Barriers to Medical Cannabis in the UK: Human Rights Implications of Criminalization and Inequitable Access

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Abstract

Although legislative amendments in 2018 legalized medical cannabis in the United Kingdom, access remains severely limited. Private prescriptions have increased, but National Health Service treatment is exceedingly rare. As a result, individuals using cannabis to manage health conditions are often forced to risk criminalization, undermining their rights and deepening existing inequalities. The discriminatory effects of drug law enforcement are well documented, particularly the disproportionate targeting of ethnic minorities. Similar inequalities affect women and those with disabilities, who may be more likely to experience health conditions treatable by medical cannabis yet face barriers to lawful access. This reflects not only the injustice of ongoing criminalization but also a broader failure to uphold core human rights, particularly autonomy and equality. This article examines the legal and systemic barriers to medical cannabis through a combined doctrinal and socio-legal approach. Analysed in light of Articles 8 and 14 of the European Convention on Human Rights, the article shows how current laws constrain access, entrench disadvantage and perpetuate harm, and argues that decriminalizing possession of cannabis for personal use is the most practical step towards addressing these inequalities.

Keywords: medical cannabis; decriminalization; human rights; Article 8 ECHR; Article 14 ECHR; equality; autonomy; drug policy.

[A] INTRODUCTION

Medical cannabis was legalized in the United Kingdom (UK) in 2018, yet it remains inaccessible.[1] Official National Health Service (NHS) data indicates that fewer than five patients have received prescriptions for unlicensed cannabis-based medicines, despite estimates that more than 1.5 million people in the UK use cannabis for medical purposes (Centre for Medicinal Cannabis 2020; UK Parliament 2024; NHS Business Services Authority 2025). In response to limited NHS provision, many have turned to expensive private clinics, where costs can reach hundreds of pounds a month (Wickware 2019). As a result, the majority are left reliant on the illegal market to manage their health, exposing them to criminalization and raising serious concerns about the protection of fundamental rights.

This article argues that, once the state has recognized cannabis as a legitimate medical treatment, continued criminalization of those who use it for medical purposes but cannot access lawful prescriptions becomes increasingly difficult to justify under Articles 8 and 14 of the European Convention on Human Rights (ECHR). The article calls for urgent reform to introduce formal decriminalization of possession for personal use in order to address the immediate harms and begin correcting the unequal enjoyment of rights. These harms are not evenly distributed but fall disproportionately along lines of disability, ethnicity and gender, reinforcing existing structural inequalities (Shiner & Ors 2018; Centre for Medicinal Cannabis 2020). Using a combined doctrinal and socio-legal approach, the article examines how the existing legal framework undermines equality from a human rights perspective. A rights-based perspective is particularly valuable given the stark divide between those protected by private prescriptions and those subject to the criminal law. Multiple rights are engaged, but the focus here is on the right to private life and protection from discrimination, arguing that criminalization unjustifiably interferes with personal autonomy in health and produces disproportionate harm.

To make this argument, the article first outlines the legal and medical context, including the 2018 reforms and the impact of restrictive NHS guidance. The second section examines the unequal impact of criminalization, especially on disadvantaged groups, framing the issue as one of substantive equality. The third section demonstrates how criminalization constitutes an unjustified interference with autonomy protected by Article 8. This is followed by an analysis of Article 14, arguing

[1] Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018, SI 2018/1055; Misuse of Drugs Regulations 2001, SI 2001/3998.

that the inequalities in access to prescriptions and the distribution of criminalization harms amount to unjustifiable indirect discrimination. The final section recommends formal decriminalization as a necessary first step, alongside longer-term measures to rectify the systemic inequalities maintained by the present system.

[B] LEGAL FRAMEWORK AND MEDICAL ACCESS

Despite the identical nature of the substance, there is a stark divide between lawfully prescribed cannabis and cannabis used for comparable therapeutic purposes that remains criminalized. This section outlines how medical access operates in the UK and how all other use, regardless of medical necessity, remains a criminal offence. The regulatory divide exposes the arbitrariness embedded in the existing legal structure, leaving individuals who rely on cannabis for therapeutic purposes vulnerable to criminalization and underscoring the urgency of reform.

Following the 2018 amendment, cannabis-based products for medicinal use (CBPMs) were rescheduled under schedule 2 of the Misuse of Drugs Regulations 2001. In practice, the framework consists of three categories. The first, "licensed CBPMs", are effectively irrelevant, as none have received marketing authorization from the Medicines and Healthcare Regulatory Agency. Second, "licensed cannabis-based medicines", such as Epidyolex, Nabilone and Sativex, have received authorization and may be prescribed on the NHS. However, their use remains highly limited due to strict adherence to National Institute for Health and Care Excellence (NICE) guidelines, which constrain prescriptions primarily to certain cases of multiple sclerosis, chemotherapy-induced nausea and treatment-resistant epilepsy (NICE 2019, updated 2021). The third and most notable category is unlicensed CBPMs, such as cannabis flowers and oils. These offer wider therapeutic potential and are closer to the forms commonly used on the illicit market. NHS provision is essentially non-existent, as these products can only be issued by specialists and NICE does not recommend them. NICE's cost-efficiency model requires evidence from randomized controlled trials, which are generally unsuited to cannabis as a natural plant, as its variable effects and psychoactive properties make double-blind testing difficult. As a result, NHS data indicates that fewer than five patients have received prescriptions for unlicensed CBPMs (Case 2020; UK Parliament 2024; NHS Business Services Authority 2025). This drives many patients to private clinics,

where access remains tightly controlled, requiring medical records, proof of diagnosis and failure of at least two conventional treatments.

The framework disproportionately disadvantages those with chronic and often underdiagnosed conditions. For example, endometriosis, which affects a significant number of women, has been shown in several studies to be managed by patients using cannabis (Armour & Ors 2019: 21; Armour & Sinclair 2023). Yet the average eight-year wait for diagnosis presents a serious obstacle to accessing lawful prescriptions (Endometriosis UK 2024). These rigid eligibility criteria, which typically require formal diagnoses and evidence of failed treatments, exclude vulnerable groups from safe and effective pain relief, compounding inequality. A more patient-centred model, valuing lived experience alongside clinical discretion, would better uphold rights. Until NHS access is expanded, the disparity between those who can obtain legal prescriptions and those who cannot remains a serious rights concern. The regulatory divide entrenches injustice and requires reform through formal decriminalization of possession for personal use.

Cannabis remains a Class B substance under the Misuse of Drugs Act 1971 (MDA) (sections 4-6), with possession punishable by up to five years' imprisonment and supply offences carrying a maximum sentence of 14 years. Although some police forces have informally deprioritized enforcement through diversion schemes, reliance on discretionary decision-making creates inconsistency and risks enabling discrimination (Stevens & Ors 2025). This is particularly evident in supply-based offences, where enforcement decisions may depend on how police interpret the circumstances of possession (Transform Drug Policy Foundation nd). Though aimed at organized crime, enforcement can capture medical users' possession of larger quantities (O'Reilly & Ors 2022). In practice, many purchase large quantities to minimize both costs and contact with criminal markets. The absence of clear protections, coupled with discretionary policing, creates legal uncertainty and systemic inequality (Coomber & Ors 2018). Similar problems arise in the policing of drug-driving. Unlike alcohol, cannabis impairment cannot be reliably measured with a breathalyser (Rolles 2022: 309). Current drug-driving tests detect trace amounts of tetrahydrocannabinol (THC) rather than impairment, meaning that THC may remain detectable after the psychoactive effects have subsided (Desrosiers & Ors 2014; Arkell & Ors 2021). This can disproportionately affect those who use cannabis consistently for chronic conditions, as regular therapeutic use increases the likelihood of returning a positive test (Rolles 2022: 314-315). Furthermore, many officers remain unaware of the legal status of medical cannabis, reinforcing stigma and discrimination. The challenges faced by lawful patients are beyond the

scope of this article, but these issues remain an important area for future research (Busby 2023; London Drugs Commission 2025: paragraphs 11.72, 11.74).

Given the growing body of evidence supporting medical cannabis and its legal recognition in 2018, it is increasingly clear that criminalization is not grounded in a rational assessment of harm but reflects the paternalistic legacy of prohibition (Nutt & Ors 2010). A rights-respecting approach must prioritize individual autonomy, particularly for those excluded from lawful access. The inconsistency and arbitrariness of the system undermine equality and erode trust in the criminal justice system. A more coherent and equitable model would centre human rights and individual freedoms, recognizing that much of the damage stems from criminalization itself. The next section explores how the criminal law interferes with fundamental rights and why human rights-led reform is essential to address entrenched social inequalities.

[C] CRIMINALIZATION AND SOCIAL INEQUALITY

In practice, the scale of medical cannabis use, combined with the lack of NHS provision, leaves people choosing between potential criminalization and costly private prescriptions for unlicensed CBPMs. This creates significant inequality. Private clinics are prohibitively expensive, with lawful medication often exceeding illicit market prices. Patients have limited choice, must purchase larger quantities, and face additional fees for consultations, clinic membership, and repeat prescriptions. The result is an inequitable, two-tiered system that disadvantages those unable to afford legal treatment (Busby 2019).

The situation not only maintains existing inequalities but actively exacerbates them. The harms of criminalization are unequally distributed, raising serious human rights concerns. It has long been recognized that the most significant harms of cannabis derive not from the drug itself but from its prohibition (Rolles & Murkin 2016: 18). A criminal record carries lifelong consequences for employment, housing and social inclusion. Chin (2002) described these as “collateral consequences”, particularly lost earning potential, which disproportionately impacts those with chronic illnesses, who already face economic hardship. Stigmatization further compounds these effects. Steve Rolles and colleagues (2016: 104) argue that prohibition is “socially corrosive” because it perpetuates stigma, “the burden of which is carried primarily by already marginalized or vulnerable populations”. Research consistently shows that policing

disproportionately targets ethnic minorities, meaning they are more likely to be harmed by both unequal medical access and criminal enforcement (Shiner & Ors 2018). Evidence on drug law enforcement shows that Black individuals are far more likely to be stopped, searched and prosecuted for drug offences despite broadly similar patterns of use. When lawful medical cannabis is effectively restricted to those able to navigate private healthcare systems, these existing patterns of uneven enforcement risk being reproduced within the emerging medical framework (Shiner & Ors 2018). These dynamics reveal how the system produces disproportionate and predictable harm to vulnerable groups. As discussed in the following section, this evidence demonstrates how the law conflicts with key principles of necessity and proportionality under Articles 8 and 14.

People with disabilities are similarly affected. They are more likely to self-medicate due to shortcomings in conventional care and often cannot afford private prescriptions, particularly at higher doses required to manage chronic conditions. Professor David Nutt (2012: 83) has described the criminalization of people who are sick or disabled as “inhumane”, forcing them into criminal markets and leaving them in avoidable pain and anxiety. Axel Klein and Gary Potter (2018: 67-68) likewise highlight how these patients are “criminalised by government, denounced by their doctors and cheated in the underground markets”, resulting in an ongoing “sense of fear and betrayal”. Stigma is also experienced in health settings, especially by those with poorly researched and understood conditions. As the London Drugs Commission (2025: paragraph 4.66) notes, NHS delays in diagnosis and treatment may leave many to self-medicate, placing them outside of legal protection. Such legal vulnerability deepens inequalities in access to healthcare, protection of rights, and exposure to harm

There is also a gendered dimension. Women are disproportionately affected by chronic pain conditions such as fibromyalgia and endometriosis, which may benefit from this medication (Clauw 2014: 1548; Zondervan & Ors 2020). Yet systemic and financial barriers persist. Diagnostic delays, dismissive treatment, and limited conventional treatment options disproportionately affect women, adding another layer of disadvantage (Dusenbery 2018). Cannabis has been shown to be highly effective in relieving pain, often outperforming conventional medications (Armour & Ors 2019: 21). As Mike Armour and Justin Sinclair (2023: 118) explain, existing pharmaceuticals are frequently ineffective and may carry significant addictive potential. They also highlight that both female-specific conditions and the role of the endocannabinoid system are under-researched, reflecting a broader medical gender bias (Armour & Sinclair 2023: 118-119). In light of the higher prevalence of these

conditions among women, combined with obstacles to lawful access to cannabis-based treatments, women are disproportionately exposed to criminalization when seeking to manage chronic pain. This matters for Article 14 because exclusion from lawful access is shaped not only by income, but also by whose pain is taken seriously, diagnosed promptly and treated adequately within mainstream healthcare.

This illustrates how social identity and structural disadvantage intersect. Coined by Kimberlé Crenshaw, the term intersectionality describes how overlapping characteristics, such as race, gender, disability and class, can produce intensified forms of marginalization (Crenshaw 1989). For example, a woman with a disability from an ethnic minority background may face greater barriers to obtaining legal prescriptions and a higher level of criminalization. These disparities require a substantive view of equality. Even though the criminal law may appear neutral, its real-world impact can deepen existing vulnerabilities and undermine the equal protection of rights (Fredman 2016: 279). Structural barriers are not experienced uniformly and are amplified at the intersections of race, gender, disability, and class. Human rights-based reform must therefore not only decriminalize possession but actively tackle the barriers that exclude marginalized groups from legal protection and medical care. The next section examines these issues through Articles 8 and 14 ECHR, arguing that decriminalization of possession for personal use is the necessary first step, alongside broader reforms aimed at repairing these inequalities.

[D] INTERFERENCE WITH AUTONOMY AND EQUALITY RIGHTS

Human rights set minimum standards of protection grounded in equality, making them central to this issue. As outlined above, the regulatory divide between lawfully prescribed cannabis and the criminalization of the same substance outside the prescription system gives rise to the issues examined in this section. Human rights limit excessive deference to state discretion, ensuring that public interest arguments do not automatically override individual rights. This is relevant where the public health justification for criminalizing unlawful medical cannabis use appears neither proportionate nor convincingly achieved. Focusing on rights under the ECHR is the most practical approach, as it is incorporated into domestic law through the Human Rights Act 1998. The European Court of Human Rights (ECtHR) has recognized positive obligations owed by the state, such as duties to safeguard life and ensure access to

healthcare, but these fall outside the scope of this article (*Lopes de Sousa Fernandes v Portugal* 2018). The core question under Article 8 is therefore whether the state can continue to criminalize therapeutic users once it has accepted that cannabis may constitute legitimate medical treatment while maintaining an exceptionally narrow framework for lawful access. Once lawful access is structured so narrowly that many therapeutic users remain outside legal protection, the resulting pattern of criminalization raises serious issues under Article 14 read with Article 8.

Article 8 safeguards the right to private life, imposing a negative obligation on states to refrain from unjustified interference. Its scope has been interpreted expansively to encompass autonomy, self-determination and bodily integrity (*Pretty v UK* 2002: paragraph 61). Criminalizing cannabis use represents a serious intrusion into an individual's autonomy in decisions relating to health (*X & Y v the Netherlands* 1986: paragraph 22; *Glass v UK* 2004). Even the threat of sanctions can cause considerable anxiety, particularly for those using cannabis to manage chronic pain. Studies of UK medical cannabis patients show that criminalization contributes to stress, stigma and fear of legal repercussions (Beckett Wilson & Metcalf McGrath 2023; Metcalf McGrath & Beckett Wilson 2024). However, Article 8 is not absolute. Under Article 8(2), interference may be permitted if done in accordance with law, pursuant to a public interest aim, and necessary in a democratic society. The first two requirements are satisfied, as criminalizing possession has a clear basis under the MDA (*Vavřička & Ors v Czech Republic* 2021: paragraph 269). These restrictions are justified on public health grounds because of concerns about unregulated illicit cannabis and lack of clinical supervision. The crucial question is then whether the current approach strikes a fair balance between competing interests and is no more intrusive than necessary.

States are generally afforded a wide margin of appreciation, particularly in areas lacking European consensus or involving complex health policy. That said, principles from case law suggest that criminalization may be disproportionate and unjustified in this context. In *Herczegfalvy v Austria* (1993: paragraph 82), stricter scrutiny was required in relation to psychiatric patients due to their vulnerability and position of "inferiority and powerlessness". In *Dickson v UK* (2008: paragraph 85), blanket restrictions violated Article 8 because they failed to conduct individual assessments and therefore imposed disproportionate interference with fundamental rights. On this basis, the continued use of criminal law against therapeutic users who cannot access prescriptions is a disproportionate interference, particularly given their vulnerability, the

lack of harm to others, and inequitable medical access. Less restrictive alternatives, such as Portugal's decriminalization model, illustrate that the present UK model is not the least intrusive means of protecting public health (Eastwood & Ors 2016; Greer & Ors 2022). The state's public health justification also becomes increasingly difficult to sustain once the law itself accepts that cannabis may be used legitimately for therapeutic purposes. This reveals a clear inconsistency. Cannabis is recognized as having legitimate medical uses, yet people who rely on the same substance for similar therapeutic reasons remain exposed to criminal sanctions when they cannot access the narrow prescription framework. As such, the present system constitutes a disproportionate interference with Article 8.

The current system also results in indirect discrimination, contrary to Article 14. Structural disadvantages mean that some individuals are more likely to require medical cannabis but less likely to access it lawfully, exposing them to disproportionate harm. Article 14 must be read in conjunction with Article 8, although a breach of Article 8 is not required provided the issue falls within its scope (*Rasmussen v Denmark* 1984: paragraph 29). This requirement is satisfied because criminalization directly engages bodily integrity and autonomy in medical decision-making. Strasbourg has interpreted Article 14 widely to protect individuals from discriminatory treatment in the enjoyment of Convention rights, even where the underlying right is not itself infringed (*Stec & Ors v UK* 2006: paragraph 55; *Guberina v Croatia* 2016: paragraph 67). Not all distinctions constitute discrimination. A violation requires differential treatment between individuals in "relevantly similar" positions based on personal characteristics (*DH & Ors v Czech Republic* 2008: paragraph 175). The grounds are interpreted flexibly and include race, gender, and disability. Lawful and unlawful medical cannabis users who rely on the substance for health reasons are in relevantly similar situations. The only distinguishing factor is their ability to secure prescriptions, which is often shaped by inequalities linked to personal characteristics. The Court has recognized disability and health status as grounds requiring strict scrutiny due to the vulnerability of these groups (*Glor v Switzerland* 2009: paragraph 84; *Kiyutin v Russia* 2011: paragraph 57). Given that medical cannabis use is inherently health-related, the discriminatory impact of criminalization requires heightened scrutiny.

Indirect discrimination arises where policies that appear neutral have "disproportionately prejudicial effects on a particular group" by wrongly failing to "treat differently persons whose situations are significantly different" (*Thlimmenos v Greece* 2000: paragraph 44; *Hugh Jordan v UK*

2001: paragraph 154; *DH & Ors v Czech Republic* 2008: paragraph 184). Evidence on drug law enforcement in England and Wales reveals how ostensibly neutral laws can produce differential outcomes in practice, disproportionately affecting marginalized groups (Shiner & Ors 2018). The effect of the existing framework is therefore not simply unequal outcomes but unequal protection from criminal sanction. Individuals using cannabis for therapeutic purposes remain subject to criminal law largely because they cannot access the narrow prescription structure, a distinction closely linked to structural inequalities such as disability, income and access to healthcare. The ECtHR's interpretation of Article 14 therefore extends beyond formal equality to look at the real impact of laws on disadvantaged groups. Although the 2018 reforms legalized medical cannabis, it was done in a manner that remains highly unequal in effect. The most severe consequences are suffered by those unable to obtain lawful prescriptions, often those who are already disadvantaged, leading to considerable disparities in respect of human rights. This reinforces the need for a substantive equality approach, as a narrow focus on formal equality risks entrenching disadvantage (Fredman 2016: 279).

As with Article 8(2), the key question under Article 14 is whether the lack of differential treatment is objectively and reasonably justified. States may restrict individual rights to pursue legitimate public interest objectives provided there is a "reasonable relationship of proportionality" between the measure and the aim of protecting public health (*DH & Ors v Czech Republic* 2008: paragraph 175). The margin of appreciation doctrine grants states a degree of discretion in determining the extent to which differential treatment is justified, particularly in complex policy areas where there is no clear European consensus. This introduces an element of uncertainty, as outcomes depend on the specific issue. Strasbourg is generally reluctant to intervene if the policy is considered proportionate, as its role is not to determine whether the policy "represented the best solution for dealing with the problem or whether the legislative discretion should have been exercised in another way" (*Šaltinytė v Lithuania* 2021: paragraph 77). This creates a challenge for arguing that the UK has exceeded its margin of appreciation in criminalizing unlawful medical cannabis users. However, the absence of individualized assessments, combined with the disproportionate burden on marginalized groups, raises serious concerns regarding the compatibility of the current regime.

The margin of appreciation introduces uncertainty, but it also allows flexibility in how Convention rights are interpreted. It provides room to argue that the fundamental nature of the rights involved, combined with entrenched inequality, justifies a narrower margin. Discrimination on

grounds of disability and health demands stricter scrutiny, requiring stronger justification from the state and narrowed discretion. For example, in *DH & Ors v Czech Republic* (2008: paragraphs 181-182), the Court held that "special consideration" was required to protect those part of a "disadvantaged and vulnerable minority". As such, the vulnerable position of unlawful medical cannabis users, particularly where disadvantage intersects with race, gender, and disability, warrants enhanced protection. This was reinforced in *Kiyutin v Russia* (2011: paragraph 74), where the state exceeded its narrow margin because the applicant's HIV health status placed him in a "particularly vulnerable group". The Court also stressed that states must correct the "lasting consequences" of stigma and "social exclusion" resulting from past discrimination (*Kiyutin v Russia* 2011: paragraphs 63-64). This reflects a substantive equality approach requiring states to take active steps to address structural disadvantage. In this context, the combined impact of limited medical provision and criminalization is magnified along multiple lines of disadvantage. The Court has also started to recognize more explicitly how different forms of disadvantage interact, suggesting that intersectional forms of disadvantage may play an increasingly important role. In *FM & Ors v Russia* (2024), the ECtHR acknowledged the relevance of intersectional discrimination, recognizing that overlapping forms of vulnerability and disadvantage may shape the enjoyment of Convention rights. The case involved trafficking under Articles 4 and 14, but it reflects a broader willingness by the Court to recognize that multiple axes of disadvantage may require a more nuanced equality analysis.

Recognition of positive obligations under Articles 8 and 14 is a crucial area for future investigation. Once the negative obligation to avoid unjustified discriminatory interference is satisfied through decriminalization, attention can turn to positive duties. Article 8 requires not only refraining from interference but also ensuring effective protection of rights, which may require a regulatory system that facilitates genuine access to treatment (*Tysiac v Poland* 2007: paragraph 110; *P & S v Poland* 2012: paragraphs 99, 108). This does not mean the state must provide specific medications, but breaches may arise where state inaction directly interferes with Article 8 (*Botta v Italy* 1998: paragraph 29; *Hristozov & Ors v Bulgaria* 2012: paragraph 108). When read with Article 14, Article 8 may also require the state to actively prevent and address discrimination relating to health and disability. In this context, the margin of appreciation narrows due to the vulnerability of affected groups and the history of disadvantage (*Jivan v Romania* 2022: paragraph 42; *Guberina v Croatia* 2016: paragraph 73).

In *Cam v Turkey* (2016: paragraph 65), the Court affirmed that failure to make adjustments may constitute discrimination but was careful to recognize limits in order to avoid placing a "disproportionate or undue burden" on states. Universal NHS-funded medical cannabis remains a long-term goal, but decriminalizing possession for personal use does not create such a burden. It represents an essential step towards reducing immediate harms and social disparities, forming the foundation for further rights-based reform.

In summary, the proportionality requirement under Article 8(2) is not met, meaning that the criminalization of unlawful medical users constitutes an unjustified interference with the right to private life. Likewise, the unjustified failure to distinguish between unlawful medical and recreational cannabis use amounts to discrimination contrary to Article 14 read with Article 8, particularly due to the vulnerability and structural inequalities involved. Future reform arguments may rely more heavily on the state's positive obligations. The broad margin of appreciation in complex areas of evolving health policy makes this harder to establish at present. The relatively recent legal status of medical cannabis and its high cost also raise resource allocation difficulties within the NHS, meaning that universal provision could currently be viewed as an excessive burden (Bone 2019: chapter 4). Courts have historically been reluctant to intervene in healthcare resource allocation decisions, recognizing the need for discretion in the distribution of limited resources. However, decriminalization would be a proportionate and effective means of addressing the discriminatory impact of current laws, reducing harm and preventing the entrenchment of social and health inequalities. Maintaining the *status quo* not only fails to protect health and rights but actively undermines them.

[E] TOWARDS HUMAN RIGHTS-BASED REFORM

Reform from a human rights perspective must be grounded in equality and autonomy. The current framework produces both a disproportionate interference with autonomy under Article 8 and unequal protection of rights under Article 14. Decriminalization responds directly to these concerns by removing criminal penalties for possession and reducing unequal exposure to sanctions faced by those unable to access lawful prescriptions. The first step towards meaningful change should therefore prioritize negative rights through decriminalization. Removing criminal penalties for possession would lessen the harmful effects of the regulatory

divide on those unable to access lawful prescriptions, while also addressing the disproportionate interference with rights identified above. Once decriminalization is implemented, attention can shift towards positive rights, including the development of enforceable obligations to facilitate access to treatment and address systemic inequalities.

Decriminalization therefore follows directly from the proportionality concerns identified under Article 8 and the unequal protection of rights under Article 14. Until the NHS adequately funds this treatment, the immediate priority is ending the harms of criminalization. Decriminalizing possession for personal use would protect individuals using cannabis medicinally but unable to afford private prescriptions, ensuring more equal enjoyment of rights. To achieve this, Alex Stevens and colleagues (2024) propose repealing sections 5(1) and 5(2) of the MDA. Repealing these provisions would constitute formal decriminalization in law, providing legal clarity and reducing the discriminatory effects of informal, discretionary policing. A similar proposal has recommended regulating cannabis under the Psychoactive Substances Act 2016 (PSA) rather than the MDA, because possession is not criminalized except in custodial settings (London Drugs Commission 2025: paragraphs 10.301-10.303, 10.311). This highlights an inconsistency in the existing framework. Possession of substances falling within the scope of the PSA is not criminalized, whereas possession of cannabis under the MDA remains a criminal offence.

It is also necessary to distinguish between different forms of decriminalization. *De jure* decriminalization involves formal legislative change removing criminal penalties for possession and would signal that possession should no longer attract stigma, reinforcing protection from discrimination and equal respect for rights. By contrast, *de facto* decriminalization describes situations in which criminal offences remain in place, but enforcement is softened through diversion schemes, warning systems, or discretionary police outcomes. In the UK, elements of *de facto* decriminalization already exist in some police forces through diversion schemes and informal responses to minor possession (Stevens & Ors 2022; Transform Drug Policy Foundation nd). However, reliance on discretion may reproduce the same inconsistencies and inequalities identified earlier in this article. Where criminal offences remain in place, individuals continue to face legal uncertainty and the anxiety associated with potential prosecution. That uncertainty itself constitutes an interference with private life under Article 8, and discretionary enforcement also risks reinforcing discriminatory outcomes. Formal decriminalization therefore provides more reliable protection for autonomy and equality.

Reform must also allow for an individualized assessment of therapeutic use. Individuals should be able to explain their medical use without needing formal proof of diagnosis, particularly given the barriers many patients face in obtaining medical recognition of chronic pain disorders. Policies that depend on strict evidential requirements, such as proof of diagnosis, may reproduce the same inequalities identified earlier in this article. Furthermore, therapeutic and recreational cannabis use do not always form a clear binary and attempts to impose strict distinctions within criminal law risk creating new forms of arbitrariness and discrimination (Hakkarainen & Ors 2019). A narrow medical exemption requiring proof of diagnosis would be likely to replicate many of the same difficulties that currently restrict access to lawful medical cannabis.

These issues are particularly relevant in relation to possession thresholds and supply offences. Individuals using cannabis therapeutically may purchase and store larger quantities in order to minimize contact with illicit markets and maintain a reliable supply to manage their health (O'Reilly & Ors 2022). Yet this may be treated as evidence of an intent to supply. A fixed threshold above which possession is automatically treated as supply would risk recreating the same harms for those with chronic illnesses or disabilities whose health circumstances may require larger quantities. This raises the same Article 14 concerns discussed earlier, as discretionary enforcement practices would continue to disadvantage those using cannabis because of health-related needs. A more equitable system would allow individuals to explain the context of their possession, including situations where larger quantities are held for personal therapeutic use.

The form that decriminalization takes varies significantly across jurisdictions. As Alissa Greer and colleagues (2022) emphasize, decriminalization is not a single model but a category encompassing a range of legal models. Key questions include which offences are removed from criminal law, how possession thresholds are defined, and whether administrative or health-based responses replace criminal sanctions. Stevens and colleagues similarly distinguish between depenalization, diversion, and full decriminalization as different responses to simple possession offences (Stevens & Ors 2022). These distinctions demonstrate that there is no single model of reform, and the detailed design of such policies requires further research. The central point for this article is that the current framework of criminalization is incompatible with the protection of autonomy and equality for those using cannabis therapeutically. Formal decriminalization of possession for personal

use represents the minimum reform necessary to address these harms, leaving more detailed regulatory questions for future development.

International experience provides useful insight into both the benefits and the challenges of decriminalization. Portugal is the clearest example. In 2001 it removed criminal penalties for possession of small quantities of drugs for personal use and replaced them with administrative responses. Crucially, this reform was accompanied by sustained investment in treatment services, harm reduction and wider social support. Research on Portugal's experience suggests that fears of dramatic increases in drug use did not materialize, and engagement with treatment and health services improved (Gonçalves & Ors 2015; Eastwood & Ors 2016: 28). The Portuguese model therefore shows how decriminalization can mitigate the impact of criminalization while shifting responses towards health-based support where appropriate.

Decriminalization is "not a panacea" yet the evidence clearly shows "the harms of criminalization far outweigh those of decriminalization" (Eastwood & Ors 2016: 9). At the same time, recent developments elsewhere demonstrate that the design and implementation matter. In Oregon, Measure 110 decriminalized possession of small quantities of drugs in 2020, but political backlash and implementation difficulties led to partial reversal in 2024 (Oregon Judicial Department 2024; Good & Ors 2025; Oregon Secretary of State 2025). British Columbia introduced a similar exemption in 2023, later narrowing its scope and subsequently allowing the measure to expire in 2026 (Ministry of Mental Health and Addictions 2021; Government of British Columbia 2026). These examples do not undermine the case for decriminalization itself. Rather, they show the importance of coupling legal reform with adequate public health infrastructure, clear communication about policy objectives and realistic expectations about outcomes (Ali & Ors 2026). They also highlight the need to learn from implementation challenges elsewhere so that UK reform is carefully designed and not vulnerable to reversal. These examples concerned the decriminalization of possession of all drugs, whereas this article focuses specifically on cannabis within the context of a partially legal medical framework.

In the UK, the case for reform is strengthened by the regulatory divide between lawful and unlawful medical use. CBPMs are legally available in principle, but access remains extremely limited. Many individuals managing chronic conditions therefore rely either on expensive private prescriptions or on the illicit market. Decriminalization of possession for personal use would not eliminate this divide entirely, but it would

substantially reduce the risk that individuals seeking relief from chronic illness face criminal sanctions. In doing so, it would mitigate the disproportionate interference with autonomy and the unequal protection of rights identified earlier in this article.

Decriminalization alone cannot resolve the wider embedded inequalities associated with medical cannabis. A rights-based approach must also deal with the limitations preventing individuals from accessing lawful treatment. Expanding NHS access, improving clinician education, and increasing investment in health and social services are essential components of meaningful reform. Criminal records for past possession offences can also create long-term barriers to employment, housing, and social participation, perpetuating stigma and structural disadvantage (Chin 2002). Expungement of previous possession convictions would be an important step in repairing the harms caused by this regulatory divide and its unequal effects (Garius & Ali 2022). Evidence from jurisdictions such as Portugal also suggests that decriminalization is most effective when accompanied by sustained public health investment and social support (Gonçalves & Ors 2015). Human rights-based reform must remove criminal penalties and begin dismantling the barriers faced by those who use cannabis.

Drug-driving law is another area that requires reform. Current legislation relies on *per se* THC limits that do not necessarily correspond to actual impairment.[2] Because THC can remain detectable long after intoxication has passed, those who use cannabis therapeutically will often exceed these thresholds despite not being impaired (Desrosiers & Ors 2014; Arkell & Ors 2021). This is especially significant for people who use cannabis regularly to manage chronic conditions. Impairment-based offences clearly serve a legitimate public safety purpose, but the same cannot easily be said of very low *per se* THC limits. Fully analysing this issue falls beyond the scope of this article but remains an important area for future research and policy reform.

Formal decriminalization of possession for personal use represents a proportionate and necessary first step towards a more coherent and equitable drug policy. By removing criminal penalties for individuals who use cannabis to manage their health, decriminalization would reduce the immediate harms produced by the current regulatory regime while allowing space for more comprehensive health-focused reforms to develop over time. A rights-based perspective on drug policy must prioritize the

[2] Drug Driving (Specified Limits) (England and Wales) Regulations 2014, SI 2014/2868, regulation 2; Road Traffic Act 1988, section 5A.

protection of autonomy and equality under Articles 8 and 14 and remain responsive to evolving medical knowledge and social needs. As global drug policy continues to shift, including growing interest in the therapeutic use of substances such as MDMA and psilocybin, the experience of medical cannabis should inform future reforms (Nutt 2023). Ensuring that individuals are not criminalized for seeking relief from illness must remain central to the development of effective and rights-respecting drug policy.

[F] CONCLUSION

The legalization of medical cannabis in 2018 marked a symbolic shift in UK drug policy, but in practice it has offered limited and uneven protection. NHS access remains highly restricted, leaving many patients reliant on private prescriptions or criminalized for self-medicating. The gap in access and the continued harms of criminalization have serious real-world consequences for individuals managing their health. Far from safeguarding public health, the current framework undermines key human rights, particularly autonomy and protection from discrimination. This article has shown that criminal law disproportionately interferes with Article 8, intruding on personal health decisions without sufficient justification. By failing to distinguish between medical and recreational use, blanket criminalization lacks sufficient objective justification and results in indirect discrimination contrary to Articles 14 and 8. This is particularly harmful for those already facing systemic barriers to access, such as women, people with disabilities, and ethnic minorities, whose marginalization is compounded by unequal enforcement.

Future developments may involve recognizing stronger positive obligations to address these inequalities. However, immediate reform must begin with formal decriminalization of possession for personal use. Such reform would not only reduce harm and prevent rights violations but also begin to dismantle stigma and structural barriers. Ultimately, the 2018 reforms risk concealing a system that continues to punish those it purports to protect. A human rights-based approach to cannabis policy must prioritize autonomy and substantive equality. Without such a shift, the law will continue to criminalize conduct it already recognizes may be medically legitimate, leaving the promise of medical cannabis reform largely illusory.

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