and scheduling of drugs under the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001. Your e-mail has been passed to the Drug Legislation Team at the Home Office for a response.

The Misuse of Drugs Act 1971 controls and classifies drugs which are considered dangerous or otherwise harmful when misused. These drugs, also referred to as controlled drugs
(‘CDs’) are also listed in Schedule’s 1 to 5 of the Misuse of Drugs Regulations 2001. The schedule classification of these CDs is based on an assessment of their medicinal or therapeutic usefulness, the need for legitimate access and their potential harm when misused.

Schedule 1 to the Misuse of Drugs Regulations 2001 covers CDs which have no medicinal or therapeutic value and are mainly used for research purposes under a Home Office licence.

Schedule 2 to the Misuse of Drugs Regulations 2001 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.

Schedule 3 of the Misuse of Drugs Regulations 2001 covers CDs which have a medicinal or therapeutic value but are less addictive than Schedule 2 drugs.

Schedule 4 of the Misuse of Drugs Regulations 2001 is divided in two parts. Part one includes benzodiazepines and Part two includes anabolic and androgenic steroids, which is subject to lighter regulation with no possession offence.

Schedule 5 of the Misuse of Drugs Regulations 2001 covers weaker preparations of Schedule 2 drugs that present little risk of misuse and can be sold over the counter as a pharmacy medicine (without prescription).

Section 31(3) of 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 consultation and recommendation from the ACMD.

I hope this provides you with the clarification you were seeking.
Yours sincerely,

Drug Legislation Team

Drugs and Alcohol Unit

Email: Public.Enquiries@homeoffice.gsi.gov.uk
Appendix 3 – Freedom of information request to the ACMD

My request:

“We name: Kenneth Ingram

My contact address: Flat 16, 2-4 Birch Lane, Longsight, Manchester M130NN

The following is a Freedom of Information Request for information from the Advisory Council on the Misuse of Drugs (ACMD). I would appreciate information regarding the ACMD’s policy on recommending that a drug be moved from schedule 1 of the Misuse of Drugs Regulations 2000 to schedule 2.

I recently contacted the Home Office to ask whether the following statement still represented their policy on moving drugs from schedule 1 to schedule 2:

“Reclassification from Schedule 1 to Schedule 2 would depend upon the therapeutic benefits of a medicinal form of the drug being satisfactorily demonstrated in the United Kingdom, or the United Nations Commission on Narcotic Drugs reducing the international controls on the drug.” (George Howarth MP HC Deb 17 December 1997 vol 303 c172W. Quote can be found at http://hansard.millbanksystems.com/written_answers/1997/dec/17/misuse-of-drugs-act#S6CV0303P0_19971217_CWA_27)

In response the Home Office explained that as a result of the statutory duty to consult the ACMD before legislative decision, ‘the rescheduling of a controlled drug under the Misuse of Drugs Regulations 2001 would not be made without prior consultation and recommendation from the ACMD’ (Full response from the Home Office is attached).

Consequently, this request for information seeks information on the following questions:

• What would trigger the ACMD to conduct a review of the position of a drug in schedule 1: i.e. would a Home Office request be required or would the ACMD begin such a review of its own volition? If the latter, what would be required in order to cause the ACMD to, of its own volition, conduct review into the placement of a drug in schedule 1?
• With regard to the above quote from George Howarth MP, would evidence ‘in the United Kingdom’ or a declaration from the UNCND be weighted any higher, by the ACMD, than research/testimony from outside the UK or from non-UN bodies.
• What level of evidence would be required in order for the ACMD to recommend moving a drug out of Schedule 1, for instance would the ACMD expect there to have been a certain amount/number of placebo-controlled clinical trials before it would make such a recommendation?
• How many reviews of the medical utility of schedule 1 drugs has the ACMD conducted?

Any information is this area that you could provide would be greatly appreciated.

Regards

Kenneth Ingram

Postgraduate Researcher and Teaching Assistant
School of Law, University of Manchester

Room 3.63, Williamson Building
Oxford Road
Manchester

M13 9PL
01612750200
kenneth.ingram@manchester.ac.uk”

ACMD response:

“

Kenneth Ingram
Flat 16
2-4 Birch Lane,
Longsight
Manchester
M13 0NN
18 November 2016

Dear Mr Ingram

Thank you for your correspondence of 24 October 2016 to the Advisory Council on the Misuse of Drugs (ACMD). Your request has been handled as general correspondence in order to provide a more substantive response.

Please see responses below to your specific questions:

1. The ACMD may decide to conduct a review of a substance in Schedule 1 if there is new evidence that the substance has a legitimate medical use and acquired a Marketing Authorisation through the MHRA (Medicines & Healthcare Products Regulatory Agency. The ACMD may also consider if the said substance has a legitimate medicinal use in another country. The ACMD would undertake such reviews either through its own volition or upon request from the Home Office.

2. In any such review of a Schedule 1 substance, the ACMD would consider all available peer reviewed evidence, from both national and international sources.

3. The ACMD may consider recommending a substance to be rescheduled from Schedule 1 if the manufacturers can demonstrate that the substance has legitimate therapeutic benefits and that a Marketing Authorisation has been acquired through the MHRA.

4. The ACMD has not yet undertaken a review to reschedule a substance from Schedule 1 to any other schedule.

I hope this addresses the points you have raised.

Yours sincerely

Zahi Suleiman
Appendix 4 – Freedom of information request to the Home Office

My request:

“Good afternoon,

I am placing a Freedom of Information Request for information regarding licences given for production, possession and supply of drugs contained in Schedule 1 of the Misuse of Drugs Regulation 2001 and designated under Section 7(4) of the Misuse of Drugs Act 1971. All drugs in Schedule 1 of the Misuse of Drugs Regulations 2001 have been designated under Section 7(4) of the Misuse of Drugs Act 1971 to the effect that their production, supply and possession are unlawful except for purposes of research or other special purposes. Regulation 5 of the Misuse of Drugs Regulations 2001 allows for the Secretary of State to provide licences to allow a person to produce, supply, offer to supply or have in his possession any controlled drug. I am requesting information on such licences for drugs designated under Section 7(4) of the Misuse of Drugs Act 1971 and contained in Schedule 1 of the Misuse of Drugs Regulation 2001. In particular I wish to know;

1. How many such licences have been given out
2. To whom such licences have been given
3. For what purposes such licences have been given (e.g. research or special purposes)
4. The drugs for which such licences have been given. If possible a breakdown of how many licences have been given for each drug.
5. The conditions that the licences place upon those to whom they were given
6. How many licences were given out which allowed for the drug in question to be supplied to humans in a clinical trial (or for any other purpose)

While information on all Schedule 1/Article 7(4) drugs is requested, the drugs of particular concern, and for which any information pertaining to licences would be greatly appreciated, are; Methyleneoxyamphetamine (AKA MDMA or ecstasy), Cannabis, Psilocin/psilocybin (active ingredient in “magic” Mushrooms), Lysergic acid diethylamide (LSD) and N,N-Dimethyltryptamine (DMT).

Thank you,
Kenneth Ingram

Postgraduate Researcher and Teaching Assistant
University of Manchester, School of Law (Williamson Building Room 3.63)
Home Office Response:

“Mr Kenneth Ingram
kenneth.ingram@postgrad.manchester.ac.uk

3 August 2016

Dear Mr Ingram

Freedom of Information Request 40396
Thank you for your email of 14 July 2016 in which you ask for information regarding licences issued for the production, possession and supply of controlled drugs contained in Schedule 1 of the Misuse of Drugs Regulations 2001 and designated under Section 7(4) of the Misuse of Drugs Act 1971. In particular you ask for;

1. How many such licences have been given out
2. To whom such licences have been given
3. For what purposes such licences have been given (e.g. research or special purposes)
4. The drugs for which such licences have been given and if possible to give a breakdown of how many licences have been given for each drug
5. The conditions that the licences place upon those to whom they were given
6. How many licences were given out which allowed for the drug in question to be supplied to humans in a clinical trial (or for any other purpose)

7. Any information pertaining to licences issued for Methyleneoxyamphetamine (AKA MDMA or ecstasy), Cannabis, Psilocin/psilocybin (active ingredient in “magic” Mushrooms), Lysergic acid diethylamide (LSD) and N,N-Dimethyltryptamine (DMT).

Your request has been handled as a request for information under the Freedom of Information Act (FOIA) 2000.
I am able to disclose some of the information that you requested, as follows, and will respond to your questions in turn.
Firstly, however, I should like to explain that the applicable legislation does not define ‘research’ or an ‘other special purpose’. Licences issued to possess, supply and produce controlled drugs could therefore include those issued for in-vitro laboratory based research, toxicology or forensics work.

In respect of questions 1, 3 and 6, I can confirm that in the last 12 months the Drugs and Firearms Licensing Unit (DFLU):

- issued 64 schedule 1 licenses to produce, possess and supply controlled drugs in the situations outlined above, and:
- issued 7 schedule 1 licenses for in vivo research and/or/clinical trials.

With reference to question 2, I can confirm that the Home Office holds this information that you have requested. However, after careful consideration we have decided that the information is exempt from disclosure under section 43(2) of the FOIA.

This provides that information can be withheld if its disclosure under this Act would, or would be likely to, prejudice the commercial interests of any person (including the public authority holding it). Section 43 is a qualified exemption and as such, is subject to a public interest test. We consider that the public interest falls in favour of maintaining the exemption. Arguments for and against disclosure in terms of the public interest, with the reasons for our conclusion, are set out in the attached Annex.

With regards to questions 4 and 7, we are unable to provide this information as we do not hold information in this format. We issue licences for a group of activities which are then determined under a schedule rather than issue for a specific activity or drug. The reasons for the grant of an individual licence are specific to that case and activities which may be covered by licences of the type you have enquired about have been outlined above.

Finally, with regards to question 5, I can confirm that licences are issued to named individuals and departments, or companies, are valid for one year and are specific to the premises address. Further general conditions relating to licences issued would relate to notification of any changes, or thefts of losses of drugs, record keeping and storage must be in accordance with the Misuse of Drugs Regulations 2001 and the Misuse of Drugs (safe custody) Regulations 1973.

Please note that these conditions are not exhaustive and can vary on a case-by-case basis. I believe this responds to all the questions you have raised. If you are dissatisfied with this response you may request an independent internal review of our handling of your request by submitting a complaint within two months to the address below, quoting reference 40396. If you ask for an internal review, it would be helpful if you could say why you are dissatisfied with the response.

Information Access Team
Home Office
Ground Floor, Seacole Building
2 Marsham Street
London SW1P 4DF

E-mail: info.access@homeoffice.gsi.gov.uk
As part of any internal review the Department's handling of your information request will be reassessed by staff who were not involved in providing you with this response. If you remain dissatisfied after this internal review, you would have a right of complaint to the Information Commissioner as established by section 50 of the Freedom of Information Act.

Yours sincerely
Ruksana Ali

Drugs and Firearms Licencing Unit