The three betrayals of the medical cannabis growing activist: from multiple victimhood to reconstruction, redemption and activism

Dr Axel Klein[a] and Dr Gary R. Potter[b]

[a]Global Drug Policy Observatory, Swansea University, Singleton Park, Swansea, SA2 8PP, UK. axelcklein@yahoo.com

[b]Lancaster University Law School, Bailrigg, Lancaster, LA1 4YN, UK. g.potter2@lancaster.ac.uk (Corresponding author)

IJDP Accepted pre-proof version

The three betrayals of the medical cannabis growing activist: from multiple victimhood to reconstruction, redemption and activism

Abstract

While cannabis has been widely used in the UK for over 50 years, it is only in recent decades that domestic cultivation has become established. Public concern, media reporting and policing policy has emphasised the role of profit motivated criminal organisations often working on a large scale and with coerced labour. However, increasingly, another population are growing for medical reasons, to help themselves and others treat or manage difficult, poorly understood, or incurable conditions.

Our study sought to further understand the motives, techniques and interactions of cannabis cultivators through interviews with 48 growers and supplementary ethnographic work. As well as those motivated to grow for personal use, social and commercial supply purposes we identified a cohort growing to provide themselves and others with cannabis used for therapeutic purposes. This paper draws primarily on interviews with a sub-group of sixteen medically-motivated growers who were not only involved in treatment, but also embraced the label "activist".

Rather than develop techniques of deception they were organising to effect a change in legislation. Rejecting the image of criminal perpetrators, they presented themselves as victims of unjust government policy, an indifferent medical establishment, and brutal and immoral criminal markets. Through cultivation, association, self-healing and apomedication, they have found voice and are shifting the debate over the status of growers and of cannabis

IJDP Accepted pre-proof version

itself. The ambiguity of their position as both producers and patients challenges the assumptions underlying legal distinctions between suppliers and users, with potentially profound implications for policy.

Key words: medical cannabis, medical marijuana, cannabis cultivation, activism, apomedication, drug policy reform

IJDP Accepted pre-proof version

Introduction

Cannabis continues to enjoy an ambiguous status in the UK. It is a Class B drug with strict penalties for possession and supply, but consumption is not a crime *per se*[1] and police rarely bring charges and do not go proactively looking for people in possession of small amounts[2]. Prominent anti-cannabis campaigners have cited the falling number of cannabis arrests in their claim that to all intents and purposes cannabis consumption has been decriminalised (Hitchens, 2012). The numbers are indeed low considering that 16% of 16-24 year olds are reportedly using cannabis (Home Office, 2016). However, there remains a significant rump of cannabis users who do face sanctions, and criminal records, for production and supply.

The UK, as other European countries, subscribes to a "balanced approach" (Home Office, 2015), making a sharp distinction between consumption, with its associated potential health and socioeconomic harms, and supply, dealt with by the police and courts. This has allowed the state to maintain an uncompromising prohibitionist policy stance even while consumption is becoming socially embedded with stable drug prices and ready availability. Import substitution continues apace, with cannabis resin from Morocco largely replaced by

IJDP Accepted pre-proof version

[1] Possession and supply are offences under the UK's Misuse of Drugs Act, 1971, but drug *use* is not.
[2] Policy varies by police force in the UK, but a general relaxation of enforcement of cannabis laws has been widely reported. See, e.g., Staufenberg (2015); Dunn (2016).

domestically produced herbal cannabis (Potter, 2010; Hargreaves & Smith, 2015).

It has been estimated that around 300,000 – 500,000 people are now growing cannabis in the UK.[3] Cultivation ties up financial resources, encroaches on indoor living space, greatly increases the risk of detection and facilitates the prosecution with incontrovertible material evidence as well as demonstrating *mens rea*. The question therefore arises why so many people are willing to risk criminalisation by amplifying their offence from cannabis possession to cultivation and supply. The paper explores the motivation of a sub-set of cannabis cultivators who use cannabis therapeutically, or supply cannabis to people with medical conditions who find relief from using different cannabis preparations.

Methods

We were awarded a small grant from the British Academy/Leverhulme Trust[4] to study cannabis cultivation in the UK, with a focus on initiation into and progression of cannabis growing careers. We opted for an inductive, ethnographic approach in the anthropological tradition, with in-depth qualitative interviews and observations of real life situations, as best suited for establishing an understanding of motivation and outlook. From previous work we hypothesized that financial benefits and the quest for quality product were

[3] The figure was repeated by several activists, and seems to be based on a calculation by the Independent Drugs Monitoring Unit reported in the Daily Mail (Hall and Camber, 2014) extrapolated from the number of cannabis farms "discovered" per month.
[4] Small grant reference SG132364.

IJDP Accepted pre-proof version

the main drivers for cultivation (Decorte, 2010; Potter, 2010; Potter et al., 2015; Weisheit, 1992), with easier access to growing technologies (via grow-shops and online retailers) and knowledge, information and advice (via cannabis websites and discussion forums) being key enablers for those who are so motivated (Potter, 2008; 2010; Bouchard, Potter & Decorte, 2011). Recognising the role of online forums in cannabis cultivation, and following the practice of other research projects (Decorte, 2010; Barratt et al, 2015), we posted notices on websites and online forums for cannabis enthusiasts, growers and activists asking people to share their stories. This meant that people contacted us if they wanted to be interviewed and were therefore a self-selecting cohort including a significant sub-sample of user-grower activists. In addition, we mobilised personal networks and onward referrals. In total, we conducted interviews with 48 cannabis growers, supplemented with many more informal conversations and online interactions. This paper draws primarily on a sub-sample of sixteen respondents, as explained below.

Where possible we visited growers at their homes and cultivation sites, observing informants with their plants and in their own environment. In other instances, interviews were conducted in pubs or cafes where respondents felt comfortable to talk. Interviews lasted between one and four hours and followed a semi-structured schedule of questions on key topics, including medical use and activism. In most cases, there was also much free flowing conversation, which created a more relaxed atmosphere and allowed informants to drive the agenda and take ownership of the information they were sharing with the researchers.

IJDP Accepted pre-proof version

On a number of occasions we conducted repeat interviews, at the suggestion of informants, to dig deeper into particular issues.

To observe interactions between cannabis cultivators, their exchanges of information on growing techniques, the preparations of medicine, and political organisation, we also attended meetings organised by cannabis activists in Kirkby Lonsdale (England) and Dublin (Ireland), and visited a commercial illegal cannabis coffeeshop in London. Most pertinently, we were able to attend the 2016 Annual General Meeting of the United Kingdom Cannabis Social Clubs (UKCSC) in Leicester. Participation at these events allowed us to cross-verify that issues raised during interviews were widespread, and distinguish between different positions and viewpoints.

Where feasible, and when granted permission to do so, interviews were recorded. In other instances, contemporaneous notes were taken. Further notes were written up after the interview or event. We worked to the ethical standards of the British Society of Criminology and Lancaster University[5] – data was securely stored, and the anonymity of all respondents maintained even though many (in keeping with their activist personas) stated that they did not mind being identified.

Pursuing a grounded theory approach (Glaser & Strauss, 1967), our theoretical model emerged through the repeat analysis of data. The sample comprised

IJDP Accepted pre-proof version

[5] Ethical clearance was granted by Lancaster University Faculty of Arts and Social Sciences research ethics committee, ref. FL16005.

cultivators growing for their personal use, those supplying friends and family (i.e., social supply) and those involved in commercial distribution. But one cohort vehemently denied any sense of criminality and rejected the charge of cannabis use as a hedonistic indulgence. Instead, they were growing cannabis for health reasons, to self-treat an illness or condition and/or to supply fellow patients. It is this subset of growers that we discuss in this article.

In response to the allegation that medical benefits serve as a pretext for recreational use (Wilkinson & d'Souza, 2014), we note that the drawing of such neat distinctions between medical and non-medical use was one thing that informants had set out to challenge. While several discussed specific, diagnosed conditions others claimed benefits for no particular illness, but a more general sense of well-being, often with a spiritual dimension. One informant reported that she only realised how much she had needed cannabis when she stopped using temporarily and then began to experience symptoms of both physical health problems stemming from a car crash and mental health problems relating to traumatic childhood experiences. The category of 'medical cannabis user' is therefore slippery (cf. Reinarman et al, 2011), as is that of 'medical cannabis grower' (Hakkarainen et al., in press). As such, attempts to clearly delineate between medical and non-medical growers among our respondents would be artificial. Instead, this article draws primarily on sixteen informants who were growing primarily to treat diagnosed conditions in themselves or others and who embraced the label "activist", but informed also by other data generated by our ethnographic approach. To emphasise the "ideal-type" medical growers at the core of this paper, we should note that several were also seeking to moderate

IJDP Accepted pre-proof version

THC strength and experimenting with preparations that had minimal psychoactive effects while still providing therapeutic relief.

Victimless crimes reconsidered – medical cultivators as anomalies in the drug war dramaturgy

By cultivating cannabis and sharing the product with other users our informants had moved from petty offender to criminal perpetrator of a class B supply offence, which carries potentially up to 14 years imprisonment. Craig opened with the familiar assertion of the victimless crime: "if I am not hurting anyone what is that crime". He then turned the more serious charge of drug production around, arguing that he was in fact helping to reduce overall criminality: "I am not contributing to a criminal market. I am not impacting negatively on anyone other than me."

It would be possible to explain such defensive statements in terms of neutralisation theory (Sykes & Matza, 1957), on the assumption that cultivators were seeking to reconcile their criminal behaviour with a conditioned urge to abide by moral and legal codes. Indeed, many informants underlined their pro-social values and integration into wider community structures. Sam and Mary emphasised the contribution they had made in the course of their professional lives as law-abiding, tax-paying, family-raising citizens, and Brendan, in a pointed comparison with members of the political elite, said he was paying tax

IJDP Accepted pre-proof version

on all inputs into his grow operation and even the income from selling his surplus cannabis.

None of these objections sways prohibition advocates who regard drug use as immoral and deserving of punishment (Husak, 2002:109-119; Sullivan & Austriaco, 2016). In justification of such punitive paternalism, prohibition advocates argue that the "majority who would use responsibly ought to be willing to give up their fun to protect the minority who would not…" since "in a free society there are plenty of other ways to have fun." (Caulkins, 2012:239 f).

Drug users have no legally enshrined right to intoxication, but carry instead the stigma of an illegitimate and immoral activity, and with the spread of drug testing technology, need increasingly to demonstrate their abstinence.[6] The drug war, in both its dramaturgy and its schematics, has therefore divided the population into users/non users (default position), with the first group potentially subject to the control of the criminal justice system but divided into separate roles with different degrees of moral culpability each triggering a different kind of intervention: the criminal supplier / hedonist consumer / addict.

Medical cannabis cultivators fall outside the scheme. They are drug producers and suppliers, whose own use resembles the hedonist in terms of control and deliberation, but the addict in frequency and dependence. Yet their motivation

[6] Although more established in the US, drug testing is on the rise in Europe in a number of contexts (Paul & Egbert, 2016). Workplace drug-testing in the UK increased significantly between 2011 and 2014 (Ironmonger, 2014).

IJDP Accepted pre-proof version

and the context of their use disrupts the frame altogether, as they grow not for profit but for necessity, use not for high but for health, and present themselves as patients not criminals. As Potter has noted previously (2010), these people are driven by need, not greed.

Inadvertent cultivators

Cultivators often presented their lives as journeys beginning with the life-changing illness and a series of cumulative events, such as the discovery of cannabis, quests for greater knowledge, encounters with significant teachers, and the decision to start growing. The stories contain elements of what the anthropologist Victor Turner (1969) describes as the ritual progress and, subsequently, the idea of social drama. Individuals experiencing a crisis that breaches the common norm are pushed outside of the conventional frame, with the sudden dissolution of structure, identity and social action. This was the diagnosis itself, which was in the case of Craig, “a life sentence”. Mary also reports a sense of helplessness when learning at 32 that she had MS, until a friend told her about the medical benefits of cannabis. She was grateful she had smoked it recreationally, because she felt able to travel to Amsterdam and acquire the technique and basic inputs for growing.

Using cannabis in a purposeful, systematic way, followed by the decision to grow, are ways in which informants report regaining control over their lives from the disease, a process Turner (1969) captures as “redressive action”. When Howard learnt he had Crohn’s disease and would “soon have my guts removed and be fed

IJDP Accepted pre-proof version

through a straw" he says he took a one-way ticket to Colorado where he met "Ganja John", a man with only one functioning kidney who taught him how to grow cannabis and use it medicinally. Now he is back in the UK in excellent health, growing his own crop and sharing his skills with others.

Receiving and sharing are recurrent elements in the narrative of medical cannabis growers, woven into a sense of *communitas* by all facing debilitating and possibly incurable conditions, and the shared status of the outlaw, liable at any moment to be raided, arrested and deprived of liberty. The decision to take such steps is difficult, like any rite of passage, and aided, necessarily by inspirational figures like the expert grower Jeff Ditchfield, whose cannabis café "Beggars Belief" in Rhyll, North Wales, is a cause celebre in medical cannabis circles.[7]

Jane was left with spinal injuries and Complex Regional Pains Syndrome after a car accident at 29. She found that smoking "half a spliff after the children had gone to bed eased the pain", and that different strains and types of cannabis acted differently. She read up about it, then learnt from Jeff Ditchfield before producing her oils. But in addition to the technical advice she also had encouragement to articulate her resentment at the structural discrimination. "I want to see it legalised and feel angry that it isn't." She thinks that cannabis

[7] The café provided space where patients met with growers to exchange hints, tips and medicines in a friendly environment. The café was raided on several occasions and Jeff Ditchfield taken to court. The jury always ruled in his favour, convinced by the defence that he was donating medicine https://jeffditchfield.wordpress.com/beggars-belief/

IJDP Accepted pre-proof version

should be regulated under the principle of consumer rights and that only vested interests of the pharmaceutical and alcohol industries are holding it back.

Three betrayals

Already let down by their bodies, our activist medical growers identified three other ways in which they felt betrayed: by the legal system that labels them as criminals, by conventional medicine that cannot help them, and by criminal operatives in the illegal cannabis market.

Criminal justice authorities

As a responsible citizen, Jane feels angry at the way she was treated during a police raid in the past, “a horrible violation”, and more recently the harassment by a police community support officer (PCSO), “a hobby bobby”, possibly alerted by a hostile neighbour. On one occasion he entered her garden unlawfully, confiscated some cannabis and issued her with a caution, dismissing her claim that this was her medicine.[8] Angered by his attitude Jane reported the incident to the police complaints commission and learnt from a sympathetic duty sergeant, who told her “you are not a criminal”, that the cannabis had not been handed in.

IJDP Accepted pre-proof version

Informants remain perplexed by police motivation. Sally, who suffers from Crohn’s disease, begged the officers who raided her house not to take her medicine. “One of the officers gave me hug and said don’t worry love, it will soon

[8] PCSOs do not have the powers to enter premises.

be legal for people like you." But they held her for seven hours at the station even though she was feeling weak and walking on crutches.

The worst thing is the continuous sense of fear. Craig says it does not matter to him, but his partner worries and wakes up in the night. Several informants use the term paranoia and discuss their strained relationship with the law. Mary describes her anxiety as a mild case of PTSD and remembers the panic one night when hearing a knock and seeing the silhouettes of two police officers through the door. It turned out that the officers were interviewing people following a break-in in the neighbourhood. But not knowing that, Mary and her husband had rushed to close the grow room and put everything in the attic. "People who are ill don't need that kind of worry". While she believes that most policemen do not want to arrest sick people there are always some who want to "make up numbers".

The cumulative effect of these experiences is that, "people are fed up of the so-called government that is being the servant of the people turning around to say that cannabis has no health benefits and make it illegal" [Doug].

<u>Conventional medicine</u>

Another target for criticism was what several informants described as 'conventional medicine', which had been unable to cure or even properly understand their conditions. There were, furthermore, incidents of misdiagnosis, inappropriate treatment, and even failed surgical interventions. Sally recalls surgeons apologising to her "after one botched operation" and blames the

IJDP Accepted pre-proof version

morphine prescription for triggering her stomach spasms and leaving her with withdrawal symptoms.

Not only were medical practitioners unable to help, but often they were very negative about cannabis use. Justin, who suffers from bipolar disorder and extreme anxiety, was told that he would only be referred to a psychotherapist if he stopped using. Confirming trends reported elsewhere in Europe (Hakkarainen et al., 2015; Grotenhermen & Schnelle, 2003), UK medical cannabis users are reluctant to confide in their doctors. According to one online survey, a third of the 623 respondents refused to disclose with another quarter reporting a hostile response.[9]

Medical practitioners only echo the negative assessment of cannabis, which was removed from the British pharmacopoeia in 1932. Several decades later it was placed in schedule 1[10] of the classificatory system created by the 1971 Misuse of Drugs Act under advisement from the medical associations. Today the main professional bodies, the British Medical Association and the Royal Pharmaceutical Society, remain unconvinced of its therapeutic properties despite the current state of knowledge (Barnes & Barnes, 2016). Even the large medical charities such as Cancer Research are sceptical: "At the moment, there simply isn't enough evidence to prove that cannabinoids – whether natural or

[9] The United Patients Alliance conducted a survey of (self-identified) medical cannabis users in the UK in 2016. The 25-question survey was distributed through social media. 623 were returned valid, reporting cannabis use in connection with a range of conditions, including depression (30%), Anxiety (26%), chronic and severe pain (24.1%), Arthritis (12%), Insomnia (21%), fibromyalgia (9%), PTSD (7%). The report was submitted to the All-Party Parliamentary Group for Drug Policy Reform. Courtesy of John Liebling.

[10] Reserved for substances that have no recognised medical benefit.

IJDP Accepted pre-proof version

synthetic – work to treat cancer in patients, although research is ongoing. And there's certainly no evidence that 'street' cannabis can treat cancer".[11]

This reluctance by medical authorities to endorse the therapeutic value of cannabis leaves cannabis-using patients feeling isolated and abandoned. Sally says "there is nothing that conventional medicine can do for me" and relies entirely on her own herbal products. Mary, too, puts her faith in a combination of diet and cannabis products, since these have a clear and positive effect.

Criminal market

Yet cannabis is not always easy to come by at the best of time, particularly when people are physically impaired. Before they started self-supplying, medical users were dependent on an often-unsympathetic criminal market. Charlie, who suffers from rheumatoid arthritis and walks with the aid of crutches, says "You'd think they would respect someone with a disability, but no. These young guys just took my money and ran off." Others report sending their partners to purchase cannabis for them, but without the social capital to operate in criminal drug markets they were taken advantage of and cheated.

Because the industry is not regulated properly opportunities arise for fraudsters and charlatans. Jane refers to a cannabis grower who was widely reported in the media claiming to have cured his cancer with cannabis. Since then a "foundation"

[11] http://scienceblog.cancerresearchuk.org/2012/07/25/cannabis-cannabinoids-and-cancer-the-evidence-so-far/#campaign

IJDP Accepted pre-proof version

has been named after him charging £300 per consultation and then £100-200 for a 1 ml syringe of cannabis oil.

For her, it is one more manifestation of systemic problems, because "prohibition opens opportunities for scammers". She has bought oil that turned out to contain only minimal amounts of THC and CBD, with "a medicinal profile similar to olive oil. Some people sell the product from commercial weed trimmings that is not even flushed properly with isopropyl alcohol." These are substandard products produced without care and pride simply for profit.

Reconstituting selfhood

The situation, as seen by our respondents, can be easily summarised. People with a medical need for cannabis but criminalised by government, denounced by their doctors and cheated in the underground markets, find themselves the victim of successive betrayals. Their rupture with prevailing norms is no wilful pursuit of egotistical or hedonistic ends, but an act of self-preservation. The resulting anomie, in the Durkheimian (1893) sense of "derangement" as a mismatch of standards between the group and the wider society, results from a tension in the social contract that guarantees a right to healthcare, but excludes the cannabis patient.

This situation mirrors the drug users of Merton's (1938) classic social strain theory, who, prevented by their own circumstances from realising society's

IJDP Accepted pre-proof version

values, retreat into an inner world. Only the medical cannabis user is no failing individual. Instead, society and its normative frame are failing her.

The turn to cannabis production, far from comprising a defeatist retreat, is a positive assertion of agency, with the cultivator assuming control over her/his therapeutic regime. It means adjusting to the possibility of arrest and prosecution and redefining the status of and relationship with cannabis.

Committing to cannabis

Medical users therefore emerge from the closet and integrate cannabis into their identity. Jane, recounting her troubles with law enforcement and informers, shrugs and says "I am a proud cannabis smoker, but it was a long journey".

Most medical cannabis growers manage their communications and interpersonal relations carefully, particularly with those whom they allow into their private space. Often negotiation is required, as in the case of Mary, whose cleaner, once opposed to drugs, now takes cannabis balms for her own mother. She believes that people in the village know about her use by now.

James has even informed his local police that he is growing cannabis. Should he ever get raided he will ask "why now, you have known about this for 2 years?" Craig, who is friends with police officers, says he is open about his cannabis use as it is important to establish a public identity as a cannabis user.

IJDP Accepted pre-proof version

One unlikely setting is the local government council. Den is a busy member of the community involved in committee work and helping organise local activities. At one council meeting about public safety and the problems caused by drinking he brought the discussion to cannabis and how safe and pro-social it was. He remembers feeling "fucking proud of myself when I walked out of that meeting."

The experience of "coming out" publicly as cannabis users is liberating and self-affirming. It means being accepted for what is seen as an important part of selfhood. To that end the most important people to be won over are often the family.

Winning over family

Sally depended through some of the most critical periods of her illness on her mother who has never taken cannabis herself, but says "I could see what pain Sally was in and thought if it works, why not." Jane's dad also proved acquiescent when he observed the results. Over the years she managed to turn a "rabid prohibitionist" into a cannabis advocate, who now applies a balm she makes to his own skin.

For many users there are stories of conversion, critical Damascene experiences where a sceptical significant other is won around. Howard convinced his mum by curing the dog. The family pet was advanced in years, very ill, foaming at the

IJDP Accepted pre-proof version

mouth despite the vet's best efforts. Then Howard fed him a few cannabis laced cupcakes and affected remission. Now both his parents fully support not only his use, but also his cultivation and political activism.

In situations of co-habitation, acceptance and support from parents or partners is a precondition for any cultivation. This invariably involves risks, as parents may withdraw support and estranged and vengeful partners can inform the authorities. But beyond the practical aspects of being given license to grow and use, it is about being accepted for who they are.

IJDP Accepted pre-proof version

Convincing doctors

For people with serious health conditions another important relationship is with their healthcare providers. While the majority of informants in the aforementioned survey avoided the topic of cannabis, or had a negative or neutral response, a significant number (40%) of doctors were supportive (cf. Sznitman, 2017). It would appear that there is far less consensus about the therapeutic value of cannabis among medical professionals than the resolute scepticism of the professional bodies would suggest. Den remembers being referred to "Professor X", a respected specialist in his condition working at a major UK teaching hospital, who confirmed that "cannabis was the best medication for my pain which was what I must have subliminally known because I had been smoking more and more." But sympathetic medical professionals are rarely well informed and often unsure about cannabis preparations.

This is where Jane had to step in. “I had to educate my doctor who now advises every patient presenting with Complex Regional Pains Syndrome to use cannabis.” Going even further, he has prescribed her with Sativex, not to use it but as a cover in case she is ever drug-tested. Mary’s doctor also came to accept cannabis when he observed her health improve. She gave him a medical cannabis textbook and says “I have normalised it in my doctor’s surgery”. The willingness of medical professionals to accept the expertise of users compares favourably with an earlier Norwegian study (Pederson & Sandberg, 2013). But convincing a medical professional requires social capital. Not all medical cannabis cultivators have the professional status and educational attainment to lend credibility to their claims in discussions with medical practitioners. Yet this does not mean they have no view or role as care givers.

Reclaiming Agency

Medical cannabis healers and apomedication

Doug, who works cannabis butter into a poultice that he applies to his injured rotary cuff, is proud to share his homemade medication. Discussing the dissemination of therapeutic expertise on cannabis in Canada, Penn (2014) noted the critical role of dispensaries organised into the Canadian Association of Medical Cannabis Dispensaries (CAMCD) in forming an “embodied health movement”. Less formally in the UK, individuals, small-scale producers such as the CBD brothers and loose, unrecognised cannabis clubs exchange information via social media and

IJDP Accepted pre-proof version

at organised events. They discuss cannabis strains, preparations, growing techniques and medical applications. Since medical authorities have vacated this space, Doug feels entitled and even morally obligated to move in to help others.

They build on the prior challenges to traditional hierarchies where medical professionals are omniscient and the patient a passive object of care. In the long-term care of chronic conditions, patients become recognised as experts and partners so that "self-management, within the boundaries of a medical regime, becomes a real option" (DoH, 2012). Pushing well beyond those boundaries, medical cannabis growers can replace the clinician by providing patients with similar diagnoses with treatment options and prognosis on disease progression.

Crucially, however, they do so outside of conventional knowledge hierarchies, as their expertise draws from a convergence of embodied health experience with knowledge filtering in a situation of information abundance. The apomediary can guide towards information sources and services but has no power over their provision or the decision making process itself (Eysenbach, 2008). Both Sally and Doug give detailed advice to people with similar gastrointestinal disorders and Mary counsels other MS sufferers. Potentially, such therapeutic relationships can turn into joint journeys of discovery, with both (or more) parties exchanging information as equal partners in the healing process.

Much occurs through Facebook and Instagram pages, in small groups or on a one-to-one basis. Since advice is often complemented by medicines and a combination of seeds, cuttings and knowhow, the process is better described as

IJDP Accepted pre-proof version

apomedication. At the frontier of medical knowledge, a space has opened where the medical cannabis patient/grower becomes a medical authority. Particularly in the case of rare conditions, advice and remedy are passed from patient to patient, who take ownership of their condition and gain experience that can be communicated to others.

Activism

The most important transferrable skills are horticultural, hence social media is abuzz with information on seedlings, plants, lighting, plant feeds, soil consistency, harvesting and drying. There are multiple motivations. Den says he "helped set up one guy" after "feeling guilty" about the money he was taking off him. For Brendan "helping people to become independent growers of quality cannabis is what I am about", something like a personal vocation. Others cite a genuine evangelism rooted in the conviction that cannabis is a positive, health-giving force, or inspiration from foundational texts by Jeff Ditchfield or others.

That push for social acceptability has raised confidence. Liam, who is in touch with over 200 growers in his area, states "the community aren't scared anymore". Finding safety in numbers after living with the fear of the knock on the door is both motivator and reward. Rachel remembers "sneakily smoking joints out of the attic." She thinks that "in terms of rebellion, growing your own is one of the biggest forms of activism you can do because you're actually challenging the system."

IJDP Accepted pre-proof version

The most comprehensive challenge is posed by the UKCSC whose "peaceful activism" aims at ending "prohibition and the unjust, unfair criminalisation of cannabis consumers".[12] Based on a model that first evolved in Spain (Decorte, 2015; Belackova et al, 2016) the clubs are registered not-for-profit organisations that provide a platform for local cannabis collectives. There is a clear firewall between local groups involved in the actual growing and the UKCSC, who provide technical advice and register the plants. They refer to official sentencing guidelines when advising growers to keep the number of plants below 10 (Sentencing Council, 2012).[13]

The UKCSC go further than campaign groups like "End our Pain"[14] or the United Patients Alliance, [15] by extending their demands to recreational and social cannabis use.

Quality

The UKCSC regard themselves as a quality-control body that warns of sub-standard suppliers while showcasing UK growers. "We have got a good quality and professional industry in this country who win cups in the US and want to feel

IJDP Accepted pre-proof version

[12]https://www.smokersguide.com/adressen/12190/ukcsc_united_kingdom_cannabis_social_clubs.html#.WPSMhrvyvow

[13] The guidance notes for drug offences advise sentencers to weigh up all factors when assessing culpability, including the output determined by the number of plants. A 'lesser role of culpability' is where the operation is 'solely for own use', and the lowest 'category of harm' is nine plants and fewer

[14] http://www.endourpain.org/

[15] http://www.upalliance.org/

people pride in using their products. Why should they miss out on this when people in another country can do it and get a head start because the law is different?" [UKCSC spokesperson].

In the West Country, Jane is a member of the local cannabis collective associated to the UKCSC and has gotten together with some other women to form a group of "Lady Gardeners". They want to meet the medical need for cannabis product that is different from the "pharma ganja" promoted by groups like 'End our Pain'. There is also a rejection by female activists of the male-dominated illegal medical supply networks and exploitative relationships with customers/patients. She takes good care of her plants, is careful to use only organic inputs, and takes pride in process and product.

Craft and pride in the product are a recurring theme. Some describe themselves as connoisseurs, and all have clear preferences about strains and the particular effects they want. Coupled to that is a disgust for inferior weed, with frequent talk about adverse side effects from adulterants, chemical fertilizers or plant pests. Much – perhaps most – of the product traded on the criminal market is of inferior quality as the purveyors are driven by greed (cf. Potter, 2010) and allowed to operate by a government that is indifferent to the needs of medical cannabis users.

IJDP Accepted pre-proof version

Changing the frame

In our fieldwork, we met people moving from the minor offence of drug possession to the trafficking offences of production and supply solely to secure a regular source of quality medicine to manage difficult conditions. They had been pushed towards cultivation by governments that, with support from the medical professions, had prohibited cannabis, and the failure of the criminal market. Many informants presented themselves as responsible people, who held down jobs, paid taxes, raised families and contributed to their communities. They saw themselves as multiple victims faced by a grim choice of breaking the law or bearing the pain, and had been pushed to re-define themselves as medical cannabis users, "expert by experience" healers, quality growers and activists.

Far from seeing themselves as criminals, medical cannabis users project the image of multiple victimhood – of government inertia, medical incompetence and criminal conspiracy (as well as a victim of whatever medical conditions afflict them). It is not so much a question of being in breach of the law, as of the law being against them. Criminal convictions were rare among medical users, as was experimentation or use of other drugs (cf. Potter et al., 2015). Instead, they would emphasise their professional achievements, educational attainments and pro-social attitudes.

One of the advantages of growing for themselves was an ample supply that allowed Jane, for instance, to "smoke pure" (i.e. not mixing cannabis with tobacco). Many do not smoke at all but use vaporisers. Hakkarainen (2016) has noted that the arrival of new delivery systems has allowed the cannabis user to rebrand themselves from "loser stoners" to "cool fashionistas". However, it is not

IJDP Accepted pre-proof version

a quest for "cool" that motivates the medical user but health concerns over the detrimental effect of smoking as a delivery system and the mixing with tobacco. Sally, amongst others, takes her cannabis only orally, either raw-juicing her cannabis plants or using the buds and trimmings to make "medibles" (medical edibles, like chocolates and biscuits). Indeed, Howard says that some "purists" are openly derogatory about smokers who mix their cannabis with tobacco.

Cannabis by contrast is endowed with extraordinary positive attributes, and some people profess affection for and gratitude to their plants. Eddie is aware that he is sounding "like a fanatic" when extolling its virtues from medicine to food to construction material. "You can even build a car out of it, I love that plant." He is not alone in using that phrase. Tony also has "a love relationship with the plant, I want to caress and talk to it. After smoking for over 25 years on a daily basis I am part cannabis, I have THC glands."

Like many gardeners, growers see character in their plants. According to Mary, cannabis has eccentricities that become manifest in the drug effect. She has a hybrid called "Fortune Teller" that "makes you think and smile and feel happy." Personality and powerful psychoactive effect merely confirm the special status of cannabis. What really sets the plants apart, for many of the medical growers, is that they have healing powers.

Den was undergoing surgery and under a severe regime of medication. "You know, I'm not claiming cannabis saved me, but if it weren't for cannabis, I wouldn't have been able to take the dosages of these drugs that they'd actually

IJDP Accepted pre-proof version

have to give me to keep it under control." Sally, Howard, Justin and Jane all attribute their health improvement to cannabis, while the MS patients Mary and Craig need it for their everyday functioning.

The extravagant claims about cannabis as a cancer cure known from media stories or websites like "illegally healed"[16] are echoed by informants who grow not to treat their own medical problems, but to divert some of their crop to help others. Liam first began producing oil when his brother was diagnosed with lung cancer. Since then he has "given it to a couple of people and they cured."

If the growing body of evidence for palliative care and pain management help transform the status of cannabis from "menace to medicine" (Waldstein, 2010), it is these spectacular achievements in "curing cancer" that imbue it with powers of non-human agency that challenge the underlying assumptions of drug policy. As Weinberg (2011) observes, social policy on drugs is predicated on the unusual powers of these substances that requires the state to protect people from themselves.

Cannabis advocates pick up on the "power" but recharge it into a benevolent force. Some of the medical cannabis cultivators would like to get a better understanding of the mechanics and participate in medical research. But others, like Brendan, are concerned about corporate takeover, the standardisation of cannabis crops, and the exploitation of a benevolent plant for profit.

[16] https://illegallyhealed.com/patient-success-stories/

IJDP Accepted pre-proof version

Not having an explanation, moreover, reinforces the nebulous status of cannabis as a non-human agent, with a quasi-sacred mission to bring health and restore sanity in a corrupt, materialist world. The very absence of rationally explained mechanisms of action has enabled self-taught activists like Liam. They can seize the opportunities opening up with rising demand for affordable cannabis medicines.

Alongside the obvious financial gains, there are intangible social benefits from participation in emerging networks where product quality is celebrated (Potter 2010). More difficult to gauge is the chance to display virtue, through altruistic acts of sharing.

Doug says that two days prior to our interview he drove 15 miles to supply cannabis oil to someone he met online, not for profit on the sale, but to help a "guy who is in pain." Turning people into healers is yet another aspect of green power. It makes Rachel feel good to help people and their families, especially "when you're really, really afraid and the walls are red hot and the helicopter is flying overhead and it's 37 degrees in the bloody tent".

Liam has been in prison for large commercial grow-operations and other offences. When he is talking about the opportunities of cannabis he refers to more than the medical needs of the 12-year-old girl he "is helping treating. She has been on the oil for 5 weeks and the change is amazing. From her having black eyes, yellow skin – she has a brain tumour – now the black eye has gone, the skin is back to pink, and she is now playing with her young brother and sister. If we

IJDP Accepted pre-proof version

didn't get the oil the doctors gave her 6 months to live, the tumour is golf ball sized. Now the oil is fighting the cancer, we think it's going to change her life."

It has also changed Liam's life, by allowing him to repair his fractured moral self and (re)construct himself into a good person.

Conclusion

There is still a lack of clear scientific understanding about when and how cannabis – and which constituent cannabinoids – does effectively treat particular medical conditions, and it may be that for some medical users effects are palliative rather than curative. Nevertheless, many people clearly perceive medical benefits – sometimes very strong benefits – from their cannabis use. Further, we acknowledge that our sample are both extreme and 'ideal' cases of medical cannabis growers, and that others claiming to grow or use cannabis for medical purposes may be less easily distinguished from recreational use or profit-oriented supply (cf. Reinarman et al, 2011; Hakkarainen et al. 2015; ; Sznitman 2017; Hakkarainen et al., in press). Nevertheless, the potential of medical cannabis growers to re-energise the UK drug policy debate, already reflected in the inching acknowledgement of medical benefits by the Medicines and Healthcare Products Regulatory Agency decision in 2016 to consider CBD products as medicines, is completely disproportionate to their number. By tracking the journey and motivation of medical cultivator activists we have argued that their anomalous position as non-hedonist users and not-for profit suppliers has broken the frame on which cannabis prohibition is based. The

IJDP Accepted pre-proof version

benefits they attest to gaining from cannabis redefines it as medicine, despite opposition from orthodox medicine and the criminal justice system. Medical cannabis growers are not criminal perpetrators but victims, a role captured by the campaign name “End our Pain”. In the US the redefinition of voters as victims of crime in the 1970s transformed the political landscape and the relationship between citizens and state (Simon, 2007). But whereas policy makers called for more state, meaning police, courts and prisons, the impetus behind medical cannabis is for a dismantling of the punitive system and a freedom from the state. There is no breakdown into anarchy, but a call for a regulated system as proposed by the UKCSC.

Pro-cannabis regulation discussions continue to be dominated by aggregate benefits expressed in terms of criminal justice savings and tax revenues (McGinty et al., 2016). But in the medical cannabis user there is a human subject to identify and sympathise with. As these calls are becoming increasingly self-confident and the practice of cultivation spreads policy makers will have to take decisions.

IJDP Accepted pre-proof version

References

Barnes, M. & Barnes, J. (2016) *Cannabis: The Evidence for Medical Use*. All party parliamentary group for drug policy reform. Retrieved 10th November 2017 from https://drive.google.com/file/d/0B0c_8hkDJu0DUDZMUzhoY1RqMG8/view

Barratt, M.J., Potter, G., Wouters, M., Wilkins, C., Werse, B., Perälä, J., Pedersen, M.M., Nguyen, H., Malm, A., Lenton, S., Korf, D., Klein, A., Heyde, J., Hakkarainen,

P., Frank, A.V., Decorte, T., Bouchard, M. & Blok, T. (2015) "Lessons from conducting trans-national Internet-mediated participatory research with hidden populations of cannabis cultivators" *International Journal of Drug Policy*. 26 (3): 238-249.

Belackova, V., Tomkova, A. & Zabransky, T. (2016) "Qualitative Research in Spanish Cannabis Social Clubs: 'The Moment You Enter the Door, You Are Minimising the Risks' *International Journal of Drug Policy* 34: 49-57.

Bouchard, M., Potter, G. & Decorte, T. (2011) "Emerging Trends in Cannabis Cultivation – and the Way Forward" in Tom Decorte, Gary Potter and Martin Bouchard (eds.) *World Wide Weed: global trends in cannabis cultivation and its control*. Ashgate: Aldershot.

Caulkins, J. (2012) "What do authors think?" In Caulkins J. (ed.) *Marijuana Legalization: What everyone needs to know*. Oxford: Oxford University Press.

Decorte, T. (2010). "Small scale domestic cannabis cultivation: An anonymous Web survey among 659 cannabis cultivators in Belgium." *Contemporary Drug Problems*, 37: 341-370.

Decorte, T. (2015) "Cannabis social clubs in Belgium: Organizational strengths and weaknesses, and threats to the model", *International Journal of Drug Policy* 26(2): 122-130.

IJDP Accepted pre-proof version

DoH [Department of Health] (2012). *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*. DoH: London. Retrieved 10th November 2017 from http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018578.pdf

Dunn, J. (2016) "Police 'have given up on cannabis' as just one in four caught with the drug are charged" Daily Mail 3rd August 2016. Available at: http://www.dailymail.co.uk/news/article-3754126/Police-given-cannabis-just-one-four-caught-drug-charged.html

Durkheim, E. (1893/1960). *The Division of Labor in Society*. (G. Simpson, Trans.) New York: The Free Press.

Eysenbach, G. (2008) "Medicine 2.0: Social Networking, Collaboration, Participation, Apomediation, and Openness." *J Med Internet Res* 2008;10(3):e22 URL: http://www.jmir.org/2008/3/e22/ doi:10.2196/jmir.1030

Glaser, B. & Strauss, A. (1967) *The Discovery of Grounded Theory: strategies for qualitative research*. Chicago: Adline.

Grotenhermen, F. & Schnelle, M. (2003) "Survey on the Medical Use of Cannabis and THC in Germany" *Journal of Cannabis Therapeutics* 3(2): 17-40.

IJDP Accepted pre-proof version

Hakkarainen, P. (2016) “Vaporizing the pot world – easy, healthy, and cool.” *Drugs and Alcohol Today*, 16(3): 185-193,

Hakkarainen, P., Decorte, T., Sznitman, S., Karjalainen, K., Barratt, M.J., Frank, V.A., Lenton, S., Potter, G., Werse, B. & Wilkinson, C. (in press) “Examining the blurred boundaries between medical and recreational cannabis – Results from an international study of small-scale cannabis cultivation” *Drugs: Education, Prevention & Policy*.

Hakkarainen, P., Asmussen Frank, V., Barratt, M.J., Dahl, H.V., Decorte, T., Karjalainen, K., Lenton, S., Potter, G. & Werse, B. (2015) “Growing medicine: Small-scale cannabis cultivation for medical purposes in six countries” *International Journal of Drug Policy*. 26(3): 250-256.

Hall, J. & Camber, R. “One cannabis plant seized every minute with one force alone finding 1,000 a week” *Daily Mail* 2nd January 2014. Retrieved 10th November 2017 from http://www.dailymail.co.uk/news/article-2532520/Cannabis-capital-Britain-Manchester-plant-seized-police-10-minutes.html

Hargreaves, J. & Smith, K. (eds.) (2015) *Seizures of drugs in England and Wales, 2014/15 (Statistical Bulletin 06/15).* London: Home Office.

Hitchens, P. (2012) “Top Politician Admits it - There is de facto decriminalisation of Cannabis” *Hitchens Blog, Mail on Sunday* 28th April 2016. Available at:

IJDP Accepted pre-proof version

http://hitchensblog.mailonsunday.co.uk/2016/04/top-politician-admits-it-there-is-de-facto-decriminalisation-of-cannabis.html

Home Office (2015) *Drug Strategy 2010 'A Balanced Approach' Third Annual Review* London: Home Office. Retrieved 10th November 2017 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/407334/Cross-Government_Drug_Strategy_Annual_Review.pdf

Home Office (2016) *Drug Misuse: Findings from the 2015/16 Crime Survey for England and Wales.* London: Home Office. Retrieved 10th November 2017 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/541319/drug-misuse-1516.pdf

Husak, D. (2002) *Legalize This!: The Case for Decriminalizing Drugs*. London: Verso

Ironmonger, J. (2014) "Workplace drug testing 'on the rise', say providers" *BBC news* 3rd October 2014. Retrieved 10th November 2017 from http://www.bbc.co.uk/news/uk-29465755

McGinty, E.E., Samples, H., Bandara, S.N., Saloner, B., Bachhuber, M.A. & Barry, C.L. (2016) "The emerging public discourse on state legalization of marijuana for recreational use in the US: Analysis of news media coverage, 2010-2014". *Prev Med*. Sep;90:114-20

IJDP Accepted pre-proof version

Merton, R. (1938). “Social structure and anomie.” *American Sociological Review*, 3: 672–682.

Paul, B. & Egbert, S. (2016) “Drug testing for evidence? A sociotechnical practice” in A. O’Gorman, G. Potter and J. Fountain (eds.) *Evidence in European social drug research and drug policy.* Lengerich: Pabst.

Pederson, W. & Sandberg, S. (2013) “The medicalisation of revolt: a sociological analysis of medical cannabis users.” *Sociology of Health and Illness*. Volume 35(1): 17-32

Penn, R. (2014) “Establishing expertise: Canadian community-based medical cannabis dispensaries as embodied health movement organisations.” *International Journal for Drug Policy*, 25 (3): 372-377.

Potter, G.R. (2008) “The growth of cannabis cultivation: Explanations for import substitution in the UK.” In D.J. Korf (ed.) *Cannabis in Europe: Dynamics in perception, policy and markets* (pp. 69-89). Lengerich: Pabst Science Publishers.

Potter, G.R. (2010) *Weed, Geed and Need.* London: Free Association Books.

Potter, G., Barratt, M., Malm, A., Bouchard, M., Blok, T., Christensen, A., Decorte, T., Frank, V.A., Hakkarainen, P., Klein, A., Lenton, S., Perälä, J., Werse, B. & Wouters, M. (2015) “Global patterns of domestic cannabis cultivation: sample

IJDP Accepted pre-proof version

characteristics and patterns of growing across eleven countries." *International Journal of Drug Policy*. 26(3): 226-237.

Reinarman, C., Nunberg, H., Lanthier, F., & Heddleston, T. (2011) "Who are medical marijuana patients? Population characteristics from nine California assessment clinics." *Journal of Psychoactive Drugs*. 43: 128-135.

Sentencing Council (2012) *Drug Offences: Definitive Guidelines.* London: Sentencing Council. Retrieved 10th November 2017 from http://www.sentencingcouncil.org.uk/wp-content/uploads/Drug_Offences_Definitive_Guideline_final_web1.pdf

Simon, J. (2007). *Governing through crime.* Oxford: Oxford University Press.

Staufenberg, J. (2015) "Cannabis possession arrests fall as UK police focus on other priorities" *The Independent* 18th October 2015. Retrieved 10th November 2017 from http://www.independent.co.uk/news/uk/politics/cannabis-possession-arrests-fall-as-uk-police-focus-on-other-priorities-a6698836.html

Sullivan, E & Austriaco, N. (2016) "A virtue analysis of recreational marijuana use". *The Linacre Quarterly*. 2: 158-173.

Sykes, G.M. & David Matza (1957), "Techniques of Neutralization: A Theory of Delinquency". *American Sociological Review*Vol. 22(6): 664-670.

IJDP Accepted pre-proof version

Sznitman, S. (2017) *Do recreational cannabis users, unlicensed and licensed medical cannabis users form a distinct group?* Conference Paper, International Society for the Study of Drug Policy, Aarhus, Denmark.

Turner, V. (1969). *The Ritual Process*. New Brunswick: Transaction Publishers.

Waldstein, A. (2010) "Popular medicine and self-care in a Mexican migrant community: toward an explanation of an epidemiological paradox." *Medical Anthropology* 29(1): 71–107.

Weinberg, D. (2011). "Sociological Perspectives on Addiction." *Sociology Compass* 5/4 (2011): 298–310.

Weisheit, R. (1992). *Domestic marijuana: A neglected industry*. New York: Greenwood Press.

Wilkinson & d'Souza, (2014) "Problems with the medicalization of marijuana." *JAMA*. 2014 Jun 18;311(23):2377-8.

IJDP Accepted pre-proof version