Prescribed Cannabis Medicines - Possession, Use and Driving

Guidance for Police

Cannabis Industry Council

Contributors

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Prescribed Cannabis Medicines - Possession, Use and Driving

Cannabis medicines have been legally prescribed in the UK since 1 November 2018. This document, together with the full evidence pack attached, provides all the information required to assess the lawfulness of possession, use and driving prior to arrest.

- Possession and public use of prescribed cannabis medicines is legal.
- Cannabis medicines are prescribed in two forms, an oil for oral consumption and dried flowers.
- Presentation of a prescription or the dispensing label on the medication combined with photo ID is sufficient evidence to confirm the legitimacy of the possession and statutory defence for the prescription holder.
- Roadside swabs (preliminary tests) are to identify the presence of an illicit controlled drug and should not be administered until the validity of the prescription is sought.
- Unless evidence can be adduced to prove that the patient was not following their prescriber's and manufacturer's guidance (generally do not drive if impaired), an investigation into a Section 5A charge should be NFA.
- If you are unsure about compliance with prescriber and manufacturer guidance, then no arrest should be made.
- If you believe the patient is impaired, you should follow PACE and investigate a Section 4 offence in which a sample of urine will suffice.
- If you are in doubt as to how to proceed and the patient is cooperative, seek further advice from a supervising officer before proceeding to arrest.
- Prescribed cannabis medicines must be treated the same way as any other prescribed medication, and this involves administration whilst in custody if required and the safe return of medication following release from custody.

Evidence Pack

To support guidance for patients and police on the possession and use of prescribed cannabis medicines, and driving with a cannabis medicine prescription

1. Possession and Use

Extract from Cannabis Industry Council Cannabis and Employment paper:

'The most notable difference between the use of prescribed medical cannabis and more traditional pharmaceuticals is the method of administration. Often, a cannabis oil is taken orally as a background analgesic and anti-anxiety medicine; this may then be supplemented by a flower for vaporisation, whenever an immediate reduction of symptoms is required. Many people prescribed medical cannabis privately are prescribed solely cannabis flower or vape cartridge medicines to help manage their symptoms.'
Cannabis Industry Council, 2023 pg.4

Many officers have difficulty believing that cannabis flowers (similar to illicit cannabis) are legally prescribed and there have been an increasing number of unlawful arrests for possession.

It is important that officers understand that most prescribed patients will possess cannabis flowers and this is lawful under section 5(1) of the Misuse of Drugs Act 1971 (restriction of possession of controlled drugs) because of an exemption in regulations made under section 7 of that Act (authorisation of activities otherwise unlawful under foregoing provisions).

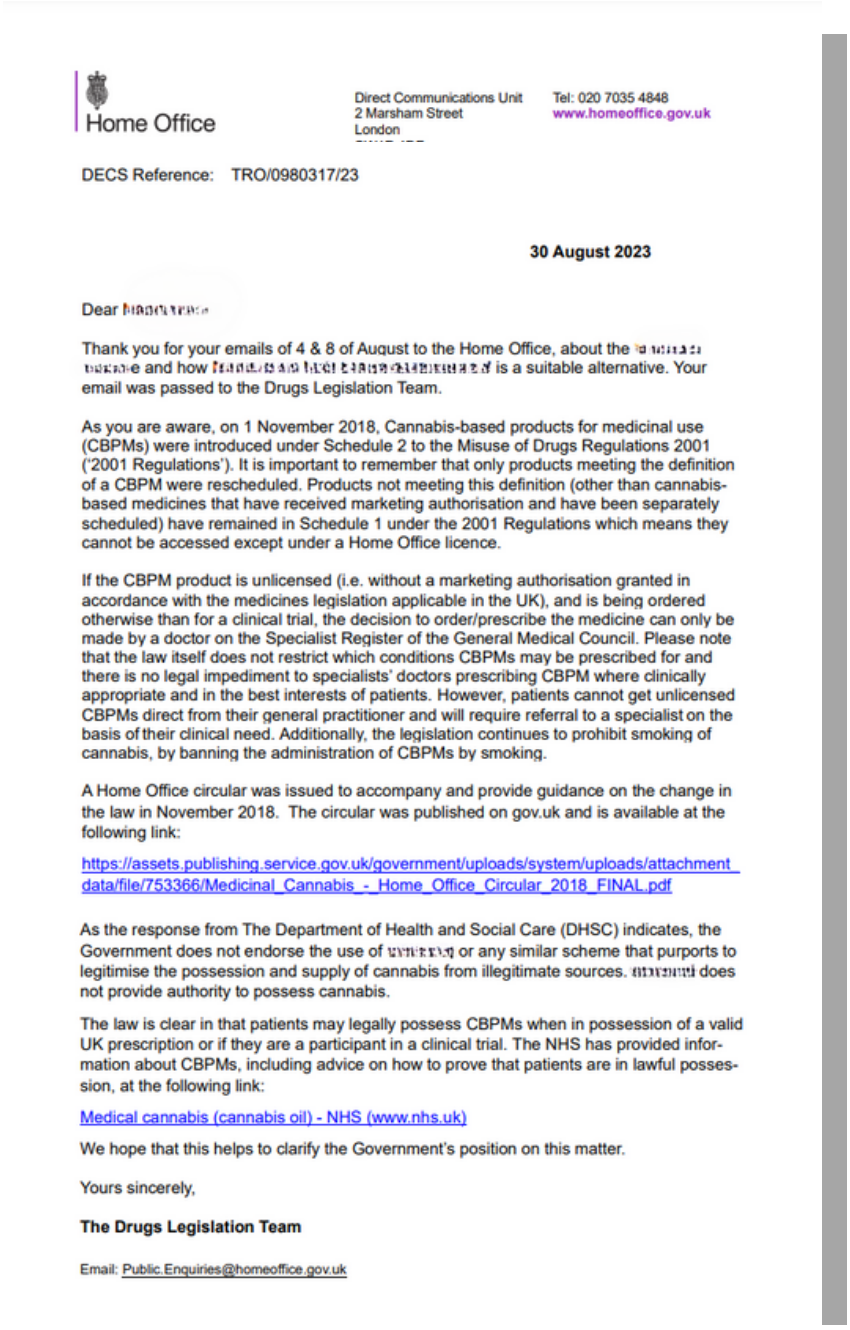
Example of typically prescribed medical cannabis flower

Accompanying vaporiser, grinder & accessories

Example of prescribed medical cannabis oil (will include label)

Prescribed cannabis medicines must be treated the same as any other prescribed medication and this involves administration whilst in custody if required and the safe return of medication following release from custody.

Proof of a prescription (attached or usually accessible via the private clinic's app on a mobile device) or furnishing the dispensing label attached to the medicine combined with a photo ID is sufficient evidence to confirm the legitimacy of the patient's legal prescription as stated below:



Home Office

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DECS Reference: TRO/0980317/23

30 August 2023

Dear [redacted]

Thank you for your emails of 4 & 8 of August to the Home Office, about the [redacted] and how [redacted] is a suitable alternative. Your email was passed to the Drugs Legislation Team.

As you are aware, on 1 November 2018, Cannabis-based products for medicinal use (CBPMs) were introduced under Schedule 2 to the Misuse of Drugs Regulations 2001 ('2001 Regulations'). It is important to remember that only products meeting the definition of a CBPM were rescheduled. Products not meeting this definition (other than cannabis-based medicines that have received marketing authorisation and have been separately scheduled) have remained in Schedule 1 under the 2001 Regulations which means they cannot be accessed except under a Home Office licence.

If the CBPM product is unlicensed (i.e. without a marketing authorisation granted in accordance with the medicines legislation applicable in the UK), and is being ordered otherwise than for a clinical trial, the decision to order/prescribe the medicine can only be made by a doctor on the Specialist Register of the General Medical Council. Please note that the law itself does not restrict which conditions CBPMs may be prescribed for and there is no legal impediment to specialists' doctors prescribing CBPM where clinically appropriate and in the best interests of patients. However, patients cannot get unlicensed CBPMs direct from their general practitioner and will require referral to a specialist on the basis of their clinical need. Additionally, the legislation continues to prohibit smoking of cannabis, by banning the administration of CBPMs by smoking.

A Home Office circular was issued to accompany and provide guidance on the change in the law in November 2018. The circular was published on gov.uk and is available at the following link:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753366/Medicinal_Cannabis_-_Home_Office_Circular_2018_FINAL.pdf

As the response from The Department of Health and Social Care (DHSC) indicates, the Government does not endorse the use of [redacted] or any similar scheme that purports to legitimise the possession and supply of cannabis from illegitimate sources. [redacted] does not provide authority to possess cannabis.

The law is clear in that patients may legally possess CBPMs when in possession of a valid UK prescription or if they are a participant in a clinical trial. The NHS has provided information about CBPMs, including advice on how to prove that patients are in lawful possession, at the following link:

Medical cannabis (cannabis oil) - NHS (www.nhs.uk)

We hope that this helps to clarify the Government's position on this matter.

Yours sincerely,

The Drugs Legislation Team

Email: Public.Enquiries@homeoffice.gov.uk

An updated comprehensive list of approved clinics, pharmacies and available cultivars can be accessed at https://medbud.wiki/

2. Driving

Extract from Cannabis Industry Council Cannabis & Driving paper:

Cannabis Based Products for Medicinal use in humans (CBPMs) were legalised in the UK in November 2018. There are now thought to be between 25,000 - 30,000 legal cannabis patients, with around 20 clinics prescribing privately and these numbers are expected to increase significantly by the end of 2023. However, the policies, procedures, and guidelines for CBPM use and driving, where they exist, are unclear, inconsistent, and poorly communicated and existing drug tests are not an accurate measure of impairment. At the same time, according to an analysis carried out by Volteface, the number of arrests for drug-driving and, more specifically, driving under the influence of cannabis, has increased substantially (+81% and +72% respectively between 2016/17 to 2020/21). These convictions primarily fall under Section 5A of the Road Traffic Act (exceeding threshold limits) rather than Section 4 (failing impairment tests). This has significant implications for medical cannabis users that need to be addressed.
Cannabis Industry Council, 2023 pg.1

The following review of evidence will show that due to the long half-life and lipid nature of cannabinoids within the central nervous system (CNS), the level of THC found in blood has no correlation to impairment, that the level can be exceeded for a long duration, especially when used regularly (medical use) and that the level cannot ascertain recent use nor dosage.

In 2018 the 2001 Misuse of Drugs Regulations were amended to legalise “cannabis-based products for medicinal use in humans” (CBPMs) (Misuse of Drugs (Amendments) Regulations, 2018), when prescribed by a doctor on the specialist register and where other treatments have failed.

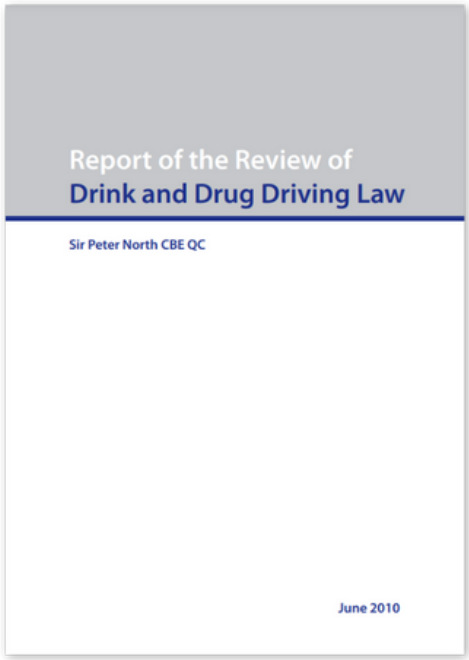
The Statutory Medical Defence within Section 5A RTA 1988:

The rationale and context of the statutory defence are outlined below.

Extract from North Review (2010): Medical defence for offence of driving above the statutory prescribed drug limit:

"Some drugs which may be proscribed for driving might also be used legitimately, in accordance with medical advice (for example morphine may be prescribed for chronic pain or diazepam (a benzodiazepine) may be prescribed for anxiety). Indeed, the Review recognises that in some circumstances it may be more dangerous for a person to drive having not taken their medically prescribed drug than driving without having taken it. Drugs have different effects on different people and levels at which they are prescribed are likely to reflect this. ***It would clearly be wrong to put in jeopardy of prosecution those who are properly and safely taking medically prescribed drugs and driving in accordance with medical advice, for whom, despite the presence of a proscribed drug, there is no evidence of any driving impairment".***

North, 2010 pg.13



Ahead of the introduction of the per se limits in 2015, DfT issued guidance for healthcare professionals which set out the new statutory "medical defence" (Department for Transport, 2014).

If a cannabis medicine has been lawfully prescribed for medical purposes and taken in accordance with instructions given by the prescriber, a driver has a defence against a charge of driving with excess THC in their blood. (If there is evidence of impairment, the driver can nonetheless be prosecuted under section 4 of the Road Traffic Act 1988.) (North, 2010 pg. 15)

The Statutory Medical Defence within Section 5A RTA 1988:

Extract from the Wolff expert panel on drug driving report (2013):

Nevertheless, the Panel's consideration of drugs used primarily for medical purposes has taken account of the particular circumstances of drivers using such medication. The Panel was keen not to create any obstacles for those on prescribed medication to continue using their medication as instructed and carry on with their normal activities, so long as this does not create a significant road safety risk for the patients themselves and other road users.

Due consideration was given to the "medical defence" in the new drug driving clause, which is designed to protect patients who take their medication in accordance with the directions from their doctor or pharmacist, and the instructions accompanying the medication (to the extent that these are consistent with the directions given).
The following defence is included in the draft legislation and is designed to safeguard those who take medication which may contain a Controlled Drug which is specified for the purposes of the new offence but who take it in line with the directions given to them by their doctor or pharmacist or contained in the Patient Information Leaflet (PIL):

"It is a defence for a person ("D") charged with an offence under this section to show that:

- *(a) the specified controlled drug had been prescribed or supplied to D for medical or dental purposes,*
- *(b) took the drug in accordance with any directions given by the person by whom the drug was prescribed or supplied, and with any accompanying instructions (so far as consistent with any such directions) given by the manufacturer or distributor of the drug, and*
- *(c) D's possession of the drug immediately before taking it was not unlawful under section 5(1) of the Misuse of Drugs Act 1971 (restriction of possession of controlled drugs) because of an exemption in regulations made under section 7 of that Act (authorisation of activities otherwise unlawful under foregoing provisions).*
- *(4) The defence in subsection (3) is not available if D's actions were—*
- *(a) contrary to any advice, given by the person by whom the drug was prescribed or supplied, about the amount of time that should elapse between taking the drug and driving a motor vehicle,*
- *or (b) contrary to any accompanying instructions about that matter (so far as consistent with any such advice) given by the manufacturer or distributor of the drug.*
- *(5) If evidence is adduced that is sufficient to raise an issue with respect to the defence in subsection (3), the court must assume that the defence is satisfied unless the prosecution proves beyond reasonable doubt that it is not."*

The new offence does not change the existing legal position whereby those who legitimately take their medication may be guilty of a road traffic offence (under Section 4 of the Road Traffic Act 1988) if they are impaired or 'unfit' to drive due to the effects of that drug.
Wolff, 2013 pg.18-19

Drug driving: guidance for healthcare professionals

Department for Transport (2014):

The first group consists of commonly abused drugs for which low limits have been set. This group includes certain medicines that will be taken by only a small proportion of drivers. Given the low limits set, a patient prescribed one of these medicines who chooses to drive could test above the specified limit but would still be entitled to raise the statutory "medical defence".

This 'zero tolerance' group currently includes:

- Cannabis (THC)[footnote 3]
- Cocaine (and a cocaine metabolite, BZE)
- MDMA (Ecstasy)
- Lysergic Acid Diethylamide (LSD)
- Ketamine
- Heroin/diamorphine metabolite (6-MAM)
- Methylamphetamine

It remains the responsibility of all drivers, including patients, to consider whether they believe their driving is, or might be, impaired on any given occasion, for example if they feel sleepy. It will remain an offence, as now, to drive whilst their driving is impaired by drugs; and, if in doubt, drivers should not drive. The statutory "medical defence" will not be extended to be available for the existing 'impairment' offence because even if legitimately taking a medicine, the patient should not be driving if actually impaired.
Department for Transport, 2014 pg.4

NatCen report: Medical Cannabis and Road Safety

A research report for the Department for Transport (June 2021):

1.3.2 Medical cannabis and driving impairment

The evidence reviewed indicated that the usual duration of neurocognitive impairment associated with use of medical cannabis containing THC is generally four hours or less. **(Grollman, 2021 pg.7)**

5.1.1 Nature and duration of impairments associated with cannabis use

Further studies found similar results (Arkell et al., 2020) (Tank et al., 2019). In these studies volunteers continued to feel impaired up to four hours after inhaling cannabis, and considered themselves still impaired, even though observable drug effects had disappeared by that point. **(Grollman, 2021 pg.26)** Impairment was self-assessed and reported by the participants and also tested through cognitive and psychomotor tests sensitive to THC impairment (Arkell et al., 2020) or via medical examination (Tank et al., 2019). A recent review of literature on impairment and use of medical cannabis (Eadie et al., 2021) reported that the usual duration of neurocognitive impairment (difficulty in articulating and processing information which may affect attention, manual dexterity, coordination, and reaction time) following use of medical cannabis containing THC is four hours or less. **(Grollman, 2021 pg.26)**

55.1.2 Relationship of impairment to types of medical cannabis

Interview participants explained that the administration route is also linked to differences in impairment. Inhaling vaporised flowers has a more intense and quicker onset, but the duration of the effects including impairment is shorter (about 4 hours for a typical dose). Oils have a slower onset but the effects last longer (about 6 hours). The differences in onset and effects due to the administration route are also indicated by a study (Celius and Vila 2018) comparing smoking cannabis containing 34 mg of THC content with taking eight oral sprays of Sativex administering 22 mg of THC. Despite the broadly similar levels of THC taken in, the maximum concentration of THC in the blood plasma was 162 µg/L at 9 minutes post-inhalation for smoked cannabis compared to 5.4 µg/L at 60 minutes after spraying for Sativex (Grollman, 2021 pg.28).

Box 2: Legal limits and impairment

There is disagreement over whether per se limits or impairment form the best basis for offences of driving under the influence of cannabis:

Interview participants highlighted the fact that long-term cannabis users may have elevated levels of THC in their blood despite not having used cannabis recently and would therefore not be impaired to drive safely. One individual raised concerns that long-term users might be criminalised without presenting an elevated risk, and equally that other patients on lower doses and with less THC in their blood may have much greater impairments, depending on other contextual factors:
"Some patients on higher doses of medical cannabis may reach that [upper limit] but might not be affected; while some patients on lower doses, who are nowhere close to the legal cut-off are severely affected and should not drive." (Interview participant)

NatCen report: Medical Cannabis and Road Safety

The literature supports this view, highlighting a poor correlation between blood THC levels and impairment. For example, one study found that a minority of long-term users may exceed legal blood THC limits even after several days of abstinence (Peng et al., 2020). Another concluded that per se limits "do not reliably represent thresholds for impaired driving" (Arkell et al., 2021, p. 107), and a review describes "equivocal evidence correlating specific blood levels of THC with psychomotor impairment" (Chow et al., 2019, p. 1304).

Although the evidence suggests that per se limits may not be an accurate interpretation of impairment in all cases, one participant explained that the argument misses the point: limits such as those in the contemporary UK drug driving legislation are not primarily about impairment but about liability. In addition, concentrations of THC at 5mg/mL are associated with increased collision risk, even if there is variation in individual impairment at that level: *"Impairment is a very dangerous word... because it's very difficult to assess. It's very subjective." (Interview participant)*

In practice, enforcement of drug-driving laws based on impairment is available to police and prosecutors. The per se limits aim to deter drug-driving regardless of impairment, and the medical defence provides prescribed drug users do not risk being prosecuted for drug driving simply for using their medication as advised (Crown Prosecution Service, 2019). (Grollman, 2021 pg.28)

5.2.1 Degree of increased risk

A review of culpability studies (Rogeberg, 2019) found that the attributable risk fraction from cannabis-impaired driving (the proportion of crashes that would be avoided if cannabis-impaired driving was eliminated) is below 2% in all but two reviewed studies, which shows that impairment linked to use of cannabis increases the risk of accidents, although with a low magnitude. The authors indeed state: *"While this indicates that the overall public health impact of cannabis impaired driving is minor relative to that of alcohol-impaired driving, it does not imply that cannabis impaired driving is safe, and the low average is consistent with the presence of a smaller group of high-dose drivers with more substantially raised risks"* (Rogeberg, 2019: 78). Most included studies were from the USA (as well as France, New Zealand and Australia) but many pre-dated more recent cannabis legalisation and related to illicit cannabis use.

It is worth noting that the degrees of increased risk noted for THC are much lower than those for driving impaired by alcohol. For example, a study from the US found that the odds ratios for fatal injury for drivers with a blood alcohol concentration of 0.08% (the legal limit in England) compared to sober drivers were 19.7 among drivers aged 16 to 20 and 7.5 for drivers aged 35 and over; the odds of fatal injury for drivers positive for marijuana was not significantly different from 1 (Romano et al., 2014). A study using data from several European countries found an odds ratio for fatal collision of 23.0 for drivers with between 0.05% and 0.08% alcohol in blood, alongside a non-significant odds ratio of 1.3 for people positive for THC alone (Bernhoft et al. 2012). (Grollman, 2021 pg.30-31)

Duration of elevated THC levels in blood

The Wolff report alluded to the half-life of THC and expected duration of THC levels in blood following a dose of cannabis:

'Blood sampling is considered to be the most effective way to measure the concentration of THC in the body. However, if a blood sample is collected from a subject who has recently used cannabis and the sample is split into two portions, one being analysed as whole blood and the other centrifuged to prepare plasma analysis, then the concentration of THC, the main active component of cannabis will be about 2 times greater in the plasma sample than in the whole blood sample. For this reason whole blood was considered to be the most appropriate biological fluid for setting thresholds because it relates best to the scientific evidence in relation to driving. Therefore whole blood will be recommended as the biological sample of choice. In addition, THC has a rapid metabolism, and if the time between the stop or accident and the blood sampling is delayed, the blood concentration may have decreased markedly (based on a half-life for THC of 1.5 hours). For instance, 5 µg/L of THC will be expected to decrease to 1.25 µg/L after 3 hours. It is therefore recommended that blood sampling occur as quickly as possible after the road traffic incident for prosecution to occur.' (Wolff, 2013)

Since the expert panel report, a number of scientific trials have proven that the above assessment regarding the half-life of THC was wrong and this brings any per se limit for THC into disrepute. Below are some examples that prove that, especially in regular users, THC levels are likely to exceed the limits far beyond the impairment window for several days.

Indeterminacy of cannabis impairment and Δ9 -tetrahydrocannabinol (Δ9 -THC) levels in blood and breath - GregoryT. Wurz1,2 & MichaelW. DeGregorio1,2 (2022):
'Previous investigators have found no clear relationship between specific blood concentrations of Δ9 -tetrahydrocannabinol (Δ9 -THC) and impairment, and thus no scientific justification for use of legal "per se" Δ9 -THC blood concentration limits. ***Analyzing blood from 30 subjects showed Δ9 -THC concentrations that exceeded 5 ng/mL in 16 of the 30 subjects following a 12-h period of abstinence in the absence of any impairment.*** *In blood and exhaled breath samples collected from a group of 34 subjects at baseline prior to smoking, increasing breath Δ9 -THC levels were correlated with increasing blood levels (P< 0.0001) in the absence of impairment, suggesting that single measurements of Δ9 - THC in breath, as in blood, are not related to impairment. When post-smoking duration of impairment was compared to baseline Δ9 -THC blood concentrations, subjects with the highest baseline Δ9 -THC levels tended to have the shortest duration of impairment. It was further shown that subjects with the shortest duration of impairment also had the lowest incidence of horizontal gaze nystagmus at 3 h post-smoking compared to subjects with the longest duration of impairment (P< 0.05). Finally, analysis of breath samples from a group of 44 subjects revealed the presence of transient cannabinoids such as cannabigerol, cannabichromene, and Δ9 - tetrahydrocannabivarin during the peak impairment window, suggesting that these compounds may be key indicators of recent cannabis use through inhalation. In conclusion, these results provide further evidence that single measurements of Δ9 -THC in blood, and now in exhaled breath, do not correlate with impairment following inhalation, and that other cannabinoids may be key indicators of recent cannabis inhalation.' (Gregory, 2022)*

Duration of elevated THC levels in blood

'Methods:
We identified relevant articles by combining terms for "cannabis" and "blood" and "concentration" and "abstinence" and searching MEDLINE, EMBASE, PsycINFO, and Web of Science. We included studies that reported THC levels in frequent cannabis users after more than 4 h of abstinence.

Results:
Our search identified 1612 articles of which 8 met our inclusion criteria. After accounting for duplicate publications, we had identified 6 independent studies. ***These studies show that blood THC over 2 ng/mL does do not necessarily indicate recent cannabis use in frequent cannabis users. Five studies reported blood THC >2 ng/mL (or plasma THC >3 ng/mL) in some participants after six days of abstinence and two reported participants with blood THC >5 ng/mL (or plasma THC > 7.5 ng/mL) after a day of abstinence.***

Conclusions:
Blood THC >2 ng/mL, and possibly even THC >5 ng/mL, does not necessarily represent recent use of cannabis in frequent cannabis users.' (Karschner, 2016)

'The results of this study argue against the utility of detectable THC or 11-OH-THC in the plasma of chronic frequent cannabis smokers as a reliable marker for recent cannabis use. Our results show that plasma THC concentrations were still detectable (LOQ 0.25 μg/L) in 87.5% of participants on day 7 of abstinence and in 3 of 5 remaining participants on day 30. These results are consistent with previous reports by NIDA [41-42] and others [43], and recent data from NIDA quantifying THC in whole blood for up to 30 days ≥0.25 μg/L in chronic frequent cannabis smokers [23]. ***For the first time of which we are aware, we demonstrate THC in plasma up to 3 days at ≥5.0 μg/L, 18 consecutive days at ≥2.0 μg/L and up to 30 days ≥0.25 μg/L after abstinence initiation in this population.'*** *(Karschner, 2016)*

THC levels in blood do not correlate with impairment:

While legislators may wish for data showing straightforward relationships between blood THC levels and driving impairment that parallel those of alcohol, the widely different pharmacokinetic properties of the two substances, leading to a rapid fall in THC levels to a relatively steady, low baseline within 20 min of an inhaled dose make this goal unrealistic. (Godfrey, 2021 pg.8)

Marijuana-Impaired Driving A Report to Congress – NHTSA (2017):
'THC level in blood (or oral fluid) does not appear to be an accurate and reliable predictor of impairment from THC. Also, when low levels of THC are found in the blood, the presence of THC is not a reliable indicator of recent marijuana use.'
'Toxicologists are not able to provide expert testimony that a specific amount of THC present in a suspect's blood (or other specimen) is definitively associated with being impaired by marijuana and render the driver unable to drive safely.'
'A number of States have set a THC limit in their laws indicating that if a suspect's THC concentration is above that level (typically 5 ng/ml of blood), then the suspect is to be considered impaired. ***This per se limit appears to have been based on something other than scientific evidence. Some recent studies demonstrate that such per se limits are not evidence-based.'*** *(Compton, 2017)*

Further evidence from a variety of sources has cast this initial conclusion in doubt. The essential problem is that because of the distinct pharmacokinetics of THC, leading to a persistence of the drug and its metabolites in blood, and enormous inter-individual variability in metabolism of THC, the establishment of per-se limits is much more complex and ill-defined than for alcohol. **The worst-case scenarios yield either false positives, resulting in conviction for driving under the influence of drugs (DUID) based on cannabis that the subject may have consumed days to weeks ago, when they are now completely unimpaired, or conversely false negative cases, where an individual's driving is in fact impaired by recently-consumed cannabis, but their THC blood or saliva level is below the per se threshold.**

C. Wickens, M. Wright, R.E. Mann, et al., Separate and combined effects of alcohol and cannabis on mood, subjective experience, cognition and psychomotor performance: A randomized trial, Progress in Neuropsychopharmacology & Biological Psychiatry (2021):
'Co-use of alcohol and cannabis is associated with increased frequency and intensity of use and related problems. This study examined acute effects of alcohol and cannabis on mood, subjective experience, cognition, and psychomotor performance. Twenty-eight healthy cannabis users aged 19-29 years with recent history of binge drinking completed this within-subjects, double-blind, double dummy, placebo controlled, randomized clinical trial. Participants received: placebo alcohol and placebo cannabis (<0.1% THC); alcohol (target breath alcohol content [BrAC] 80 mg/dL) and placebo cannabis; placebo alcohol and active cannabis (12.5% THC); and active alcohol and cannabis over four sessions. Profile of Mood States (POMS), Addiction Research Centre Inventory (ARCI), verbal free recall (VFR), Digit Symbol Substitution Test (DSST), Continuous Performance Test (CPT), and grooved pegboard (GPB) task were administered before and approximately 75 min after drinking alcohol (1 h after smoking cannabis ad libitum). Significant effects of condition were found for the POMS...

THC levels in blood do not correlate with impairment:

(Tension-Anxiety, Confusion) and ARCI (MBG, LSD, PCAG, Euphoria, Sedation), predominantly with greater increases emerging after cannabis or alcohol-cannabis combined relative to placebo. Significant effects were found for VFR (immediate total and delayed recall, percent retained), DSST (trials attempted, trials correct, reaction time), and GPB (non-dominant hand) predominantly with greater declines in performance after alcohol and alcoholcannabis combined relative to placebo and/or cannabis. Cannabis appeared to affect mood and subjective experience, with minimal impact on cognitive performance. Alcohol appeared to impair cognitive and psychomotor performance, with minimal impact on mood and subjective experience. Acute effects of alcohol and cannabis combined were additive at most.'

'Results of this study suggest that, overall, cannabis effects were more frequently significant on mood and subjective experience than cognitive and psychomotor performance, whereas alcohol effects were more frequently significant on cognitive and psychomotor performance than mood and subjective measures. Evidence for additive effects was observed on some measures as well.' (Wickens, 2022)

Relevance of the Limits in regard impairment:

Extract from the Forensic Science Regulator - Section 5A Road Traffic Act 1988 Use of Limits (2015)

Drugs Not Routinely Prescribed:

- ***4.3.3 The limits set for the drugs for which there is no widespread medicinal use are very low and were not set through consideration of any impairment. Effectively a zero tolerance approach was adopted.***
- ***4.3.4 For these drugs the legal limit does not necessarily provide any indication that the individual's behaviour and/or abilities have been affected by the drug. (Forensic Science Regulator, 2015)***

Below is the guidance officers should follow following a claim of the statutory medical defence under Section 5A (3) of the RTA 1988:

MG DD/B (B14 & B15) states:
Officers should note that Sec 5A (3)(4) and (5) RTA provide a statutory defence to any offence of excess specified drugs contrary to Sec 5A (1) and (2) RTA. It is for the subject to raise the defence and, if not raised elsewhere, opportunity to do so is provided at MG DD/B15. Such a defence is not available to the subject where the offence is one of driving etc whilst unfit through drugs contrary to Sec 4 RTA. Consequently, evidence of impairment should always be made, it will be for the officer to decide which offence to pursue and to what degree to investigate the claim being made. ***Where there is no evidence of impairment and the charge can only be one of excess specified drugs, it will be essential to thoroughly enquire into the circumstances and accuracy of the claim.*** *See note at B15 concerning PACE (below).*

If the answer alleges drug consumption which may provide a statutory defence to Excess Specified Drugs, no further questioning should be undertaken other than in accordance with the PACE. It will however be wise to interview the subject and investigate the claim thoroughly before any decision is made about charge / prosecution. The statutory defence is for the subject to raise and applies where a drug is being used in accordance the prescriber's, supplier's or manufacturer's directions (sec 5A(3)(4)& (5)) (GOV.UK, 2017).

Conclusion

This evidence pack provides all the evidence required to investigate the lawfulness of possession and driving prior to admittance to custody.

- ✓ Cannabis medicines have been legally prescribed in the UK since 1 November 2018
- ✓ Possession and public use of prescribed cannabis medicines is legal
- ✓ Cannabis medicines are prescribed in two forms, an oil for oral consumption and dried flowers
- ✓ Presentation of a prescription or the dispensing label on the medication combined with photo ID is sufficient evidence to confirm the legitimacy of the possession and statutory defence for the prescription holder
- ✓ Roadside swabs (preliminary tests) are to identify the presence of an illicit controlled drug and should not be administered until the validity of the prescription is sought
- ✓ Unless evidence can be adduced to prove that the patient was not following their prescribers guidance (generally do not drive if impaired) investigation into a Section 5A charge should be NFA
- ✓ If you believe the patient is impaired, you should follow PACE and investigate a Section 4 offence in which a sample of urine will suffice

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Annex 1

Home Office Circular 2018: Rescheduling of cannabis-based products for medicinal use in humans

- **Broad Subject: Drugs – Medicinal Cannabis**
- **Issue Date: 1 November 2018**
- **From: Crime, Policing and Fire Group (CPFG) – Drugs and Alcohol Unit**

Introduction

This circular draws attention to the contents of the Statutory Instrument (SI) – SI 2018/1055. The new provisions, The Misuse of Drugs (Amendments) (Cannabis and Licence Fees) (England, Wales and Scotland) Regulations 2018, ("the 2018 Regulations") come into force today (1 November 2018). The SI together with the associated explanatory memorandum is available at: http://www.legislation.gov.uk/uksi/2018/1055/contents/made.

Summary

We are amending the Misuse of Drugs Regulations 2001 ("the 2001 Regulations") and Misuse of Drugs (Designation) Order 2015 to reschedule cannabis-based products for medicinal use in humans to Schedule 2 of the 2001 Regulations and to impose additional access and administration restrictions in relation to these products. This means that from today (1 November) there will be a legal route for cannabis based products for medicinal use to be prescribed by doctors on the General Medical Council (GMC) specialist register in the strictly controlled circumstances required by the 2001 Regulations without the requirement for a Home Office licence…

The full document can be accessed here:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753366/Medicinal_Cannabis_-_Home_Office_Circular_2018_FINAL.pdf

About the CIC

The Cannabis Industry Council (CIC) is a leading membership organisation representing the entire UK cannabis industry. Membership is open to organisations and business which either work within or operate from the United Kingdom, the Channel Islands, and the Isle of Man.

Together, our mission is to lead the industry to success and enable it to speak with one voice – for, and by, the sector.

Learn more

A collective voice for the medical cannabis, CBD, and hemp sector across the UK.

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