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The Rt Hon Priti Patel MP
Secretary of State
Home Office
2 Marsham Street,
London,
SW1P 4DF

Dear Secretary of State

Re: WE THE UNDERSIGNED ("WTU")

I write on behalf of "*We the Undersigned Have a Human Sovereign Right to Cannabis*", a community group that is united in the shared belief that that the private acts of production and consumption of cannabis should not be prohibited in law.

The purpose of this letter is to invite the Secretary of State to agree to end the criminalisation of cannabis consumers. In particular, "We the Undersigned" invites you to remove criminal and civil sanctions for the unlicensed acts of possession, cultivation, preparation and distribution of cannabis for private, non-commercial, adult purposes.

A. Introduction

1. The WTU asserts that the unlicensed acts of possessing, cultivating, preparing or sharing all varieties of cannabis at home for private, non-commercial adult purposes causes no significant harm to individuals, communities or society. The WTU further asserts that the criminalisation of their beliefs and practises infringes upon their inalienable human rights to: a freedom of consciousness, free development of personality, freedom of association, autonomy of health, expression of identity and to hold private beliefs and practices in the many uses and benefits of herbal cannabis; insofar as much, their actions cause no harm to others or their property. People who

carry out such actions, whilst causing no harm to others, in the privacy of their own homes, social clubs or public places, should not live in fear of suffering the harms of criminalisation, as a result of outdated UK drug policy.

2. For these reasons, the Secretary of State is respectfully invited to repeal the criminalisation of the aforementioned actions with cannabis. In particular, "*We the Undersigned"* invites you to remove criminal and civil sanctions for the unlicensed acts of possession, cultivation, preparation and distribution of cannabis for private, non-commercial, adult purposes.

3. Moreover, The WTU further invites the Secretary of State, under their special powers granted by Ss 8.1 of the MODA 1971, to take action to amend legislation to implement a licenced and controlled cannabis market, permitting venues for cultivation, purchase and consumption of cannabis for adult purposes; equal in nature to the rights, protections and responsibilities that are granted to those who choose to produce, consume, purchase or distribute the recreational drug alcohol.

B. The criminal law relating to cannabis in England and Wales

4. The criminal law on the possession of cannabis in England and Wales has developed in response to a series of reports by independent committees. On 13th February 2020, the Home Office wrote to We The Undersigned to suggest that the government has no plans to "*decriminalise cannabis (sic)*" because, "*… there is clear scientific and medical evidence that cannabis is a harmful drug which can damage people's mental and physical health, and harms individuals and communities."*[1] "We The Undersigned" assert that as research now proves that criminalisation is more harmful to individuals, communities and costly to society than the alleged potential harms of cannabis, it is therefore necessary to start by summarising the evidence upon which the Home Office relies and how it has impacted on the development of the criminal law relating to cannabis.

5. On 1st November 1968, the Advisory Committee on Drug Dependence published a report on cannabis. Overall, the report concluded that the adverse effects which the consumption of cannabis in even small amounts may produce in some people "*should not be dismissed as in-significant"*. The Committee felt that, "*the dangers of its use as*

[1] The letter reflected a UK Government response to a petition calling for a referendum on the legalisation of cannabis: https://petition.parliament.uk/archived/petitions/214030

commonly accepted in the past and the risk of progression to opiates have been overstated, and that the existing criminal sanctions intended to curb its use are unjustifiably severe."

6. Parliament then passed the Misuse of Drugs Act 1971. The Misuse of Drugs Act 1971 prohibits the importation and exportation of a controlled drug (s.3), the production and supply of a controlled drug (s.4), the possession of a controlled drug (s.5), and the cultivation of any plant of the genus, cannabis (s.6).

7. The Misuse of Drugs Act 1971 defines a "*controlled drug*" as any substance or product specified in Part I, II or III of Schedule 2 to the Act. Class A, B and C drugs are any of the substances and products specified in, respectively, Parts I, II and III of Schedule 2 These different grades correspond with the seriousness attached to the offences relating thereto. Prior to 29th January 2004, cannabis and cannabis resin were class B drugs, while cannabinol (except where contained in cannabis or cannabis resin) and its derivatives were class A drugs.

8. On 4th November 1998, the House of Lords Science and Technology Committee published its Ninth Report, entitled "*Cannabis: The Scientific and Medical Evidence*." The Committee provided detailed recommendations on the medical use of cannabis. However, it concluded that there was "*not enough rigorous scientific evidence to prove conclusively that cannabis itself has, or indeed has not, medical value of any kind*" (§8.1). The report went on to address the argument that the personal possession of cannabis should be decriminalised. It concluded, at §8.18, that cannabis was "*neither poisonous …, nor highly addictive"*. The Committee did not believe that it can cause schizophrenia in a previously well user with no predisposition to develop the disease. However, the Committee did consider that cannabis: (a) was intoxicating, (b) could have adverse physic effects, (c) could lead to psychological dependence through regular use, (d) could lead to unpleasant symptoms through withdrawal, (e) impairs cognitive function through use, (f) increases heart rate and lowers blood pressure. At §§8.20-8.21, the Committee referred to other "*possible, though not proved"* risks posed by cannabis. It was on the basis of this "*evidence"* that the Committee recommended, at §8.23, that cannabis and its derivatives should continue to be controlled drugs.

9. In 1997, an independent inquiry was set up, under the chair of Viscountess Runciman DBE, to report into the Misuse of Drugs Act 1971. Chapter 7 of the inquiry's report addresses cannabis. It includes an overview of specialists' views on the relative harmfulness of cannabis compared to other illicit drugs. The report concludes that

"*Cannabis is not a harmless drug"*. It questioned whether cannabis can cause schizophrenia, but concluded that it was intoxicating enough to impair the ability to carry out safety-critical tasks, it can have adverse physic effects ranging from temporary distress, through transient psychosis, to the exacerbation of pre-existing mental illness, it can lead to psychological dependence, withdrawal may involve unpleasant symptoms, it impairs cognitive function, it carries risks to people with cardiovascular conditions, and smoking cannabis carries similar risks of respiratory disorders to smoking tobacco. Their report suggested that there are also long-term risks. The report cited the British Medical Association that, "*The acute toxicity of cannabinoids is extremely low; they are very safe drugs…"*. It recommended that cannabis should be transferred to class C, possession of cannabis should not be an imprisonable offence, and that prosecution of offences of cannabis possession should be the exception. It did not recommend the decriminalisation of the cultivation of small numbers of cannabis plants for personal use but suggested that this should be a separate offence to production and should be neither arrestable nor imprisonable.

10. In March 2002, the Advisory Council on the Misuse of Drugs published a report on "*The Classification of cannabis under the Misuse of Drugs Act 1971"*. This report suggested that the classification of cannabis as Class B was disproportionate "*in relation both to its inherent toxicity, and to that of other substances (such as amphetamines) that are currently within Class B"*. In making this recommendation, however, the Council explained that it "*wishe[d] to be clearly understood that cannabis is unquestionably harmful … the dangers associated with the use of cannabis preparation are widely known"*. The report set out the Council's view of the acute and long-term health risks of cannabis.

11. The then Home Secretary announced his acceptance of this report in July 2002, on the basis that it would reflect more accurately the relative harmfulness of drugs, give the misuse of drugs legislation greater credibility and indicate the Government's priority to tackle class A drugs.

12. On 29th January 2004, Parliament reclassified cannabis, cannabis resin, cannabinol and cannabinol derivatives as class C.

13. In 2007, the Home Secretary asked the Advisory Council on the Misuse of Drugs to review the classification of cannabis. The Council published a report, "*Cannabis: Classification and Public Health"*, in 2008. Once again, the Council recommended that cannabis remain a class C substance. However, the cover note to the report opined

that "*the use of cannabis is a significant public health issue. Cannabis can unquestionably cause harm to individuals and society."*

14. On 24th July 2018, the Advisory Council on the Misuse of Drugs recommended that cannabis-derived medicinal products should be placed in Schedule 2 of the Misuse of Drugs Regulations 2001. This was because the Council agreed with the Chief Medical Officer that there was evidence of therapeutic benefit for some cannabis-derived products in some medical conditions. It also recommended further clinical trials. The Home Secretary accepted this recommendation on 26th July 2018 and subsequently legislation was introduced on 1st November 2018 to permit the use of cannabinoids for medical purposes.

15. The evidence of the harm said to be caused by cannabis has not been reviewed in any meaningful sense since 2007. Nor has the Secretary of State ever reviewed the benefits that cannabis can bring to those who use it. New evidence is available. Given that the prohibition of cannabis has been justified on the basis of developing evidence, it is incumbent on the Secretary of State to review that prohibition in the light of this new evidence.

C. The Medical Evidence

16. In 1996 the Department of Health commissioned Dr Philip Robson to review the scientific literature regarding the potential therapeutic utility of cannabis and its derivatives. The review was based upon primary sources. It was provided to the Department of Health in 1998 but not published publicly. An abridged version was published in the *British Journal of Psychiatry* in February 2001 (Volume 178, Issue 2, pp.107-115). Dr Robson concluded that cannabis and some cannabinoids are effective antiemetics and analgesics and reduce intraocular pressure. There is evidence of symptom relief and improved well-being in selected neurological conditions, AIDS and certain cancers. Cannabinoids may reduce anxiety and improve sleep. He also found that cannabis is safe in overdose but often produces unwanted effects, typically sedation, intoxication, clumsiness, dizziness, dry mouth, lowered blood pressure or increased heart rate.

17. Since Dr Robson's report, a number of respected research papers have been published, which demonstrate the considerable therapeutic benefits of cannabis use. These reports also undermine the suggested medical risks of cannabis use. The reports include the following (amongst many others):

a. On 2nd November 2011, a collection of experts including DI Abrams of the oncology department of the San Francisco General Hospital, published a report which suggested the benefits of cannabis use in the management of chronic pain: "*Cannabinoid-Opioid Interaction in Chronic Pain"*.[2]

b. A number of reports have also emphasised the positive benefits of cannabis use for uses as varied as: the regulation of bone mass;[3] for the central nervous system;[4] in the treatment of human osteoporosis;[5] for hand bone strength;[6] for pain management;[7] for the treatment of Chrohn's Disease;[8]

c. On 30th January 2015, Dirk W. Lachenmeiera and Jürgen Rehm published a study in the *Scientific Reports* (Sci. Rep. 2015: 5: 8126): "*Comparative risk assessment of alcohol, tobacco, cannabis, and other illicit drugs using the margin of exposure approach."* Using the margin of exposure approach, this study suggested that alcohol was a "*high risk"* drug (with an MOE of less than 10) whereas cannabis was low risk (with an MOE of less than 10,000).

d. Between 4th and 7th June 2018, the Fortieth meeting of the Expert Committee on Drug Dependence of the World Health Organisation took place. The meeting was dedicated to carrying out pre-reviews of cannabis and cannabis-related substances. In its report, the Expert Committee on Drug Dependence suggested that the argument that cannabis causes schizophrenia was "*contentious"*. The Committee also noted, in a pre-report, that cannabis was an effective analgesic,[9] that its use was associated with a reduction in pain associated with diabetic

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[2] Clinical Pharmacology & Therapeutics (2011); 90 6, 844–851

[3] See, for example, I. Bab and A. Zimmer, "*Cannabinoid receptors and the regulation of bone mass*": 2008 paper British Journal of Pharmacology 123 (2) 182-188.

[4] Shenglong Zou and Ujendra Kumar, "*Cannabinoid Receptors and the Endocannnabinoid System: Signalling and Function in the Central Nervous System"*: Int J Mol Sci. 2018 Mar; 19(3): 833.

[5] M. Karsak and others: "*Cannabinoid receptor type 2 gene is associated with human osteoporosis*", *Human Molecular Genetics*, Volume 14, Issue 22, 15 November 2005, Pages 3389–3396,

[6] M. Karsak and others, "The cannabinoid receptor type 2 (CNR2) gene is associated with hand bone strength phenotypes in an ethnically homogeneous family sample", Hum. Gen. 2009 Nov;126(5):629-36

[7] E.B. Russo and A.G. Hohmann, "*Role of Cannabinoids in Pain Management"*, in *T.R> Deer et al (eds), Comprehensive Treatment of Chronic Pain by Medical, Interventional, and Integrative Approaches* (American Academy of Pain Medicine, 2013), pp.181-197.

[8] T. Naftali, "*Treatment of Crohn's Disease with Cannabis: An Observational Study*", The Israel Medical Association journal: IMAJ 13(8): 455-8.

[9] WHO Expert Committee on Drug Dependence Pre-Review, "Section 4: Therapeutic use" (2018), p.7.

peripheral neuropathy,[10] and that its administration decreased attack pain from migraines and cluster headaches.[11]

e. On 8th August 2018, the Harvard Medical School published a report that found that there was little support for cannabis use as a cause of schizophrenia.[12]

18. This expert medical evidence reflects the anecdotal evidence gathered by We The Undersigned, who have received 123 testimonials from members of the community group, each explaining the significant positive benefits that cannabis use have had on their lives and medical conditions. We The Undersigned have also received a report from Professor MP Barnes, honorary professor of neurological rehabilitation at the University of Newcastle, dated August 2019. This report concludes that:

> *"In summary, cannabis has a long, distinguished history and it is only in the last 50 or 60 years of many thousands of years of usage that a socio-political negative view has been taken. Cannabis undoubtedly has significant benefits for a large variety of conditions given that it acts through the ubiquitous endocannabinoid system. There are thousands of strains of cannabis with varying proportions of THC and CBD and other minor cannabinoids and terpenes. Each one will have a subtle difference for a given individual and their health and well-being. It is a health remedy that is different from other medicines in that it is simply part of a family and does not fit into a pharmaceutical model and should not be forced down a pharmaceutical route. There are drawbacks for the use of cannabis in some people like any other activity, but overall the risk: benefit ratio is in my opinion strongly in favour of cannabis being more widely used to the benefit of many millions of people across the world."*

19. This report, further research and the detailed testimonials provided to We The Undersigned, are attached to this letter.

D. Evidence of Use

20. It is now also clearly established that cannabis is widely used in British society. The National Audit Office suggests that cannabis is widely used among adults and young

[10] Ibid, p.8.
[11] Ibid, p.9.
[12] https://psychcentral.com/news/2013/12/10/harvard-marijuana-doesnt-cause-schizophrenia/63148.html?fbclid=IwAR1mj9jBrz_M4vmorE8q9ispnqdtOO0AQR4sz-JT6oJlpRcagQIGdpzuVck

adults, with 6.7% of adults having used cannabis in 2014/15.[13] Government statistics suggest that 7.18% of the British population have used cannabis in the past year.[14]

21. In addition, a YouGov poll published in October 2019 estimated that 11% of UK adults had tried a CBD product, while the UK CBD market in 2019 was £300 million. This figure is expected to reach £1 billion by 2025.[15]

22. The size of the cannabis marketplace has three important impacts for the prohibition of cannabis:

    a. It means that the UK Government is missing out on considerable revenue that would be generated if the market were legal;

    b. It means that law enforcement interventions are less likely to be effective.[16]

    c. It suggests that the law enforcement approach to cannabis use is ultimately ineffectual. The significant levels of ongoing cannabis use supports the UK Government's conclusions that, "*Illicit drug markets are resilient and can quickly adapt … Activity solely to remove drugs from the market, for example, drug seizures, has little impact on availability*".[17]

    d. It means that considerable resources are expended each year on this, ultimately ineffectual, law enforcement policy. This policy has a detrimental societal impact, as set out in section E of this letter, below.

E. The Impact of Criminalisation upon cannabis consumers

23. There were 169,964 drug offences recorded by the police in 2014/15, of which three quarters were offences of cannabis possession.[18]

24. This law enforcement approach to the use of cannabis is expensive. Central government spend on enforcement and related activities was estimated to be £1.6

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[13] UK Government: "*An evaluation of the Government's Drug Strategy 2010"*, p.23.
[14] https://www.consultancy.uk/news/23334/legal-cannabis-market-of-uk-could-pass-2-billion-mark-by-2024
[15] Ibid.
[16] Reuter, P. and Kleiman, M. (1986) 'Risks and prices: An economic analysis of drug enforcement'. In Crime and justice: An annual review of research, 7, Morris, N. and Tonry,
M. (eds.) pp 289–340. Chicago: Chicago University Press. The conclusions of this 1986 study remain applicable today, as the UK Government accepts: "*An evaluation of the Government's Drug Strategy 2010"*, p.101.
[17] UK Government: "*An evaluation of the Government's Drug Strategy 2010"*, p.10.
[18] UK Government: "*An evaluation of the Government's Drug Strategy 2010"*, p.25.

billion in 2014/15.[19] It is suggested that the overall spend, including of police and criminal justice agencies, is likely to be significantly higher.

25. The UK Government accepts, "*there are potential unintended consequences of enforcement activity such as violence related to drug markets and the negative impact of involvement with the criminal justice system*."[20] We The Undersigned respectfully suggest that the description of such unintended consequences as "*potential"* is a considerable understatement.

26. In addition to the consequences suggested by the UK Government, the prohibition of cannabis also impacts in a detrimental way on the environment and the public perception of the criminal justice system and on race relations.

27. The suspected possession of drugs (particularly cannabis) is the single-biggest justification for the use of "*stop and search"* police powers. In 2016/17, the reason given for 185,959 out of 299,780 uses of "*stop and search"* was the suspected possession of drugs (particularly cannabis) – over 62% of stop and search cases. Of those searches, nothing was found in 126,147 cases (over two thirds of cases). The outcome of those searches was linked to drugs in only 46,814 cases.[21] The figures suggest that stop and search is a particularly blunt instrument that does not lead to drugs-related outcomes in the overwhelming majority of cases said to have been justified to search for drugs.

28. The unjustified use of police powers in support of a law enforcement approach to cannabis possession is likely to have a significant impact on trust in the police, something which is damaging in a country that adopts an approach of "*policing by consent"*.

29. It also has a particularly damaging impact on race relations. Individuals from Black and minority ethnic groups are just under four times as likely to be stopped and searched compared with those who are White. In particular, individuals who are Black (or Black British) are over eight times more likely to be stopped than those who are White.[22] It is suggested that many of the uses of stop and search on Black people in

[19] UK Government: "*An evaluation of the Government's Drug Strategy 2010"*, p.10.
[20] UK Government: "*An evaluation of the Government's Drug Strategy 2010"*, p.10.
[21] Home Office: "Best Use of Stop and Search table", BUSS_02.
[22] Home Office, "*Police powers and procedures, England and Wales, year ending 31 March 2017"*, p.7.

England and Wales were initially said to be justified on the basis of a suspicion of possession of cannabis.

30. The figures in respect of those arrested, charged, and prosecuted for drugs offences show a similar racial imbalance. Figures obtained through the Freedom of Information Act 2000 suggest that:

a. The proportion of Black and minority ethnic people who were arrested in England and Wales for possession of cannabis was 67.2% in 2016, 67.9% in 2017, and 69.7% in 2018. The proportion of Black and minority ethnic people who were arrested in England and Wales for supply of cannabis was 74.3% in 2016, 72.6% in 2017, and 74.6% in 2018.

b. The proportion of Black and minority ethnic people who were charged and bailed to Court for possession of cannabis was 72% in 2016, 72.2% in 2017, and 74.1% in 2018. The figures for those charged and detained for Court and for those charged by way of postal requisition were similar. So too were the figures of those who were charged with supply of cannabis.

F. International consensus

31. Given the new evidence set out above, it is no surprise that an international consensus is developing that recognises that it is unlawful to criminalise cannabis. Recent cases include the following:

a. In *R v Parker* (2000) 188 DLR (4th) 385, the Ontario Court of Appeal held under the Canadian Charter that an absolute prohibition on possession of cannabis without any medical exemption violated the accused's right to liberty in a manner not according with principles of fundamental justice, and declared the prohibition illegal, while suspending the declaration for a year;

b. In *Ravin v State of Alaska* 537 P.2d 494, the Supreme Court of Alaska found that a statute prohibiting possession of marijuana in Alaska was in breach of the right to sanctity of the home in the United States constitution;

c. In *Minister of Justice and Constitutional Development* [2018] ZACC 30, the Constitutional Court of South Africa upheld the High Court's finding that the criminal law on the mere possession, use or cultivation of cannabis by an adult in private for his own personal consumption was unconstitutional. The Constitutional

Court judgment notes that the personal possession of cannabis had been decriminalised by legislation in 33 jurisdictions around the world;

d. On 31st October 2018, the First Chamber of the Supreme Court of Mexico ruled that the fundamental right to the free development of the personality allows persons of legal age to decide, without any interference, what kind of recreational activities they wish to carry out. While that right is not absolute, the Court was clear that the effects caused by cannabis did not justify an absolute prohibition on its consumption.[23]

32. In addition to these clear Court rulings, a number of legislatures around the world have also taken steps to legalise the possession and consumption of cannabis. These legislatures include a number of US states who voted to decriminalise the use of cannabis in the recent elections.

33. More recently, the Commission on Narcotic Drugs (CND), the United Nation's central drug policy-making body, voted to remove cannabis from Schedule IV of the 1961 Single Convention on Narcotic Drugs — where it was listed alongside specific deadly, addictive opioids, including heroin, recognized as having little to no therapeutic purposes. This vote recognises the medicinal and therapeutic potential of the herb.[24]

G. Conclusion

34. The new evidence, summarised above, demonstrates conclusively that: (a) cannabis has a positive, health benefit in a wide variety of uses, (b) the health risks of cannabis have been considerably overstated, (c) cannabis remains widely used in the UK, with the result that the UK Government is missing out on considerable revenue that would be generated if the market were legal, (d) the law enforcement approach to cannabis use has proven to be ultimately ineffectual, (e) the law enforcement approach undermines trust and confidence in the criminal justice system, (f) the law enforcement approach has an unjustified disproportionate impact on Black and minority ethnic communities.

[23] https://transformdrugs.org/press-release-mexican-supreme-court-ruling-means-recreational-cannabis-is-now-legal-for-adults/

[24] https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_63Reconvened/Press_statement_CND_2_December.pdf

35. It is therefore no surprise that an international consensus has developed that the criminalisation of the unlicensed possession, cultivation, preparation and non-commercial sharing of cannabis {and personal use of cannabis} is unconstitutional and contrary to fundamental human rights causing social, medical and economic discrimination. We The Undersigned assert that criminalising people for the above actions infringes their rights as defined by {s Articles: 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 14, 17 and 18} and further note that the constitutional provisions in issue in the cases set out above are similarly worded to article 8 of Schedule 1 of the Human Rights Act 1998.

36. Therefore, based upon this preliminary evidence presented by the community of the WTU, the Secretary of State is respectfully invited to agree to repeal the criminalisation of the aforementioned actions with cannabis.

Yours sincerely

Robert Jappie
Partner