

STATES OF JERSEY



FUTURE APPROACH TO PERSONAL CANNABIS USE IN JERSEY

Lodged au Greffe on 19th December 2025
by the Minister for Health and Social Services
Earliest date for debate: 3rd February 2026

STATES GREFFE

PROPOSITION

THE STATES are asked to decide whether they are of opinion –

- (a) to request the Minister for Health and Social Services to bring forward detailed proposals to be considered by the Attorney General (if adopted) to cease prosecution for offences associated with personal possession and associated cultivation of small quantities of cannabis subject to indicative thresholds, and treat personal cannabis use as a public health issue;
- (b) to request the Minister for Health and Social Services to bring forward detailed proposals to repeal or amend offences associated with personal possession and cultivation of small quantities of cannabis, subject to specific thresholds in law; and
- (c) to request the Minister for Health and Social Services to bring forward detailed proposals for a trial of government-controlled production and sale of non-medical cannabis to understand and evidence whether safe and responsible regulation delivers public health benefits.

MINISTER FOR HEALTH AND SOCIAL SERVICES

REPORT

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Glossary

Cannabis: the Class B drugs “*cannabis*” and “*cannabis resin*”. This collectively includes both the cannabis plant, any naturally occurring product or preparation derived from the cannabis plant, such as fresh or dried herbal flower, resin, oils, tinctures or other extracts in liquid forms.

Cannabis Social Clubs (CSCs): Cannabis social clubs are private, non-profit organisations in which cannabis is grown and distributed to registered club members. As there is no profit, there is no motive to encourage cannabis consumption – hence clubs provide an alternative to illicit cannabis or government-controlled production and sale.

Cannabidiol (CBD): a non-psychoactive component of cannabis, it can interact and lessen some of the effects of THC. There is an ever-growing market for health and wellness products that contain CBD.

Criminalisation: making an action illegal and punishable in law (for example, drink-driving is punishable by fine or sentence).

Decriminalisation: an action is illegal and an offence is committed but there is no penalty in specific circumstances.

Legalisation: Actions are legal and not an offence, but associated offences may be introduced to protect other people from harm (for example, it is legal to possess and smoke cigarettes, but smoking is illegal in certain places).

Non-profit and for-profit markets: **for-profit** markets exist primarily for financial gain and profit. These are usually made up of private businesses. Examples include alcohol and tobacco markets. **Non-profit** markets are rarer and exist primarily for public good or other beneficial purposes. These are usually run by government agencies, non-profit organisations or charities. Examples could include Norway’s government monopoly on alcohol, or charity gambling events where revenue is used to fund good causes.

Regulation: actions are regulated with a framework of controls to ensure public health and safety. Two examples of current regulation are medicines and alcohol (for example, it is legal for a shopkeeper to sell alcohol if a licence is held, but it is illegal for the shopkeeper to sell alcohol to under 18s).

Utensils: refers to equipment used to produce or consume cannabis, for example, pipes and bongs used to smoke cannabis.

Personal cannabis use: refers to the possession, cultivation and consumption of cannabis by a person, whose sole intent is to use the cannabis themselves rather than to supply the cannabis to others (whether or not they are supplying for profit). The definition of Personal cannabis use in this report does not include social supply (see below). Personal cannabis use differs from **commercial cannabis activities**, which are activities undertaken with the intention of profiting from the production and supply of cannabis, whether legally or illegally.

Public good: In relation to drug policies, the concept ‘public good’ means the development of policies that deliver benefits to the wider public and to distinct groups of people (for example, people who use drugs) by helping improve their health, welfare or safety. This is distinct from policies motivated by economic factors alone (for example, increase profit etc).

Social supply: social supply is supplying drugs to friends and acquaintances (either for free or ‘at cost’) as opposed to selling drugs to strangers for profit¹.

THC: Delta-9-tetrahydrocannabinol: is the psychoactive component of cannabis that causes the individual to feel ‘high’. It affects both the nervous system and the brain.

¹[Beyond drug dealing: Developing and extending the concept of ‘social supply’ of illicit drugs to ‘minimally commercial supply’](#)

Section 1: Background

BACKGROUND TO PROPOSITION

1. In June 2024, the States Assembly debated P.31/2024 (as amended), agreeing that the Council of Ministers should bring forward proposals related to proposed approaches to the decriminalisation, legalisation and regulation of non-medical cannabis².

2. The purpose of this report and proposition is, in accordance with P.31/2024, to set out high level information related to three different approaches to shifting public policy away from criminalisation for personal use of cannabis, towards a health based harm reduction approach, and to ask the Assembly which of the three Options should be subject to further development by the Minister for Health and Social Services. In this proposition, and for the avoidance of doubt:

- Option A is to request the Minister for Health and Social Services to bring forward detailed proposals to be considered by the Attorney General (if adopted) to cease prosecution for offences associated with personal possession and associated cultivation of small quantities of cannabis subject to indicative thresholds, and treat personal cannabis use as a public health issue;
- Option B is to request the Minister for Health and Social Services to bring forward detailed proposals to repeal or amend offences associated with personal possession and cultivation of small quantities of cannabis, subject to specific thresholds in law;
- Options C is to request the Minister for Health and Social Services to bring forward detailed proposals for a trial of government-controlled production and sale of non-medical cannabis to understand and evidence whether safe and responsible regulation delivers public health benefits.

3. Should Option A, B and/or C be approved for continued development by the Assembly then further research, consultation and policy development will be undertaken to support the design of detailed policy proposals for future debate by the States Assembly. Specifically, should Option A be approved for continued development, either on its own or in combination with any other Options, it must be noted that any detailed proposals that are adopted by the Assembly, at a future date, would need to be considered by the Attorney General. This is because it is the Attorney General who is officially responsible for the prosecution service and for guidance as to prosecutions in Jersey.

4. Voting for multiple Options	
States Members may vote for one Option, or more than one Option. The effects of voting for more than one Option are explained in Section 4. In summary:	
Table 1: Overview of voting for either single or multiple options	
Voting for:	

² Note: P.31/2024 also required rescheduling of cannabinal and its derivatives which will be provided for by Order of the Minister by the end of 2025.

Option A only	<p>A detailed proposal will be developed where it would still be an offence for people to possess, cultivate or socially supply cannabis. But prosecution for those offences would cease if amounts were below an indicative threshold (e.g. 5 days' supply for possession, a single day's supply for social supply*) and the cannabis was deemed to be for personal use.</p> <p>The detailed proposal would also introduce a significant number of harm reduction methods and prevention strategies as part of treating personal cannabis use as a public health issue.</p> <p>If this detailed proposal, based on Option A, was adopted by the Assembly for implementation, it would be subject to consideration by the Attorney General.</p>
Option B only	<p>A detailed proposal will be developed to repeal or amend the Law so that it would not be an offence for people to possess or cultivate cannabis below a specific threshold (e.g. 15 grams or 2 mature plants*).</p> <p>The cannabis must be for personal use only and any form of onward supply would remain an offence.</p> <p>The detailed proposal would also increase generic and targeted health promotion messaging on cannabis use.</p>
Option C only	<p>A detailed proposal will be developed that would enable a trial of government-controlled production and sale of non-medical cannabis. Jersey residents, who register to become part of the trial would be able to legally purchase non-medical cannabis for personal use (“legally purchased cannabis”) subject to trial rules etc.</p> <p>Trial participants will commit an offence if they:</p> <ul style="list-style-type: none"> • supply legally purchased cannabis to any other person • possess cannabis, other than legally purchased cannabis • cultivate cannabis
Option A and B	<p>A detailed proposal will be developed to repeal or amend the Law so that it would not be an offence a person to possess or cultivate cannabis below the specific threshold (e.g. 15 grams or 2 mature plants*).</p> <p>The detailed proposal detailed proposal would also set out that if a person possesses or cultivates more than the specific threshold, then an offence would still be committed, but the person would not be prosecuted IF it is below the indicative threshold (e.g. 5 days' supply for personal use*). The social supply of small amounts of cannabis that falls within an indicative threshold for a single days' supply for personal use would remain an offence, but prosecution would cease, this would be subject to further consideration by the Attorney</p>

	<p>General if the detailed proposals-based Option A were approved by the Assembly at a future date. However, supply that falls outside of any indicative limit would remain an offence and would be prosecuted.</p> <p>The combined detailed proposals would also introduce a significant number of harm reduction methods and prevention strategies as part of beginning to treat personal cannabis use as a public health issue.</p>
Option A and C	<p>A detailed proposal will be developed that would enable a trial of government-controlled production and sale of non-medical cannabis. Jersey residents, who register to become part of the trial would be able to legally purchase non-medical cannabis for personal use (“legally purchased cannabis”) subject to trial rules etc.</p> <p>Trial participants may commit an offence if they supply legally purchased cannabis to other people (onward social supply outside of the trial is not permitted) and as such they would also be barred from the trial.</p> <p>It will be an offence for a person who is not a trial participant to possess or cultivate cannabis, but that person would not be prosecuted if the amount possessed or cultivated is below an indicative threshold (e.g. 2 days’ supply*) this would be subject to further consideration by the Attorney General if the detailed proposals based on Option A were approved by the Assembly at a future date.</p>
Option B and C	<p>A detailed proposal will be developed to repeal or amend the Law so that it will not be an offence for people to possess or cultivate cannabis below a specific threshold (e.g. 15 grams or 2 mature plants*). The cannabis must be for personal use only as any onward supply would remain an offence.</p> <p>The detailed proposal would also, if adopted, enable a trial of government-controlled production and sale of non-medical cannabis. Jersey residents, who register to become part of the trial would be able to legally purchase non-medical cannabis for personal use (“legally purchased cannabis”) subject to trial rules etc.</p> <p>Trial participants will commit an offence if they supply legally purchased cannabis to others, this includes people who are part of the trial and people who are not part of the trial.</p>
Option A, B and C	<p>Adopting all three Options would result in the development of detailed proposals that would capitalise on the effects and benefits of all three Options. Options A and B would have the combined effect as described above. The detailed proposals would also, as a result of the adoption of Option C, include the</p>

	<p>further development of a time limited government-controlled production and sale trial.</p> <p>Trial participants may commit an offence if they supply legally purchased cannabis to other people (onward social supply outside of the trial is not permitted) and as such they would also be barred from the trial.</p>
<p>*Example amount for illustrative purposes only</p>	

5. No change to current approach

If States Members do not want to change Jersey’s current approach to criminalisation for personal use of cannabis, they can vote to reject all three Options.

If all three Options are rejected, Jersey would retain its current framework in relation to controls on personal cannabis use, with matters being dealt with at Parish Halls in accordance with the Attorney General’s Guidance. See paragraph 31 for information about the Attorney General’s Guidance.

Furthermore, Jersey would effectively be deciding not to reform its public policy on drugs control and would therefore avoid any potential diversion from UK public policy. See paragraph 12 for information on the UK response to drugs reform.

6. Note: Non-medical cannabis

The three proposed Options focus on use of cannabis for non-medical purposes only.

Non-medical cannabis refers to cannabis which is used for non-medical purposes i.e., it is not medical cannabis which has been prescribed by a clinician, in accordance with the law, to treat illness or symptoms (see paragraph 10).

Non-medical cannabis is cannabis used for recreational purposes, and for other purposes, such as self-medication. It includes medical cannabis, where that medical cannabis is being used contrary to its prescribed purposes or by persons other than the patient.

BACKGROUND TO CANNABIS AND CANNABIS POLICY

What is cannabis?

7. Cannabis is the most widely consumed illicit drug in Jersey, the UK and Europe. Cannabis refers to any plant in the genus cannabis or its preparations for use (such as in herbal, resin and liquid forms).

8. Hemp is a form of cannabis cultivated for industrial use to make biomaterials, cosmetics, animal feed, food and supplements. One of the key differences between hemp and other forms of cannabis is their cannabinoid content. Cannabinoids are compounds found primarily in the cannabis plant; many are psychoactive with the most

widely known psychoactive compounds being tetrahydrocannabinol (THC) and cannabidiol (CBD).

9. CBD is a non-psychoactive cannabis compound, but it has biological effects and can influence the effect of psychoactive cannabinoids. CBD products are widely available in health food shops.

What is medical cannabis?

10. Medical cannabis or Cannabis Based Products for Medicinal Use (CBPMs) are typically herbal and oil-based cannabis preparations which are prescribed to patients for the treatment of various conditions. CBPMs include both licenced and unlicensed CBPMs.

- a. *Licensed* CBPMs have undergone testing and have been granted marketing licences by medicines regulators to treat certain conditions such as epilepsy. In Jersey, licenced CBPMs (such as Sativex, Drobabinol and Epidiolex) are only prescribed by hospital consultants.
- b. *Unlicensed* CBPMs are medicines that have not undergone full testing to prove their safety or effectiveness in treating any medical conditions and have not received a marketing authorisation license from medicine regulators. In Jersey, unlicensed CBPMs are prescribed by doctors in multiple private cannabis clinics as a treatment for a wide range of conditions (e.g. insomnia, pain).

11. In 2023 an audit of unlicensed CBPMs dispensing in Jersey was published. That audit found that:

- the volume of unlicensed dispensing in Jersey is notably higher than the UK by percentage of population (4.01% of the Jersey's population received a prescription for a CBPM compared to 0.04% of England's population; 6.08% of Jersey's working age population received a prescription for a CBPM compared to 0.05% in England).
- a number of patients received prescriptions from two or more prescribers in Jersey.
- Multiple prescriptions were for amounts that would reasonably be assumed to be more than 1 months³ supply of medical cannabis (NICE and NHS guidance advises no more than 30 days' supply should be provided to a patient)⁴.

BACKGROUND ON UK RESPONSE TO DRUGS POLICY REFORM

12. In considering Options A, B and C, the Assembly are asked to note that drugs policy in Jersey must accord with three United Nations conventions that provide for global drug control which have been extended to Jersey (see paragraph 23 for more detail). The UK, as the signatory to those Conventions, is accountable to the UN for Jersey as part of the UK's compliance and, as such, it must be anticipated that the UK will

³ <https://www.nice.org.uk/guidance/ng46/chapter/recommendations>

⁴ <https://www.nhs.uk/sites/default/files/2019-08/Controlled%20drug%20prescribing.pdf>

examine closely any actions taken by Jersey which, in the UK's opinion, may impact on their own compliance.

13. Government of Jersey officers have discussed the three Options set out in this proposition with UK Government officials (from the Home Office, Foreign Office and Ministry of Justice). In doing so, Jersey has evidenced that other jurisdictions, that are also signatories to the three UN Conventions, have actively implemented public policies which accord with the three Options, i.e. we do not think that Jersey is proposing anything that has not been determined to be Convention compliant by those other jurisdictions.

14. At this juncture, the UK has not provided detailed comment on the three Options, but it has sought legal advice on actions permitted under the three UN conventions and agreed that, once informed of the Assembly's decision on whether to pursue Option A, B and / or C, they will advise Jersey of their position. In doing so, the UK will need to consider matters related, but not limited, to:

- a. compliance with the three UN drug control Conventions,
- b. matters such as border security (e.g. if cannabis is legal in Jersey, will this have an impact on illegal cannabis importation at the UK's borders?),
- c. the potential impact that Jersey's public drug policy could have / be considered to have on the various other international conventions / arrangements (related to matters such as travel and trade) for which Jersey is reliant on the UK.

15. Hence, in determining which Options to adopt, if any, the Assembly must note that:

- a. the Health Minister requires a decision on the Assembly's preferred Option/s in order to bring forward detailed proposals to the Assembly.
- b. the Health Minister's ability to realise the preferred Option/s could be impacted by the UK. It is understood that the UK will advise Jersey of its legal position once it is informed of the preferred Option/s and dialogue will continue throughout the development of any detailed proposals.

16. Therefore, any decision taken by the Assembly is a decision that supports further development of Options, and associated liaison with the UK. The Assembly is not, at this juncture, being asked to determine Jersey's public policy in relation to personal cannabis use.

17. UK response to drugs policy reform in devolved administrations / overseas territories

In 2023 the Scottish Government⁵ called on the UK Government to either decriminalise all drugs for personal use in Scotland (including updating the drug classification system to reflect harms cause) or devolve powers to Scotland to enable them to reform their drugs laws⁶. The UK Government said that there were no plans to alter the current stance on drugs policy across the UK.

⁵ <https://www.gov.scot/news/drug-law-reform-proposals/>

⁶ [A Caring, Compassionate and Human Rights Informed Drug Policy for Scotland - A caring, compassionate and human rights informed drug policy for Scotland - gov.scot](#)

In 2022, Bermuda's parliament passed a Bill legalising the supply of recreational cannabis and removing its status as a controlled drug, permanently. However, Royal Assent was withheld as it was concluded that the Bill was not consistent with obligations held by the UK and Bermuda under the Single Convention on Narcotic Drugs and the Convention on Psychotropic Substances⁷.

18. Local information suggests that the traditional illicit cannabis market has largely been displaced by diverted medical cannabis, i.e., people are securing prescriptions for medical cannabis as opposed to using illicit cannabis and / or supplying or selling their medical cannabis to others. It is therefore reasonable to assume that any future changes to Jersey's drug policy may impact the medical cannabis market.

19. Work is currently underway to develop improved monitoring and regulation of medical cannabis prescribing in Jersey to help ensure patient safety.

Cannabis use in Jersey

20. Local data is not sufficient to estimate the prevalence of total cannabis use in Jersey (medical and non-medical). UK data indicates 6.8% of people (aged 16 to 59 years) have used cannabis in the last year⁸ compared to 8.4% of people (aged 15 to 64) across the EU⁹. Noting that an audit of medical cannabis prescribing in Jersey indicates around 4% of the local population (aged 18 and over) are in receipt of a medical cannabis prescription¹⁰, it is probably reasonable to assume that overall use of medical and non-medical cannabis in Jersey may be closer to EU rates than to UK rates

21. In 2018, 13% of Year 10 students and 27% of Year 12 students who responded to Jersey's Children and Young People's Survey reported they had used cannabis in the previous year, with these rates subsequently dropping year-on-year to 8% and 21% in 2024. This drop corresponds to a drop in self-reported alcohol and other drug use amongst young people and is contrary to concerns that access to diverted medical cannabis would result in higher rates of use amongst young people.

Cannabis Use Disorder

22. The prevalence of Cannabis Use Disorder (CUD) (also known as addiction or dependency) in Jersey is unknown, but CUD is estimated to affect around 10% of people who use cannabis for non-medical and medical purposes respectively¹¹. Across the EU it is estimated that around 1.5% of adults use cannabis daily (or almost daily) with daily use indicating potential dependency¹². The legalisation of the sale of cannabis in some high-income countries may increase the prevalence of CUD by making more potent cannabis products more readily available. Any change to Jersey's approach to cannabis should inform users about the risks of CUD and provide information on how to obtain assistance if they develop cannabis-related mental and/or physical health problems.

⁷<https://www.gov.uk/government/news/governor-of-bermuda-update-on-cannabis-licensing-bill>

⁸Office for National Statistics (2024) Drug misuse in England and Wales: year ending March 2024.

⁹https://www.euda.europa.eu/publications/european-drug-report/2025/cannabis_en

¹⁰ <https://www.gov.je/Government/Pages/StatesReports.aspx?ReportID=5794>

¹¹<https://pmc.ncbi.nlm.nih.gov/articles/PMC8655458/>

¹²https://www.euda.europa.eu/publications/european-drug-report/2025/cannabis_en

BACKGROUND TO UN REPORTING FRAMEWORK AND INTERNATIONAL APPROACHES

23. Global drug control is shaped by three United Nations drug conventions:
- a. **Single Convention on Narcotic Drugs 1961:** aims to combat the production, trafficking and abuse of narcotic drugs
 - b. **Convention on Psychotropic Substances 1971:** aims to control the production, distribution and consumption of psychotropic substances (extends beyond the narcotics controls in the 1961 convention)
 - c. **Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988:** aims to promote and strengthen global cooperation to combat drug trafficking and related offenses.
24. Taken together the three Conventions:
- a. define the legal obligations of States that are signatories to the Conventions
 - b. shape national drug policies through scheduling, criminalisation and public health mandates
 - c. enable operational coordination across borders to combat drug trafficking and misuse.
25. The UK is a signatory to the three Conventions, which have all been extended to Jersey. This means Jersey must comply with Conventions in a similar way to the UK but possesses no direct power or influence at the UN level. The UK has the authority and power to represent Jersey at the UN and will seek to protect the UK's own compliance by monitoring and acting on actions in Jersey which could breach the conventions.
26. See Appendix 1 for more detail on the UN Conventions.

BACKGROUND TO JERSEY LEGISLATION

27. The Misuse of Drugs (Jersey) Law 1978 is the primary piece of legislation that controls narcotic drugs in Jersey. The Law:
- categorises certain substances or products into three classes of controlled drugs (Class A, B and C),
 - imposes various restrictions on those controlled drugs, in relation to importation, exportation, production, supply, manufacture, possession, etc.,
 - creates a series of criminal offences for breaches of those restrictions. E.g., producing or supplying a controlled drug could result in a prison sentence of up to 14 years (or a fine) whereas possession carries a potential sentence of up to 5 years (or a fine).
28. Cannabis and cannabis resin are categorised as Class B drugs, and Cannabinol and cannabinol derivatives are categorised as Class A drugs (although these will be reclassified as Class B drugs before the end 2025). As a controlled drug, cannabis's cultivation, production, supply, importation, etc. are tightly controlled. Possession of associated utensils is also prohibited (e.g.: bongs, pipes).
29. Various Orders under the Law make associated provisions. Examples include:

- a. cannabis cultivation is permitted by Ministerial licence¹³,
- b. cannabis can be both a prohibited controlled drug and a medical product that can be prescribed, supplied and administered, although medical cannabis cannot be smoked legally,
- c. Centeniers may impose a fine (£200) where a person is charged with possession of cannabis (or importation of personal amounts) where the person accepts the decision of the Centenier.

30. See Appendix 2 for additional information about relevant legislation in Jersey.

Attorney General's guidance in relation to cannabis

31. The Attorney General is officially responsible for the prosecution service and for guidance as to prosecutions in Jersey. The Attorney General is also the titular head of Jersey's Honorary Police and provides Directions and Guidance to Centeniers on how Parish Hall Enquiries should be conducted in relation to offences involving the possession of controlled drugs. The Attorney General's Direction and Guidance for Centeniers dealing with cases of the possession of controlled drugs¹⁴ states that:

"...it is in the public interest for certain cases of possession and importation for personal use only of controlled drugs to be dealt with by way of written caution at a Parish Hall rather than by prosecution (i.e. summary fine at a Parish Hall or in the Magistrate's Court)."

32. Therefore, a Centenier may deal with a person by way of written caution for a first or second offence of possession (or importation) of a range of class A, B and C drugs. This includes cannabis for personal use only if the amount is less than 15 grams, if the individual admits the offence, and certain criteria are met. These criteria can include that the individual attends the Alcohol & Drug Service for education and harm-reduction advice and does not commit any other offences during a set time period.

33. All written cautions will be recorded in writing, with a record of that written caution being maintained by the Police, but it will not appear on the person's criminal record.

34. Where a person commits a third offence of possession of a personal amount (or a second offence within less than 12 months after their first offence, or where the Centier determines a fine should be imposed), the Centenier may impose a fine (£200 for cannabis).

35. Where a fine is imposed, a record of that fine will be maintained by the Police, but it will not appear on the person's criminal record.

36. Parish Hall written cautions and fines are not addressed by the Rehabilitation of Offenders (Jersey) Law 2001; hence they stay on a person's police record in perpetuity.

¹³A number of companies in Jersey have been granted a licence, by the Health Minister, to cultivate cannabis in order to manufacture cannabis based medical products. These companies have been through a thorough application and assessment process, which includes inspected by officials from the Drugs and Firearms Licencing Unit from within the Home Office. They must demonstrate adherence to strict security, procedural and cultivation standards.

¹⁴<https://www.lawofficers.je/publications/guidance-and-directives/parish-hall-enquiries/controlled-drugs/>

37. All other offences which a Centenier or the Attorney General feels are not appropriate for Parish Halls must be dealt with the via Youth, Magistrate or Royal Court. Outcomes can range from fines to probation, treatment orders or imprisonment.

38. In general, decisions about whether to prosecute are taken by individual Centeniers but the Attorney General has ultimate authority and can overrule a Centenier’s decision. More detail about the Attorney General’s Directions and Guidance is in Appendix 2.

BACKGROUND TO DRUGS POLICY

Summary of approaches to drugs policy

39. There are three main approaches to drugs policy:

- criminalisation (or prohibition) - drug use and related activities (such as possession for personal use) is illegal, punished, and treated primarily as a criminal justice issue
- decriminalisation - personal drug use and related activities are illegal but considered minor offences which are not punished
- legalisation (legal regulation) - where personal drug use is a legal with no need for police involvement, unless in relation to activities that are outside the law (for example, the personal use of cannabis is legal, but importation of cannabis is illegal)

40. Beneath these three main approaches there exists a continuum of different responses, which runs from the death penalty as one extreme, to permitting commercial production of drugs as the other extreme.



Further information on three main approaches to drugs policy is set out in Appendix 3.

Shifting approaches to drug policies in other jurisdictions

41. Governments worldwide have historically adopted punitive approaches to drugs in order to eliminate use. To date, elimination has not been achieved and there is growing recognition that punitive approaches include harmful consequences¹⁵. This recognition is creating a shift towards more effective approaches to drug policy which typically aim to delay the onset of use and to prevent harms associated with use¹⁶.

Table 2: impact of key policy interventions

Policy intervention	Impact on use	Impact on harms
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¹⁵<https://www.ohchr.org/en/stories/2025/04/effective-and-humane-approach-drug-policies>

¹⁶Babor et al. (2018) Drug Policy and the Public Good: Second Edition. Oxford University Press.

<p>Abolishing criminal laws on use of drugs</p>	<p>Abolishing drug laws appears to have no significant effect on:</p> <ul style="list-style-type: none"> • the age at which people start to use drugs (i.e. it does not seem to encourage use by children and young people)^{17, 18}, • the prevalence of drug use or problematic use (i.e. it does not increase levels of use, problematic use or dependency). However, it can appear to increase use if more people report using drugs and / or access services on the basis that they no longer feel concerned about disclosing their drugs use, • on the amount of drugs people use (i.e. it does not increase or decrease the amounts used). 	<p>Abolishing criminal drug laws is usually done as part of efforts to remove or address the harms caused by those laws. This is usually done as part of a public health approach where potential harms are actively addressed through health service or other prevention actions.</p> <p>Abolishing criminal laws in isolation of additional public health approaches can lead to unmitigated risks and harms.</p>
<p>Legalise possession and supply of drugs through controlled markets</p>	<p>Evidence suggests non-profit markets have little effect on use. These markets usually prioritise safety and social responsibility over making profits. These rely on passive sales without advertising or the need to encourage use to create new customers.</p> <p>For-profit markets have a larger effect on use. These markets typically focus more on profits and may involve free market competition and aggressive advertising or sales tactics.</p> <p>However, the effects of legalising the sale of drugs on consumption levels are often contested. One example is the Netherlands, where cannabis is openly for sale, and usage rates are relatively low compared to other European countries, which prohibit cannabis sales.</p>	<p>Non-profit markets typically prioritise safety over revenue and feature more controls to reduce harm.</p> <p>For-profit markets typically pose higher risks of harms as they are driven by revenue where excessive or regular use leads to increased profits. Lobbying from businesses can also put pressure on governments to relax controls originally designed to reduce use or harm.</p>

¹⁷<https://academic.oup.com/jpubhealth/article/45/2/e215/6779883>

¹⁸Babor et al. (2018) Drug Policy and the Public Good: Second Edition. Oxford University Press.

42. Indeed, the UN’s Chief Executives Board for Coordination – the highest-level coordination forum of the United Nations system chaired by the UN Secretary-General - recently called for jurisdictions to:

“promote alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use, and to promote the principle of proportionality, to address prison overcrowding and over incarceration by people accused of drug crimes.”

43. At present, over 30 countries have adopted some form of decriminalisation of possession for personal use (whether ceasing prosecution or repeal of offences from law) with several others moving beyond decriminalisation toward the introduction of government-controlled production and sale or for-profit sale:

Table 3: High level overview of global approaches

Approach type	Country or States
Broadly equivalent to Option A – ceasing prosecution	Australian States (Australian Capital Territory, Northern Territory, South Australia), Spain, Connecticut, Delaware, Hawaii, Czech Republic, Denmark, Estonia, Mexico, Barbados, Croatia, Italy, Poland, Slovenia
Broadly equivalent to Option B – repealing offences	Armenia, Belize, Brazil, Chile, Colombia, Colorado, Costa Rica, Germany, Dominica, Jamaica, Luxembourg, Malta, Minnesota, Missouri, New Jersey, New Mexico, New York, Peru, South Africa, Spain, Vermont, Washington
Broadly equivalent to Option C – trial of government-controlled production and sale	Switzerland, Uruguay Note: <ul style="list-style-type: none"> • Germany and Luxembourg are in process of setting up government trials that would be equivalent to Option C • Netherlands has also established a trial for the legal supply as an extension of the long-standing for-profit sale in coffee shops model.
Permit ‘for profit’ production and sale in law (not provided for in Options A, B or C)	Canada and various US States (Alaska, California, Colorado, Illinois, Maryland, Massachusetts, Maine, Nevada, Ohio, Virginia)

See Appendix 4 for an overview of different countries approaches to cannabis.

44. Whilst evidence of the effects and benefits of ceasing prosecution or repealing offences relating to personal use is generally well established, there is comparably less evidence as to the effects of government-controlled production and sale, as this is still a relatively novel approach.

45. When comparing models across jurisdictions (as set out in the table above), it is important to bear in mind that each jurisdiction faces its own unique issues which inform their local decisions regarding drugs policy. Therefore, no two approaches are exactly alike. The variation in models across jurisdictions can make comparisons and evaluations between them difficult, and it should not be assumed that a drug policy from one jurisdiction will have the same outcomes when applied to a different jurisdiction.

46. It is similarly anticipated that any future detailed proposals developed for Jersey will be unique to Jersey and will not directly replicate the provisions of other jurisdictions.

47. The countries that have moved towards introducing government-controlled production and sale (equivalent to Option C) have generally done so by:

- legalising the regulated sale and supply of cannabis on a trial basis, with a view to testing and producing evidence on which models of production and sale are the most effective at reducing harm (these trials have not been declared by the UN as non-Convention compliant), or
- legalising the sale and supply of cannabis on a permanent basis and, in doing so, accepting the risk of criticism and potential sanction as signatories to the UN Conventions (e.g. Uruguay).

Local drugs policy/policy context

48. As described in paragraph 32, there are already some elements of non-prosecution in Jersey's current approach to drugs, as provided for in the Attorney General's Direction and Guidance (e.g. in relation to possession and importation for personal use). However, that Direction and Guidance, and the associated elements of non-prosecution, does not extend to possessing utensils and cannabis cultivation for personal use. More importantly, a person is still arrested for possession and/or importation for personal use, is still charged and will still receive a written caution, albeit will not incur a fine for first or second offence.

49. Furthermore, Jersey law continues to provide for punishment across a spectrum of drug offences. The law currently does not formally differentiate between "personal" and "commercial" offences or punishments. Prison penalties for offences involving cannabis can be up to fourteen years for cultivation or intent to supply, and up to five years for possession. However, if a person is charged with possession of a Class B drug (without intent to supply), a Centenier has the power to impose a written caution or fine (see paragraph 32). Where a written caution or fine is imposed, the case must be related to personal possession as opposed to commercial supply.

50. It is not envisaged that any commercial supply offences would be repealed or amended as a result of any detailed proposals that may be developed as a result of Option/s A, B or C. Offences in relation to intent to supply, possession or cultivation amounts above any personal thresholds, and cultivation of above personal limits will remain in law and will continue to be prosecuted.

Relevant Jersey strategies

51. There are a number of government strategies which are relevant to Jersey's drugs policy. These include:

- Jersey's Substance Use Strategy 2023 to 2033
- Youth Justice Review 2019

- Sustainable wellbeing/Future Jersey
- Building A Safer Community Framework

52. **Jersey’s Substance Use Strategy 2023 to 2033**¹⁹ sets out how Jersey will respond to substance use, including alcohol and drugs. It takes a “health and social” approach i.e. it focuses on addressing health and social harms associated with substance use, as distinct from a punitive approach. The strategy acknowledges that the current policy of criminalisation of drug use creates issues that may impact the improvement of people’s health and social outcomes. Key strategy objectives include:

- a. Reviewing how small quantities of controlled drugs are dealt with to ensure alignment with a health and social based approach. This includes a focus on identifying and responding to wider risk factors that influence substance use and offending behaviour,
- b. Review of existing legislation, ensuring that Jersey’s laws are workable within the current drug landscape and are consistent with a health and social approach,
- c. Continue progression away from criminalisation toward decriminalisation and legalisation. This will include ensuring alignment to existing government commitments related to health improvement and protecting children,
- d. Protecting children, young people, and others at risk of exploitation by organised crime. This includes exploring legislation options to provide amnesty in cases of coercion.

53. Arguably Jersey’s current drugs policy fails to align with our Substance Use Strategy.

54. **The Youth Justice Review (2019)**²⁰ recommended a multi-agency approach to youth justice, focusing on the rights and needs of children. That review informed the Youth Justice Roadmap, which outlines an approach to youth justice that is restorative in nature and addresses the needs of children involved in offending behaviours, primarily through prevention, early intervention, and rehabilitation. It is arguable that the current approach to drugs policy could negatively impact the improvement of some key outcomes of the Youth Justice Review. Ideally, a revised approach to drugs policy should enable, strengthen and benefit the existing Youth Justice Roadmap and its intended outcomes.

55. **Sustainable wellbeing / Future Jersey (2017)**²¹ sets out Jersey’s commitment to sustainable wellbeing. Sustainable wellbeing is about improving long-term community, economic and environmental wellbeing. The Public Finances (Jersey) Law 2019 requires decisions on taxes and spending to take sustainable wellbeing into account.

56. Progress on sustainable wellbeing is measured through Island Outcome Indicators (IOIs), and it is intended that, wherever possible, all policy proposals should increase sustainable wellbeing. Therefore, any changes to Jersey’s drug policy should work to improve community wellbeing—including supporting people to be safe and secure, in addition to healthy—whilst minimising impact on economic and environment outcomes. This includes supporting people’s employment and economic activity. As

¹⁹<https://www.gov.je/Health/AlcoholDrugs/pages/substanceusestrategy.aspx>

²⁰<https://statesassembly.je/publications/assembly-reports/2019/r-70-2019>

²¹<https://www.gov.je/Government/PlanningPerformance/GovernmentProgramme/pages/jerseys-trategicframework.aspx>

such, all public policies should consider IOIs in their development and balance potential benefits against risks.



57. It is acknowledged that drug policy changes can impact a wide range of IOIs. (A full list of potential impacted IOIs can be found in Appendix 7). Changes made in one area can affect indicators in another area. One example is that unrestricted cannabis use in some young people could lead to poorer educational attainment and increased risk of mental health problems. To mitigate this risk, prevention methods specific to young people feature as part of all three Options.

58. **Building a Safer Community (BASC) Delivery Framework²²** (2024 – onwards) The Building a Safer Community Framework is an approach to community safety in Jersey which requires coordinated effort from a wide range of stakeholders across the Island. The Framework encompasses prevention to community safety and how the island responds to crime, pro criminal behaviour and associated harm.

59. It is envisaged that elements of the BASC Framework will be incorporated into any detailed proposals related to Option A, B and / or C, to ensure that those proposals align with the framework.

Rationale for changing Jersey’s approach to drug policy

60. In addition to failing to align with, or having some negative impact on, adopted government strategies (as described above), there are other key problems or policy failings that arise from Jersey current approach to drugs policy, as described in the table below.

Table 4: Underlying problems and key considerations

Barriers to accessing support
Stigma around drug use
<ul style="list-style-type: none"> • Criminalisation stigmatises people who use drugs as immoral and as threats to society • Stigma acts as a barrier to seeking treatment and is a predictor of worsening substance use

²²[https://www.gov.je/SiteCollectionDocuments/Crime%20and%20justice/Building%20a%20Safer%20Community%20\(BASC\)%20Framework.pdf](https://www.gov.je/SiteCollectionDocuments/Crime%20and%20justice/Building%20a%20Safer%20Community%20(BASC)%20Framework.pdf)

- Without change, people could delay seeking support, leading to worse health outcomes

A public health focused drugs policy should reduce stigma allowing more people to access support.

Someone may not be truthful about their cannabis use for fear of judgement, and only seek support once problems are too severe to ignore. Stigmatising language, such as referring to people as “addicts,” has negative implications. Stigma is often perpetuated by negative stereotyping, association with criminality, and public opinions on morality. This can create a cycle of stigma which is hard to break and further prevents people from speaking openly or seeking support.

Fear of arrest if disclosing use or involvement in illegal activity

- Criminalisation creates fear of arrest and the associated legal consequences
- Fear can create trust issues with health and broader support services
- Without change, people may delay seeking support or calling for help in emergencies

A public health focused drugs policy should reduce fear of arrest and increase trust with services.

When attempting to assess cannabis use, people will down-play the extent out of fear of admitting that they are regularly in possession. This makes meaningful interventions difficult and costly as it may take time before someone is truthful about their use. Young people are known to lie about cannabis use in cases where someone is experiencing an adverse reaction. This makes it difficult to assess immediate medical or welfare needs or to understand if a problem is part of a long-term mental health problem or short-term intoxication.

Restrictions on public health interventions

Difficulty in providing brief interventions

Brief interventions are short, structured conversations which aim to change health-related behaviours. For example, supporting small changes to reduce alcohol consumption. These are delivered by trained workers, usually in health or community settings (e.g. a receptionist at a GP surgery, a practice nurse assessing a new patient, a health visitor advising new parents).

- Cannabis criminalisation restricts open and honest dialogue about use
- This creates challenges and missed opportunities

A public health focused drugs policy should enable and encourage cannabis brief interventions

Brief interventions are evidence-based and can reduce levels of use and associated harms. They can also increase access to services and signpost to other areas of support (e.g. mental health). Once enabled, cannabis brief interventions can be embedded into existing and new initiatives. These could include being part of wider community or primary care health checks.

Restrictions on enabling harm reduction actions

- Criminalisation prohibits possession and supply of utensils used for drug activities, which can prevent individuals from using utensils which could reduce harm.

A public health focused drugs policy should enable actions and interventions which reduce harm.

Vapes are less harmful than smoking cannabis and prevent second hand smoke. However, legislation treats these devices as drug utensils when used with non-medical cannabis. This makes it difficult to encourage safer methods of use, whether in face-to-face conversations or health promotion literature.

Challenges for effective young person prevention

- Criminalisation often tries to dissuade drug use by eliciting fear and emphasising risks
- These methods are not effective in preventing use by a child or young person

A public health focused drugs policy should use effective prevention approaches with children and young people.

Effective drug prevention tends to include behaviour change, resilience and attitudes towards health. Prevention is also much more than education - with wider systemic public health, trauma-informed and community-based approaches showing long-term benefits. These approaches appear more consistent and workable within public health-based drug policies. The lack of criminalisation also enables better links to early intervention and low-level support for children and young people.

Limitations on meaningful health advice

- It is difficult to issue public-facing health advice on safer cannabis use when cannabis itself is illegal
- Without change, preventable harms may continue due to a lack of public advice on safe use

A public health focused drugs policy should maximise opportunities to provide meaningful health advice.

The illegal nature of cannabis prevents large-scale public education or health advice. Advice deemed to be reasonable to protect health and welfare may be seen as encouraging illegal activity and so cannot be issued. This restricts meaningful advice to specialist substance use services where the advice is too late, as people are already using cannabis. Health advice on cannabis may also be ignored if people do not want to be seen viewing things related to illegal activities.

Detrimental impact of criminal justice system

No acknowledgement of social supply

Social supply is supplying drugs to friends and acquaintances (either for free or ‘at cost’) as opposed to selling drugs to strangers for profit²³

²³https://www.researchgate.net/publication/262797020_Beyond_drug_dealing_Developing_and_extending_the_concept_of_'social_supply'_of_illicit_drugs_to_'minimally_commercial_supply'

- “Social supply” is not currently recognised in Jersey law as a lesser offence. On arrest, stating that “some of the cannabis is for a friend” shows intent to supply, which is a more serious offence than possession
- Without change, people will continue receiving serious criminal records for small amounts

A public health focused drugs policy should acknowledge social supply and respond accordingly.

A young person is found in possession of three joints and, in their defence, tell the police that one is for a friend. The young person is now charged with intent to supply, in addition to possession, and must be dealt with at court. There is no separate minor offence associated with social supply, and the punishment for intent to supply can be substantive. If the young person instead pleaded guilty to possession, they would likely be dealt with at Parish Hall Enquiry by proxy of the small amount involved.

Impact of arrest and repeated interaction with police

- Arrests and repeated police interactions can have negative immediate and lasting impacts
- An individual may experience stress, trauma, distrust in policing, and other social consequences
- Without change, health and social outcomes could worsen

A public health focused drugs policy should reduce police interactions and arrests.

Harms may raise from being arrested in front of family or neighbours, experience of custody, missing work, stigma associated with arrest.

Impact of criminal record

- Criminal records are disclosable under enhanced DBS checks
- Without change, islanders, and especially young people, may continue to face barriers accessing education, employment or training due to past criminal records

A public health focused drugs policy should resolve barriers caused by criminal records.

A person applying to train as a nurse could be refused as their DBS check includes reference to previous possession of a Class B drug but does not specify that it was for 2 grams of cannabis only, and hence is unlikely to be considered relevant by a prospective employer.

Disproportionate effect of specific groups of disadvantaged people

- Certain groups of people, who already encounter disadvantage, are more likely to use cannabis (e.g. people addicted to other substances and young people with complex needs) and hence, more likely to go to Court with the intended consequences
- These intended consequences (e.g. a criminal record) serve to further compound disadvantage

A public health focused drugs policy should take account of patterns of use by specific groups of people and avoid compounding inequalities.

Impact on families

- Criminal punishments can affect employment which, in turn, can have a negative effect on the whole family, including children (whether through reduced income and/or stigma and/or strained relations)

A public health focused drugs policy should protect families, including children, from disproportionate harms.

Impact on children from parental arrest or charge

- When reporting on drugs charges, the media names individuals, which risks identifying their children. If identified, their children then suffer consequences (e.g. being bullied, stigmatised or unfairly discriminated against)

A public health focused drugs policy should protect the safety, dignity and privacy of parents and children.

Criminal justice burden and efficiency

Financial and resourcing costs to Police, Parish Halls and Courts

- Pursuing criminal punishments can be time consuming and costly. Pursuing personal cannabis offences may not be cost-effective or an efficient use of resources

A public health focused drug policy should reduce criminal justice burden and use resources more efficiently.

In 2024, police prepared 82 cases for charges relating to possession of cannabis. Activities included in these cases involved arrest, custody, forensic drug analysis, investigation, interview, and preparation of case files for charge by a Centenier (where appropriate).

Whilst Parish Hall Enquiries are considered to be more cost-effective than the Courts, additional costs may still be incurred in relation to educational sessions with Alcohol & Drug Service staff, follow-up administration and additional reviews for when Deferred Decisions are used. Where matters are dealt with by the Court, higher costs are incurred (court officers, police, and legal advisors time covering court preparation, social enquiry reports, trial) and include costs associated with sentencing, which may include Probation and Aftercare or, more rarely, Prison (e.g. for cultivation rather than possession).

Drug market effects

Supporting illicit drugs markets

Illicit drugs markets are the result of sustained demand without legal supply. Cannabis is generally acquired in Jersey through illicit markets or diversion of prescribed medical cannabis.

Note: illicit cannabis importations into Jersey have decreased significantly from 146.1kg of cannabis seized in 2017²⁴ to 15.9kg of cannabis seized in 2024²⁵. Anecdotally, it is thought that illegally imported cannabis has been largely displaced by diverted medical cannabis.

A change of policy could:

- reduce reliance on, and benefit to, illegal markets
- prevent diversion of medical cannabis.

Funding organised crime

- Sales of illicit cannabis will fund crime networks in the UK and elsewhere. These networks are associated with child exploitation, modern slavery, human trafficking, etc.

A public health focused drugs policy should undermine the funding of organised crime networks.

Safety of drugs purchased on illicit market

The illicit drug markets clearly lack any regulation. This means that drugs sold pose additional risks, including:

- poor quality or unreliable potency of the product
- coercion, exploitation and violence towards users (including targeting vulnerable people; violence for unpaid drug debts)

A public health focused drugs policy should improve public safety and address unsafe markets.

Drug policy considerations

Criminalisation has not achieved its objectives (i.e. it has not eradicated use) nor is it effective in preventing harm

Evidence shows that criminalisation policies have resulted in unintended consequences (e.g. increasing social inequalities, adversely affecting the lives of people who use drugs, failing to protect people from unsafe drugs) and government costs (e.g. policing, courts, etc.) without necessarily having any impact on commercial drug trafficking.

A public health focused drugs policy should meet realistic objectives and both prevent and address harms.

Cannabis harms are disproportionate to legal status

- Current responses to personal cannabis use do not appear proportionate to its lower level of health and social harms in comparison to other substances including alcohol
- Disproportionate responses are costly, ineffective and can increase harms
- Without change, impacts to islanders and cost to government may continue or worsen

²⁴<https://www.gov.je/Freedom%20of%20Information%20library/ID%20FOI%2020201014%20Drugs%20seizures.pdf>

²⁵<https://www.gov.je/government/freedomofinformation/pages/foi.aspx?ReportID=8384>

A public health focused policy should respond proportionately to harms.

Alcohol is understood to cause more harm to individuals and others than cannabis. This is due to alcohol having more severe and a broader range of adverse effects than cannabis. These effects and risks are not simply the result of more people using alcohol than cannabis. Despite harms, alcohol is legally regulated while cannabis is criminalised. Criminal punishments for cannabis can result in additional harms greater than the drug itself.

Compliance with relevant United Nations drug conventions

- United Nations drug control conventions are extended to Jersey
- Changes to drug policy may contravene the Conventions, potentially resulting in diplomatic disputes, sanctions and exclusions

A public health focused drugs policy should comply with and further the aims of the UN drug conventions.

If a policy decision was to contravene the UN Conventions, it could be flagged at UN level and damage Jersey's/UK's international reputation. It is theoretically possible that the INCB could impose direct sanctions on Jersey/the UK, in the form of restrictions on the importation of medicines (that are also controlled drugs) into Jersey/the UK but, this power has never been exercised. One example is the Netherlands, which has been permitted to operate a cannabis sale model for years, and the INCB has never taken action.

United Kingdom relations and impact on travel, trade and other agreements

- Jersey has social, economic and constitutional links with the UK
- Changes to drug policy may have implications to various agreements in place
- If this occurs travel, trade and other constitutional matters may be impacted

Any policy change should seek to maintain a positive relationship with the UK and Guernsey

Changes to Jersey's drugs policy may impact on UK relations. As stated in paragraph 14, the UK will advise on its response to any proposed changes to Jersey's drug policy after it has been provided details proposals. Jersey will similarly need to liaise with the Guernsey to understand the impact of changes to drugs policy on interisland co-operation.

Implementation

Ongoing monitoring

- There is currently minimal local data on cannabis use and outcomes

Any change to drugs policy should be accompanied by increased monitoring to ensure safe and effective outcomes.

Changes to drug policies can have far reaching consequences, many of which may take time to appear. Being able to identify success and unintended consequences allows for ongoing improvement and better long-term outcomes. If data is not held, it will be difficult to understand if a policy has positive, negative or mixed results.

Realisation of public benefit

- It will take time for changes to drugs policy to embed and deliver benefit
- The inability to evidence impact / benefits in the short to medium term may be interpreted as lack of effectiveness hence it is critical to manage all stakeholders expectations (including the public) and, at the same time, to identify and delivery early benefits.

IMPACT OF CANNABIS USE AND MITIGATIONS

Predictors of problematic and dependent use

61. Predictors of problematic and dependent use of cannabis include biological, psychological, and social factors. These can include genetic predisposition, brain changes, childhood trauma, mental health and psychological traits, unhealthy coping mechanisms, family or peer influences, or self-medicating due to lack of healthcare access. Problematic or dependent cannabis use is rarely the result of cannabis use itself, it is often driven by other factors, some of which can be prevented or mitigated.

62. There are a wide range of evidence-based approaches which could be adopted to help prevent increases in cannabis use. These will be built into delivery of the three proposed Options:

- Discourage cannabis use - encourage islanders to reduce or stop using cannabis entirely
- Delay onset of use in children, young people, and adults through primary prevention and other prevention efforts (e.g. supervised leisure activities for children and young people, which reduce risky behaviours and promote positive behaviours, promotion of healthy lifestyles and selective and targeted support.)
- Reduce risks and strengthen protective factors, which can lead to problematic and dependent use (e.g. through specific advice to higher risk groups, increased screening within services, and targeted prevention.)
- Introduce brief interventions as part of early intervention efforts to encourage people to access support services (e.g., a receptionist at a GP surgery, a practice nurse assessing a new patient, a health visitor advising new parents).

Association of psychosis-related outcomes and cannabis use

63. It is widely acknowledged that some cannabis users experience psychosis-related outcomes, which can range from sub-clinical expressions to full clinical diagnoses (e.g., from non-persistent paranoia or uneasiness to people with severe disorders of mental functioning and behaviour including, for example, schizophrenia). Appendix 8 provides additional information about psychosis-related outcomes.

64. The relationships between cannabis use and psychosis-related outcomes are, however, generally considered to be associations rather than being causal. Studies regularly identify the same three variables as being associated with increased risk of cannabis-induced psychosis-related outcomes:

- Predisposition through genetics, individual's personal history or their familial history of mental health conditions. This may include conditions like schizophrenia, brief psychotic disorder, etc.
- Cannabis-related factors, such as strength and frequency of use. E.g. frequently using high THC strains, bingeing on cannabis or using daily.

- Age of first cannabis use, e.g. using at a young age.

65. A number of evidence-based interventions can be used to prevent psychosis-related outcomes. These will be built into delivery of the three proposed Options:

- Discourage cannabis use - encourage islanders to reduce or stop using cannabis entirely
- Raise awareness regarding potential genetic predisposition
- Raise awareness of early signs and symptoms which could prevent psychosis-related outcomes from worsening or progressing
- Provide advice regarding risks of high THC levels and use patterns which could put certain individuals at increased risk (such as children and young people, or adults with relevant family histories)
- Training professionals to spot signs and symptoms of early psychosis-related outcomes
- Introduction of brief interventions as part of early intervention to encourage earlier access to mental health support. E.g. a receptionist at a GP surgery, a practice nurse assessing a new patient, a health visitor advising new parents

Smoking tobacco and cannabis together

66. The harmful effects of tobacco smoke are well understood, but the harmful effects of cannabis smoke are less well known. Cannabis smoke can contain more tar, hydrocarbons and different risks than tobacco smoke²⁶. While the associations between cannabis and lung cancer are weaker than tobacco, cannabis smoking is associated with mouth cancer, chronic bronchitis, and impaired respiratory function. Using cannabis and tobacco together can increase those harms and make it more difficult to reduce or stop using both substances.

67. While cannabis and tobacco smoke contain different carcinogens many can be eliminated through the use of vaporisers²⁷, which also reduce lingering smells and the risks of second-hand smoke. Hence, regardless of the Option/s adopted by the Assembly, work will continue to:

- discourage tobacco use and prevent children and young people from beginning to smoke
- target at-risk individuals to reduce or stop smoking (whether tobacco or cannabis)
- encourage safer alternatives (for example, using edibles, vaping cannabis or smoking with tobacco-free alternatives)

Immediate and short-term harms of cannabis use

68. Immediate and short-term effects of cannabis use can include increased heart rate, nausea or vomiting, confusion, anxiety, paranoia, delayed reaction times, impaired motor skills or distorted perceptions. While generally considered temporary, and rarely requiring medical intervention, accidents and harms can still occur. In many cases, these can be reduced through simple actions.

²⁶Agrawal, A., Budney, A. J., & Lynskey, M. T. (2012). The co-occurring use and misuse of cannabis and tobacco: a review. *Addiction*, 107(7), 1221-1233.

²⁷Melamede, R. (2005) Cannabis and tobacco smoke are not equally carcinogenic. *Harm Reduct J.* 18; 2:21.

69. A number of evidence-based interventions can be used to limit immediate and short-term harms. Any Option/s adopted by the Assembly will include work related to:

- Raise awareness of potentially dangerous/possible interactions with other medicines
- Discourage the use of cannabis alongside alcohol or other drugs
- Encourage people to eat before using cannabis
- Encourage harm reduction practices (e.g. short inhalations, reducing amounts used and THC levels) and socially responsible use (such as using away from children)
- Raising awareness of drug, mindset and setting factors, whether as part of prevention or at point of sale. For example, covering:
 - recommended dosages,
 - effect of recent mood, or current thoughts, feeling, emotions
 - effect of ongoing mental health issues, and
 - using in a safe environment, with other trusted people nearby.
- Training staff of cannabis outlets to offer advice and to respond to welfare concerns such as nausea or anxiety
- Limit THC levels on regulated products

Long-term health effects of cannabis use

70. The long-term effects of cannabis use on a person can include an increased risk of addiction to cannabis. Long-term use can also impact a person's memory, concentration, and ability to think and make decisions. These effects can last from several days, to months or longer after you stop using cannabis. They may not be fully reversible, even when cannabis use stops²⁸.

71. A number of evidence-based interventions can be used to mitigate the long-term effects of cannabis use. These include:

- Raise public awareness of cannabis risks and it should not be thought of as “healthy” especially if smoked
- Raise awareness amongst people who use cannabis of the key physical and mental health conditions that result from use, and their early signs and symptoms
- Provide targeted health promotion advice and interventions to individuals with certain higher risk profiles
- Incorporate cannabis use into standard health discussions to allow for brief interventions and early treatment of people who use cannabis

Road safety and cannabis use

72. Matters related to road safety and drug use are not straightforward²⁹; whilst cannabis use has been shown to impair driving, the extent of impairment is affected by multiple factors including:

- how the cannabis was consumed
- an individual's frequency of use and tolerance to cannabis

²⁸<https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/health-effects/effects.html#a2>

²⁹https://www.euda.europa.eu/system/files/publications/8805/20181120_TD0418132ENN_PDFA.pdf

- whether cannabis is used in isolation or with other substances. E.g., where alcohol use is below the drink-drive limit, but the alcohol has been combined with cannabis, the levels of impairment can be significantly raised

73. Hence, regardless of Option/s adopted by the Assembly, steps will continue to be undertaken to:

- Support current work in tandem with other Ministers to address drug driving and wider road safety which includes the following:
 - defining drug-impaired driving by law, based on a specific level of THC in blood
 - defining impaired driving through combined alcohol and cannabis use by confirmed detection of both substances either in isolation or alongside each other
 - introduction of roadside testing for drug driving
- Consider and mitigate the risks of combined alcohol and cannabis use on road safety
- Enable meaningful education and awareness raising of risks to the public and those who use cannabis (whether medical or non-medical).

Section 2: Development of proposed options

INITIAL DEVELOPMENT

74. The three proposed Options were developed following a process of desk research, which included consideration of a wide range of international drug policies and associated outcome/evidence reviews. This research enabled identification of key matters for consideration (as per column A below,) which were then examined from the perspective of UN Convention compliance, perceived relative risks and the potential impact on health, safety and criminal activity outcomes, in order to determine if they should be incorporated into high level Options for discussion with the public and key stakeholders (as per column B below) or excluded (as per column C below).

Table 5: Initial decision on key matters

Column A	Column B	Column C
Key matters considered	Included in Options	Not included in Options
Alternatives to criminalisation	<ul style="list-style-type: none"> • Removal of punishment (Option A) • Repeal/amendment of offences (Option B) • Government controlled production and sale (Option C) • Private non-profit production and sale (Option C) 	<ul style="list-style-type: none"> • Private companies will not be permitted to sell cannabis for profit.
Forms of cannabis	<ul style="list-style-type: none"> • Natural preparations of cannabis plant (dried flower, resin, liquid preparations) • Products made from natural preparations of cannabis (pre-rolled joints, dry herb vape capsules, edibles) 	<ul style="list-style-type: none"> • Medical cannabis not included (improved controls to be brought forward through existing legal powers) • Isolated cannabinoids and cannabiol derivatives and associated products not included (e.g.: THC or edibles only containing TH C)
Defining <i>small quantities for personal use</i>	<ul style="list-style-type: none"> • Indicative threshold in law e.g. number of days' supply (Option A) • Specific threshold in law e.g. maximum grams or millilitres (Option B) 	
Restrictions related to places	<ul style="list-style-type: none"> • Permit the smoking of cannabis on private premises 	Options will not ban using (except for potentially smoking)

where cannabis can be used	<ul style="list-style-type: none"> • Explore if the smoking of cannabis should be banned in public places • Ensure consistency with existing smoking bans • Potentially ban smoking of cannabis in some areas where tobacco can be smoked (e.g.: in beer gardens) <p>(matters related to vaping and edible cannabis to also be considered)</p>	or being under the influence of cannabis in public places.
Using cannabis in presence of under 18s	<ul style="list-style-type: none"> • Exclude under 18s from entering cannabis supply outlets (Option C) • Existing smoking ban near schools to apply to cannabis as well as tobacco • Explore additional safeguarding or child protection methods in the development of all Options 	Options will not criminalise use of cannabis (including smoking, vaping eating) in the presence of under 18s
Social supply	<p>Explore removal of punishment associated with social supply. Including:</p> <ul style="list-style-type: none"> • indicative threshold (low amount as social supply for immediate use) • limited financial gain (e.g. supplying for free or to cover costs) • social supply only between friends /people with established connection • ban on soliciting or advertisement of social supply 	
Other forms of supply	<ul style="list-style-type: none"> • Licensed regulated sale and supply • Explore other routes for non-profit sale and supply, e.g. cannabis social clubs (Options A, B, and C). <p>See paragraph 124 for information on cannabis social clubs</p>	Options will not: <ul style="list-style-type: none"> • repeal/amend offences associated with supply via illicit market • permit unregulated sale and supply
Cultivation and preparation	<p>Home cultivation for personal use</p> <ul style="list-style-type: none"> • Repeal/amend existing offences • Include controls on how it is grown to prevent spread in the wild • Indicative or specific number of plants per adult, not per household (to consider possession of plants alongside possession of previously harvested / prepared product) • Retain offence for preparation of product above specified amounts 	<p>Home cultivation</p> <ul style="list-style-type: none"> • No requirement to grant individual licenses for home cultivation • No requirement for records of

	<p>Commercial cultivation to supply for non-medical cannabis market (ie. regulated sale and supply in Jersey)</p> <ul style="list-style-type: none"> • Regulated licenced cultivation and supply only • Set quantities for cultivation • Records of plants and harvest to enable seed to sale monitoring • Automated grow systems • Allow natural preparations e.g. dry flower and oil. 	<p>plants and harvest for personal cultivation</p> <ul style="list-style-type: none"> • Not permitting automated grow systems • Not permitting isolation of cannabinoids e.g. THC, CBN <p>Commercial cultivation</p> <p>Options will not permit:</p> <ul style="list-style-type: none"> • outdoor growing • unregulated commercial growing • isolation of cannabinoids e.g. THC, CBN
Supply with restrictions to under 18s	<ul style="list-style-type: none"> • Consideration of new offences related to supply to under 18s (including social supply by adults) • Regulation of cannabis supply outlets, including ban on sales to under 18s 	
Protect people from coercion into cannabis related activities	<p>Reduce dependence on illicit market, and associated exploitation and coercion of users and participants in illicit markets, by:</p> <ul style="list-style-type: none"> • allowing people who use cannabis to self-cultivate • replacing illicit market with regulated sale and supply 	
Driving under the influence of cannabis	<p>Prevention</p> <ul style="list-style-type: none"> • Potentially explore use of standardised THC ‘units’ to help people understand safe 	

	<p>amounts (cannabis equivalent drink-drive limit with units of alcohol)</p> <ul style="list-style-type: none"> • Training for cannabis supply outlet staff to prevent drug-driving • Ensure cannabis supply outlets are on bus routes and close before last buses leaves • Public awareness campaigns 	
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Public consultation

75. A public consultation on potential approaches to non-medical cannabis ran from 30 May to 11 July 2025. The aim of the consultation was to gather public views to help inform the Options to be presented to the Assembly.

76. It is important to note that people who responded to the consultation chose to do so because of their interest in subject. It must not be assumed that their individual or collective views are representative of wider public opinion.

77. The consultation process included public meetings and an online survey. See Appendix 5 for full details regarding survey findings.

78. 10,199 survey responses were received; however, it was evident from initial analysis that the majority of responses were completed by automated software or bots. Repeat IP address submissions that conformed to a specific pattern were therefore excluded from these results, leaving 2,063 responses that were deemed to be from the public in Jersey.

79. Key findings include:

- 47% of respondents supported allowing a regulated sale and supply model (Option C)
- 34% of respondents supported allowing personal possession and home growing by individuals or within cannabis social clubs
- 12% of respondents said there should be no change in the current policy approach

80. Respondents who said there should be no change to current policy gave the following top three reasons for their response:

- cannabis is harmful to people’s health and should stay illegal
- changing the law could make cannabis more accessible to people, including young people
- legalising cannabis could lead to more addiction and mental health problems

81. Respondents who said there should be a change in approach to allow personal possession, home cultivation or cannabis social clubs gave the following top three reasons for their response:

- it is not right that people are criminalised for personal cannabis use
- the current approach wastes police and court time

- allowing some activities, like possession or home cultivation could reduce organised criminal involvement.

82. Respondents who said that regulated sale or supply of cannabis should be allowed gave the following top three reasons for their response:

- people should not be prosecuted for personal cannabis use
- the current approach wastes police and court time
- a legal cannabis market could generate revenue for other services.

83. The survey also asked if Jersey should begin to consider universal decriminalisation of **all drugs**. 80% of respondents supported the exploration of a different approach to universal drugs policy, and moving away from a criminalisation approach.

Stakeholder consultation

84. In addition to public consultation, there was direct engagement with key groups of stakeholders between July to September 2025. This included dedicated workshops, meetings with service representatives, and discussions as part of existing multi-agency meetings.

Table 6: Stakeholders who were consulted

Health / support services	Justice and Home Affairs	Other
Substance Use Services Forum <ul style="list-style-type: none"> • Alcohol & Drug Service • Sanctuary House • Shelter Trust • Silkworth Group • Jersey Street Pastors • Jersey Youth Service • Director of Mental Health Services 	Operational <ul style="list-style-type: none"> • Jersey Customs and Immigration Service • Jersey Probation and Aftercare • States of Jersey Police • States of Jersey Prison Service Strategic <ul style="list-style-type: none"> • Building A Safer Community • Criminal Justice Policy • Criminal Justice Working Group 	Medical Cannabis Producers <ul style="list-style-type: none"> • Caprica • Green Island Growers • Northern Leaf • Jersey Biopharmaceutical Council Advisory bodies <ul style="list-style-type: none"> • Advisory Council on Misuse of Drugs • Children’s Commissioner • Independent Drug Policy Consortium

85. Key themes arising from stakeholder feedback included:

- a. Need for change: All stakeholders either directly stated there is a need for change of approach in relation to cannabis for personal use or indicated support in principle for a change of approach. Health service/support service stakeholders felt that criminalising personal cannabis use (and other drugs) had led to unintended consequences, many of which were evidenced in their own lines of work.

- b. Proposed options: All stakeholders broadly felt that the three Options were rational and responsible approaches (subject to provision of more detail). Stakeholders noted the requirement to explain the problems/issues each of the three Options is intended to address to aid understanding.
- c. Areas of concern: Often focused on how proposals would be implemented, rather than what the proposals aimed to achieve. In many cases, concerns about how aspects of proposals would be actioned were due to the current lack of detail.
- d. Impact of proposals: Stakeholders stated that it was difficult to fully understand the likely impact of the three proposed Options due to lack of detail at this stage of development (as per Paragraph 3, Assembly direction on preferred Option is required to enable detailed proposal development). In particular, the stakeholders found it difficult to consider the potential impact, or potential opportunities, of the proposed Options on their individual services or ways of working (e.g., how would proposals affect arrangements with the UK and France? How would the Police test if an amount of cannabis was over or under a specific threshold?).
- e. **Need for caution by learning from medical cannabis**: Many stakeholders referenced the need to learn from legislation changes that permitted the prescribing of medical cannabis in absence of any controls to ensure patient safety. Stakeholders felt that appropriate time should be taken to ensure any changes to cannabis policy result in safe, effective and practical outcomes, and that those changes should be considered against the backdrop of current high levels of medical cannabis prescribing in Jersey and the associated decline in illicit cannabis imports.
- f. The stakeholder feedback was used to refine the three proposed Options as presented in this proposition.

Independent Drug Policy Consortium

86. The Independent Drug Policy Consortium (“IDPC”) is a global network of over 190 members and a trusted source of expertise on drug policy reform. IDPC was founded in 2006 and, since 2011, has been an independent, not-for-profit organisation legally registered in the UK. The network is a collaborative initiative and a trusted source of expertise on drug policy reform. It focuses on issues related to drug production, trafficking and use; and promoting objective and open debate on the effectiveness, direction and content of drug policies at national and international level. The IDPC provide advice to UN Member States, national and regional governments, civil servants and policy makers.

87. The IDPC Secretariat was commissioned to provide advice and expertise on the three Options, this included:

- option design
- harm reduction and health prevention design
- identification of potential gaps or oversights in respect of drug policy
- relevant information, learnings and insights from other jurisdictions
- report structure and editorial critique.

88. Advice was also sought from the IDPC regarding the compliance of Options A, B & C with the three UN Conventions, and during problem identification (see table 4), inclusion and exclusion decisions (see table 5). The IDPC said:

- a. Decriminalisation (Option A and B)
 - *“No specific obligations to criminalise or penalise the ‘use’ of drugs exist per se within any of the Conventions.”*
 - *“All three Conventions also include a specific clause allowing for ‘an alternative’ to conviction or punishment”*
 - *The current position of the International Narcotics Control Board (INCB)[is]: “For minor drug-related offences including possession of small quantities of drugs for personal use committed by people who abuse drugs, the conventions do not oblige States to adopt punitive responses.”*

- b. No prosecution of offence (Option A)
 - The INCB acknowledges that there are a *“restricted number of exceptions to the treaty obligation to establish the non-medical use of drugs as a ‘punishable offence’”,* which are:
 - *“Application of alternative sanctions for “personal drug use instead of conviction and punishment”, including treatment, education, aftercare, rehabilitation and social reintegration;”*
 - *“The principle of proportionality allowing States to refrain from punishment;”*
 - *“Discretion permitted by virtue of Article 36(4) of the 1961 Convention, which recognises “that offences shall be prosecuted in conformity with the domestic law of a Party.”*
 - In this analysis of the treaties, the INCB also states: *“The Board [i.e. the INCB] has consistently explained that, within these limits, measures to decriminalise or depenalise the personal use and possession of small quantities of drugs are consistent with the provisions of the drug control conventions.”*

- c. Regulated / government-controlled production and sale (Option C)
 - *“The UN treaties include exemptions from the broad prohibitions where a drug is being used for ‘scientific or medical purposes’. Some member states have sought to use these prominent exemptions for a novel strategy to explore commercial retail cannabis markets by undertaking ‘pilot’ retail markets, ‘research studies’ or ‘policy experiments’. Such approaches are often government authorised, overseen by academic institutions, subject to careful evaluation on agreed outcome indicators, and geographically and time limited.”*
 - *“Ultimately, multilateral entities exist to serve the needs of their member states and, appreciating the direction that cannabis reforms are taking globally, there does appear to be some willingness to allow such experiments as a way of navigating these unchartered waters in international law.”*

89. In summary, the IDPC advises that Options A, B and C *“can be taken forward”* within the current wording of the UN Conventions. IDPC advice on Convention compliance will continue to be sought during the development of final detailed proposals, to ensure compliance with the three relevant UN Conventions. A full copy of the IDPC advice is provided in Appendix 6.

Section 3: Proposed Options

90. The Assembly is asked to consider three Options for change, with each option to be voted on separately. Members may vote for one Option or more than one Option. Should members wish to see no change to Jersey's current approach, they may vote to reject all Options.

91. This Section of the report describes the Options at a high level and sets out matters that will be considered in more detail once the Assembly has indicated which Option/s should be subject to further detailed development. As stated in paragraph 15, developing the Assembly's preferred Option/s will require ongoing discussion with the UK to understand their position. In addition, should detailed proposals for Option A to cease prosecution, be developed and adopted by the Assembly, then these detailed proposals would need to be considered by the Attorney General.

92. Section 4 of the report then describes the effect of adopting one or more of the Options.

Indicators and metrics

93. All the Options would require development of detailed indicators and metrics to understand the impact of implementing the Option/s. These include:

- a. the health, wellbeing and wider outcomes (e.g. employment, mental and physical impacts) for people who use cannabis
- b. changes in rates of use or to the cohorts of people who are using cannabis
- c. impact on the illicit commercial cannabis market and the legal medical cannabis market
- d. impact on wider society, including in relation to crime and antisocial behaviour

94. These metrics would be critical to understanding whether the changes are positive or negative or require further mitigation. At this stage, the proposed Options are not sufficiently detailed to set out what those indicators should be, but this detail will be brought forward should the Assembly decide to progress any Option/s.

Option A: Bring forward detailed proposals to be considered by the Attorney General (if adopted) to cease prosecution for offences associated with personal possession and associated cultivation of small quantities of cannabis subject to indicative thresholds in law, and treat personal cannabis use as a public health issue

95. Option A aims to address the following identified problems. These problems are fully explained in Table 4, and are mostly negative consequences of criminalisation:

- Barriers to accessing support as a result of:
 - Stigma around drug use
 - Fear of arrest if disclosing use or involvement in illegal activity
- Restrictions on public health interventions:
 - Difficulty in providing brief interventions
 - Restrictions on enabling harm reduction actions
 - Challenges for effective young person prevention

- Limitations on meaningful health advice.
- Detrimental impact of criminal justice system, such as:
 - No current acknowledgement of social supply
 - Impact of arrest and repeated interaction with police
 - Impact of criminal record
 - Disproportionate effect on specific groups of disadvantaged people
 - Impact on families
 - Impact to children from parental arrest.
 - Burden on Police, Parish Halls and Courts
- Drug market effects
 - Problematic acquisition of cannabis

96. Option A will address those negative consequences through the delivery of two main aims and associated actions:

- Aim 1: Cease prosecution for personal cannabis use offences within indicative thresholds
- Aim 2: Respond to personal cannabis use as a public health issue (as opposed to a criminal justice issue) and increase access to earlier help and support

Aim 1: Cease prosecution of personal cannabis use offences within indicative thresholds

Aim 1 / Action 1: Cease prosecution for the possession of small amounts of cannabis, for the cultivation and production of small amounts, and for social supply of small amounts

97. Subject to development of detailed proposals and further consideration by the Attorney General should those detailed proposals be adopted, activities associated with cannabis for personal use could be considered minor offences for which individuals will not be prosecuted. *Personal cannabis use* offences would most likely include:

- a. possession of small amounts of cannabis for personal use only.
 - a. cultivation and production for small amounts of cannabis for personal use only. Cultivation would likely include growing a small number of cannabis plants at home, as well as potential requirements for any plants to be hidden from public view. Production would likely include harvesting, drying and storing the leaves and flowers, and potentially processing oil or resin. It would not include extraction of THC.
 - b. associated social supply of small amounts of cannabis. As stated in the glossary, social supply is supplying drugs to friends and acquaintances (either for free or ‘at cost’) as opposed to selling drugs to strangers for profit.

98. In all cases those small amounts would need to fall within indicative thresholds (see below).

99. Treating *personal cannabis use* as a minor offence, which is not prosecuted, would mean that arrest, investigation and charge would not be necessary, providing that the offence was within all provisions/agreed criteria set out in law (see below).

100. Instead of taking formal action (arrest, etc.), the Police would most likely issue *words of advice* (i.e. they would address the matter informally, as required and as appropriate to the circumstances). If the Police issue words of advice, a record would be kept, but this would not appear on a person's criminal record, nor would it be disclosed in Court proceedings. The purpose of keeping a record of words of advice is, for example, to support the identification of repeated offences that:

- indicate patterns of potential problematic cannabis use by the individual,
- are potentially borderline vis-à-vis what is permitted in law (e.g. smoking cannabis in public where this is not permitted), or
- suggest that a commercial drugs offence may be committed.

101. For the purpose of clarity, personal cannabis use would remain an offence, but would be, subject to future consideration by the Attorney General, a minor offence for which prosecution would cease BUT the following would remain serious offences for which current practices related to arrest and charge would continue:

- a. commercial drugs offences (whether or not for cannabis)
- b. possession of other drugs for personal use
- c. possession associated with the intent to supply, or offer to supply, for commercial purposes
- d. possession with intent to import or export.

102. In cases of ambiguity as to whether an offence was a *personal cannabis use* offence; the police would investigate which may include arrest or interview under caution as it does now.

Indicative thresholds

103. The distinction between possession (and cultivation/production) for personal cannabis use and for commercial activities would, in part, be differentiated by the amount of cannabis involved i.e. it would be a small amount based on indicative thresholds rather than specific thresholds as per Option B (e.g. 5 days' supply as opposed to 6 grams).

104. Use of indicative thresholds avoids the criminalisation of people who are known to possess larger amounts, and for whom criminalisation would simply work to compound existing harms and vulnerabilities or have a detrimental effect on their life chances and outcomes. This can include, for example:

- a. people who are dependent on cannabis, and
- b. younger adults and teenagers whose cannabis use may be driven by factors such as a recognised propensity toward higher risk, their peer relationships etc.

105. Examples of indicative thresholds used in jurisdictions which have moved away from criminalising people for cannabis offences include:

- possession of an amount that can be reasonably demonstrated to be for personal use only
- possession of X days' supply of cannabis, accepting that a day's supply for a person who is dependent on cannabis will be more than a day's supply for an occasional user
- cultivation of X number of plants, correlated to an amount that can be reasonably demonstrated to be for personal use only, or

- in relation to social supply, an amount that can reasonably demonstrated to be a single day's supply which is for the purpose of supply to a person known to the individual without soliciting or without profit.

106. It is envisaged that, in most cases, small amounts of cannabis intended for personal use would not be confiscated by police or disposed of. Confiscation can be detrimental to the individual's immediate health and safety in cases of dependency and can increase demand for drugs which benefits illicit markets (where there is no legal market). This would be subject to development of detailed proposals related to powers to confiscate and dispose for safeguarding purposes, for example, in situations involving children or in response to welfare concerns.

107. The law would also likely make other provisions/establish additional criteria to distinguish between a *personal cannabis use* offence and a *commercial drug* offence. For example, it is envisaged that the law would require the individual to:

- admit to committing a personal cannabis offence to differentiate from a *commercial* cannabis offence (and the police must be satisfied that it is). Non-admission would most likely require arrest and investigation.
- co-operate with police to ensure no other offence has occurred including *commercial drug* offences (and if they decline to do so, they may be subject to prosecution), and
- any other criteria that may be set out in law, pending further consultation.

108. In ceasing prosecution for personal cannabis use offences, consideration would need to be given to the provisions within the Misuse of Drugs (Jersey) Law 1978 which state that it is an offence for the occupiers or managers of premises to knowingly allow the following activities to take place in those premises (including outdoor premises, such as pub beer gardens):

- smoking of cannabis
- production and supply of cannabis, including the offer to supply.

109. There would be an inherent contradiction in not prosecuting a person for using, cultivating or socially supplying cannabis (within threshold of personal cannabis use) but in prosecuting their landlord for knowingly allowing that activity.

110. The treatment of cannabis for personal use as a minor offence could be achieved in several ways, including by defining exemptions within existing legislation (most notably the Misuse of Drugs law) or through the creation of a modern new drugs law.

Aim 1 / Action 2: Consider ceasing disclosure of criminal records for historical *personal cannabis use* offences

111. In the event that prosecution is ceased for personal cannabis use offences (and, hence, there is no offence recorded on a person's criminal record), it will be necessary to consider whether comparable cannabis offences, committed before the changes, should continue to be automatically disclosed on a person's DBS check, or declared in Court proceedings as a past conviction. If the practice of automatic disclosure was to continue, it would create a disparity between people who committed the same offence before and after the changes to prosecution practice.

112. The ceasing of disclosure of historical offences is recommended by the IDPC³⁰.

113. Further work would be needed to understand how:

- a. ceasing to disclose historical offences would operate, including if there are circumstances in which they should not be excluded from disclosure (for example, in relation to the travel and work visas, or when applying to work in specific roles e.g. lawyer)
- b. whether historical offences should be removed from public records, as distinct from simply ceasing disclosure, and how the removal process would work.

If proposals were developed and adopted by the Assembly to achieve this action, they would be subject to consideration by the Attorney General.

Aim 1 / Action 3: Consider whether people currently awaiting / subject to punishment for a *personal cannabis use* offence should be released from that punishment

114. If prosecution is ceased, there may be a small number of people who are awaiting punishment for a personal cannabis use offences (e.g. scheduled to appear in Court) or who are currently subject to punishment for that offence (e.g. subject to a probation or treatment order or paying off a fine). Consideration will be given to potentially releasing those people from that punishment. If proposals were developed and adopted by the Assembly to achieve this action, they would be subject to consideration by the Attorney General.-

115. Doing so is recommended by the IDPC.

Note: Current practice versus Aim 1 actions

Currently (as detailed in paragraph 32) when a person is found to be in possession of an amount of cannabis that is below 15 grams, or the person has imported that cannabis, that person can be arrested, investigated and charged. Where that cannabis is for personal use only, the Centenier is permitted, by the Attorney General's guidance, to deal with the matter at a Parish Hall (i.e. the person, having been arrested and charged, is not prosecuted in Court - they can instead be given a written caution or fine at the Parish Hall).

Aim 1 goes beyond the provisions of the AG's guidance by amending the law to cease all prosecution activity for the offences of possession AND cultivation and social supply of amounts of cannabis which are deemed for personal use. Words of advice could be given by the Police but there would be:

- no requirement to attend the Parish Hall for written caution or fine, and
- no further prosecution action provided the additional criteria (as detailed above) were also met.

Whilst the AG's current guidance makes provision for importation as well as possession, it is not proposed that, under Option A, provision is made in law for non-prosecution of importation, on the basis that the UN Conventions are explicit about the requirement on jurisdictions to seek to eradicate importation.

³⁰<https://cdn.sanity.io/files/6u5teakk/production/920a87fb6f6634e6db17f84d9eefefd13c6aa54a.pdf>

Regardless of adoption of Options A, B or C, the AG's guidance will continue to be relied on for matters related to other drugs e.g. Cocaine, Amphetamine and LSD.

Aim 2: Respond to personal cannabis use as a public health issue (as opposed to a criminal justice issue) and increase access to earlier help and support

Aim 2 / Action 1: Shift responsibility for responding to personal cannabis use from criminal justice to public health

116. Personal cannabis use is currently treated as a criminal justice issue first, and a public health issue second. Delivery of Option A supports a shift towards treating personal cannabis use (including the possession and cultivation of cannabis at amounts used by people with cannabis dependency) as a public health issue as first, and a criminal justice issue second. In doing so, it works to avoid the criminalisation of people, where the effects of criminalisation serve to compound existing harms and vulnerabilities, and have a detrimental effect on their life chances and outcomes.

117. In practice, delivery of Option A would see the prevention of personal cannabis use fall under the responsibility Health and Care Jersey - as prevention would focus on supporting people not to use cannabis; to reduce their cannabis use; or use cannabis in a way that minimises harm - as opposed to seeking to prevent cannabis use through criminal justice solutions. Commercial drug activities and personal cannabis activities that fall outside of the provisions of Option A (or Option B if also adopted) would remain a criminal justice issue under the remit of Justice & Home Affairs.

118. This accords with a significant and growing body of evidence which indicates that public health responses to personal drug use can be more effective than criminal justice approaches, in terms of both outcomes and cost. Furthermore, responding to substance use as public health issue aligns with the Government of Jersey's Substance Use Strategy³¹, as endorsed by the Council of Ministers in April 2023.

119. Adoption of Option A would, therefore, require increased access to earlier help and support, as described below.

Aim 2 / Action 2: Increase prevention, early identification and access to support services

120. Supporting people in their decisions not to use cannabis in the first instance, or to stop or reduce their use, requires a range of prevention interventions, clear messaging and increased voluntary access to support services. Any prevention gaps for children and young people will be addressed as a priority. Specific proposals, and costings, related to the following types of prevention will be developed as part of detailed Option A proposals:

³¹<https://www.gov.je/Health/AlcoholDrugs/pages/substanceusestrategy.aspx>

- a. **Health promotion:** approaches used will promote healthy lifestyles, build personal skills and create supportive environments. Cannabis use will be framed as an unhealthy behaviour like alcohol use. PSHE lessons in schools are anticipated to focus on maintaining healthy behaviours, practical skills, and building resilience. People who use cannabis regularly would be encouraged to seek appropriate support and to use cannabis in lower risk ways.
- b. **Universal prevention:** primary prevention aims to prevent substance use in the first place. This is usually done by reducing early risk factors and strengthening protective factors. For children and young people, this can include supervised leisure activities. These activities reduce risky behaviours and promote positive behaviours, such as after-school sports or recreational activities, including at weekends and during holidays.
- c. **Selective prevention:** some specific subgroups of the population have a higher risk of problematic cannabis use and harms. This includes men, young adults, or those with a history of mental health issues or childhood trauma. Selective prevention would target at-risk groups with tailored advice or support. Examples include, routinely screening for cannabis use in mental health services or as part of men's health checks. To protect others, advice could be given to potentially higher risk workplaces (e.g. where people use vehicles or heavy machinery).
- d. **Indicated prevention:** support is targeted at individuals (rather than groups) who show early signs of personal risk. Individuals are often identified following conversations with service providers, self-disclosure, health assessments, or observed behaviours or symptoms. Interventions focused on small lifestyle changes to prevent problems from worsening are then provided. Examples could include: psychoeducation for individuals who experience psychotic-like symptoms, advice to families whose children have started using cannabis, or encouraging people who regularly use cannabis to cut down.
- e. **Case identification:** refers to the identification of individuals, through formal diagnoses or indication of significant symptoms. Examples include:
 - Problematic cannabis use. Associated with bingeing, heavy use and health or social problems caused by cannabis.
 - Dependent cannabis use. Categorised by daily use, significant impact on daily activities, and withdrawal symptoms.
 - Significant anxiety or depression. Based on assessment levels and prolonged duration indicating potential mood disorder diagnosis.
 - Psychotic symptoms and early signs of psychosis. Such as recurring or persistent symptoms associated with psychosis, those with a clinical high risk of a first-episode psychotic disorder.

121. Most case identification would occur in health care settings or with the support of a trained professional. People meeting criteria for the above would then receive either **early intervention** or **standard treatment**.

- a. **Early intervention** aims to prevent low-level substance use or health problems from worsening. This could mean someone is experiencing moderate (but not necessarily severe) problems directly caused by cannabis use. Early intervention tends to focus on structured support to meet behaviour change goals. Examples include:
 - reducing cannabis use (frequency and/or amount) to less harmful levels
 - temporarily stopping cannabis use for an agreed duration. This could be to reset tolerance, so less cannabis is needed in future; to see how sleep or

- other problems change without cannabis use or as a step towards stopping cannabis use entirely
- addressing any mental health, physical health or social problems a person may be experiencing which could be the direct result of, or made worse, by cannabis use
 - providing road safety advice to people who regularly use cannabis or disclose recent cannabis use during a road check but are not deemed to be impaired
- b. **Standard treatment** generally involves higher-level and longer-term support than early intervention, with treatments usually being delivered by specialists or multi-disciplinary teams. Examples include:
- professionally supervised cannabis reductions or detoxes where cannabis use has become dependent
 - regular sessions with keyworkers working towards treatment goals, which may include addressing other health problems, employment, or housing issues
 - 1:1 or group work to identify and manage triggers or prevent future lapses or relapses into problematic patterns of use

Aim 2 / Action 3: Actively work to reduce stigma and fear of arrest which prevents people seeking support

122. Stigma and fear will be addressed through:

- Public messaging to explain what it means for cannabis use to be treated as a health issue (ie. disclosing personal cannabis use will not result in prosecution) to help change the narrative on cannabis, and to encourage earlier access to support.
- professionals working with people who use cannabis will receive advice or training. This will cover how best to reduce stigma and fear to increase support access.

Aim 2 / Action 4: Involve people who use cannabis in the development and delivery of policies, prevention and support services

123. Involving people with lived experience of cannabis use can be invaluable in designing policies, prevention interventions and support services. This could include people who use cannabis, their peers or family members; people with problematic use; people with experience of the criminal justice system for cannabis-related offences and people with long-term health conditions or disabilities.

124. Note: Cannabis social clubs

- a) Cannabis social clubs are private, non-profit organisations in which cannabis is grown and distributed to registered club members. As there is no profit, there is no motive to encourage cannabis consumption, hence the clubs provide an alternative to illicit cannabis or government-controlled production and sale.
- b) A number of jurisdictions permit cannabis social clubs on the basis that they are an extension of decriminalisation policies (ie. cannabis social clubs

provide a legitimate way for club members to secure cannabis without resorting to the illicit market or to home growing on an individual basis).

- c) The jurisdictions that have implemented cannabis social clubs have determined that they are compliant with the UN Conventions, and the UN has chosen not to take action related to their establishment.
- d) Detailed consideration was not initially given to cannabis social clubs in developing the Options set out in this report however, the IDPC in subsequently reviewing those Options, have recommended that Jersey should consider permitting cannabis social clubs on the basis that:
 - there are positive examples of cannabis social clubs in other jurisdictions and,
 - given Jersey's small population size, Jersey residents who use cannabis (for non-medical purpose) could become club members
- e) For this reason, if the Assembly determined that more detailed consideration should be given to Option A, B and / or C, it proposed that this should include matters related to the establishment of cannabis social clubs.
- f) Cannabis social clubs are licenced and regulation in most jurisdictions (e.g.: Malta and Germany) but not in all (e.g.: Spain)

Case study; Malta

Malta ceased prosecuting possession of cannabis in 2015. In 2021 Malta amended the law to provide that it is no longer a criminal offence to possess personal amounts of cannabis and to cultivate up to 4 plants (See Appendix 4 for more information). As part of process of legalising cannabis, a separate authority was established in law (Authority for the Responsible Use of Cannabis) which was tasked with oversight of harm reduction initiatives and with licencing and regulation of non-profit cannabis social clubs.

Option B: Bring forward detailed proposals to repeal or amend offences associated with personal possession and cultivation of small quantities of cannabis, subject to specific thresholds in law.

125. Option B aims to address the following specific problems; these problems are fully explained in Table 4:

- Barriers to accessing support
 - Stigma around drug use
 - Fear of arrest if disclosing use or involvement in illegal activity
- Detrimental impact of criminal justice system
 - Impact of arrest to individual
 - Social / community impact
- Burden and efficiency on criminal justice system
 - Financial and resourcing costs to Police, Parish Halls and Courts
- Drug market effects

- Problematic acquisition of cannabis

126. Option B aims to address these problems through the delivery of two main aims, each with associated actions:

Aim 1. Reduce burden on the criminal justice system by repealing offences associated with personal use, possession and cultivation of small quantities cannabis

Aim 2. Better protect public health and welfare through additional controls

Aim 1 / Action 1: Define thresholds below which it would not be an offence to possess, cultivate and produce, or socially supply cannabis

127. It is envisaged that offences in the law would be repealed or amended so that possession and cultivation and production is not an offence when it is for personal use and within specific thresholds (i.e. personal cannabis use is not an offence). This differs from Option A, which provides that personal cannabis use is a minor offence, but it is not prosecuted. Furthermore, Option B, unlike Option A, does not make provision in relation to social supply (i.e. all supply, including social supply, remains an offence under Option B).

128. Amendments to the law would set out:

- a. the specific thresholds for personal cannabis use in terms of permitted amounts (i.e. maximum grams or millilitres for cannabis in solid or liquid forms)
 - b. the circumstances / criteria that must be met which, subject to consultation, may include:
 - the individual admits to the possession, etc. of the cannabis in question
 - the individual confirms the cannabis is for their personal use and there is no immediate evidence to the contrary
 - there is no immediate evidence that:
 - the amounts possessed are above the specific thresholds
 - a commercial drug offence has occurred
 - the individual is in possession of any other drugs for personal use
 - there is intent to supply or offer to supply for commercial purposes, or to import or export.
- Subject to further consultation it is envisaged that any police involvement would cease if the amounts were below the threshold and the criteria were met. However, if there is any uncertainty, the police may determine that further enquiry is needed, and if necessary, move to arrest and charge.
 - There are several ways in which the law could be amended to repeal or amend current offences to achieve this aim including:
 - by defining exemptions to existing drugs offences based on thresholds (i.e. the amount of cannabis a person may possess)
 - creating a new “Class” of drugs within current legislation which caters for defined thresholds of cannabis.

Aim 1 / Action 2: Repeal or amend offences associated with an occupier or manager of premises to knowingly allow cannabis activities to take place on those premises (subject to thresholds established in law)

129. There are provisions within the Misuse of Drugs (Jersey) Law 1978 which state that it is an offence for the occupiers or managers of premises to knowingly allow the smoking and/or production and supply of cannabis on those premises. If personal cannabis use is no longer an offence, these offences of knowingly allowing the smoking and/or production of cannabis would also need to be repealed or amended so that it is no longer an offence to allow smoking and/or production of cannabis for personal use on premises.

130. Subject to consultation, it is envisaged that amendments would extend to private residential premises only (i.e. using and cultivating cannabis for personal use is permitted in a private home but is not permitted in other places). Retaining the current offences for non-residential premises would prevent cannabis use in workplaces and to prevent the establishment of cannabis cafes etc. A cannabis cafe is a café in which people buy cannabis (or cannabis products) alongside food and drinks and generally consume that cannabis in the café.

Aim 2 Better protect public health and welfare through additional controls

Aim 2 / Action 1: Expand smoking regulations to outdoor settings

131. Currently, smoking laws ban smoking in most indoor places except for private homes and a few other indoor places (e.g., in a hotel room if the proprietor has designated the room as a smoking room). The current ban applies to cannabis as well as tobacco. Smoking is, however, permitted in most outdoor spaces, including children's play areas, Government parks or gardens and Ramsar sites.

132. Consideration would need to be given extending the smoking ban to other areas (whether all smoking or targeted specifically to smoking cannabis). Benefits of expanding either cannabis-specific or general smoking include:

- preventing risks of second-hand smoke to others; smoking in outdoor busy urban areas can pose risks to others.
- reducing visibility of smoking in public places; smoking visibility can influence perceptions of smoking as a social norm.
- reducing environmental and wider social impacts, such as littering and public nuisances.
- controlling smell, which has been a significant issue in jurisdictions which have ceased prosecution or repealed offences related to personal cannabis use.

Aim 2 / Action 2: Increase generic and targeted health promotion messaging on cannabis use.

133. Repealing or amending offences associated with personal cannabis use will support the provision of meaningful advice on cannabis use (i.e. the provision of health advice would no longer be seen as having the potential to encourage illegal activities) which, in turn, can help prevent harms and encourage healthier behaviours. This advice would likely include the following:

- developing guidelines for lower-risk non-medical cannabis use, similar to guidelines related to lower-risk alcohol use
- targeting at-risk groups with tailored advice, e.g. young people or islanders with a history of mental health issues.
- community-based awareness and behaviour change campaigns which could include, but is not limited to, having street pastors provide advice about

cannabis as part of the night-time economy or utilising other existing community engagement infrastructure

- increasing harm-reduction messaging and interventions, and encouraging harm-reduction actions
- improving awareness of personal risks and access to suitable support services, helping empower people who use cannabis to spot risks and self-refer sooner.

134. Note: the generic and targeted health promotion messaging which form part of Option B are generally focused on occasional / non-problematic users of cannabis - as this aligns with the repealing or amending of offences for specific amounts of cannabis. This is in contrast to Option A, which provides for much more extensive health prevention activity focused on both potentially problematic and non-problematic users - as this aligns with non-prosecutions for indicative amounts, which will provide for people who are higher users due to dependency.

Option C: Bring forward detailed proposals for a trial of government-controlled production and sale of non-medical cannabis to understand and evidence whether safe and responsible regulation delivers public health benefits.

135. This option would aim to address the following key problems, which are fully explained in Table 4:

- Barriers to accessing support
 - Stigma around drug use
 - Fear of arrest if disclosing use or involvement in illegal activity
- Restrictions on public health interventions
 - Difficulty in providing brief interventions
 - Restrictions on enabling harm reduction actions
 - Challenges for effective young person prevention
 - Limitations on meaningful health advice
- Detrimental impact of criminal justice system
 - Impact of criminal record
 - Disproportionate effect on specific groups of disadvantaged people
 - Impact on families
 - Impact to children from parental arrest
- Drug market effects
 - Problematic acquisition of cannabis
 - Impact of unsafe illicit markets
 - Funding organised crime networks

136. UN Conventions limit the uses of cannabis to "scientific" use or "medical" use, thereby effectively prohibiting the legal sale and supply of non-medical cannabis. However, as set out in paragraph 88, several jurisdictions (which are signatories to those UN Conventions) have taken the view that "scientific" use includes establishing time-limited trials of government-controlled production and sale of non-medical cannabis.

137. The International Narcotics Control Board (INCB), which has the power to sanction jurisdictions for failure to comply with the Conventions, has not taken any action in relation to those trials and, as noted by the IDPC (see Appendix 6), from an INCB perspective, *“there does appear to be some willingness to allow such experiments as a way of navigating these unchartered waters in international law.*

138. Note: the sanctions that the INCB could apply include diplomatic pressure (‘naming and shaming’) and / or by imposing a cap on, or refusing permission for, a country to import controlled substances for medical use (e.g. refusing permission to import morphine).

139. Therefore, based on precedents set in other jurisdictions, Jersey could establish a trial of government-controlled production and sale of non-medical cannabis, without breaching the UN Conventions if the purpose of that trial was to understand and evidence whether safe and responsible regulation delivers public health benefits. This could include examining the effectiveness/cost-effectiveness of government-controlled production and sale when compared to current routes of supply (i.e. supply through the illicit market and/or diversion of medical cannabis).

140. **Note:** As stated in paragraph 15, the Health Minister’s ability to establish a government-controlled trial of production and sale of non-medical cannabis (and to bring forward the legislative changes necessary to do so) could potentially be constrained by the UK’s position on UN Convention compliance.

141. Establishing a trial would require detailed analysis of data collected as part of that trial including in relation to:

- **Individuals:** frequency and patterns of cannabis use, as well as self-reported health and wellbeing outcomes. These could be measured through sales data and repeated surveys of participants over the duration of the trial. This data could allow for comparisons between different groups of people based on demographics and other factors to support greater understanding of the impact of cannabis use. These comparisons, which are currently not possible due to a lack of data, are critical to helping understand the impact of cannabis, to supporting, prevention efforts or to improving outcomes.
- **Other relevant key indicators and outcomes:** would be measured through newly collected and collated data. These could include triangulation with other data such as criminal justice (e.g. participants supplying cannabis outside of trial protocols) and health service data (e.g. admissions to mental health or support services).
- **Long-term sustainable wellbeing:** Jersey’s Island Outcome Indicators could be used to understand wider societal impacts including, but not limited to, safety and security, economy, and healthy/active lives. These would include relevant indicators across community, environmental and economic domains. The findings could help understand wider impacts and balance potential benefits with risks.

Partnering with research institution

142. Whilst the Government of Jersey would retain control over all aspects of the trial, it would partner with a research institution to design the data collection aspects of the trial, ensuring that effective datasets are developed to support evaluation of the health, social and economic impacts of the trial.

143. Other jurisdictions that have established comparable trials have also partnered with research institution. As an example, in Switzerland, the city of Zurich partnered with the University of Zurich and the Canton of Basel-Landschaft partnered with the Swiss Institute for Addiction and Health Research. In addition, those trials are also being overseen by Switzerland’s Federal Office of Public Health.

144. Regular meetings would be held with research partners to provide for continuous monitoring of emerging trial data, allowing for any unintended consequences/issues to be identified and rectified in the immediate term. The trial data would also be triangulated alongside other government data to monitor the impact on health, safety, crime, workplace participation, etc., enabling all appropriate adaptations to be made to ensure the safety of all Islanders - not just trial participants.

145. The process of continuous data collection and monitoring would be coupled with transparent ongoing reporting of findings (e.g. annual updates and/or reports on completion of each trial phase) to enable public scrutiny, and examination by other bodies (e.g. relevant academic bodies, UK government, and UN bodies). This, in turn, would support a growing international evidence base on the effects of cannabis and associated harm reduction.

Trial period

146. Subject to development of detailed proposals, it is anticipated that the trial would run over an agreed number of years. In Switzerland, the trial period is 5 years, with Germany’s pending trial also proposed to be 5 years. The trial period would need to be sufficiently long to gather the data necessary to reach robust conclusions, and to be assured as to the reliability and validity of findings and conclusion.

Participation

147. Participation in the trial would only be open to Jersey residents above a specified age. The age limit would need to be determined but, in other comparable trials or permanent schemes, the age limits are:

Table 7: Minimum age of participation in various supply models

Country	Minimum age limit
Switzerland (trial)	18
Luxembourg (proposed)	18
Uruguay (permanent)	18
Spain (cannabis social club model)	18
Relevant US states (permanent)	21
Canada (permanent)	18 (Alberta), 21(Quebec), 19(all other provinces)

148. Trial Participants must:

- a. give informed consent,
- b. agree to follow study protocols,
- c. complete questionnaires over the duration of the trial, and

- d. agree for anonymised key health and other data to be used for research and safeguarding purposes. E.g. allowing healthcare data to be cross-referenced if a participant has been admitted as a mental health inpatient.

149. Unique identifier cards would be issued to participants to allow them to enter and buy cannabis from regulated cannabis supply outlets, and to possess cannabis as part of the trial. The unique identifier cards would allow for purchasing patterns to be tracked and to ensure that participants complete all required health questionnaires. Breaches of trial rules would result in unique identifier cards being suspended or revoked.

150. For the purposes of clarity:

- a. the only people who could buy cannabis from the regulated controlled supply outlets would be trial participants
- b. if a trial participant supplies cannabis purchased via a cannabis supply outlet to another person, it would be an offence. This includes whether they supply to the third party for free or for payment.

Regulation of supply

151. Cannabis supply outlets would be subject to GoJ control and oversight but run as non-commercial not-for-profit enterprises (or profits capped at a predetermined level). Doing so would align with the trial aims, which focus on protection of public health and welfare rather than supplying cannabis for profit. Consideration would be given to adopting a *disinterested management model*, as used in Carlisle, to control the sale and consumption of alcohol. In summary, licensed premises are managed by staff who are paid a wage independent of sales or who are government employees, with a view to helping ensure that staff are not motivated to sell alcohol but are, instead, motivated to operate the premises in accordance with regulations.

152. The regulations would likely include the provision of point-of-sale harm-reduction advice, which could be personalised to an individual based on their responses to trial questionnaires or to ongoing use patterns. One example could be high monthly consumption being flagged. Harm reduction advice and information on support for cannabis use could also be displayed within cannabis supply outlets.

153. Existing Jersey based cannabis cultivators could be commissioned under strict licences to produce cannabis to supply the trial. Cannabis could be produced in line with Good Agricultural and Collection Practices (GACP) and EU Good Manufacturing Practices currently used for medical cannabis to ensure product safety and consistency and, thereby, help protect the health of trial participants.

Trial aims

154. The trial would have two key aims (beyond contributing to the international evidence base on the effects of cannabis and associated harm reduction):

- safely test and examine the controlled sale of non-medical cannabis, taking a phased approach
- implement a wide range of controls to protect and improve public health and welfare.

Aim 1: Safely test and examine the controlled sale of non-medical cannabis, taking a phased approach

155. It is envisaged that the trial would take place over a series of phases to test different models of regulated sale. Phase 1 would be the most restrictive, with the trial then progressing through a series of incrementally less restrictive phases.

156. Moving to less restrictive phases would only occur if it was deemed safe to do so after extensive analysis of data, consultation with relevant stakeholders, and resolution of any unintended consequences or other issues identified. In the event of serious problems which cannot be mitigated, decisions could be taken to revert to the previous phase or suspend the trial on temporarily or permanent basis.

157. Trial phases

Subject to development of detailed proposals, it is envisaged the trial phases could be structured along the following lines:

Phase 0: Preparation:

- Essential pre-trial work would be completed including study protocols, securing resources needed, partnering with a research institution and collection of baseline data
- All legislative and policy changes needed to run the trial would be completed (e.g. changes to the Misuse of Drugs Law to permit the sale of cannabis in cannabis supply outlets)
- Cultivation licences would be issued, and potential proof-of-concepts could begin. These would focus on ensuring that cannabis destined for use in the trial meets appropriate quality, strength and consistency standards.
- Other procedures and practices could be dry ran to ensure smooth implementation (such as seed-to-sale tracking and other procedures designed to limit diversion into the illicit market).
- Cannabis supply outlets would be established, including staff recruitment and training.
- Trial participants would register and complete any relevant pre-trial tasks, potentially including completing an online harm reduction course

Phase 1: On-licence only - Cannabis bought by participants for use in supply outlets only; similar to on-licence alcohol sales or on-licence cannabis cafes.

Phase 2: Off-licence sales - Cannabis bought by participants for use off premises; similar to alcohol off-licences.

Phase 3: Continued monitoring and testing of new approaches: monitoring continues to understand longer-term impacts. Some restrictions may be relaxed, and new approaches may be trialled. These could include cannabis social clubs.

Phase 4: Completion of study: Final analysis of data would take place and a final report presented to the States Assembly setting out all findings and recommending next steps.

158. Post completion of the trial, the Assembly would be asked to decide next steps which could include:

- a. stopping the trial
- b. continuing the trial with a view to adapting or exploring other models of government-controlled production and sale, which may include rolling back to the most optimal phase
- c. continuing the trial to gather more data over a longer period
- d. adopting a permanent policy of government-controlled production and sale of non-medical cannabis if UN Conventions are amended to allow this in future.

Aim 2: Implement a wide range of controls to protect and improve public health and welfare

159. A series of controls, based on established alcohol, tobacco and medicine best practices, would be implemented. These controls may include, but not be limited to, the following:

- a. **Oversight:** a cross-Ministerial group would be established to oversee the trial and ensure appropriate evidence-based decisions are taken.
- b. **Participation registration:** checks would be required before registration is permitted (age, residency requirements, known health conditions, medical history.)
- c. **Point of sale checks:** before a sale is made, participants would be asked about recent medication use and current health conditions, in addition to a discussion of risks and mitigations.
- d. **Product safety:** product standards could be established for non-medical cannabis for sale via the trial. These could include:
 - cultivation to accord to Good Agricultural and Collection Practices (GACP) and/or EU Good Manufacturing Practice,
 - permitted THC levels and limits for all products,
 - additional specific limits for products permitted to be sold to under 25's, and
 - product packaging requirements (child-safe; packaging design that is not visually appealing).
- e. **Availability:** strict opening hours for cannabis supply outlets, with controls on location and density. Purchase limits restricting how much cannabis can be bought.
- f. **Price:** price of cannabis/cannabis products set by government. Pricing policy to aim to be sufficiently low to disrupt illicit market, but high enough to discourage over-consumption. Pricing could increase for purchases which exceed recommend usage amounts. Price promotions and offers would be banned.
- g. **Revenue:** as a non-profit monopoly, government would generate revenue from cannabis sales, providing funds to off-set costs associated with running the trial and mitigating risks through prevention / health and wellbeing support.
- h. **Marketing:** advertising, promotion, and sponsorship of cannabis, cannabis products and outlets would be banned.
- i. **Road safety:** road safety messaging would be embedded on packaging and/or displayed in outlets. Cannabis supply outlets could potentially only be permitted if near bus routes.
- j. **Community impact:** complaints about specific supply outlets to be monitored with a view to ensuring they operate without causing nuisances, antisocial behaviour or other risks.

- k. **Intoxication:** cannabis outlets would not sell alcohol and would be required to refuse sale to cannabis to someone who is drunk or appears heavily under the influence of other drugs.
- l. **Monitoring:** as set out above, trial participants would be required complete regular questionnaires over the duration of the trial, which would be triangulated with data on amounts sold and other existing government data.
- m. **Reducing illicit cannabis use:** the availability of legal cannabis, from regulated producers with seed-to-sale tracking, would likely reduce reliance on illicit cannabis (whether illegally imported or illegally cultivated), which could reduce harms from unregulated illicit cannabis.
- n. **Screening:** trial participants could be regularly screened for problematic or dependent cannabis use, or early signs of mental or physical health problems, and then referred to appropriate support.
- o. **Health services' responses:** as part of the trial, new/tailored pathways may be developed to support health and wellbeing of cannabis users (e.g. increased early intervention support may be required if the trial results in people seeking treatment sooner). Service providers may also be required to share relevant information to prevent harm, such as, if a trial participant experiences a significant side effect or harm as a direct result of cannabis use.
- p. **Second hand smoke:** smoking of cannabis, with or without tobacco, would be discouraged. Supply outlets, which allow cannabis use on premises, could prohibit smoking and only allow vaping or edible forms.
- q. **Education and advice:** Harm reduction approaches would be built into the trial. Public-facing information, inside and outside the trial, would focus on encouraging healthy behaviours. Examples include:
 - It would be made clear that cannabis use is not risk free or healthy, and attempts would be made to persuade people towards healthier consumption choices. Smoking cannabis, either on its own or with tobacco, would be discouraged. Consideration would be given to alternative methods of consumption and products would be explored.
 - Advice and support on how to cut down to healthier levels of use could be included with sales, as part of regular questionnaires, or displayed in outlets.
 - Risk and harm reduction conversations would also be personalised to participants by using information provided in questionnaires during the trial.
 - Additional forms of support including referral to specialist services could also be included
- r. **Discouraging participation in illicit markets:** Anyone caught breaking trial rules could: have their unique identifier cards revoked, be unable to purchase cannabis, and be prosecuted if in possession of cannabis outside of the trial. However, if Options A and / or B are also enacted, anyone breaking trial protocols may not necessarily be breaking the law but will still be removed from the trial.

Section 4: Voting for multiple Options

160. States members may vote for one Option, more than one Option or no Options. This section of the report explains the effects of voting for different combinations of options.

161. The effects of voting for no Options or one Option only, in relation to personal cannabis use are set out below. Regardless of Options selected, matters relating to commercial drugs offences and the personal use of all other drugs, will remain Offences.

Table 8: Voting for a single option or no options

Voting for:	Effect
No Options	<p>There will be no changes to Jersey’s policy with regard to all elements of cannabis use and no further detailed development of any approach will take place.</p> <p>All cannabis use will remain an offence for which people are prosecuted and will get a criminal record. Where they possess no more than 15 grams they may, in accordance with the Attorney General’s guidance, be dealt with in the Parish Hall where they may be given a written caution or fine, but no criminal record.</p> <p>Jersey will continue to respond to cannabis use as a criminal justice issue (with the attendant potential to compound harm and disadvantage) as opposed to treating cannabis use as a public health issue (with the attendant opportunities to reduce harm).</p>
Option A only	<p>A detailed proposal will be developed that will include ceasing prosecution for possession, use, cultivation and social supply of personal amounts of cannabis. It will remain an offence for people to possess, cultivate or socially supply cannabis, but could be considered a <u>minor offence</u> for which individuals will not be prosecuted, if below an indicative threshold (e.g. a days’ supply). Commercial supply in all forms would remain an offence that would be prosecuted.</p> <p>The use of indicative thresholds, as opposed to specific thresholds in Option B, avoids the criminalisation of people who are known to possess larger amounts of cannabis, and for whom criminalisation would simply work to compound existing harms and vulnerabilities or have a continued detrimental effect on their life chances and outcomes. This can include, for example: people who are dependent on cannabis, and younger adults and teenagers whose cannabis use may be driven by factors such as a recognised propensity toward higher risk, their peer relationships, etc.</p> <p>Should Option A be approved for continued development, either on its own or in combination with any other Options, it must be noted that any detailed proposals that are adopted by the Assembly, at a future date, would need to then be considered by the Attorney General. This is because it is the Attorney General who is officially responsible for the prosecution service and for guidance as to prosecutions in Jersey.</p> <p>In addition, the detailed proposal will treat personal cannabis use as a public health issue (as opposed to a criminal justice issue)</p>

	and provide increased levels of health protection and prevention activity, including access to earlier help and support.
Option B only	<p>A detailed proposal will be developed to repeal or amend the Law so that it would not be an offence to possess or cultivate cannabis below a specific threshold (e.g. 15 grams or 2 mature plants*). The cannabis must be for personal use only as other drug related offences will still apply as they do now. Possessing amounts over the threshold will also be an offence.</p> <p>Option B uses specific thresholds to set amounts of cannabis that a person would be able to legally possess:</p> <ul style="list-style-type: none"> • this provides certainty for occasional/non-dependent or problematic users (and for the criminal justice system) • It does not provide flexibility for people who are known to possess larger amounts of cannabis due to dependency on cannabis. <p>The benefits of providing health information and prevention measures as described in Option B are limited to health promotion messaging only, and fall short of fully treating personal cannabis use as a Public Health issue as in Option A.</p>
Option C only	<p>A detailed proposal will be developed that will set out how Jersey residents who register to participate in a time limited, government run trial can legally purchase non-medicinal cannabis for personal use (“legally purchased cannabis”). The detailed proposal would also contain the full detail on all aspects of the government-controlled trial.</p> <p>Trial participants would commit an offence if they:</p> <ul style="list-style-type: none"> • supply legally purchased cannabis to other people (i.e. social supply is not permitted under Option C) • possess cannabis, other than legally purchased cannabis • cultivate cannabis <p>Trial participants will no longer be able to legally purchase cannabis if they break trial rules or are prosecuted for other cannabis offences.</p> <p>Any person who is not a trial participant will continue to commit an offence if they possess cannabis for personal use, with that offence being dealt with in accordance with the Attorney General’s guidance.</p>

*Example amount for illustrative purposes only

Voting for both Options A and B

162. Option B when viewed in isolation provides fewer benefits, more limited outcomes and limited controls beyond the initial policy change itself. When viewed as an addition to Option A, then the benefits and outcomes of both Option A and B combine

and complement each other. Both options together counteract weaknesses of Option B while additionally strengthening Option A.

Table 9: Effect of Option B in isolation of when combined with Option A

	Option B in isolation	Option A and B in combination
Smoke-free areas	Implemented but personal cannabis use ultimately remains a criminal justice issue.	Implemented, but with cannabis also treated as a public health issue. Other prevention interventions can be strengthened as well.
Possession of cannabis for personal use	<p>If below specific threshold of 15 grams*, then no offence takes place. Police involvement is not needed.</p> <p>If above specific threshold of 15 grams*, then offence takes place. Police involvement continues and prosecution follows.</p> <p>This could worsen inequalities by criminalising islanders who are dependent on cannabis and use more than specific thresholds due to tolerance and daily use.</p>	<p>If below specific threshold of 15 grams*, then no offence takes place. Police involvement is not needed.</p> <p>If above specific threshold of 15 grams* but consistent with <i>personal use</i> then a minor offence takes place, but no prosecution follows. Further police action is not needed.</p> <p>This is likely to address inequalities by preventing islanders who are heavily dependent on cannabis from being prosecuted.</p>
Cultivation of cannabis	<p>If below specific threshold of 2 mature plants* then no offence takes place. Police involvement is not needed.</p> <p>If above specific threshold of 2 mature plants*, then offence takes place. Police involvement continues and prosecution results.</p> <p>This would not take into account the yield of harvestable cannabis from each plant. Some islanders may cultivate a higher number of plants to compensate for low THC levels or small yields.</p> <p>A plant limit that is too low and rigid may unintentionally encourage cultivation of high THC strains only. The level of all specific limits will need to be thoroughly considered as part of</p>	<p>If below specific threshold of 2 mature plants* then no offence takes place. Police involvement is not needed.</p> <p>If above specific threshold of 2 mature plants*, but consistent with personal use, then a minor offence takes place, but no prosecution follows. Further police action is no longer needed.</p> <p>This would lead to a more balanced and compromised approach compared to Option B on its own. A specific number of plants would also be deemed legal while anything above this threshold, would not, but where the person can demonstrate the plants are required purely for personal use, then no further action could result.</p>

	detailed proposal development if Option B is approved.	
Social supply of cannabis	Would not be permitted. All supply would remain an offence that is investigated and prosecuted.	The social supply of small amounts of cannabis that falls within an indicative threshold for a single day's supply for personal use is included within the scope of Option A. Therefore, whilst a minor offence would be committed the offence would not be prosecuted.
Health information and prevention as a result of repealing/ amending offences	The benefits of providing health information and prevention measures as described in Option B are limited to health promotion messaging only, and fall short of fully treating personal cannabis use as a Public Health issue as in Option A. This is because Option B would continue to treat cannabis use as a criminal justice rather than a public health issue. Therefore, Option B would lack the additional prevention opportunities that exist within Option A.	With certain offences repealed or amended, and personal cannabis use treated as a Public Health issue, there would be wider benefits across the prevention system. Examples include: <ul style="list-style-type: none"> • there would be no ambiguity on treating cannabis as a Public Health issue as offences relating to personal cannabis use would be repealed or amended (rather than just being unpunished), making cannabis education simpler to understand and deliver • conversations between professionals and people who use cannabis would be more open and honest – comparable to smoking • engagement with early intervention and specialist support services may be higher due to the absolute removal of arrest fears and a further reduction in stigma as cannabis use would no longer be viewed as criminal activity. • Increased early intervention and treatment would also feature as part of detailed proposals where Options A & B are combined.

*Example amount for illustrative purposes only.

163. Note to Options A and B

Options A and B, only focus on cannabis and do not provide for matters related to other drugs. In the event that Option A proposals are brought to fruition and are evidenced to deliver significant public health benefits, the Assembly may deem it appropriate to consider its public policy approach to other drugs.

As set out in Paragraph 83, the public survey undertaken in Spring / Summer 2025 asked if Jersey should consider universal decriminalisation of all drugs, with 80% of survey respondents supporting the exploration of a different approach to universal drugs policy and moving away from a criminalisation approach.

164. Note to all Options

Regardless of adoption of Options A, B, or C, the Attorney General's guidance will continue to be relied on for possession of, and importation of, amounts below the limits set out in the current guidance of other drugs e.g. Cocaine, Amphetamine and LSD.

Voting for Option C and Option A and/or Option B

165. Option C if voted for in isolation provides for the development of detailed proposals that would set out how Jersey could establish a time-limited trial of government-controlled production and sale of non-medical cannabis, and how trial participants could legally purchase cannabis for personal use.

166. However, if Option C is voted for in isolation, the resulting detailed proposals would see the following groups of people continue to commit an offence if they possess cannabis for personal use:

- any person under 18 (assuming over 18s only can be trial participants)
- any person who is not resident in Jersey (assuming residency requirements are associated with the trial), requiring police action and public expense
- any person who uses cannabis on a first time/occasional basis who has not registered for the trial
- any person who was previously a trial participant but did not accord with trial rules (which would likely include people with problematic use or dependency)

167. If Option C is adopted alongside Option A, this will cause detailed proposals to be developed that will provide for the ceasing of prosecution for personal cannabis offences and the further development of proposals for a time-limited government-controlled production and sale trial. Whilst further consideration will be given to the finer details of the two detailed proposals, including their interaction, it is worth noting that trial participants in other countries, such as Switzerland, are not subject to the same personal use possession thresholds as people who are not part of a trial. In addition, should Option A be approved for continued development, in combination with Option C, it must be noted that any detailed proposals that are adopted by the Assembly, at a future date, would need to be considered by the Attorney General.

168. If Option C is adopted alongside Option B, it will cause detailed proposals to be developed that will repeal or amend offences for personal cannabis possession, use and cultivation above specific thresholds for the general population. It will also result in further development, as part of the proposals, of a time-limited government-controlled production and sale trial, that would allow trial participants to purchase cannabis for

their personal use within trial rules. The supply of cannabis by a trial participant to a third party outside of the trial would constitute an offence, as would the supply of cannabis between two non-trial participants. This is because the general offence on any supply of cannabis is retained as part of Option B. As with Option A, the specific details of how the two detailed proposals would interact would be considered and developed during the next phase of work.

169. Adopting all three Options would result in the development of detailed proposals that would capitalise on the effects and benefits of all three Options. Options A and B would have the combined effect as described in Table 9 above. It would also cause the further development, as part of the proposals, of a time limited government-controlled production and sale trial. Trial participants may commit an offence if they supply legally purchased cannabis to other people (onward social supply outside of the trial is not permitted) and, as such, they would be barred from the trial.

Shifting responsibility for responding to personal cannabis use from criminal justice to public health

170. Personal cannabis use is currently treated as a criminal justice issue first, and a health issue second:

- Delivery of Option B shifts personal cannabis use offences, within the specific thresholds, outside of the criminal justice system by repealing or amending the associated offence and provides some health prevention activity.
- Delivery of Option A builds upon Option B, supporting a further shift towards treating personal cannabis use (including potentially problematic personal use of cannabis, which may include the possession and cultivation of cannabis at higher levels than Option B) as a public health issue as first, and a criminal justice issue second.

Financial and manpower implications

Costs of developing the Assembly's preferred Option/s

171. The costs associated with delivery of the three Options cannot be established at this stage. Detailed cost benefit analysis will be undertaken further to:

- a. the Assembly deciding the Option/s to be progressed
- b. the UK advising on its position vis-à-vis that Option.

172. The resource required to support development of the Assembly's preferred Option/s will include:

- Officer resources to develop any approved Options (policy, legal adviser, law drafting)
- Officer resources to advise on emerging Options (Health, Criminal Justice and Children and Education)
- IDPC and / or other expert advice to support the emerging options
- Costs associated with consultation, including consultation with people who use cannabis, the Mental Health Partnership Board, the Substances Use Services

Forum, children and young people, wider public, and specific identified groups / stakeholder

- Establishment of, and participation in, an Options Development Steering Group, which will include representatives from the Criminal Justice Working Group, Justice and Home Affairs Services, including the Police and Customs and Immigration, Criminal Justice Policy, relevant health services, the Children, Young People, Education and Skills Department, the Department for the Economy and Law Officers.
- Establishment of, and participation in, an Option Development working group /s focused on developing the detailed proposals, data gathering, identification and analysis of implementation constraints (plus associated solutions), detailed cost benefit analysis.

173. It is anticipated that the officer resources required to undertake development of Options A, B and/or C will be prioritised from within existing financial allocations. This will restrict the availability of officer capacity, across all the Departments referenced above, to undertake the development of other policy initiatives throughout 2026 and into 2027.

174. It is envisaged that detailed development of proposals related to Options A and B (including liaison with the UK) will take around 18 months, with development of Option C proposals taking around 24 months. Those timeframes will be dependent of a range of factors, including the ability of key stakeholders to participate in shaping and informing the Options.

Costs of delivering the Option/s

175. As set out above, whilst detail costings have not been developed, areas of expenditure, in relation to Option/s delivery (post-adopted of that Option/s by the Assembly) will include:

- a. For all Options:
 - health promotion messaging and information (costs of development and delivering)
 - development and delivery of support and advice services (costs of development and delivering)
 - education and training for professionals (costs of development and delivering)
- b. For Option C:
 - In addition to the areas of expenditure detailed and costs associated with Option C will also include:
 - partnering with a research institution
 - design and delivery of data collection, sampling and evaluation of data
 - securing specialist advice from experts in regulated production and sale models to ensure: quality and safety of product, tracking of cannabis to supply outlet, limiting diversion into the illicit market
 - establishment of cannabis supply outlets and staff recruitment (if GoJ controlled), and staff training
 - licencing of cannabis supply outlets and licencing of cultivation for supply through those outlets

- costs of setting up and managing participant registration and deregistration, if required (including costs associated with investigation of deregistration matters)
- further policy Officer, legal adviser and law drafting time

176. It is anticipated that:

- a. for Options A and B, some of these costs may be offset through delivery of criminal justice system savings (for example, reduced requirement for the police and Parish Hall involvement in personal cannabis use matters), although further analysis will be required to determine if savings are cost releasing.
- b. for Option C, all costs will be offset by revenue generated via the sale of cannabis as part of the trial.

Children's Rights Impact Assessment

A Children's Rights Impact Assessment (CRIA) screener has been prepared in relation to this proposition and is available to read on the States Assembly website.

Appendix 1 - More detail on UN Conventions

At the highest level, international drug policy is shaped by three United Nations drug control conventions. The United Kingdom is a signatory party to all three conventions, which have also been extended to Jersey. As such, Jersey's compliance with the conventions is the responsibility of the United Kingdom.

Single Convention on Narcotic Drugs (1961)³² – extended to Jersey in 1977

The Single Convention was established with the aim of combating production, trafficking, and abuse of narcotic drugs. The convention has a dual focus of limiting the use of narcotics to medical and scientific purposes whilst also curbing illicit drug trafficking. The convention seeks to control the production, distribution and consumption of narcotic drugs, particularly those that are prone to abuse by establishing a licencing system and controlling substances used in medicine by limiting their use. The convention classifies narcotic drugs into various schedules based on their potential for abuse. Many jurisdictions have adopted similar classification systems for their controlled drug legislation including Jersey and the United Kingdom. The convention established the Commission on Narcotic Drugs (CND) as the body which shapes global drug policy. It also established the International Narcotics Control Board (INCB) which is responsible for monitoring implementation and compliance with the convention.

Legal Significance

- Consolidated earlier drug control treaties into a unified legal framework for narcotic drugs.
- Established a scheduling system for classifying drugs based on abuse potential and therapeutic value.
- Created the International Narcotics Control Board (INCB) to monitor compliance.

Policy Significance

- Laid the foundation for global prohibitionist drug policy.
- Mandated criminalisation of unauthorised drug activities and state monopolies for cultivation.
- 1972 amendments emphasised treatment and rehabilitation of drug users.

Operational Significance

- Requires national control systems and annual reporting to the INCB.
- Supports international enforcement cooperation.
- Influences national legislation and enforcement strategies globally.

Convention on Psychotropic Substances (1971)³³ – extended to Jersey in 2003

The UN Convention on Psychotropic Substances aims to control the production, distribution, and consumption of psychotropic substances that may lead to abuse and harm to public health. The convention builds on the framework of the 1961 Convention extending its control system to substances other than narcotics, specifically those that affect the central nervous system, including: stimulants, depressants, hallucinogens, and other substances that have psychoactive effects.

³² https://www.unodc.org/pdf/convention_1961_en.pdf

³³ https://www.unodc.org/pdf/convention_1971_en.pdf

Legal significance

- Extended existing controls to synthetic psychotropic substances like LSD, MDMA, and benzodiazepines.
- Introduced a four-tier scheduling system tailored to synthetic drugs.
- Allows flexibility in national implementation of controls to recognise the medical importance of some psychotropics.

Policy Significance

- The convention responded to the rise of synthetic drugs and known limitations of the 1961 framework.
- Balanced public health protection with access to essential medicines.
- Encouraged regulation of advertising, packaging, and prescription practices.

Operational Significance

- Requires licensing, record-keeping, and import/export controls.
- Mandates reporting obligations to the INCB.
- INCB monitors compliance and provides technical assistance to jurisdictions.

Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)³⁴—extended to Jersey in 1997

The Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)—commonly known as the 1988 Vienna Convention—aimed to strengthen global cooperation to combat drug trafficking and related offenses. It complements earlier treaties like the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances but focused more sharply on law enforcement and criminal justice measures.

The Convention was adopted in response to the growing threat of transnational drug trafficking, organised crime, and the laundering of drug-related proceeds. It reflected a shift from purely health-focused drug control to a more security-oriented approach.

Legal Significance

The 1988 Convention is a law enforcement-focused treaty that criminalises a wide range of drug-related activities, including:

- Drug trafficking
- Money laundering
- Diversion of precursor chemicals
- Participation in criminal organisations

It obliges states to adopt extradition, mutual legal assistance, and controlled delivery mechanisms.

Policy Significance

³⁴ https://www.unodc.org/pdf/convention_1988_en.pdf

This Convention marked a shift toward transnational criminal justice cooperation. It was a response to the growing threat of organised crime and the limitations of earlier treaties in addressing illicit trafficking.

It reinforced the “war on drugs” paradigm, emphasising punitive measures and international coordination. It also encouraged states to integrate drug control into broader criminal justice and anti-corruption policies.

Operational Significance

Key operational features include:

- International cooperation in investigations and prosecutions.
- Asset forfeiture and anti-money laundering frameworks.
- Control of precursor chemicals used in drug manufacture.
- Extradition agreements and transfer of proceedings.

The Convention has been instrumental in shaping cross-border enforcement strategies, including joint operations and intelligence sharing.

Recent shifts

Recently the United Nations³⁵ and other international and national organisations, have begun to amend their rhetoric regarding the continued prohibitionist approach to drug policy globally. It is now recommended to:

- Promote alternatives to conviction and punishment in appropriate cases, including the decriminalisation of drug possession for personal use.
- Develop evidence-based and human rights-based policies.
- Remove penalties for personal drug use and related activities.
- Adopt approaches that aim to reduce harm and increase support for those who use drugs.
- Reprioritise policing and law enforcement efforts.
- Invest in health services and prevention services related to drug use.
- Explore new approaches scientifically, including regulated markets.

³⁵ <https://transformdrugs.org/assets/files/PDFs/un-ceb-report-briefing-2019.pdf>

Appendix 2 Current relevant legislation

Misuse of Drugs (Jersey) Law 1978

1. The Misuse of Drugs (Jersey) Law 1978 is the primary piece of legislation that controls narcotic drugs in Jersey.
2. The Law:
 - establishes the Advisory Council on the Misuse of Drugs,
 - categorises certain substances or products into three classes of controlled drugs (Class A, B and C),
 - imposes various restrictions related to their importation, exportation, production, supply, manufacture, possession, etc.,
 - creates a series of criminal offences for breaches of those restrictions,
 - includes penalties that vary between drug classes and activities,
 - allows the Minister for Health and Social Services to grant licences and to make Ministerial Orders,
 - makes various related provisions, e.g. in relation to powers to enter and search premises, and to obtain information.
3. The Misuse of Drugs Law currently classifies cannabis and cannabis resin as Class B drugs. Cannabinol and cannabinol derivatives are currently classified as Class A drugs. However, an Order to reclassify these substances as Class B drugs will be made this autumn.
4. As cannabis (including industrial hemp) is a controlled drug under the Misuse of Drugs Law, its cultivation, production, supply, importation and exportation are tightly controlled. Possession of utensils for the purpose of committing an offence is also prohibited by the Law. The Misuse of Drugs Law and its secondary legislation provide a complex web of exemptions for a number of different purposes. These are exemptions summarised below.

Misuse of Drugs (General Provisions) (Jersey) Order 2009

5. Article 2 of the Misuse of Drugs (General Provisions) (Jersey) Order 2009 (the “General Provisions Order”) provides exemptions from certain provisions of the Misuse of Drugs Law. Paragraph 5 of Article 5 exempts cannabinol or cannabinol derivatives from provisions related to importation, production and possession provided that:

“the combined weight of cannabinol and cannabinol derivatives contained in the preparation is not more than 3% of the weight of cannabidiol contained in the preparation”.

6. Article 10 of the General Provisions Order permits the cultivation of cannabis plants under Licence. The Minister for Health and Social Services is the authority that grants the licence, and a person in possession of a licence is able to cultivate cannabis. Any licence granted usually contains various conditions that must be complied with, such as number of plants cultivated, etc. The first licences for the

commercial cultivation of medicinal cannabis in Jersey were issued in December 2020 and number of licences have been issued since then.

7. Article 20A of the General Provisions Order also prohibits the administration of medicinal cannabis by smoking it.
8. Article 28A of the Misuse of Drugs Law provides for Centeniers to impose a fine of Level 1 on the standard scale (£200), where a person is charged for possession (or importation of personal amounts) of a Class B or Class C drug where they accept the decision of the Centenier.

Misuse of Drugs (Designation) (Jersey) Order 1989

9. The Misuse of Drugs (Designation) (Jersey) Order 1989 (“the Designation Order”) essentially provides two lists of controlled drugs, the list found in Part 1 of the Order are designated drugs to which Article 12(4) of the Law applies. The list found in Part 2 of the Order are designated drugs that are excepted from the list set out in Part 1.

10. The Part 1 list contains the following entries:

- *“Cannabinol (not falling within paragraph 5 or 6 of Part 2)*
- *Cannabinol derivatives (not falling within paragraph 5 or 6 of Part 2)*
- *Cannabis (not falling within Paragraph 4 or 5 of Part 2)*
- *Cannabis resin (not falling within paragraph 5 of Part 2).”*

11. However, the Part 2 list exempts the following:

“A liquid formulation –

(a) containing a botanical extract of cannabis –

- (i) with a concentration of not more than 30 milligrams of cannabidiol per millilitre, and not more than 30 milligrams of delta-9-tetrahydrocannabinol per millilitre, and*
- (ii) where the ratio of cannabidiol to delta-9-tetrahydrocannabinol is between 0.7 and 1.3;*

(b) which is dispensed through a metered dose pump as a mucosal mouth spray; and

(c) which was approved for marketing by the Medicines and Healthcare Products Regulatory Agency of the United Kingdom on 16th June 2010.”

And

“A controlled drug (not falling within paragraph 4) that –

(a) is –

- (i) cannabinol,*
- (ii) a cannabinol derivative, other than dronabinol or a stereoisomer of dronabinol,*
- (iii) cannabis, or*
- (iv) cannabis resin; and*

- (b) *constitutes or is contained in a medicinal product, as defined by Article 2 of the Medicines (Jersey) Law 1995, that is manufactured –*
- (i) *in compliance with the principles and guidelines of good manufacturing practice laid down by Commission Directive 2003/94/EC of 8 October 2003 laying down the principles and guidelines of good manufacturing practice in respect of medicinal products for human use and investigational medicinal products for human use (OJ L 262, 14.10.2003, p. 22) as amended from time to time, and*
 - (ii) *by a manufacturer who holds a certificate of good manufacturing practice issued under Article 111(5) of Directive 2001/83/EC of the European Parliament and of the Council of 6 November 2001 on the Community code relating to medicinal products for human use (OJ L 311, 28.11.2001, p. 67) as amended from time to time.”*

12. Therefore, by operation of the exemption from Article 12(4), and by the exemption contained within Article 12(4) from the operation of Article 12(3) of the Misuse of Drugs Law, cannabinol, a cannabinol derivative, cannabis or cannabis resin can be both a prohibited controlled drug and a medicinal product that can be prescribed, supplied and administered.

Misuse of Drugs (Licence Fees) (Jersey) Order 2020

13. The fee for a licence to cultivate, produce, supply and possess cannabis (other than industrial hemp) at a specified site is £8,485.60 per site plus any fee levied by the Home Office.

14. The fee for a licence to cultivate industrial hemp, defined as:

“means a plant of the genus Cannabis with a tetrahydrocannabinol content not exceeding 0.2%, cultivated for the purpose of using only –

- (a) the mature stalk of any such plant*
- (b) fibre produced from mature stalk of any such plant; or*
- (c) the seed of any such plant;”*

is set at £1,131.40 per site.

15. The fee for personal import or export of a licenced drug is set at £28.30 per licence application, this includes licences to personally import medicinal cannabis that has been prescribed to a person in Jersey by a doctor outside of Jersey.

16. The fee for commercial import or export of a licenced drug is set at £113.20 per licence application.

Offences and penalties as per legislation

17. Any person who contravenes the prohibitions contained in the Misuse of Drugs Law commits an offence.

18. The table set out in Schedule 4 of the Misuse of Drugs Law provides for the Penalties for contravening Articles of the Misuse of Drugs Law.
19. For example, “*Producing, supplying or being concerned in the production, supply or offering to supply a controlled drug*” could result in a prison sentence of up to 14 years, a fine or both. Whereas “having possession of a controlled drug” carries a potential prison sentence of 5 years or a fine, or both. However custodial sentences, in Jersey, solely for possession of cannabis are rare.

Additional guidance applicable to prosecutions for drug related offences

20. The Code on the decision to prosecute³⁶ (i.e. to charge). This guidance, which is applicable to criminal offences generally, sets out when a prosecution should be pursued. It includes two key tests for a prosecution, firstly whether there is sufficient evidence to provide a realistic prospect of conviction (the evidential test), and secondly whether a prosecution is warranted in the public interest (the public interest test).
21. Direction 2/2023 on the conduct of Parish Hall Enquiries³⁷. This explains that a person may be warned to attend a Parish Hall Enquiry where it reasonably appears to a police officer that an offence may have been committed, and explains that the purpose of a Parish Hall Enquiry is for a Centenier to decide: (i) whether there is sufficient evidence to justify a charge; (ii) if so, whether the public interest requires a charge to be laid; and (iii) if a charge is appropriate and whether the matter can be dealt with at the Enquiry.
22. Where a Centenier concludes that the public interest requires a prosecution, the Centenier should charge the person, and either warn the person to attend at Court on the first available date, or place the person on bail, for a reasonable sum, pending appearance at Court.
23. The Direction provides that, in such cases, the Centenier should make clear to the person that a record of a fine will be kept by the police and may be made available on a future occasion to a court or a Parish Hall Enquiry, although it will not amount to a “conviction”. Payment of the fine by the person concludes the proceedings in respect of the offences which the Centenier has charged.
24. If the person does not admit the offence, the Centenier cannot proceed to deal with him or her at the Parish Hall Enquiry, and the Direction provides that the Centenier should then warn the person to attend court.
25. A deferred decision is possible if the Centenier considers that the evidential test is met and the attendee consents for the Enquiry to be adjourned. In such a case, the decision on whether to prosecute may be deferred for up to six months. A

³⁶<https://www.lawofficers.je/publications/code-on-the-decision-to-prosecute/code-on-the-decision-to-prosecute/>

³⁷<https://www.lawofficers.je/publications/guidance-and-directives/parish-hall-enquiries/controlled-drugs/>

deferral may be accompanied by voluntary probation or other appropriate voluntary community measure agreed by the person. This may include, if the person and the victim agree, a supervised meeting between the person and the victim, or such other reparation as the Centenier thinks appropriate, which is agreed by the person. When the Enquiry reconvenes, if the person has complied with the agreed measures and there are no new circumstances which should be considered, the Direction provides that the Centenier would be expected to determine that the public interest did not lie in the commencement of a prosecution at that stage. The Centenier may, however, still issue a caution or warning.

26. Treatment orders can be made as conditions of either probation orders, if a person is sentenced to probation, or binding over orders. They generally refer to treatment carried out by the Alcohol and Drugs Service (A&D). The option of a treatment order is agreed with A&D during the Social Enquiry Report stage before sentencing. Treatment orders are part of community sentences. They do not result in imprisonment but do result in a criminal record. If someone breaches a treatment order, they will return to court for further sentencing.

Appendix 3 Common approaches to drugs policy

1. **Criminalisation (or prohibition):** where all drug use and related activities (such as possession for personal use) is illegal, punished, and treated primarily as a criminal justice issue. Jurisdictions are increasingly exploring alternatives to this approach as evidence shows it has significant unintentional consequences with little benefits to the state. Criminalisation includes either or both of the following:
 1. *Criminalisation with diversion*, where certain schemes, policies or practices aim to divert targeted offenders away from courts or custodial sentences, such as Jersey's use of Binding Over Treatment Orders and Probation Order Treatment Orders.
 2. *Criminalisation with depenalisation*, where punishments for certain drug related offences are reduced, such as changes to the Misuse of Drugs (Jersey) Law 1978³⁸, which allows some possession offences to be dealt with via fines at Parish Halls in accordance with the Attorney Generals published guidance.

2. **Decriminalisation:** *personal* drug use and related activities are illegal but considered minor offences which are not punished. *Personal* drug use offences are instead treated primarily as a *public health* rather than a *criminal justice* issue. All other *commercial* drug offences remain illegal, punishable and are treated as criminal justice issues. Jurisdictions are increasingly exploring and implementing decriminalisation approaches due to its strong evidence base in reducing harm. Decriminalisation can be achieved through either:
 1. A *De facto* approach, which is achieved through guidance to individual police forces or formal decisions from prosecutors or the Courts. This is similar to our current approach of Attorney General Guidance and Parish Hall Enquiries when dealing with small amounts of drugs³⁹. Policy components or models can include:
 - i. **Police guidance**, in which individual police officers make discretionary decisions or police forces implement their own policy instructing officers to deal with certain offences on the spot with cautions or words of advice, or to simply no longer prioritise attending or dealing with certain offences.
 - ii. **Pre-court guidance**, in which guidance exists to deal with certain offences outside court. This typically occurs after arrest and charge, but before sentencing. This may include any number of diversionary schemes in which people are diverted from the criminal justice system to health or social interventions, where ongoing compliance can result in no further action.
 - iii. **Court guidance**, in which the Courts themselves decide whether certain offences should be diverted or dealt with outside of court (potentially as a civil rather than criminal

³⁸https://www.jerseylaw.je/laws/current/l_10_1978#_Toc201307659

³⁹<https://www.gov.je/SiteCollectionDocuments/Government%20and%20administration/ID%20Personal%20amounts%20of%20certain%20controlled%20drugs.pdf>

matter). This may include standard court diversion or the use of “drug courts,” in which an individual’s circumstances are taken into consideration before being sentenced for a criminal offence or diverted away from court into appropriate health and social support.

- iv. **Indicative thresholds**, in which activities such as amounts considered for “personal possession” are loosely defined from individual circumstances on a case-by-case basis. This is to take account of individual circumstances where drug dependence has led to a higher tolerance or where the drugs are known to be of low strength.
 - v. **Specific thresholds**, where amounts deemed to be “personal possession” are tightly defined by weight or volume in all situations. This is usually to make police and criminal justice procedures easier but, in isolation, can risk criminalising individuals whose tolerance, due to dependency or low purity and strength, may require possessing amounts over the specific limits in law.
2. A *De jure* approach is achieved through legislation which provides for exemptions or removes the punishment for offences. This is generally recommended over guidance as it enables a more consistent and effective framework. Policy components or models can include:
- i. **Entirely removing an offence**, where an activity is no longer considered an offence. For example, removing cannabis use as a specific offence.
 - ii. **Partially removing an offence**, where an activity only becomes an offence at a certain point. For example, possession is only considered an offence when the amount possessed is above a specific threshold defined in law.
 - iii. **Exemption through licences**, legislation can allow individual licences to be issued which exempt an offence from taking place. For example, issuing prescriptions to possess cannabis for medicinal use.
3. **Legalisation (legal regulation)**: Where personal drug use is a legal activity with no need for police involvement unless a certain activity is outside of what is legally allowed. E.g. The personal use of cannabis is legal, but importation of cannabis remains illegal. Legalisation may include cultivation, production (into resin or oil), sale, supply or other activities or restrictions similar to how medicines, alcohol, tobacco or vaping are currently regulated. Legalisation can be further understood in two ways:
4. *Legalisation without regulation*, in which certain activities are legally allowed but not regulated. This can range from legalising personal use only while still prohibiting sale and supply (Option 2), or at the other extreme end of the spectrum complete free-market commercial sales with no regulation or controls in place. Legalisation models can include:

- i. **Removing offences making certain activities legal**, such as possession or cultivation of small amounts of cannabis through specific thresholds on grams and number of plants.
 - ii. **Unregulated private cannabis social clubs or growing co-operatives**, these private organisations allow members to use, share or cultivate cannabis as a group. Without regulation conditions such as age limits, numbers of plants, amounts shared, number of members allowed, or other considerations are not controlled and therefore difficult to enforce.
 - iii. **Unregulated commercial sale and supply or free-markets**, in which cannabis sales and supply are allowed but little or no regulations are put in place. This may include uncontrolled sales, advertising, or lack of quality control and safety.

- 5. *Legalisation with regulation*, often shortened to “**legal regulation**” is where certain activities are allowed and regulation is introduced to provide controls over those activities. There are now growing recommendations internationally to explore and trial the legal regulation of cannabis to improve and protect public health outcomes. Models can include:
 - i. **Regulated private cannabis social clubs or growing co-operatives**, in which private clubs and members must register and follow specific regulations such as age limits, number of plants, amounts shared, or other conditions.
 - ii. **Regulated commercial sale and supply**, where commercialisation (for profit) is allowed and regulated. Premises and activities generally require licences which include regulatory conditions. This may include restrictions on advertising, product quality and strength, age limits or other conditions.
 - iii. **Regulated government monopoly**, where only government or government approved organisations are permitted. Regulations and controls are strictly enforced to ensure activities promote public health and social welfare. Profits are capped and any excess revenue is considered government revenue. As revenue is dependent on the number of people using the commodity a careful balance is needed to ensure attempts to increase government revenue do not rely on creating more customers or undermining wider public health and social welfare efforts.

Appendix 4 Approaches to cannabis policy in different jurisdictions

Australia

1. Australia's cannabis laws are complex due to the nature of their federal system, where states and territories have significant autonomy. This has led to a patchwork of regulations, with some states adopting decriminalisation measures while others maintain strict penalties. For example, South Australia and the Northern Territory have partial decriminalisation schemes for minor offenses, while Queensland and New South Wales enforce criminal penalties. In the Australian Capital Territory (ACT), adults can legally possess up to 50 grams of cannabis and grow two cannabis plants per person, with a maximum of four plants per household. However, sale and distribution remain illegal, resulting in a partial legalisation model not too dissimilar to Option 2. These state-to-state inconsistencies complicate enforcement and the public's understanding of cannabis laws.
2. One of the drawbacks of the ACT model is that the lack of a legal supply chain perpetuates illicit-market activity. The federal government has yet to endorse recreational legalisation, however the Greens party has proposed legislation to create a regulated market. This plan includes home cultivation, cannabis cafes, and a central distribution body, aiming to generate up to \$700AUD million annually in tax revenue.
3. From a public health perspective, cannabis remains the most widely used illicit drug in Australia, with 11.5% of people aged 14 and over reporting recent use in 2022–2023⁴⁰. The government has focused intervention efforts on education and treatment, with cannabis accounting for 16% of all drug treatment episodes⁴¹. The rise in cannabis use among young adults has prompted calls for more targeted prevention strategies.
4. Crime and enforcement remain central issues in the ongoing cannabis policy debate. Cannabis-related law enforcement costs in Australia exceed \$1.7 billion annually, with most offenses involving personal possession or cultivation⁴².

Germany

5. Germany's recreational cannabis model was formalised through the Cannabis Act (Cannabisgesetz) in April 2024. The law legalises possession of up to 25 grams of cannabis in public and 50 grams at home for adults aged 18 and over, along with the cultivation of up to three cannabis plants per person. Consumption of cannabis is prohibited near schools, playgrounds, and in pedestrian zones during daytime hours.
6. This reform is part of a two-pillar strategy:
 - Pillar 1 legalises possession of cannabis for personal use and non-commercial cannabis clubs,

⁴⁰<https://www.aihw.gov.au/reports/illicit-use-of-drugs/cannabis-ndshs>

⁴¹<https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/drugs-of-concern/cannabis>

⁴²<https://www.penington.org.au/wp-content/uploads/2023/12/Cannabis-in-Australia-2023-Report.pdf>

- Pillar 2 envisions pilot projects for regulated commercial cannabis sales.

The two-pillar model aims to reduce illicit-market activity and improve public health outcomes.

7. The non-commercial cannabis clubs, which became legal in July 2024, allow up to 500 adult members to collectively cultivate and distribute cannabis under strict conditions. These clubs must be registered and operate without profit motives. The clubs are designed to provide safe access to cannabis while avoiding commercialisation. However, criticisms of the club model are that it may not meet total demand or compete effectively with illicit markets, especially in urban areas, and it is time consuming to regulate.
8. The second pillar—pilot projects for commercial sales—is still pending and subject to ongoing political uncertainty. The aim of the pilot projects is to evaluate the impact of regulated cannabis sales on public health, youth access, and criminal activity. The Federal Ministry of Food and Agriculture would oversee licensing for these initiatives, which would be conducted in collaboration with universities as research partners.
9. From a public health perspective, the legalisation aims to reduce exposure to contaminated cannabis and promote safer consumption. However, a recent study projects that legalisation may lead to 400,000–800,000 new users and an increase in cannabis use disorder, with associated mental health burdens⁴³. The study estimates that the health losses from increased consumption could outweigh the gains from reduced contamination. These findings underscore the need for robust prevention, education, and treatment initiatives to accompany any legalisation efforts.
10. The removal of cannabis from the Narcotics Act has simplified access and reduced legal risks for consumers and producers. However, the absence of a regulated supply framework has created a hybrid model—legal possession and cultivation without a fully legal supply chain, similar to Option 2, which can only ever go some of the way towards addressing the problem of illicit supply.

Jamaica

11. Jamaica decriminalised personal cannabis possession in 2015 through amendments to its Dangerous Drugs Act, allowing adults to possess up to two ounces (56.7 grams) without criminal penalties. While full legalisation of personal possession has not been implemented, Jamaica has developed a regulated framework for medical, therapeutic, and sacramental cannabis.
12. Under Jamaican law, individuals can cultivate up to five cannabis plants for personal use. However, public consumption remains prohibited, consumption is only allowed in private residences or designated areas.
13. Recent studies highlight the public health challenges associated with cannabis use in Jamaica. The 2023 National Drug Prevalence Study found that 30.4% of

⁴³<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0330879>

Jamaicans had used cannabis in their lifetime, with 17.1% reporting current use. Alarming, 65.9% of past-year users were deemed high-risk for dependence, which was a 15% increase from 2016⁴⁴. Early initiation and high consumption rates contribute to problematic cannabis use, underscoring the need for targeted prevention and treatment programs.

Malta

14. Malta's recreational cannabis model, established through the Cannabis Reform Act in December 2021, was the first European Union member state to legalise adult-use cannabis. The law permits individuals aged 18 and over to possess up to 7 grams of cannabis in public and up to 50 grams at home. Additionally, adults may cultivate up to four cannabis plants per household for personal use. This reform was designed to shift cannabis policy from criminalisation to a public health-oriented harm reduction approach, aiming to reduce stigma, and the burden of criminal records for users and promote treatment service access.
15. The regulatory framework is overseen by the Authority on the Responsible Use of Cannabis (ARUC), which manages licensing, compliance, and enforcement. Legal access to cannabis is facilitated through non-profit Cannabis Harm Reduction Associations (CHRAs), also known as cannabis clubs. These clubs are restricted to Maltese residents and capped at 500 members each. Members can receive up to 7 grams of cannabis per day, with a monthly limit of 50 grams. CHRAs also distribute up to 20 cannabis seeds per month, to members, for home cultivation, but are prohibited from marketing or operating on-site consumption lounges.
16. Malta's cannabis policy has faced recent setbacks. In 2025, the government introduced Bill 128, which imposes a €235 fine for public consumption and extends this penalty to private residences if cannabis odour causes a nuisance to neighbours. This amendment has sparked controversy, with critics arguing that it undermines personal privacy and contradicts the harm reduction ethos of the original reform.
17. From a public health perspective, Malta's model aims to reduce exposure to contaminated cannabis and promote safer consumption practices. The legalisation of cannabis has enabled users to access regulated products through CHRAs or home cultivation, reducing reliance on the illicit market. However, the prohibition of public consumption and the new odour-related fines may discourage open dialogue and education around responsible use.
18. Economically, Malta's cannabis reform has not created a commercial market. The distribution is limited to non-profit associations, and retail sales remain illegal. While CHRAs provide a legal supply chain, their limited scale and strict regulations may not meet required demand, especially in urban areas. The absence of any commercial form of retail also means that Malta has not capitalised on any potential tax revenues or job creation associated with cannabis legalisation seen in other jurisdictions with more commercially orientated models.

⁴⁴<https://www.moh.gov.jm/high-risk-patterns-of-substance-use-detected-among-jamaicans/>

19. While legalisation has reduced criminal penalties for possession and cultivation, enforcement of public consumption and odour complaints has led to continued policing of cannabis users, 39 individuals have faced prosecution for public consumption since legalisation⁴⁵.

Netherlands

20. The Netherlands has a unique approach to cannabis policy, characterised by a tolerance model that dates back to the 1970s. While cannabis remains technically illegal under the Dutch Opium Act, its possession and sale in small quantities are tolerated under strict conditions. This policy has allowed the proliferation of 'coffeeshops'—licensed establishments where adults can purchase and consume cannabis. However, recent developments have seen the Netherlands transition toward a more regulated framework, culminating in the Controlled Cannabis Supply Chain Experiment⁴⁶ (CCSCE).

21. Under the traditional tolerance policy, coffeeshops could sell up to 5 grams of cannabis per person per day, provided they adhered to the AHOJ-G criteria: no advertising, no hard drugs, no nuisance, no underage clientele, and no large quantities⁴⁷. Despite this front-door legality, the back-door supply—cultivation and wholesale distribution—remained illegal, creating a paradox that fuelled illicit production and organised crime⁴⁸. The new policy experiment seeks to resolve this by licensing growers and establishing a closed, quality-controlled supply chain for coffeeshops in ten municipalities.

22. The CCSCE began in April 2025 and involves 80 coffeeshops across ten cities including Breda, Tilburg, and Groningen. These shops are now required to source cannabis exclusively from government licensed producers. The experiment aims to assess the feasibility of a regulated supply chain and its impact on public health, safety, and crime. Government inspectors monitor compliance, and scientific research is being conducted by institutions such as RAND Europe and the Trimbos Institute.

23. Public health is a central concern in the Netherlands' evolving cannabis policy. The CCSCE emphasises product safety, potency control, and consumer education. Coffeeshops are encouraged to provide information on responsible use, and contaminated products are actively monitored. While cannabis use has increased since the 1970s⁴⁹, it remains in line with broader European trends. The government hopes that regulated production will reduce exposure to harmful substances and promote safer consumption practices.

24. One of the primary goals of the experiment is to reduce the influence of organised crime in cannabis production and distribution. By legalising the supply chain, the

⁴⁵<https://timesofmalta.com/article/39-prosecuted-smoking-cannabis-public-since-law-changed-2021.1102137>

⁴⁶<https://www.government.nl/topics/controlled-cannabis-supply-chain-experiment>

⁴⁷https://www.rand.org/content/dam/rand/pubs/research_reports/RRA2700/RRA2735-1/RAND_RRA2735-1.summary-English.pdf

⁴⁸<https://idpc.net/news/2014/08/front-door-back-door-the-paradox-of-the-netherlands-cannabis-policy>

⁴⁹<https://sencanada.ca/en/content/sen/committee/371/ille/presentation/korf-e>

government aims to eliminate the black market and improve public safety. Early reports suggest a decline in cannabis-related offenses and a shift in police resources. However, challenges remain, including resistance from coffeeshops concerned about product quality and pricing, and the continued popularity of illicit hashish which is not produced or supplied as part of the experiment.

25. Economically, the cannabis sector in the Netherlands generates significant revenue, with coffeeshops contributing an estimated €400 million annually in taxes⁵⁰. The experiment introduces new opportunities for licensed growers and may pave the way for broader market reforms. However, the limited scope of the experiment and the exclusion of hashish from initial phases have raised concerns about market competitiveness and consumer satisfaction. The long-term economic impact of potential reforms will depend on the experiment's outcomes and potential policy expansion.

26. Compared to other countries, the Netherlands' model remains distinct. Unlike Uruguay's state-controlled system or Canada's commercial framework, the Dutch approach pairs a tolerance-based approach with regulation of commercial supply. The experiment represents a shift toward formal legalisation without embracing full commercialisation. Lessons from the U.S. and other jurisdictions highlight the risks of unregulated markets, including increased consumption and associated health issues.

Switzerland

27. Switzerland has taken a cautious but progressive approach to cannabis legalisation. In 2024 the country launched pilot projects in several cantons to evaluate regulated cannabis supply chains. The pilots allow selected participants to purchase legally grown cannabis under strict conditions, such as participants must be over 18, reside in the respective city, and agree to regular health monitoring. The cannabis products included in the pilots are evaluated for quality and potency, and sales are tracked to prevent diversion into illicit markets. These pilot projects are designed to simulate a legal market environment while maintaining tight regulatory oversight and are overseen by the Federal Office of Public Health. They were designed to gather scientific data on public health, consumption patterns, and crime reduction, forming the basis for future national policy.

28. Switzerland's approach is focused on achieving public health and harm reduction goals. The country has a history of progressive drug policy, including supervised heroin programs⁵¹ and decriminalisation of minor cannabis possession⁵². The pilot projects continue this tradition by prioritising safety, education, and scientific evaluation over commercial interests. Unlike models in North America, Switzerland's pilot projects prohibit advertising and limit product variety to reduce appeal to youth and prevent overconsumption.

⁵⁰<https://www.unodc.org/documents/ungass2016/Contributions/Civil/Transform-Drug-Policy-Foundation/Cannabis-policy-in-the-Netherlands.pdf>

⁵¹<https://transformdrugs.org/blog/heroin-assisted-treatment-in-switzerland-successfully-regulating-the-supply-and-use-of-a-high-risk-injectable-drug>

⁵² <https://idpc.net/news/2013/09/switzerland-decriminalises-cannabis>

29. Public opinion in Switzerland has gradually shifted in favour of cannabis reform⁵³. Surveys indicate growing support for legalisation, particularly among younger demographics. The pilot projects have been met with interest and participation, suggesting a societal readiness to explore alternatives to prohibition. However, concerns remain about potential increases in youth use and the adequacy of regulatory controls. The government has emphasised the importance of ongoing evaluation and transparency throughout the pilot projects.
30. From a legal standpoint, Switzerland's pilot model operates within the constraints of international drug control treaties. By framing the pilot projects as scientific research, the country avoids direct conflict with its treaty obligations. This strategy has drawn attention from other European nations seeking to reform cannabis laws without breaching international agreements.
31. In late August 2025, after many years of consideration and debate, Switzerland began public consultation on the Federal Act on Cannabis Products (CanPG), a draft bill proposing full legalisation and regulated sale and supply under a non-profit, harm-reduction model⁵⁴. The proposed permanent legislative framework includes state-regulated dispensaries, plain packaging, advertising bans, and THC-based taxation. The policy emphasis is on public health rather than commercial opportunity and utilises data created by the pilots to inform the proposals, with all revenue reinvested into education and treatment programs.
32. Under the proposed legislation cantonal governments will retain control over retail operations, allowing for regional flexibility. The bill also prohibits vertical integration, preventing companies from controlling multiple stages of the supply chain; this aims to avoid market monopolies and ensure transparency. The Swiss model is designed to comply with international drug treaties by prioritising harm reduction and public safety.

United Kingdom

33. The United Kingdom's recreational cannabis model is defined primarily by prohibition, with cannabis classified as a Class B controlled substance under the Misuse of Drugs Act 1971. This means that possession, cultivation, and supply of cannabis for non-medical use is illegal and can result in fines, imprisonment, or both. Despite growing public support for reform⁵⁵, the UK government has maintained a prohibition approach, citing concerns over public health, youth exposure, and social harms.
34. In 2018, the UK legalised medical cannabis under strict conditions, allowing specialist doctors to prescribe cannabis-based medicinal products (CBMPs) for specific conditions such as treatment-resistant epilepsy and multiple sclerosis. However, access through the NHS remains extremely limited, and most patients

⁵³<https://www.swissinfo.ch/eng/business/majority-of-swiss-support-the-legalisation-of-cannabis/46751234>

⁵⁴ <https://internationalcbc.com/switzerland-opens-public-consultation-on-cannabis-legalization/>

⁵⁵<https://yougov.co.uk/topics/health/survey-results/daily/2025/05/28/7c2aa/2>

rely on private clinics, which offer prescriptions for a broader range of conditions including chronic pain, anxiety, and PTSD.

35. The UK's regulatory framework for cultivation of medicinal cannabis is overseen by the Home Office, which licenses cultivation and distribution of cannabis for medical and scientific use. CBD products with very low THC content (less than 1mg per product container) are legal for sale, provided they meet specific safety and labelling standards. However, recreational cannabis remains outside the scope of legal access. Enforcement of cannabis laws continues, with possession punishable by up to five years in prison and supply offenses carrying sentences of up to 14 years.
36. Public health experts have expressed concern about the impact of prohibition on vulnerable populations. The London Drugs Commission's 2025 report⁵⁶ recommended decriminalising personal use, shifting cannabis from the Misuse of Drugs Act to the Psychoactive Substances Act, and focusing enforcement on dealers rather than users. These proposals aim to reduce stigma, improve access to treatment, and address systemic inequalities.
37. Economically, the UK presents a paradox: it is one of the largest producers and exporters of medical cannabis globally with Jersey contributing to export tonnages, yet domestic access remains tightly restricted. In 2023, the UK produced over 124.1 tonnes of legal cannabis for export, accounting for approximately 36% of global medical cannabis production⁵⁷.
38. Public opinion in the UK is shifting. Surveys show increasing support for legalisation⁵⁸. Advocacy groups, MPs, and public health experts continue to push for reform, citing the benefits of regulated markets, reduced criminalisation, and improved public health outcomes.

United States

39. The United States' recreational cannabis model is a complex and evolving patchwork of state-level policies operating under a general federal prohibition. As of 2025, 24 states and the District of Columbia have legalised cannabis for adult recreational use, while 40 states permit medical cannabis use. Despite this widespread legalisation, cannabis remains a Schedule I substance under the federal Controlled Substances Act. Classification in Schedule I is reserved for substances with a high abuse potential and no accepted medical use. The federal government has recently proposed rescheduling cannabis to Schedule III, which could ease some restrictions but would not fully legalise recreational use nationwide.
40. State-level legalisation has led to diverse regulatory frameworks. States like Colorado and California have embraced commercial models with private

⁵⁶<https://www.london.gov.uk/sites/default/files/2025-05/FINAL%20LDC%20REPORT%20-%20The%20Cannabis%20Conundrum%2028-5-25.pdf>

⁵⁷<https://releaf.co.uk/education/cannabis-101/statistics/how-much-cannabis-does-the-uk-export>

⁵⁸<https://yougov.co.uk/politics/articles/51415-how-do-mps-views-on-drugs-policy-compare-to-the-british-publics>

enterprise, retail stores, and tax revenues. Other states such as Virginia and Washington D.C. have legalised possession but have not taken steps to permit any legal commercial distribution channels. Most states allow personal cultivation, though limits on the number of plants vary. The lack of federal oversight means that each state essentially operates its own cannabis economy, with varying degrees of success and transparency. States generate substantial tax revenues from cannabis sales, which fund public services and social equity programs. However, federal prohibition limits access to banking services and capital, forcing many businesses to operate in cash⁵⁹. Federal reform, including banking legislation, is seen as essential for stabilising and expanding the industry.

41. Public health outcomes from legalisation are mixed. Legal markets offer safer, regulated products, reducing exposure to contaminants and adulterants. However, increased availability has led to concerns about cannabis use disorder, especially among youth and heavy users. Studies show rising adult use, but stable or declining youth use in legal states⁶⁰. Some states have implemented potency caps, packaging requirements, and public education campaigns to mitigate harm. The Centres for Disease Control and Prevention (CDC)⁶¹ and National Institutes of Health (NIH)⁶² emphasise the need for continued stronger surveillance and research.

42. Finally, public support for legalisation continues to grow, with polling showing over two-thirds of Americans favouring legal recreational cannabis⁶³.

Uruguay

43. Uruguay's recreational cannabis model, implemented in 2013, stands as a pioneering example of state-led drug policy reform⁶⁴. Unlike commercial models seen in North America, Uruguay's approach focuses on promoting public health and harm reduction rather than profit generation. Legislation change created a fully regulated market for cannabis, allowing access through three legal channels: home cultivation, membership in cannabis social clubs, and purchase from licensed pharmacies. This framework was designed to undercut the illicit market, reduce drug-related violence, and ensure product safety and quality.

44. The Instituto de Regulación y Control del Cannabis (IRCCA) oversees the entire system, from licensing producers to monitoring distribution. Individuals can grow up to six plants at home, yielding a maximum of 480 grams annually. Cannabis clubs, which must register with IRCCA, can cultivate up to 99 plants and serve 15–45 members. Pharmacy sales began in 2017, with strict controls on pricing, potency, and packaging. Only Uruguayan citizens or permanent residents over 18 can register to purchase cannabis legally, and monthly purchase limits are enforced to prevent diversion onto the illicit market. Licensed producers operate under tight

⁵⁹<https://www.goodwinlaw.com/en/insights/publications/2024/03/insights-finance-ftec-navigating-challenges-solutions-cannabis-payment-processing>

⁶⁰<https://pmc.ncbi.nlm.nih.gov/articles/PMC6348863/>

⁶¹<https://www.cdc.gov/mmwr/volumes/74/wr/mm7412a1.htm>

⁶²<https://nida.nih.gov/about-nida/noras-blog/2025/01/new-roadmap-cannabis-cannabis-policy-research>

⁶³<https://news.gallup.com/poll/514007/grassroots-support-legalizing-marijuana-hits-record.aspx>

⁶⁴<https://pmc.ncbi.nlm.nih.gov/articles/PMC5505872/>

government controls, limiting their ability to innovate or expand. Cannabis social clubs, while non-profit by law, offer more flexibility and lower entry barriers. Estimates suggest annual revenues of \$4–4.8 million for producers, \$1.1–2.2 million for pharmacies, and \$8–17.7 million for clubs⁶⁵. Despite its non-commercial orientation, the model has generated economic opportunities within a tightly regulated framework.

45. From a public health perspective, Uruguay’s policy aims to reduce harm by controlling cannabis potency and ensuring product safety. The government provides educational resources and promotes treatment for problematic use.

46. One unintended consequence has been the emergence of a “grey market,” where legally produced cannabis is distributed outside official channels⁶⁶. This reflects gaps in implementation and enforcement, as well as potential consumer dissatisfaction with the products available. Some users prefer unregulated sources due to potency preferences.

⁶⁵ <https://jied.lse.ac.uk/articles/10.31389/jied.250>

⁶⁶ <https://idpc.net/publications/2024/10/intended-and-unintended-effects-of-cannabis-regulation-in-uruguay>

Appendix 5 Public Consultation Findings

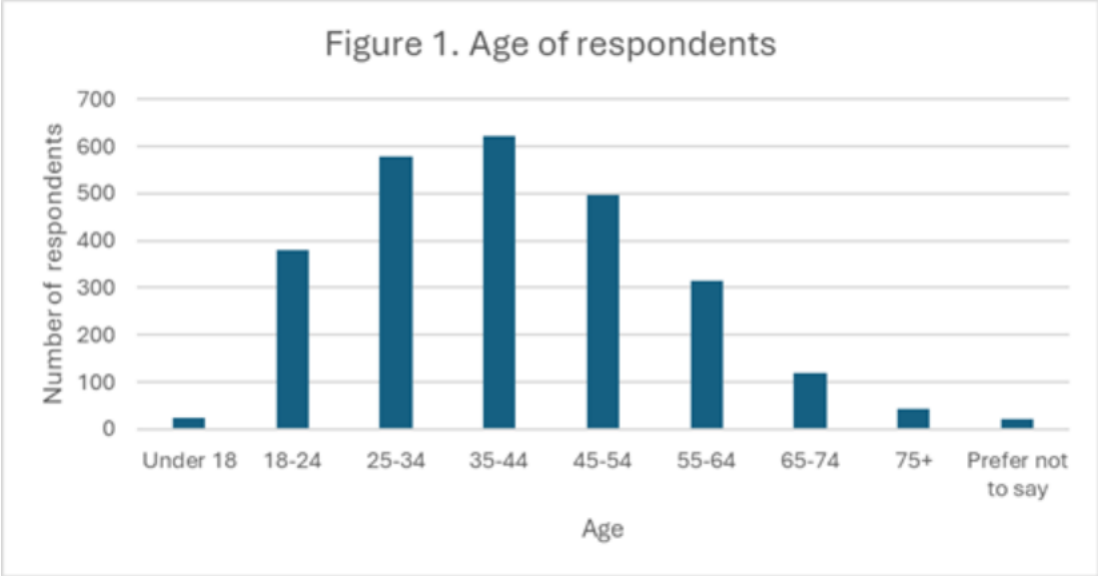
A public consultation on potential approaches to non-medical cannabis ran from 30 May to 11 July 2025. The aim of the consultation was to gather public views on potential approaches to non-medical cannabis in Jersey to inform the development of proposed approaches for consideration by the Assembly in 2025.

The public were encouraged to participate via:

- General media (press notice and notes to the media)
- Social media posts

10,199 survey responses were received. However, after initial analysis of responses, it quickly became evident that—due to IP Address, timing, and response patterns—it was clear the vast majority of the survey responses were completed by automated software or bots. Therefore, any repeat IP address submissions that conformed to a specific pattern and/or timing of response were excluded from these results. After exclusion, 2063 responses were deemed to be from members of the public in Jersey.

Age profile of respondents



When looking at the age profile of respondents we can see that all age groups were represented in survey responses, with the majority of respondents (65%) being aged between 25 and 54. Further analysis of attitudes to options, broken down by age, will form part of the next phase of work to develop any detailed proposals for final consideration by the States Assembly. Further consultation on detailed proposals will explicitly aim to increase response rates from young people and members of the public aged over 65.

Key findings

Question 2

“Which of the following options best reflects your view on our future approach to non-medical cannabis?”

Don't

All non-medical cannabis activity should remain illegal.

Change

Allow personal possession of cannabis only

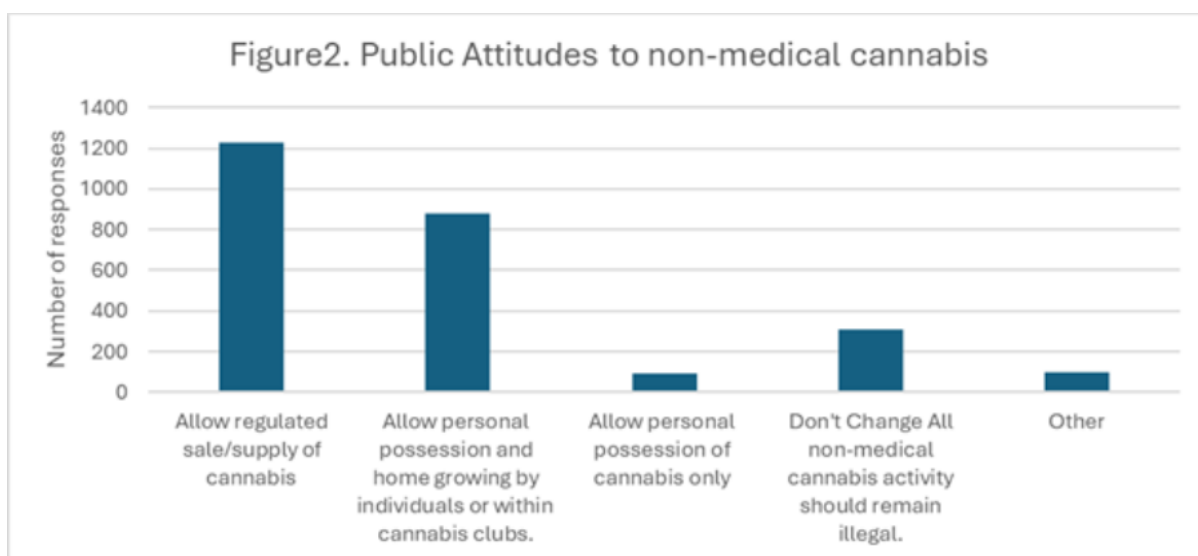
Personal possession of non-medical cannabis below a certain amount is permitted and results in no enforcement action. Growing and any supply or sale remain illegal.

Allow personal possession and home growing by individuals or within cannabis clubs

Personal possession is permitted. People can also grow a limited number of cannabis plants for their own use and/or can grow and share non-medical cannabis within registered clubs.

Allow regulated sale/supply of cannabis

Non-medical cannabis can be sold and supplied to adults with Government controls and restrictions in place (similar to tobacco and alcohol)."



Question 2 of the consultation asked respondents to pick which response above best reflected their view on what any future approach to non-medical cannabis in Jersey should broadly look like.

A regulated sale and supply type model was the most popular response with 47% of respondents expressing a preference for this approach. A wider decriminalised model that specifically provided for some measures to tackle illicit supply was the second most popular choice (34%). This was markedly different to the levels of response for a decriminalisation of personal possession only approach that would not take any steps to address illicit supply (3%). 12% of respondents stated that there should be no change to the current policy approach. It is unknown how many of those respondents are aware of the current Attorney General’s guidance in Jersey which, for personal possession of personal quantities of drugs, which provides for Parish Halls to be able to deal with first and second offences of personal possession and importation of personal amounts of drugs under certain thresholds.

The survey was designed to adapt the next set of questions that the respondent was presented with depending upon their answer to Question 2.

If the respondent chose “***Don’t change***” as the answer that best reflected their view on a potential future approach, then they would have been presented with the following question:

“Question 3

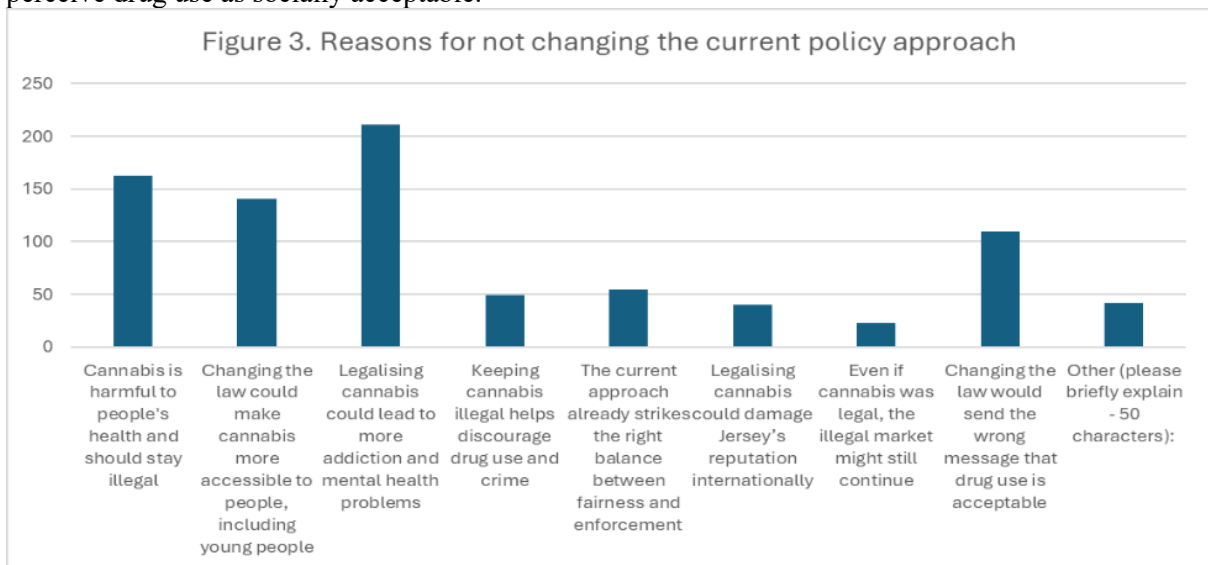
You've said that you think Jersey shouldn't change its approach to non-medical cannabis.

Tell us your reasons for this, select up to 3 of the options below, or add another.”

The reasons that were provided are as follows:

- Cannabis is harmful to people's health and should stay illegal - **163**
- Changing the law could make cannabis more accessible to people, including young people - **141**
- Legalising cannabis could lead to more addiction and mental health problems - **211**
- Keeping cannabis illegal helps discourage drug use and crime - **49**
- The current approach already strikes the right balance between fairness and enforcement - **55**
- Legalising cannabis could damage Jersey’s reputation internationally - **40**
- Even if cannabis was legal, the illegal market might still continue - **23**
- Changing the law would send the wrong message that drug use is acceptable - **110**
- Other

42 respondents picked “Other”. Of the additional responses provided through this option, the majority related to concerns regarding: the smell of cannabis use, that use can lead to mental health problems and paranoia, and concerns that children would perceive drug use as socially acceptable.



If the respondent chose “*Allow personal possession of cannabis only*” or “*Allow personal possession and home growing by individuals or within cannabis clubs*” as the answer that best reflected their view on a potential future approach, then they would have been presented with the following question:

“Question 3a

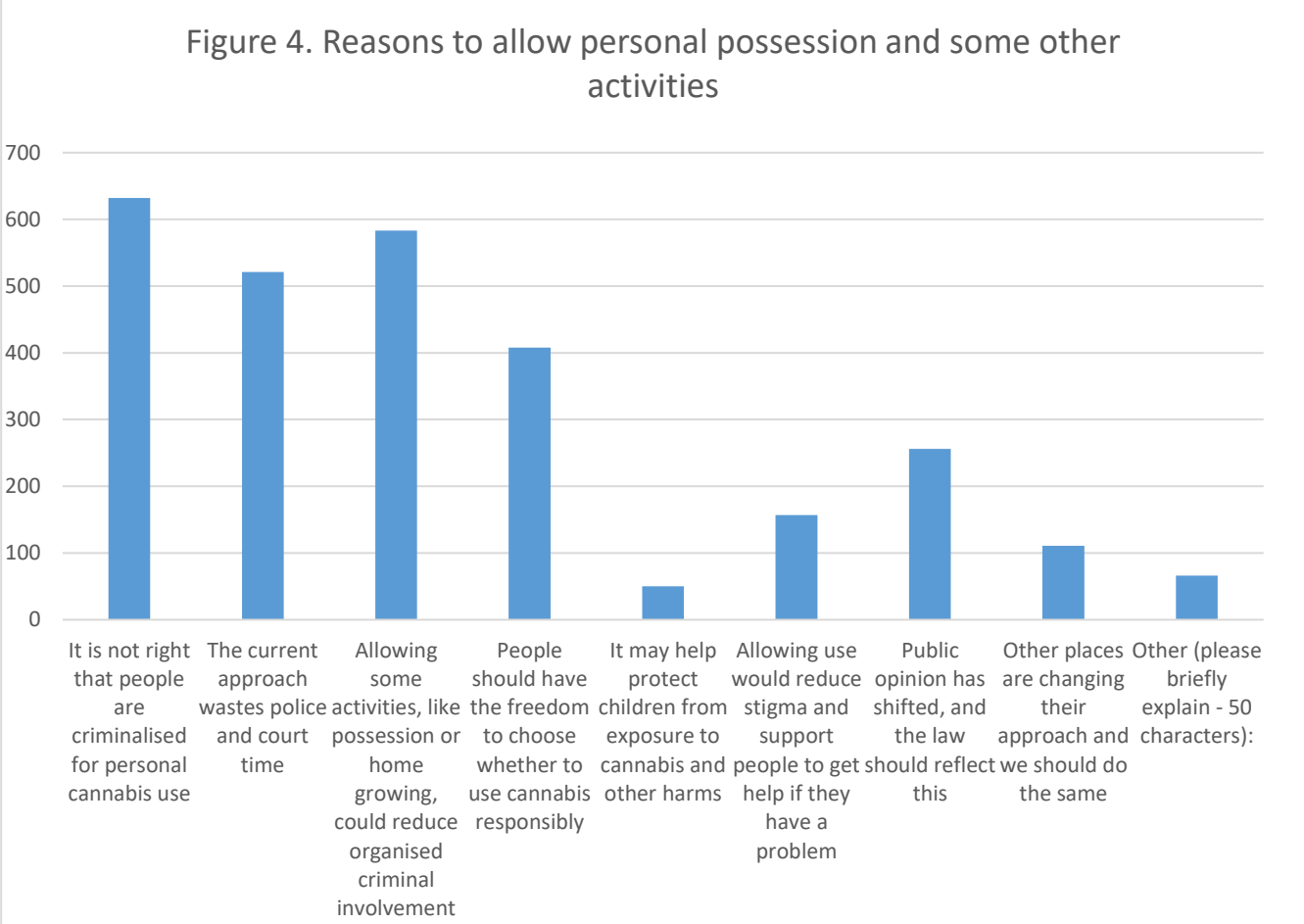
You've said that you think Jersey should change its approach to non-medical cannabis to allow some activities (such as possession, home growing or sharing cannabis in registered clubs).

Tell us your reasons for this, select up to 3 of the options below, or add another.”

The reasons that were provided are as follows:

- It is not right that people are criminalised for personal cannabis use - **632**
- The current approach wastes police and court time - **521**
- Allowing some activities, like possession or home growing, could reduce organised criminal involvement - **583**
- People should have the freedom to choose whether to use cannabis responsibly - **408**
- It may help protect children from exposure to cannabis and other harms - **50**
- Allowing use would reduce stigma and support people to get help if they have a problem – **157**
- Public opinion has shifted, and the law should reflect this - **256**
- Other places are changing their approach, and we should do the same - **111**
- Other

66 respondents picked “Other”. Of the additional responses provided through this option, the majority related to concerns regarding the cost of medicinal cannabis, children accessing the illicit market, and comparisons to alcohol as a more harmful substance.



If the respondent chose “*Allow regulated sale/supply of cannabis*” as the answer that best reflected their view on potential future approach, then they would have been presented with the following question:

“Question 3b

You've said that you think Jersey should change its approach to allow the regulated sale and supply of cannabis.

Tell us your reasons for this, select up to 3 of the options below, or add another.”

The reasons that were provided are as follows:

- People shouldn't be prosecuted for personal cannabis use - **572**
- The current approach wastes police and court time - **487**
- A legal cannabis market could generate revenue for other services - **484**
- Regulated sales can restrict access for underage and at-risk users, unlike the illegal market - **385**
- Cannabis should be regulated like alcohol and tobacco - **432**

- Allowing use and regulation could reduce stigma and support people to get help if they have a problem - **192**
- A regulated market could help the local economy - **462**
- Other places are changing their approach and we should do the same - **112**
- Regulation could reduce organised crime - **353**
- Other

76 respondents picked “Other”. Of the additional responses provided through this option, the majority related to: users wanting to select all options, ability to control quality, reducing all the problems associated with illicit supply, and that it would be a revenue stream for government.



Question 5

This question took a slightly different direction. It was felt that the consultation on non-medical cannabis was a good opportunity to explore the public’s attitudes towards amendments to wider drugs policy, as is advocated for by the Substance Use Strategy: *“Some countries, like the Czech Republic and Portugal, do not generally treat personal drug use as a crime (including both cannabis use but also other drugs), People are usually offered advice, education, or support instead of being criminalised.*

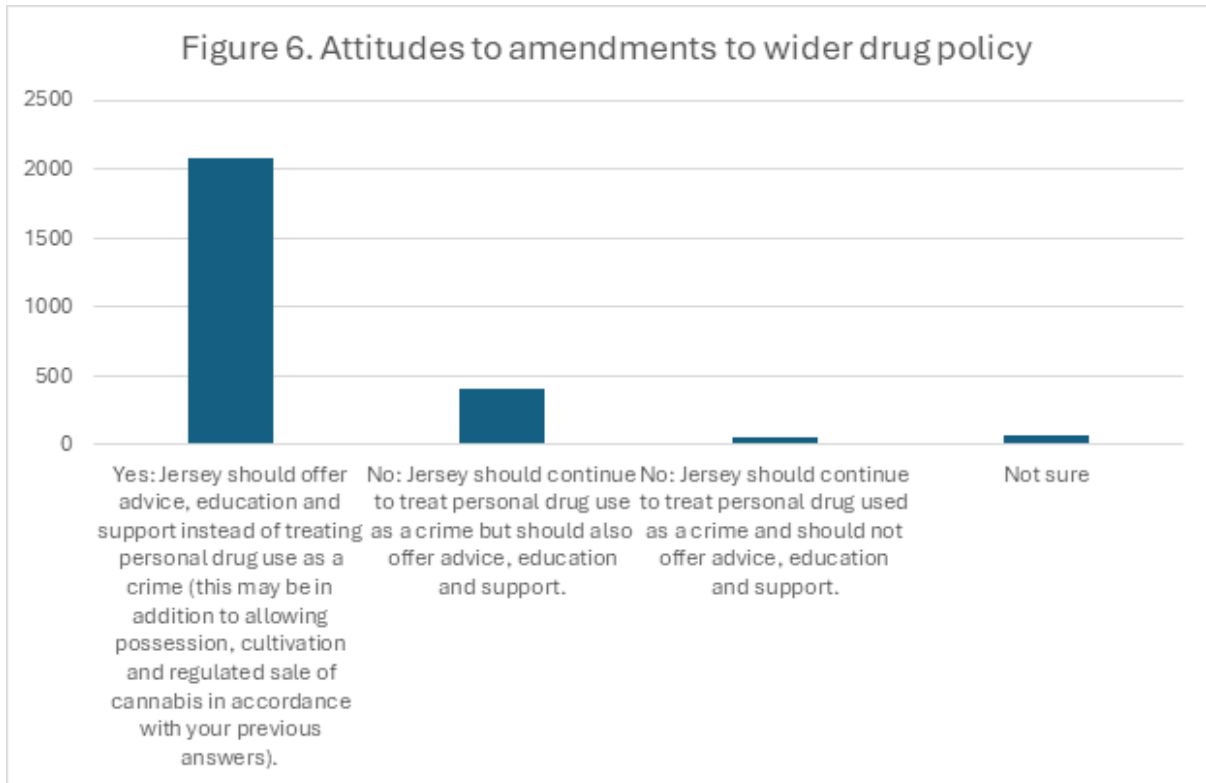
Do you think Jersey should consider developing a similar approach to all personal drug use?”

Yes: Jersey should offer advice, education, and support instead of treating personal drug use as a crime (this may be in addition to allowing possession, cultivation, and regulated sale of cannabis in accordance with your previous answers).

No: Jersey should continue to treat personal drug use as a crime but should also offer advice, education, and support.

No: Jersey should continue to treat personal drug used as a crime and should not offer advice, education, and support.

Not sure”



80% of respondents supported the exploration of a different approach to universal drugs policy and a move away from a criminalisation approach. Therefore, should any of the proposals within this proposition be adopted, officers will also begin policy development on a separate, second more long-term piece of work. This work would consider, for debate in the States Assembly, whether the current approach to wider drug policy is still the right approach and consider high level approaches that could amend wider drugs policy in Jersey.

**Appendix 6 International Drug Policy Consortium – Commissioned Advice on
DRUG LAW REFORM AND OBLIGATIONS
UNDER THE INTERNATIONAL DRUG CONTROL FRAMEWORK:**

**THE LEGAL FRAMEWORK FOR 1) DRUG DECRIMINALISATION AND 2)
CANNABIS REGULATION**

INTRODUCTION

At the United Nations (UN) level, current drug policies are shaped by three international drug control conventions:⁶⁷

- The 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol)
- The 1971 Convention on Psychotropic Substances
- The 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

The United Kingdom is a signatory party to all these conventions – which all open with concern for “the health and welfare of mankind” and that “the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering”. State parties are required to implement the various control measures contained within the conventions, which must also be read and implemented in line with international human rights obligations.

DRUG DECRIMINALISATION

Decriminalisation is usually defined as the removal of criminal sanctions for specific drug related activities – in most jurisdictions, possession for personal use of a controlled substance or a group of/all controlled substances. Criminal penalties can be replaced by civil or administrative responses, although some States refrain from applying any punishment or response.⁶⁸ The International Narcotics Control Board (INCB) defines decriminalisation as the “process through which an offence is reclassified from “criminal” to “non-criminal” through legislative action.”⁶⁹

Decriminalisation in the context of the treaties

The primary general obligation of the UN drug control treaty system is laid down in [Article 4 of the 1961 Convention](#): “parties shall take such legislative and administrative measures as may be necessary ... to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs”.

⁶⁷https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Ebook/The_International_Drug_Control_Conventions_E.pdf

⁶⁸ Stevens, A., Hughes, C. E., Hulme, S., & Cassidy, R. Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *European Journal of Criminology*, 19(1), 2022, 29-54. <https://doi.org/10.1177/1477370819887514>

⁶⁹ Drug treaty compliance is monitored by the International Narcotics Control Board – a quasi-judicial body established under the 1961 Single Convention. See: https://www.incb.org/documents/Publications/AnnualReports/AR2022/Annual_Report/E_INCB_2022_1_eng.pdf

Crucially, however, there is no specific obligation to criminalize or penalize the ‘use’ of drugs per se within any of the conventions.⁷⁰

Drug ‘use’ is not mentioned in the penal provisions of the 1961 Convention (Article 36), the 1971 Convention (Article 22) nor the 1988 Convention (Article 3). The 1961 Convention only requires the prohibition of use of Schedule IV drugs if the Party determines that doing so is "the most appropriate means of protecting the public health and welfare" at the national level – see Article 2(5b). But the ‘use’ of drugs was consciously omitted from the articles that list the drug-related acts for which criminal measures are required – this is best captured in the Commentary to the 1988 Convention in relation to Article 3: "It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence".⁷¹

With regards to possession of drugs, all three Conventions are more explicit, but sufficient flexibilities exist, nonetheless. Article 33 of the 1961 Convention states that Parties shall "not permit the possession of drugs except under legal authority [only for medical and scientific purposes]" and Article 36(1) obliges Parties to make possession a punishable offence. However, a crucial distinction is made between possession for personal use and that for supply and trafficking – with the latter unquestionably being the main focus of the Conventions themselves. Indeed, it is this focus on trafficking which has been used to support interpretations that it “does not appear that article 36(1), obliges Parties to criminalize possession of drugs for personal use.”⁷² According to Bewley-Taylor and Jelsma (2012), “This view is also bolstered by the drafting history of article 36 which was originally entitled ‘Measures against illicit traffickers.’ Since it is based closely upon the earlier instrument, a similar situation exists in relation to the 1971 Convention”.⁷³

Article 3(2) of the 1988 Convention does state that “each party shall adopt such measures as may be seen necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs”. But even this comes with a significant caveat – “Subject to its constitutional principles and the basic concepts of its legal system” – which can, and has, been used to defend decriminalisation approaches in many contexts by citing national legislation, policy or judicial decisions. This important “degree of flexibility when dealing with possession of drugs for personal consumption” was also reinforced earlier this year in a UNODC Policy Note entitled *Legal and Policy Considerations on Decriminalization of Drug Use and Possession for Personal Use*.⁷⁴

Crucially, all three Conventions also include a specific clause allowing for "an alternative to conviction or punishment": Article 36(b) of 1961, Article 22(b) of 1971 and Article 3(4) of 1988. These clauses explicitly allow for "measures of treatment, education, after-care, rehabilitation and social reintegration" to be used instead of punishment.

⁷⁰<https://www.tni.org/en/publication/the-limits-of-latitude>

⁷¹ https://www.unodc.org/documents/commissions/CND/Int_Drug_Control_Conventions/Commentaries-OfficialRecords/1988Convention/1988_COMMENTARY_en.pdf

⁷² Neil Boister (2001) *Penal Aspects of the UN Drug Conventions*. ISBN:978-90-41-11546-1.

⁷³ <https://www.tni.org/en/publication/the-limits-of-latitude>

⁷⁴ https://www.unodc.org/res/scientists/drug-policy-publications_html/UNODC_policy_note_Legal_and_policy_considerations_on_decriminalization_of_drug_use_and_possession_for_personal_use_2025.pdf

Finally, it is also worth noting the current position of the INCB – the self-proclaimed ‘guardians of the treaties’: “For minor drug-related offences including possession of small quantities of drugs for personal use committed by people who abuse drugs, the conventions do not oblige States to adopt punitive responses.”⁷⁵ It is worth noting that INCB has not taken a formal position on whether growing for personal use is permissible under the auspices of a decriminalised possession approach.

No Sanction models and treaty compliance

There are a number of countries that have implemented no punishment responses to the possession of drugs, including cannabis. In many instances, the decision not to punish possession of a controlled substance (particularly in private settings) has been established through Constitutional Court decisions that uphold a citizen’s right to privacy. Countries that operate a no sanction model include Spain, Germany and Uruguay.⁷⁶

Spanish legislators relied on [Article 3\(2\) of the 1988 Convention](#) as the legal basis for decriminalisation of possession for personal consumption, supply of drugs without profit (social supply), and cultivation of cannabis.⁷⁷

Whilst the INCB has not explicitly commented on no sanction models of decriminalisation, their own analysis of the flexibility within the Treaties is helpful. The INCB acknowledges that there are a “restricted number of exceptions to the treaty obligation to establish the non-medical use of drugs as a ‘punishable offence’”, which are:

- 1) Application of alternative sanctions for “personal drug use instead of conviction and punishment”, including treatment, education, aftercare, rehabilitation and social reintegration;
- 2) The principle of proportionality allowing States to refrain from punishment;
- 3) Discretion permitted by virtue of [Article 36\(4\) of the 1961 Convention](#), which recognises “that offences shall be prosecuted in conformity with the domestic law of a Party”.

In this analysis of the treaties, the INCB also states: “The Board has consistently explained that, within these limits, measures to decriminalize or depenalize the personal use and possession of small quantities of drugs are consistent with the provisions of the drug control conventions.”⁷⁸

Additional flexibility is also provided by all three Conventions in the recognition of State’s own constitutional obligations and legal norms (see the discussion above, particularly in relation to [Article 3\(2\) of the 1988 Convention](#)).

Practically, any decision not to punish an individual – including through administrative measures – can be interpreted as permissible through the principle of proportionality, and the basic concepts of a State’s legal system. Even application of alternative

⁷⁵ https://www.incb.org/documents/News/Alerts/Alert12_on_Convention_Implementation_June_2019.pdf

⁷⁶ https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2989771; Stevens, A., Hughes, C. E., Hulme, S., & Cassidy, R. Depenalization, diversion and decriminalization: A realist review and programme theory of alternatives to criminalization for simple drug possession. *European Journal of Criminology*, 19(1), 2022, 29-54. <https://doi.org/10.1177/1477370819887514>

⁷⁷ https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2989771

⁷⁸ https://www.incb.org/documents/Publications/AnnualReports/AR2022/Annual_Report_Chapters/040_Chapter_I.pdf

sanctions could be defined as prioritising voluntary routes, such as treatment, harm reduction and education.

As highlighted above, real world examples of no punishment models include Spain, Germany and Uruguay. Portugal's well-documented model of decriminalisation, in practice, results in roughly two-thirds of people caught in possession of drugs having the case against them suspended, with no further sanctions applied. The INCB has explicitly supported Portugal's model as a possible "model of best practice", while also acknowledging that it is not unique in its decriminalisation of possession for personal use and that "fines, warnings, probation, counselling and exemption from punishment are favoured by most European justice systems".⁷⁹ The Netherlands operates a de facto decriminalisation model that also carries no punishment for possession. In the UK, the Psychoactive Substances Act 2016 also carries no penalties for possession for personal use (except in custodial settings) for substances that would fall within the remit of the Act. The Act also restricts police powers to search an individual, only allowing police to exercise this power if an individual is suspected of committing an offence detailed in the legislation, noting that possession alone is not an offence.

CANNABIS REGULATION AND TREATY COMPLIANCE

As growing numbers of UN member states have sought to reform domestic policy and law to implement some form of regulated cannabis production and supply for adult recreational (non-medical and scientific) uses, different approaches have been adopted for negotiating the resulting tensions with UN treaty obligations.

Some countries have essentially side-stepped or denied the problem. The **US Federal Government** response to the cascade of state-level regulations and reforms has been to, variously, argue that it is either not an issue (as cannabis remains nominally illegal under Federal law), or that there is sufficient flexibility in the treaties to allow the reforms.

Others, including **Canada**, have acknowledged that their reforms are non-compliant with specific treaty obligations – but have sought what some analysts have termed a status of 'respectful' or 'principled non-compliance' in which an acknowledgement of non-compliant status is accompanied by an explanation of actions, clear reporting to the relevant bodies of policy outcomes, and efforts to resolve emerging tensions in the context of established UN processes. **Uruguay** has adopted a similar position, arguing that reform of the treaty system is needed, and whilst (at least tacitly) acknowledging that its reforms are non-compliant, arguing that they were made in service of the UN Charter goals of health, human rights and security – which take precedence over lesser technical treaty obligations.

If the INCB determines that a country is failing to comply with the Conventions, it can apply diplomatic pressure by 'naming and shaming' them in its annual reports, and/or by reporting to relevant UN mechanisms such as the Commission on Narcotic Drugs (CND) and the Economic and Social Council (ECOSOC). INCB also has the power to recommend sanctions, potentially including requesting the CND to limit the medical trade of controlled medicines in that country. However, while this has occasionally been threatened, it has never been invoked – not least because it would infringe other over-riding obligations such as the right to health.

⁷⁹ https://www.incb.org/documents/Speeches/Speeches2016/INCB_side_event_POR.pdf

However, even member states who recognise that enforcement powers are weak, and who view the drug treaty provisions as redundant, counterproductive and malfunctioning, understand that the power of the wider treaty system relies on consensus and adherence. Non-compliance can be perceived as a threat to international law more generally, particularly where breaches are unacknowledged and no remedies are being sought. For this reason, many member states pursuing the benefits of cannabis reform have sought to work within the grey areas of the treaty flexibility, or to ‘finesse’ the system – whilst nominally staying within the parameters of what is permitted.

In some jurisdictions, flexibility has been used to support the emergence of non-profit membership-based cannabis associations – operating as a form of ‘collective decriminalization’ in which the association grows and supplies the members, as a self-contained and non-commercial enterprise. Originally pioneered in [Spain](#), formalised licensed versions of the association model have subsequently been included within reforms implemented in [Uruguay](#), [Malta](#) and [Germany](#). The INCB has not yet specifically commented on the treaty compliance of these models (despite opportunities in its annual reports to do so, if they felt there was a pressing issue). Notably, the European Union – which has its own provisions preventing commercial production and supply of scheduled drugs above and beyond the UN treaty prohibitions – has allowed these collective supply models to proceed.

Pilots and experimentation

The UN treaties include exemptions from the broad prohibitions where a drug is being used for ‘scientific or medical purposes’. Some member states have sought to use these prominent exemptions for a novel strategy to explore commercial retail cannabis markets by undertaking ‘pilot’ retail markets, ‘research studies’ or ‘policy experiments’. Such approaches are often government authorised, overseen by academic institutions, subject to careful evaluation on agreed outcome indicators, and geographically and time limited. It has therefore been argued that these models sit within the ‘scientific’ treaty exemptions. The [Netherlands](#), for example, has used this argument to justify its current experiment with legal supply to some of the cannabis coffee shops (which have been formally tolerated since the 1970s but not previously legally supplied).⁸⁰

Similarly, [Switzerland](#) has established an experiment with legal production and retail for adult non-medical use in six cities.⁸¹ The governments of [Germany](#), [Luxembourg](#) and [Czechia](#) have all also outlined plans for similar scientific experiments, utilising the same argumentation and flexibilities regarding the drug control treaties. Despite potential weakness of these legal arguments, the INCB has not yet declared these experiments to be non-compliant, and the European Union (with its even more stringent rules) has also allowed the [Netherlands](#) to proceed with its pilot.

Ultimately, multilateral entities exist to serve the needs of their member states and, appreciating the direction that cannabis reforms are taking globally, there does appear to be some willingness to allow such experiments as a way of navigating these uncharted waters in international law.

⁸⁰ <https://www.government.nl/topics/controlled-cannabis-supply-chain-experiment>

⁸¹ See, for example: <https://www.bag.admin.ch/en/overview-of-authorised-pilot-trials-with-cannabis>

Appendix 7 Potential impact on Island Outcome Indicators

These tables reflect rational assumptions based on available evidence of which Island Outcome Indicators could be impacted. It is not possible to estimate for all indicators whether Options A, B or C would have better or worse impacts without first developing more detailed proposals which will take into account these indicators.

Community health and safety		
<p>Learn and grow</p> <ul style="list-style-type: none"> • Trust in adults (A,B,C): may increase as a result of reduced stigma and fear allowing more trusting conversations • Eng and Maths GCSE (A,B,C): may improve as a result of more effective prevention and early intervention • Development of 2 year olds (A,B,C): will need to be monitored, and any risks mitigated • Children aged 4-5 learning (A,B,C): will need to be monitored, and any risks mitigated • Breastfeeding (A,B,C): will need to be monitored, and any risks mitigated • Ave points in level 3 quals (A,B,C): may improve as a result of more effective prevention and early intervention • 16-18 years and NEET: may improve as a result of less barriers to education, employment and training. 	<p>Safety and security</p> <ul style="list-style-type: none"> • Safe neighbourhoods (A,B,C): may improve as result of changing perceptions of young people and drug use following prevention • Road traffic collisions (A,B,C): will need to be monitored however little change is anticipated • Fires per 1000 population (A,B,C) will need to be monitored as smoking poses fire risks • Crimes per 1000 population (A,B,C): will need to be monitored, understood and, where meaningful, mitigated • Claims for STIA (A,B,C): will need to be monitored and, where meaningful, mitigated • Children bullied at school (A,B,C) may decrease as a result of bullying due to parental arrest or substance use. <p>Vibrant and inclusive</p> <ul style="list-style-type: none"> • Trust in government (A,B): may increase as a result of reduced stigma and fear, and increased engagement with people with lived experience • Socialisation outside household (A,B,C): may increase as a result of increase social inclusion by reducing stigma, fear, increased prevention and engagement with people with lived experience • Life satisfaction (A,B,C) may increase as a result of effective prevention, harm reduction, earlier intervention and increased access to services. • Discrimination (A,B) may decrease as a result of reduced stigma and impact of criminal records 	<p>Healthy active lives</p> <ul style="list-style-type: none"> • Prevalence of smoking (A,B,C): will need to be mitigated to ensure rates continue to decline • Physical activity (A,B,C): will need to be mitigated and any risks mitigated • Mental wellbeing measure (A,B,C) may increase in islanders who would otherwise experience negative consequences of criminalisation. Increased prevention and early intervention may also lead to improved wellbeing in some cohorts. • Multi-morbidity conditions (A,B,C): may decrease as a result of increased prevention, early intervention, and service access. • Expected poor health at 65 (A,B,C) may improve due to long-term effects of increased prevention, early intervention and service access. • Avoidable mortality (A,B,C) may reduce through successful prevention and treatment. • Alcohol consumption: (A,B,C) will need to be monitored, understood and potentially mitigated to ensure rates continue to reduce.

Economy		Environment
<p>Affordable living (A,B): Reduced employment barriers and job losses, and may result in improvements in:</p> <ul style="list-style-type: none"> • Deprivation • Hard to cope financially • Household income • Lack of savings • Low-income households • Mortgage affordability • Rental Stress <p>Business environment</p> <ul style="list-style-type: none"> • % of workforce active (A,B,C): may increase due to removal and reduction of barriers to workplace • Workforce qualifications (A,B,C): may increase for islanders who have or would have otherwise received convictions which are barriers to education and professional training 	<p>Jobs and growth (A,B,C) Reduced employment barriers and job losses as a result of past or prevented future convictions may lead to increases in:</p> <ul style="list-style-type: none"> • Job satisfaction rate • People in work • Productivity <p>Increased cost savings and possible excess revenue from a trial could increase:</p> <ul style="list-style-type: none"> • Value of strategic reserve 	<p>Built environment</p> <ul style="list-style-type: none"> • Satisfaction with housing (A,B): may increase for islanders whose criminal records impact housing options <p>Natural environment (ABC)</p> <ul style="list-style-type: none"> • Indicator (birds) (A,B,C): will need to be monitored and any risks mitigated as cannabis is cultivated outdoors • Indicator (butterflies) (A,B,C): will need to be monitored and any risks mitigated as cannabis is cultivated outdoors <p>Sustainable resources (A,B,C): The effects of any large-scale increase in cannabis cultivation would need to be monitored with any risks to the following mitigated:</p> <ul style="list-style-type: none"> • Energy consumption • Water consumption • Water quality

Appendix 8: Further information on psychosis related outcomes

18. Psychosis-related outcomes span a continuum ranging from sub-clinical expressions to full clinical diagnoses.
19. **Schizotypal personality traits include:** individual personality and behavioural aspects such as acute discomfort, reduced capacity for close relationships, cognitive or perceptual distortions and eccentricities in behaviour⁸². At a sub-clinical level these traits may not necessarily reflect having schizotypal personality disorder but rather one or some associated traits which may persist or subside over time.
20. **Psychotic-like experiences include:** acute or recurring, but rarely persistent, experiences which are like psychosis. This can include hallucinations, paranoia, uneasiness with people, difficulty thinking, confused speech patterns, changes in feelings or emotions, and other changes in personality or behaviour. Psychotic-like experiences are not necessarily a sign of psychosis, as many can be the direct result of cannabis or other drug effects, side effects of medication, sleep disturbances, or a wide range of other reasons including other mental and physical health problems not associated with psychosis. In cases of cannabis use an individual experiencing paranoia, mild hallucinations and difficulty thinking could be described as having a psychotic-like experience as when the intoxicating effects wear off the person returns to normal.
21. **Psychotic symptoms include:** generally recurring or persistent symptoms associated with psychosis which are unlikely to be explained as temporary psychotic-like experiences.
22. **Early signs of psychosis also referred to as a Clinical-High-Risk State include:** signs and symptoms which reflect the imminent development of a first-episode psychotic disorder⁸³. This includes presence of genetic risk factors (family history), cognitive symptoms and psychotic symptoms that indicate the likelihood of a psychotic episode.
23. **Diagnosed psychotic disorders include:** severe disorders of mental functioning and behaviour which significantly disrupts an individual's functioning capacity. These primarily include schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, and delusional disorder. Secondary disorders include substance-induced psychosis, medication-induced psychosis, psychosis due to medical conditions, and psychosis associated with mood disorders. These disorders often require ongoing treatment and support⁸⁴.

⁸² <https://www.sciencedirect.com/topics/neuroscience/schizotypal-personality-disorder>

⁸³ <https://pmc.ncbi.nlm.nih.gov/articles/PMC5216870/>

⁸⁴ <https://www.sciencedirect.com/topics/social-sciences/psychotic-disorder>