Drugs and Human Rights:

Private Palliatives, Sacramental Freedoms and Cognitive Liberty

ABSTRACT: This paper reviews the impact of ten years of domestic incorporation of the European Convention on Human Rights on the evolution of the United Kingdom’s primary piece of prohibitive drugs legislation, the Misuse of Drugs Act 1971. The significant cases where traditional interpretation of this Act has been challenged in the courts using the Convention are discussed. Structured thematically, this paper looks at the interplay between drug prohibition and human rights in addressing complex issues, such as our right to self-medicate, to practice our religion(s) freely, and to explore our own consciousness. The intention is to expose the untapped potential of the ECHR as a tool with which to fundamentally challenge the (discriminatory) drug policy of the United Kingdom.

Key words: Misuse of Drugs Act 1971; European Convention on Human Rights; self-medication; religious freedom; cognitive liberty; drug discrimination.

Introduction

The Misuse of Drugs Act 1971 (MDA) is the key piece of legislation through which the Government of England and Wales attempts to exert control with respect to those drugs considered to be dangerous or otherwise harmful. This is done primarily through the criminalisation of various activities - such as possession, supply or manufacture – involving the substances listed within the Act. The European Convention on Human Rights (ECHR) was implemented to protect a common heritage of political traditions, ideals, freedom and the rule of law collectively across European states; it was incorporated into domestic law in the UK a decade ago via the Human Rights Act 1998 (HRA). Both the MDA and the ECHR have in common that they are intended to operate as organic, living instruments, developing, *inter alia*, through the jurisprudence of the courts.

A consideration of the impact the ECHR has had on the evolution of the MDA is offered here. The significant cases where traditional interpretation of the MDA has been challenged using the ECHR are discussed, accompanied by a side analysis of the judicial discourse found therein. Structured thematically, this paper looks at the interplay between drug prohibition and human rights in addressing complex issues, such as our right to self-medicate, to practice our religion(s) freely, and to explore our own consciousness. Such
matters are located within the broader context of a theoretical consideration of drug politics and philosophy, both on the domestic and international front. In essence, the intention is to expose the untapped potential of the ECHR as a tool with which to evolve the drug policy of the United Kingdom.

**Drugging Oneself**

One of the most important areas where the MDA and the ECHR have been challenged as being incompatible is as regards self-medication. Before considering the cases that raise this contested right to drug oneself – centring upon cannabis use - some background context is necessary. The MDA is supplemented by Regulations\(^1\): these divide those drugs that are controlled by the Act into five Schedules, corresponding to their perceived therapeutic usefulness. Drugs that are placed in the highest category, Schedule 1, are considered to have no medicinal use; as a consequence, research into and prescription of such drugs is severely restricted and can only take place under a Government license. Cannabis currently resides in the hinterland that is Schedule 1. This, in spite of the fact that it has a history of medical usage dating back thousands of years, both in the Orient, in many Middle Eastern countries, and in the West. However, a variety of factors - such as difficulties in standardising dosages of plant compounds - has seen cannabis replaced by other drugs from the pharmacopoeia over the years. Twinned with concerns about potential diversion of medicinal cannabis for recreational purposes, this resulted in the restrictive scheduling\(^2\).

The medical (and indeed criminal) scheduling of cannabis has long been controversial: as far back as 1998\(^3\) and re-emphasising their findings once more in 2001, the Select Committee on Science and Technology argued for the transfer of cannabis from Schedule 1 to Schedule 2 of the Regulations, commenting that:

In choosing to ignore the long history of safe therapeutic cannabis use, and in classifying cannabis extract … as a “new medicine”, the Government and the Medicines Control Agency
are treating a long-established herbal extract as if it were just another synthetic chemical, and are thus not making an informed scientific judgment\textsuperscript{4}.

The Government’s response to this recommendation was revealing: ‘Allowing raw cannabis (which would usually be smoked) as a medicine would seriously blur the distinction between misuse and therapeutic use\textsuperscript{5}. This conflation of the use of cannabis to relieve pain with the use of cannabis to give pleasure is, to a certain extent, understandable (even whilst the decision to prohibit both may be less so): the two concepts are not diametrically distinct. Rather, there is ‘semantic ambiguity inherent in the words “pain” and “pleasure”’\textsuperscript{6}, with the two further entwined in that pleasure-seeking is a route to pain avoidance. Indeed, much drug use – most notably, perhaps, heroin usage – can be conceived of as a form of self-medication, whether it be directed at physical or psychological pain.

The Government’s concern evidences the central role played by discourse in this area, the crucial matter of how we define that which we do, with ‘misuse’ being unwelcome, and only ‘therapeutic’ usage of drugs being sanctified: ‘[t]he drug can only be permitted into the space of “health” once it has been declassified as a “drug” and reclassified as a “medicine”’.\textsuperscript{7} This shift can be effected partially through a change in terminology, but also through altering the method by which cannabis is ingested, namely, to medicalise it, by only allowing it to be administered in the more clinical form of, for example, a spray. This is exactly what has been done with the creation of GW Pharmaceutical’s Sativex, licensed in certain other countries - such as Canada - but not (as yet) in the UK. The Government has made it clear that, should a cannabis-based medicine be licensed by the Medicines Control Agency in the future, they would be amenable to it being prescribed. Indeed, in the interim, they are allowing Sativex to be prescribed on a named-patient basis under a specially created general Home Office license, covering any doctor who wishes to prescribe it – and any patient who wishes to take it – so long as the Home Office Drug Branch Licensing Section is informed of their details.
Government fears of recreational usage of cannabis are thus alleviated by disallowing a therapeutic exception to the ban on the plants themselves. Allowing preparations of cannabis in the therapeutic realm – rather than legitimising smoking of the herb – serves another very important function: as a natural plant, cannabis cannot be patented, whereas a synthesised preparation containing active cannabis constituents, of course, can be. This introduces us to (and partially explains) an interesting paradox. Natural plants are avoided in Western bio-medicine, with synthetic preparations heralded as the cure to all our ills; the pharmaceutical companies have great interest in this distinction being maintained. In contrasting ‘natural’ with ‘synthetic’ drugs:

\[\text{[o]ne side wishes to place drugs on the inside, the other wishes to place them on the outside [of society]. The trouble is that drugs and the drugged Self will continually resist both of these positions: as a dangerous supplement they undermine any clear distinction between natural and alien, foreign and domestic, inside and outside}^8.\]

Compounding the complexity, which of these constructs leads to the drug-taker being viewed as an ‘insider’ or an ‘outsider’ is context dependent, with ‘synthetics’ being more likely to be heralded in the therapeutic realm – to be portrayed as ‘cure’ rather than ‘poison’ – yet, as will be illustrated, depicted as being a greater crime to manufacture in the courts. The (over-stated) distinction between ‘natural’ and ‘synthetic’ thus has wildly divergent meanings, with the milieu in which drugs are ingested becoming central to the meaning imbued: ‘whereas illicit drugs are positioned as corrupters of liberal bodies, medically prescribed drugs … are positioned as restorers of liberal bodies’\(^9\). The paramount issue here is one of control, both pharmaceutical, financial and political: ‘[t]he role of therapy … is not only one of support and assistance for the afflicted but one of social control of the patient and ideological control of the values implicit in therapy and illness behaviour’\(^10\).
Yet, whilst the benefits of ‘natural’ cannabis ingestion may have fallen out of official medical favour, those same properties that have seen it used therapeutically for millennia remain. Not surprisingly, therefore, unsanctified self-medication with cannabis continues, for a range of different conditions. Such unauthorised usage has led to prosecutions under the MDA, frequently followed by appeals challenging the legitimacy of ensuing convictions, bolstered by claims that prohibitions on self-medication conflict with the rights enshrined within the ECHR. A group of such cases was heard conjunctly by the Court of Appeal in *R v Quayle; R v Wales; R v Taylor and another; R v Kenny; Attorney General’s Reference (No 2 of 2004)*11. The medical conditions that the individuals involved were attempting to alleviate by smoking cannabis were broad in range, from phantom-limb pain to pancreatitis. Further, the convictions under the MDA that they were challenging varied, from cultivation, to possession with intent to supply, to simple possession.

The subject of the Attorney-General’s appeal, Mr Ditchfield, had been acquitted at trial by a jury who accepted his defence of necessity to the charge of supplying cannabis to cancer and MS sufferers. As an important aside, it is worth noting that the very fact that juries have been increasingly willing to accept such defences in recent years - refusing to denounce as legally guilty those who engage in these practices - is a strong indicator that the law has fallen out of step with the ethics of the public. Unhappy with this decision, the Attorney-General was questioning whether the defence of necessity was available to a defendant charged with such an offence where they intended to supply it to another for the purpose of alleviating pain. Conversely, Quayle, Wales and Kenny were appealing against the decision of their respective trial judges not to put the defence of necessity before the jury, thus, arguably, usurping its role. The Attorney-General’s question was answered in the negative and the appeals against conviction were dismissed. The judicial reasoning reflected a clear desire to uphold both the prohibitive scheme of drug control and the power of the medical profession:
the defence of necessity … would, if it exists in law, enable individuals to undertake otherwise unlawful activities, without medical intervention or prescription, with a view to the use for medicinal purposes of cannabis either by themselves or by others for whom they say that they assumed responsibility as unqualified medical practitioners¹².

But what of the ECHR? Did its existence affect interpretation of the defence of necessity and, hence, the issue of a right to self-medication? The most pertinent provision of the ECHR was viewed by the courts as being Article 8: ‘Everyone has the right to respect for his private and family life’. The primary point made by the court in relation to this provision was that, were Article 8 to have relevance to the defence of necessity, this would be limited to immediate sufferers, and most definitely not extended to those involved in supply to such. This judicial restriction on where Article 8 could potentially have relevance was pertinent to the appellants Taylor and Lee, who together ran a holistic clinic that supplied cannabis to patients, many of whom were HIV positive, or suffering from AIDs: ‘[t]oday, in therapeutic societies, only the physician is allowed to dispense “dangerous drugs”. If anyone else does so, he is called a “pusher”, and is again condemned and punished regardless of the consequences of his efforts’¹³.

Even in those instances where cannabis was possessed for self-medication, the court pointed to the potentially legitimate derogations found in Article 8(2), namely, that this right can be interfered with where ‘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’. However, the court stopped short of ruling upon whether any – and if so which – of these might apply here, claiming that they lacked the detailed information necessitated in order to make such a decision:
The court’s decision would involve an evaluation of the medical and scientific evidence … a greater understanding of the nature and progress of the tests of cannabis which have taken and are taking place, and a recognition that, in certain matters of social, medical and legislative policy, the elected Government of the day and Parliament are entitled to form overall policy views about what is best not just for particular individuals, but for the country as a whole, in relation to which the courts should be cautious before disagreeing. 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{14}.

Thus, importantly, any real decision on this seems to have been deferred, as opposed to definitively decided. However, some intriguing comments were made as regards the defence of necessity requiring extraneous circumstances capable of objective scrutiny by judge and jury. The issue of whether ‘pain’ satisfied such extraneous requirements was doubted:

\[ \text{the law has to draw the line at some point … Courts and juries have to work on evidence … } \]

There is, on any view, a large element of subjectivity in the assessment of pain not directly associated with some current physical injury\textsuperscript{15}.

The fear underpinning this comment is that, if pain is hard to objectively verify, perhaps cannabis is being smoked – heaven forfend! – for pleasure.

These issues were revisited a few years later in the case of \textit{R v Altham}\textsuperscript{16}. Following a severe road accident, Altham had lost one of his hips. Unable to find legitimised pain relief, he gained respite through smoking cannabis. Although given an absolute discharge – perhaps a sign of the law falling out of step with the court’s ethics? - Altham brought an appeal on principle. Interestingly, his lawyer accepted that the (initially mooted) Article 8 arguments had been closed down by \textit{Quayle}\. This is contestable: as demonstrated above, such arguments were only subjected to partial analysis in that case. As a result, Altham’s appeal
rested upon whether his Article 3 rights had been breached; namely, that ‘no one shall be subjected to torture or to inhuman or degrading treatment or punishment’. It was advanced that Altham had suffered ‘degrading treatment’ as the only route by which he believed he could avoid pain had been blockaded by the MDA, necessitating that he break the law, thus risking any ensuing punishment.

Altham argued that, to avoid conflict with Article 3, the MDA should be read as if it were subject to the defence of medical necessity. The court was unimpressed with his logic: ‘In our judgment the state has done nothing to subject the appellant to either inhuman or degrading treatment and thereby engage the absolute prohibition in Article 3’\(^\text{17}\). There was no support for stretching the ambit of Article 3 to render the state liable for refusing to permit those in pain to take whatever steps they felt were necessary to alleviate it, regardless of the fact that such measures may breach the criminal law. This approach is consistent with the line of jurisprudence on Article 3, which makes it clear that, whilst Article 3 embodies a positive obligation to prevent ill treatment, it does not go so far as to require that the state provide - or indeed legalise – desired remedies to deal with those injuries or illnesses that arise from accidental or natural causes\(^\text{18}\).

What is the verdict on the judicial approach to self-medication with cannabis in these cases? Would it have been preferable had the courts taken a broader view of the sorts of activities that Article 8 – or even Article 3 – should protect, and to read the prohibitions in the MDA down accordingly, in line with section 3 of the HRA? An interesting issue to consider here is that, regardless of scientific research into the medical benefits of cannabis – itself somewhat contradictory and inconclusive – if an individual convinces themselves that cannabis is the answer to their health problems, this goes a long way towards it actually being such\(^\text{19}\). If these individuals are willing to risk the posited side effects of cannabis smoking, should this not be a decision that they are free to make, as self-determining, autonomous beings? Is it justifiable to contribute to such individuals’ pain and anxiety by restricting their
options or, worse, by imposing upon them the extra burden of being hauled through the courts with a view to punishment being inflicted?

Who we are is largely constituted by the choices that we make. To interfere with these choices is thus to threaten our very individuality: ‘If other people tell me what I should choose for my own good, then in what sense are we talking about my good, as opposed to other people’s perceptions and attitudes?’ Compounding the problem, such perceptions and attitudes appear to be driven more by unsubstantiated ideology than by sound ethical reasoning. If it is to be convincingly argued that restrictions on the therapeutic usage of cannabis are justifiable, then what would need to be shown is that they curtail harm to others: nowhere has this been adequately demonstrated. In short, in answer to the question:

should I be free to use cannabis to alleviate my pain and anxiety? The answer, based on my individual freedom, is yes. Medical facts are too vague to overturn my informed choice, concrete harm is not inflicted on innocent third parties, and considerations of … symbolic harm cannot outweigh the suffering that can probably be removed by the drug.

Religious Freedom

Alongside the issue of autonomy to self-medicate, the yearning to practice one’s religion how one sees fit is another sphere where there is enormous potential for conflict between the MDA and the ECHR: this latent discord stems from the fact that certain drugs have a lengthy history of entwinement with religious practices. This is particularly true of entheogenic drugs – those substances that users believe generate the divine within – that are often taken to occasion spiritual experiences:

For as long as we know of, there have been at least a few people in every culture, the mystics and the saints, who were able through prayer, meditation, or other techniques to bring upon themselves mystical states of consciousness, also called primary religious experience. In some
cultures, this direct experience of the sacred was available to everyone … through the sacramental use of psychoactive plants and preparations.\textsuperscript{22}

Thus, there is a very real issue that prohibitive drug laws can be interpreted as stifling religious freedom; indeed, where drug use is viewed as a central sacrament, they could even be experienced as a form of religious persecution. Religious freedom is protected by Article 9 of the ECHR, which reads: ‘Everyone has the right to freedom of thought, conscience and religion; this right includes freedom … to manifest his religion or belief, in worship, teaching, practice and observance’.

The compatibility of the prohibitions in the MDA with Article 9 was tested in the case of \textit{R v Taylor}\textsuperscript{23} in the context of Rastafarian cannabis use. Taylor was arrested entering a Rastafarian temple with around 90 grams of cannabis. He admitted that he was intending to supply this to others, for religious purposes, as part of a regular act of worship: smoking cannabis whilst studying the bible is customary for Rastas, who believe this pursuit brings them closer to Jah. At trial, the prosecution had ‘conceded’ that Rastafarianism is a religion and had not contested that Taylor was supplying cannabis for religious purposes: thus, Article 9 was clearly engaged. However, whilst the protection of freedom of thought, conscience and religion is absolute, there are permissible derogations under Article 9(2) that apply to the freedom to \textit{manifest} one’s religion or belief, though these must be ‘necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or the protection of the rights and freedoms of others’.

In determining whether any derogation applied, heavy reliance was placed upon the international context, upon the fact that the MDA was perceived as being the legislative enactment of the UK’s obligations under various UN Drug Conventions: the existence of these Conventions was taken as commanding evidence of international agreement that there was a need for a categorical ban on such substances for the sake of the public good.
Detrimentally, by accepting the very existence of the Conventions as constituting evidence of a pressing social need for prohibition, the court made little use of the wealth of medical, sociological or religious material available, both on cannabis and Rastafarianism. Such reliance on the Conventions was replicated in the Court of Appeal, in refusing leave to appeal against conviction: ‘The Single Convention on Narcotic Drugs 1961 ... recognises that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with economic danger to mankind … That Convention applies to cannabis’\(^{24}\). The hyperbolic use of language here is noteworthy, especially given that cannabis is not considered to be addictive (and that addiction is itself a highly complex and contested phenomenon); neither is cannabis medically classified as a narcotic.

How legally persuasive is the reliance on the UN Drug Conventions in \textit{Taylor}? In order to ascertain this, it is necessary to look at how constrictive the system of global prohibition truly is in relation to decisions made in domestic courts. The present system of worldwide drug control is regulated by three international conventions: the 1961 Single Convention on Narcotic Drugs; the 1971 Convention on Psychotropic Substances; and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. It is worth noting that – unlike the ECHR – none of these Conventions have been incorporated into the domestic law of the UK: on this basis alone, obligations arising out of the ECHR should take precedence in the courts’ decision-making. Regardless, if the resolution had been made in \textit{Taylor} either to read the MDA down to avoid conflict with the ECHR, or to issue a Declaration of Incompatibility under section 4 of the HRA, this could potentially have led to a clash with the Conventions, given that they require parties to establish as criminal offences a variety of drug-related activities. However, these Conventions explicitly allow exemption from enforcement on human rights and constitutional grounds, clearly anticipating limitations such as those demarcated by the ECHR:
thus, if the highest courts in signatory nations ruled that prohibition of a single drug or a selection of outlawed substances was unconstitutional then the Parties involved would no longer be bound by the limitations of the Conventions with respect to those drugs. Such action would be perfectly legitimate according to the provisions of the treaties themselves.²⁵

Of course, it is generally accepted that the real power behind the Conventions is fear of upsetting the US, of the economic and political sanctions that may ensue. Keeping this in mind, it is revelatory to look at how the US has itself dealt with pleas for religious exemptions from drug prohibitions, along with any potential conflict with the Conventions.

Worthy of note in relation to the US is the existence of The Religious Freedom Restoration Act 1993 (RFRA), enacted following concerns that First Amendment rights to religious freedom were not being adequately safeguarded. Under the RFRA, the Federal Government may not substantially burden a person’s exercise of their religion, even if the burden results from a rule of general applicability (such as drug prohibition); in order to do so, they would need to show that their actions were in furtherance of a compelling government interest and that the approach adopted was the least restrictive means of doing so. This Act was applied in the case of Gonzales v O Centro Espirita Beneficente Uniao do Vegetal²⁶, concerning a New Mexican branch of a Brazilian church seeking a religious exemption allowing them to continue their sacramental use of ayahuasca tea, containing DMT, a controlled substance. What is interesting here is that, despite expressed concerns about both the safety of ayahuasca, and as regards the potential for it to be diverted from religious to recreational usage, in this collision between religious freedom and drug prohibition, the former won out. Crucially, in contrast with Taylor – and in spite of the US often being seen as the strictest guardians of the UN Drug Conventions – the State was found to have failed to prove that adherence to the Conventions was a compelling interest that the court needed to take into account in their decision-making. This undermines the validity of the weight given to the Conventions in Taylor, opening up possibilities for the future.
Further, this is not an isolated case of religious exemption from prohibition in the US: in a similar vein, the Native American Church (NAC) has a long standing permission to use peyote, as have all members of every recognised Indian Tribe. Yet, interestingly, when a plea for Rastafarian dispensation to use cannabis was brought in the US, it was unsuccessful. Are there justifiable differences between these groups and their sacramental drug use, or is this tantamount to religious discrimination? In *State v McBride* the Court distinguished between the Native American and Rastafarian communities on three main bases, as summarised by Edge:

Firstly, peyote was used in limited quantities and during specific ceremonies by the NAC, whereas Rastafari use of cannabis was found to be unlimited – making it much more difficult to regulate if religious use was allowed. Secondly, abuse of peyote was far less common than abuse of cannabis – again making it more difficult to properly regulate religious cannabis use. Thirdly, and a point stressed by the Court, the US has a special duty to respect the political and cultural integrity of Native Americans.

Thus, whether primacy is given to religious freedom or to the ‘church of prohibition’, appears to be both culturally contingent and drug specific. However, it is worth noting that, once again, international obligations did not unduly influence the court’s judgement, further undermining the primacy afforded to them in the UK in *Taylor*.

**Beyond Religious Freedom**

It will be remembered that the protections in Article 9 go beyond freedom of religion, also safeguarding freedom of both thought and conscience. What is the logic behind bundling these ostensibly disparate liberties together? If one takes an expansive view of religion, the overlap becomes clearer: philosopher William James defined religion as ‘the feelings, acts, and experiences of individual men (*sic*) in their solitude, so far as they apprehend themselves
to stand in relation to whatever they may consider the divine.\textsuperscript{31} Thus, religion, in its broadest sense, encompasses our understanding of the world and our part in it: as such, everyone has their own religion, inextricably bound up with their thoughts and their conscience. Adding drugs into the mix, particularly entheogenic drugs - many of which are controlled by the MDA - fudges the interface between religion, thought and conscience yet further. The relayed experiences of entheogenic drug users expose the lack of adequacy of any binary distinction between those experiences viewed as ‘sacred’ and those viewed as ‘profane’; this goes to the core of the issue of whether it is justifiable that ‘religious experiences’ involving sacramental drug use might be protected, but not other drug-induced experiences, potentially of equal significance to the individual involved.

The Australian case of \textit{Hanes}\textsuperscript{32} encapsulates the difficulties inherent in trying to distinguish ‘religious’ from ‘non-religious’ entheogenic drug experiences. Hanes sought judicial review of the Human Rights and Equal Opportunity Commission’s decision not to inquire into his complaint that the prohibition of salvia – an entheogenic herb - constituted a breach of his human rights; specifically, Hanes argued that his rights under Article 18 of the International Covenant on Civil and Political Rights – a provision that largely mirrors Article 9 of the ECHR - were being transgressed. Hanes’ contention was that his use of salvia facilitated his ability to commune with nature and the ‘Spirit of the Earth’, an experience he described in quasi-religious terms as ‘Nature Philosophy’. Whilst the authenticity of Hanes’ beliefs are not disputed, nonetheless, a sense pervades here of an individual finding it necessary to contort their direct experiences into a shape that approximates those of established religions. This is understandable from a pragmatic point of view: it has been (somewhat acerbically) remarked upon that, in order to qualify for a religious exemption from prohibition:

\begin{quote}
\text{[t]he drug must be not only religiously important to its user but also an essential part of a traditional rite of communal significance … It is as though mountain climbing were regarded as}
\end{quote}
generally so dangerous and useless that climbers would be fined and jailed unless they could prove they were making a pilgrimage to a holy site on the peak certified by an established church.\textsuperscript{33}

This, paradoxically, in spite of the fact that an offshoot of taking psychedelic drugs is often a questioning of long-held, traditional beliefs: ‘The psychedelics are a red-hot, social/ethical issue precisely because they are de-conditioning agents. They will raise doubts in you if you are a Hassidic rabbi, a Marxist anthropologist, or an altar boy because their business is to dissolve belief systems.’\textsuperscript{34}

Hanes’ strategy failed: whilst the court was prepared to accept that ‘Nature Philosophy’ was not only a belief system but also one that was manifested via the use of salvia – without, interestingly, finding it necessary to rule upon whether or not it was a religion – his application for judicial review was dismissed. It was felt that the scheduling of salvia justifiably fell within the limitations contained within Article 18(3), which - paralleling Article 9(2) - allows derogations from the right to manifest religion or beliefs where these are deemed necessary to protect the public. It seems that it is easy to be magnanimous when determining those activities that engage human rights’ protection, if one is similarly ‘generous’ in finding that the same such conduct falls within the derogations.

Returning to the UK, an important challenge that went beyond the religious freedom protections of Article 9 to focus, \textit{inter alia}, on the ‘thought and conscience’ limbs of this provision, was that of Hardison.\textsuperscript{35} In 2004, Hardison was found to have a chemical laboratory at his home and was subsequently charged with eight counts under the MDA, including producing 2C-B, DMT and LSD, controlled drugs of Class A. In his defence, Hardison emphasised the absolute protection of freedom of thought contained within Article 9, contending that laws that proscribe psychotropic drugs offend against cognitive liberty. Cognitive liberty can be defined as ‘the right to choose one’s own cognitive processes, to
select how one will think, to recognise that the right to control thinking processes is the right of each individual person” 36.

Reading Article 9 so that it safeguards cognitive liberty was postulated by Hardison as being far from a subsidiary issue: rather, he contended that individual sovereignty over one’s interior environment constitutes the very core of what it means to be free. By shutting down his right to utilise certain drugs, Hardison argued, the MDA interfered with his freedom of thought: his logic was that, given thought has a physical basis in electrochemical phenomena in the cerebral cortex, psychotropic drugs are an important technology through which consciousness can be modified, catalysing alternative perspectives. As Weil has noted, ‘our overall map of the human mind is incomplete when some mental lands are “off limits” to exploration. This is reminiscent of the fifteenth century fear of sailing out into the ocean because you might fall off’ 37. Weil continues:

From an information processing perspective, a mindbody state is analogous to a software program. By increasing the number of programs we use in a computer, we expand our productive use of the computer: by increasing the number of mindbody states we use, we increase the productivity of our minds ... By needlessly restricting the accessibility of drug produced states, current laws limit what we can know about our minds and how we can use them 38.

Hardison predicted that, in expectation of ever greater precision in understanding and manipulating higher cognitive processes, it is incumbent upon us as a society to evolve individual rights in anticipation of these developments; the significance of cognitive liberty - and controversies in this area - seems deemed to increase exponentially in the years to come. His claims are bolstered by an important piece of research carried out by the Office of Science and Technology who were tasked by the Government with forecasting the major issues that will arise in relation to drug policy over the next twenty years. They concluded:
There has been an increase in interest in cognition enhancers, chemicals intended to optimise the performance of a specific function of the brain (mental cosmetics). We are on the verge of a revolution in the specificity and function of the psychoactive substances available to us\textsuperscript{39}.

In anticipation of this psychoactive revolution, it seems wise to evolve the jurisprudence on Article 9 so that it adequately safeguards freedom of thought, in terms of people’s right to take - and to refuse - drugs that affect cognition.

**Drug Discrimination**

A further lens through which the prohibitions within the MDA can be viewed as being incompatible with the rights and freedoms as guaranteed in the ECHR is that of drug discrimination. This concept permeated Hardison's defence; accordingly, discussion of his case will continue from this related perspective. The trial judge, Niblett, heard a number of preliminary issues prior to the case going before a jury, hinged upon Hardison's allegation of drug discrimination: ‘My argument is simple: I feel drug users are demonised in this society, and I am a drug user’\textsuperscript{40}. Hardison was seeking to stay trial proceedings as an abuse of process: he argued that the Government must objectively justify the disparate treatment he received or, failing this, that the MDA must be read and given effect to in a fashion compatible with his rights and freedoms. Alternatively, a Declaration of Incompatibility was seen to be required.

As Hardison reminded the court, the MDA’s primary legitimate aim is to reduce potential risks to individuals and society from the misuse of ‘dangerous or otherwise harmful drugs’\textsuperscript{41}; hence, the Act explicitly concerns itself with the regulation and control of ‘drugs which are being or appear … likely to be misused and of which the misuse is having or appears … capable of having harmful effects sufficient to constitute a social problem’\textsuperscript{42}. In relation to Hardison’s case, this then begged two questions: why was the legislation being
used to control non-dependency forming drugs – such as those Hardison was making – that, further, only appeal to an ‘eccentric few’ and are thus not a threat to society?; conversely, why was the legislation not being used to control the demonstrably more dangerous drugs alcohol and tobacco?

This artificial divide between controlled drugs and alcohol and tobacco is increasingly being recognised as unsustainable, even from official sources. Most notably, the extensive investigation of the drug control system by the Select Committee on Science and Technology that resulted in the publication *Drug Classification: Making a Hash of it?* concluded that ‘the current classification system is not fit for purpose and should be replaced with a more scientifically based scale of harm’\(^43\). This damming conclusion was both informed and confirmed by a paper published in *The Lancet* that disseminated the results of a scientific assessment carried out by a group of experts – led by David Nutt, Chair of the Advisory Council on the Misuse of Drugs - of the harm rankings of both illicit and licit drugs\(^44\). The key indicators of harm were taken to be: physical harm to the individual user caused by the drug; the tendency of the drug to induce dependence; and the effect of such drug use on families, communities, and society. In relation to physical harm, tobacco and alcohol outstripped all illicit drugs: indeed, at the highest end of the scale, they together accounted for about 90% of all drug-related deaths in the UK. As for inducing dependency, the sharp distinction between non-dependency associated drugs, such as LSD, was elicited, as against those accepted as frequently associated with powerful dependency, such as crack cocaine and tobacco. With regard to social harm, alcohol scored highly, with its strong connection to both violence and accidents.

Overall, the scientists observed a surprisingly poor correlation between harm score and, firstly, whether or not a drug was deemed lawful, and, secondly, its classification:
Our findings raise questions about the validity of the current MDA classification, despite the fact that this is nominally based on an assessment of risks to users and society. The discrepancies between our findings and current classifications are especially striking in relation to psychedelic-type drugs. They also emphasise that the exclusion of alcohol and tobacco from the MDA is, from a scientific perspective, arbitrary. We saw no clear distinction between socially accepted and illicit substances … Discussions based on a formal assessment of harm rather than on prejudice and assumptions might help society to engage in a more rational debate about the relative risks and harms of drugs\textsuperscript{45}.

Such debate is essential, given that this research can be seen as undermining the foundations of the punishment system that underpins prohibition.

In spite of the strength of this informed denigration – and of the then Home Secretary Charles Clarke’s initial promises to the contrary - neither the rational debate nor any review of the classification system has been forthcoming. The Government’s justification for continuing with the \textit{status quo} is very telling, and worth reproducing in full:

[T]he drug classification system under the MDA is not a suitable mechanism for regulating legal substances such as alcohol and tobacco. The distinction between legal and illegal substances is not unequivocally based on pharmacology, economic or risk benefit analysis. It is also based in large part on historical and cultural precedents. A classification system that applies to legal as well as illegal substances would be unacceptable to the vast majority of people who use, for example alcohol, responsibly and would conflict with a deeply embedded historic tradition and tolerance of consumption of a number of substances that alter mental functioning. Legal substances are therefore regulated through other means. However, Government acknowledges that alcohol and tobacco account for more health problems and deaths than illegal drugs\textsuperscript{46}.

An interesting acknowledgement here is that, whilst alcohol \textit{can} be harmful, most people who use it do so responsibly: it is notable that such paradigms of autonomous self-
regulation are never applied to use of the controlled drugs, where the worst-case-scenario is almost always posited as the only possible outcome. Further, the assertion elsewhere within the report that the Government, whilst not rendering alcohol and tobacco use illegal, do not take the harms that they may cause any less seriously, is patently untrue, as demonstrated by the lack of imprisonment of alcohol distillers and cigarette manufacturers. Most crucially, this Governmental response unambiguously accepts that drug policy is largely informed by historical and cultural precedents (for which read prejudices) and its unaltered perpetuation is ‘justified’ on the basis that to do otherwise would upset the (voting) public – not to mention Members of Parliament - many of whom use alcohol and tobacco. Thus, the MDA can be seen as regulating historically contingent taste, with use of the controlled drugs being ethically indistinct from use of alcohol and tobacco. In the words of Martin Luther King: ‘An unjust law is a code that a numerical or power majority group compels a minority group to obey but does not make binding on itself. This is difference made legal’\footnote{47}.

However, the question is, given the existence of the ECHR, is such discriminatory commandeering of the MDA legal? Under the Convention - specifically, under Article 14 - the rights and freedoms contained therein are meant to be enjoyed on a non-discriminatory basis. To fall within the scope of Article 14, claimants must show that they have been subjected to prejudicial treatment in comparison to analogous groups in terms of protection of their rights and freedoms under one or more of the Articles of the ECHR, with exceptions only being made where the disparity in treatment can be objectively and reasonably justified. This approach seems ethically sound: ‘Even if only one person wanted to use LSD, and no one else wanted to allow him to do so, its prohibition would require a justification. The only acceptable answer to the “why his preferences and not mine?” question requires a principle that cites a morally relevant difference between the permissible and the prohibited’\footnote{48}. Hardison contended that, in breach of Article 14, he was being discriminated against in relation to a number of the Articles in the Convention, such as Article 9, as reviewed above. In essence, it must be questioned why certain drug-mediated states – such as those effected by
intake of alcohol and tobacco – are tolerated, whilst others are not? How is it that such rationally untenable divisions persist?

**Discriminatory Discourse**

As alluded to above, one of the chief ways in which this discriminatory situation is perpetuated is through sharp contrasts in the styles of discourse used to describe involvement with illicit as against licit substances. This occurs, *inter alia*, in Governmental rhetoric, in official policy documentation, and through the courts. The importance of discourse should not be underestimated: ‘It is now widely recognised and accepted that our language both reflects and shapes our experiences … [W]e had no problem with drugs until we quite literally talked ourselves into having one’⁴⁹. A prejudicial narrative is crucial in shutting down the possibility of rational debate: ‘Moral consensus is always expressed in terms of general slogan-phrases, which designate the one who would not be in agreement as a public enemy’⁵⁰. Thus, a useful exercise is to critically analyse drugs discourse, unearthing the relationship between language and accepted ‘truth’: ‘[w]hen we deconstruct, we expose the workings of assumption, commonsense and intuition … a large part of the appeal of prohibitionist arguments derives from their “intuitive sense”’⁵¹. Unmasking the techniques of discourse is crucial as they operate as an insidious form of coercion: it pays to ‘tear off the disguises that control hides behind, thus helping us to see that our antidrug rhetoric is not health, science, or morality, but raw coercive power’⁵².

An illustration of discriminatory drug discourse in the courts is found in the rejection of Hardison’s human rights’ based arguments, in an analysis of the justifications given for refusing to even allow such contentions to be articulated in front of the jury. The distinction between ‘natural’ and ‘synthetic’ drugs again rears its head, although – as compared to the discussed preference for ‘synthetic’ *Sativex* over ‘natural’ cannabis – ‘natural’ drugs are seen as being more acceptable here, with the court commenting of Hardison:
He claimed to regard the bond between man and such plants as a sacred one, although the prosecution was to say that his assertions about the benefits which he claims the use of such drugs generate was just an excuse for his commercial production of hard drugs on a large scale. Indeed, the evidence suggested that the appellant’s production of the drugs was the manufacture of them by chemical synthesis – in other words, the artificial production of compounds from their constituents rather than by the extraction of natural products from plants\(^53\).

Such comments reinforce the overly simplistic binary: not only is the presumed superiority of ‘natural’ over ‘synthetic’ context-specific, as demonstrated above, but the substances synthesised by Hardison - such as DMT – replicated material that is widely produced throughout nature, including by the human pineal gland\(^54\).

Consider, as a further illustration, the disparity between Judge Niblett’s description of Hardison’s motivation, as contrasted with that provided by Hardison, who explained himself thus: ‘All molecules that I produced or possessed were constructed and/or utilised in the intentional pursuit of cognitive, intellectual, scientific, and/or spiritual education, enablement, and exploration; and/or in therapy as emotional and psychological amelioratives\(^55\). As an important aside, in support of Hardison’s claims about the potential benefits to be derived from ingesting the substances that he was synthesising, it is worth noting that research into LSD-assisted psychotherapy recommenced in April 2008 (following an enforced 35 year hiatus directly attributable to global prohibition): Gasser’s study in Switzerland is evaluating the impact of LSD in alleviating anxiety in patients suffering from advance-stage cancer and other life-threatening illnesses\(^56\). However, upon sentencing, Judge Niblett was dismissive of Hardison’s own description of his motivations, offering instead the following perspective on them: ‘[t]he most serious element of this case is that you were not doing this for your own consumption or the good of mankind but … for greed … a human emotion that goes back to the dawn of time’\(^57\). Indeed, whilst appealing his conviction, Hardison remarked upon the terminology that had been applied to him throughout his journey through the criminal justice
system, observing that he had been subjected to a barrage of slanderous allegations by various judges and prosecutors, having been described, *inter alia*, as ‘dangerous’, ‘greedy’ and ‘evil’. Such denigrating rhetoric was, of course, essential in giving surface justification to the manifestly disproportionate 20 year sentence that Hardison was handed down.

It is revealing to contrast this sentence with the 15 years that can be expected for an ‘average’ murder, the 5 years that can be anticipated for a rape where there are no aggravating factors, and the fact that Hardison received his 20 year term in the same week in which terrorist Kamel Bourgass was sentenced to 17 years for conspiring to commit a public nuisance by the use of poison, the chemical weapon ricin, with *intent to endanger life*. In the words of Szasz, ‘Clearly we regard drug heresy as a graver threat to our society than violent crime. This may seem like madness, but there is method in it. The method … lies in the threat autonomy poses to authority’.

Any suggestion of a lack of proportionality in sentencing was refuted by the Court of Appeal; the importance of discourse was again apparent here, with Hardison’s arguments being trivialised as a ‘portmanteau defence’. This response is unsurprising: drug users ‘are always given plenty of space to repeat and reinforce the current drug rhetoric, for example by confessing, but no space is made for them to offer a route that would lead away from the current discourses’. However, it is submitted that the absence of proportionately is actually so acute here as to potentially engage Article 3 of the ECHR, entering into the realm of inhuman or degrading treatment, especially taking into account the scientific evidence detailed above which confirms that: ‘No laws enforced by such harsh punishments rest on a more flimsy rationale than those prohibiting the use of recreational drugs’. Nonetheless, all of Hardison’s human rights’ based arguments - conjunct with drug discrimination - were given short shrift when he (unsuccessfully) applied for leave to appeal in the higher court, being largely side-stepped via an (over)emphasis on both *Taylor* and the UN Drug Conventions.
Evolving Freedoms

To date, claims that the prohibitions contained within the MDA are incompatible with the protections ostensibly afforded by the ECHR have been unsuccessful in the UK courts. To briefly recap, with regards to therapeutic use of cannabis, in *Altham* the court did not find Article 3 to have been engaged; in relation to Article 8, whilst in *Quayle* the idea was (briefly) entertained that this right *might* be engaged – though strictly in relation to self-medication, not therapeutic supply – it was made clear that, even were that considered to be the case, an (unspecified) derogation would be presumed to apply. Article 9, with its protection of religious freedom, was readily seen to be engaged in *Taylor*, perhaps surprisingly, given that Taylor was involved in cannabis supply rather than simple possession; however, his asserted right to a religious exemption from criminalisation collapsed following a reliance (once again) on the derogations, alongside an (over)reliance on the international Drug Conventions. Hardison’s contention that the prohibitions on the use of certain psychoactive drugs negatively impacted upon his cognitive liberty was dismissed out of hand by the courts, with Article 10 not considered to have been engaged; his argument that the lack of proportionality in sentencing for drug offences potentially engaged Article 3 was similarly refuted.

The challenges that have been brought to date have revealed that - somewhat predictably - even in those circumstances where drug-taking is accepted by the courts as engaging a protected human right, an exception to making an exception is created through reliance on the derogations, on the necessity of protecting the public. Whilst the public, indeed, has a right to be protected, the futuristic weaving of prospective worst-case-scenarios arising out of individuals’ drug-taking is used to justify an expansive reading of the derogations, rendering the Articles to which they apply utilitarian in operation in this sphere, thereby fatally undermining them. This reveals that the sanctioned derogations can be used by the courts to avoid protecting certain people’s freedoms where to do so would be unpopular, either with politicians or the public; they have been described as amounting to ‘an
invitation to the courts to make value judgments behind the veil of legal objectivity”\(^{66}\). In order for the ECHR to deliver the protection of freedoms that it promises, it needs to be remembered that human rights are supposed to enjoy a privileged legal status: ‘rights by their nature are designed to trump consequentialist, utilitarian or majoritarian considerations’\(^ {67}\).

Notably, the Court of Appeal’s consideration of the relevance of Article 8 to self-medication was only partial; further, neither the argument for an Article 9 right to sacramental drug use, nor the challenge to prohibition mounted under Article 10, were tested in a high court, with leave to appeal being refused to both Taylor and Hardison. Added to this, the Government’s acceptance of the historically and culturally contingent – rather than scientific and rational - nature of the division between licit and illicit substances, as demarcated by the MDA, gives credence to any future challenges regarding (lack of) proportionality in sentencing, possibly including recourse to Article 3, as well as to broader claims regarding the discrimination inherent in prosecutions for drug offences, employing Article 14. Thus, the scope for the ECHR to be co-opted to evolve drug policy is far from exhausted.

The other major ground upon which attempts to evolve a human rights’ based approach to drug policy looks set to falter is the courts’ reliance upon the UN Drug Conventions to dismiss any such claims. It is hoped that - by flagging up the allowances for constitutional exceptions contained within the Conventions themselves - this paper has demonstrated that international obligations do not posit an insurmountable barrier to creating exemptions from prohibition where it can be demonstrated that drug-taking engages an enshrined right. Further, the brief comparative look at the US revealed that, in equivalent circumstances, failure to adhere to the Conventions was not considered by their courts to create a barrier to delineating a legal space for use of drugs in a variety of religious settings.

Whilst indemnities from drug prohibition world-wide have so far been restricted to (somewhat obscure) sacramental drug use, it has been advanced that privileging the ‘sacred’
over the ‘profane’ is philosophically an untenable distinction: accordingly, the possibility exists for crafting a range of constitutional exemptions. At its zenith, this line of argument could lead to recognition by the courts that the drug prohibitions within the MDA unduly interfere with freedom of thought as protected by Article 10. The making of such an acknowledgement would (almost inevitably) ultimately lead to the collapse of prohibition. However, perhaps it is somewhat unrealistic to expect radical judgments from the courts in this arena? It is apposite in closing to offer a pragmatic evaluation of the likelihood of the ECHR being successfully utilised to evolve the MDA in the future. It has been argued that ‘the judiciary has almost unlimited freedom in human rights adjudication, subject only to one overriding constraint, namely, that they do not challenge the executive in politically sensitive areas’; unfortunately, drug policy is one of the most politically sensitive areas there is. And yet, to end on a more hopeful note, drug policy is equally – if not more – politically charged in the US where, nonetheless, arguments based on freedom have opened up chinks in the armour of prohibition. Whilst judicial recognition of the impingement of the prohibition of (certain) drugs upon cognitive liberty – and, indeed, upon liberty itself - may be a distant reverie, successfully drawing upon the ECHR to win incremental gains in the spheres of drug-taking as a form of self-medication or as a religious sacrament seems more conceivable.

1 Misuse of Drugs Regulations 2001.
2 Select Committee on Science & Technology, Cannabis, the Scientific and Medical Evidence (London: Select Committee on Science and Technology, 1998), ch. 2.
3 Ibid.
4 Select Committee on Science & Technology, Therapeutic Uses of Cannabis (London: Select Committee on Science and Technology, 2001), para. 25.
5 Government Reply to the Report of the House of Lords Select Committee on Science & Technology, Cannabis, the Scientific and Medical Evidence (London: House of Lords, 1999), para. 22.
8 Ibid., p. 66.
12 Ibid., para. 54.
14 R v Quayle (note 10), para. 69.
15 Ibid., para. 77.
17 Ibid., para. 24.
19 Csordas and Kleinman (note 10).
21 Ibid., para. 336.
24 Ibid., para. 10.
31 W. James, The Varieties of Religious Experience (New York: Longmans, 1925), p. 31
32 2007 WL 1551069 (FCA).
35 [2007] 1 Cr App R (S) 37.
37 Ibid.
38 Ibid., p. 139.
40 Lewes Crown Court, 13th January 2005, 3.
41 Misuse of Drugs Act 1971, preamble.
42 Ibid, s. 1(2).
47 M.L. King, Letter from a Birmingham Jail, (1963)
49 T. Szasz, (note 13), p. 11.
52 Driscoll (note 7), p. 94.
53 [2007] 1 Cr App R (S) 37, para. 8.

57 Hove Crown Court, April 22nd 2005, Judge’s Sentencing Remarks.
62 Szasz (note 13), pp. 188-189.
64 Driscoll (note 7), p. 58.
65 Husak (note 48), p. 2.
67 Ibid., p. 223.
68 Ibid., p. 216.