Submission – Draft Road Traffic Law (Drug Limits) Regulations 202- Anonymous 4 – 17th February 2026

To ensure equity and safety, drug-driving legislation must adopt a uniform, risk-based approach that applies similar standards across all medications, rather than targeting specific substances. Implementing strict, zero-tolerance or ultra-low limits solely on Cannabis-Based Products for Medicinal Use (CBPMs) is directly discriminatory against patients, particularly when more impairing substances, such as stronger prescription opioids, are permitted under higher, impairment-based limits.

The Current Legal Landscape (UK & Jersey)

In both the UK and Jersey, medical cannabis is a legal prescription, allowing patients to drive, provided they are not impaired and are adhering to their prescription.

- **UK Law (England, Scotland, Wales):** The Roads Traffic Act 1988 permits a "statutory medical defence" if a patient is driving with a valid prescription, is not impaired, and follows the doctor's advice. While a low 2µg/L blood limit for THC exists, patients can legally drive if they are not impaired, even if they exceed this limit.
- **Jersey Law:** Similar to the UK, medicinal cannabis is lawful. Patients may drive as long as they are not impaired. Jersey authorities advise patients to carry their prescription to verify its legality to the States of Jersey Police.

Consequences of Discriminatory Legislation: Legislating against medicinal cannabis patients based on the *presence* of THC rather than *actual impairment* is not only unscientific, as THC stays in the system long after its effects wear off, but it carries significant legal, social, and human rights consequences for the state:

1. **Human Rights Challenges & Legal Liability:** Imposing strict limits on a legally prescribed medicine, while not doing the same for other prescriptions, can be viewed as indirect discrimination under human rights legislation (e.g., European Convention on Human Rights, Article 8—respect for private life).
2. **Judicial Review and Litigation:** Patients and legal advocates can initiate judicial reviews of the legislation, arguing that it is irrational and disproportionate. This can lead to costly legal battles for the government.
3. **Invalidation of Statutory Defence:** If the law is designed to make it functionally impossible for a patient to drive (by setting a limit so low that all users exceed it), it undermines the "statutory medical defence," making the legislation void, unfair, and liable to be overturned.
4. **Employment and Service Discrimination:** Discriminatory laws can lead to patients being unlawfully fired, having insurance denied, or facing loss of employment, prompting wrongful termination lawsuits against employers and, by extension, liability for the state that created the enabling legislation.
5. **Social and Economic Stigma:** Such laws perpetuate the stigma that medical cannabis is illicit, despite legal status, hindering patient access to treatment and violating medical privacy.

Conclusion:
Legislation must prioritise assessing actual impairment over arbitrary threshold limits. Failure to do so risks, at best, a discriminatory framework and, at worst, successful legal challenges that prove the state is penalising vulnerable citizens for treating their conditions legally.