CULLINAN & ASSOCIATES
Environmental and green business attorneys

MEDIA STATEMENT

CONSTITUTIONAL CHALLENGE TO THE CRIMINALISATION OF PSILOCYBIN MUSHROOMS

On 12 April 2024, Monica Cromhout and Melinda Ferguson launched an application out of the Pretoria High Court, challenging the constitutionality of provisions in the South African Drugs Act and Medicines Act that criminally prohibit the possession, use, and dealing in, of psilocybin mushrooms.

In South African law, as things stand, psilocybin is classified alongside heroin and fentanyl as a Schedule 7 substance, or as *"undesirable"* and *"dependence-producing"*. This means that an adult in possession of psilocybin mushrooms, or growing them or sourcing them, entirely for private use, is a criminal in the eyes of the law.

The full application, which is bookmarked and word-searchable, follows this statement.

MONICA CROMHOUT – THE FIRST APPLICANT

Monica Cromhout is 79 years old. She never drank alcohol or smoked cigarettes or cannabis. She is a retired trauma counsellor, now astrologer. After recovering from cancer, and in order to cope with a terrible bout of depression after the death of her husband, when modern medicines and anti-depressants were not assisting her, she decided to experiment with psilocybin. After she was convinced of psilocybin's benefits and how much it had helped her, she began to supervise other adults who wished to try it. This to ensure that they could do so safely, in a comfortable setting, going in with the correct mindset, and using the correct types of mushrooms.

Cromhout was arrested and charged, amongst other things, for drug dealing. Her criminal trial is still pending.

She alleges that criminalisation unjustifiably limits various constitutional rights, including the rights to privacy and personal autonomy (which links to the right to dignity).

While the application may, at first blush, seem novel, the applicants demonstrate that what they seek is only a very modest development of the law, which is entirely consistent with various prior decisions of the Constitutional Court.

In 2018, the Constitutional Court, in the *Prince* matter, unanimously found that the same Acts infringed the right to privacy, on the basis that they criminalised the use or possession in private, or cultivation in a private place, of cannabis by an adult for their own personal consumption.

The applicants argue that, after the Constitutional Court has found that adults have a right to the private use and possession of cannabis, it should follow that they also have a right to the private use and possession of psilocybin. That is particularly so since the wealth of expert evidence demonstrates that psilocybin: is not addictive and, used properly in the right setting, has various and numerous benefits, carrying very low risk.

Indeed, as Cromhout explains: *"Part of an adult person's rights to autonomy and dignity, privacy, freedom of expression, and freedom of association, means that they are free and able to choose to participate in a range of different activities, even where these activities may have significant risks of harm. There are, for example, risks in taking commercial airline flights; and driving cars or buses on busy roads. People undertake life-threatening surgeries for purely cosmetic reasons. People participate in a range of extremely dangerous sporting activities like skydiving, rugby, mountain climbing, big wave surfing, and base jumping. But the law permits all of this. The law also presently allows for the consumption of far more harmful substances, such as alcohol and tobacco (and, now, cannabis)."*

THE EXPERT EVIDENCE

The applicants have filed an expert affidavit from Professor David Nutt in support of their application. He is a Professor at Imperial College, London, and a world-renowned neuropsychopharmacologist. Professor Nutt's scientific literature review and expert opinion demonstrates that psilocybin and psilocyn are incorrectly scheduled as *"undesirable"* and *"dependence-producing".*

Professor Nutt's expert affidavit demonstrates that psilocybin: (1) does not produce withdrawal symptoms; (2) does not increase the risk of addiction (even in people with a history of substance abuse); (3) is not associated with any negative long-term changes in personality or cognitive function; and (4) is not a substance with any meaningful risk of lethal overdose (in fact, there is no clear evidence of any lethal overdose caused by psilocybin).

Professor Nutt explains that psilocybin use is far less harmful than legal substances such as alcohol, tobacco and cannabis (which present potential for addiction). If properly sourced and used in a proper setting, psilocybin has – at worst – mild temporary side effects: it is not meaningfully harmful, it is not addictive, and the risks of someone having a *"bad trip"* are minimised further when the proper steps are taken.

Even those potential mild side effects are far outweighed by its benefits. Professor Nutt tells us that naturally-occurring mushrooms are effective in treating addiction and conditions such as severe depression and PTSD. The evidence he sets out in his affidavit shows: that images taken of the brain using an fMRI machine demonstrate that psilocybin use suppresses the area of the brain that drives depression; and that psilocybin use was able to significantly reduce alcohol consumption in alcoholics. One of the benefits of psilocybin is that it appears to increase the brain's neuroplasticity, which refers to the ability for neural networks to shift and rewire. In lay terms, the research shows that psilocybin use makes it easier for a person to break out of established negative habits (for example, addictions created by substances like alcohol, crack cocaine and heroin).

MELINDA FERGUSON – THE SECOND APPLICANT

Melinda Ferguson, the second applicant, is an award-winning publisher, bestselling author, and a freelance journalist, contributing to print and radio for various media companies.
Ferguson's success story, pulling herself out from the clutches of a trauma-based addiction to heroin and crack cocaine, is detailed in her 2020 best-selling book, *"Smacked"*. Ferguson's recovery has been an inspiration to thousands of addicts and she is frequently invited as a speaker at schools and public events. Ferguson explains that psilocybin mushrooms have helped her - not only with turning her back on those addictions, but with healing from the trauma associated with the difficulties that she experienced when in active addiction.

Ferguson intimately knows of the stigma attached to drug users and abusers and appeals to the Court to recognise that regulation of psilocybin would be a less-restrictive means of mitigating any alleged harms, compared with exposing adults who wish to try psilocybin to the dangers of acquiring psilocybin from traditional drug dealers, and/or the trauma of the criminal justice system.

Ferguson explains that, during her recovery, she came to realise that the *"route of addiction is about avoiding internal feelings, thoughts, problems and trauma. Alcohol, heroin and crack cocaine are the vehicle to escape"* and that *"Psilocybin is fundamentally different because it is not a substance used to escape those internal feelings, thoughts, problems, and trauma. Psilocybin is a unique method of confronting them"*.

THE RESPONDENTS

The *respondents* are the South African Ministers of: (1) Justice and Constitutional Development; (2) Public Prosecutions; (3) Health; (4) Police; and (5) Social Development.

Given the Constitutional Court's findings in the *Prince* decision, and the wealth of expert evidence demonstrating that psilocybin is neither *"undesirable"* nor *"dependence-producing"*, the applicants have invited the respondents *not to* oppose this application. The applicants have suggested that Parliament and the respondents be given 24 months in which to decide how best to regulate psilocybin.

IMPACT AND IMPORTANCE

If the application succeeds, psilocybin use by adults in South Africa would be regulated, not criminally prohibited.

It is worth noting that key figures such as President Kgalema Motlanthe and Justice Edwin Cameron have previously made public statements challenging the assumption that criminal prohibition serves the goal of harm reduction.

The applicants' founding papers highlight many other foreign countries, which never even saw fit to outlaw mushrooms in the first place, or are electing to bring them back into their legal systems, in recognition of that psilocybin use should be regulated, instead of criminalised.

Cromhout emphasises that the people approaching her to supervise them while they take psilocybin *"are not simply (as one might expect) artists, hippies, or other creatives. They include high-powered businessmen and women, politicians, doctors, lawyers, engineers, and former members of the military and SAPS. … Many of these people are forced to hide the fact that they have elected to undertake a psilocybin experience, which they found deeply helpful to them because, if it was discovered that they*

were involved in unlawful conduct, this could have a significant impact on their careers, livelihoods, and even personal freedoms. But that is not so if the same people use and abuse cigarettes, alcohol, gambling, or cannabis".

There are, undoubtedly, many people in South Africa who would benefit from psilocybin, but who do not wish to try it because it is a criminal offence to do so. The applicants emphasise that psilocybin being legal would not oblige any adult person to try it – that would remain entirely their choice.

RULE 16A NOTICE

Concluding the following application pack is a Notice in terms of Rule 16A, which invites *'friends of the court'* to join these proceedings with unique perspectives and facts that might not be covered by the applicants, or any opposing respondents. The document also serves as a handy summary of the legal and constitutional issues that have been raised for consideration.

PRIVACY & QUERIES

The applicants would like their privacy to please be respected. So, please refer media and other queries to paul-michael@greencounsel.co.za and ricky@greencounsel.co.za.

Thank you!

THE CULLINANS EARTH MEDICINES TEAM
18 APRIL 2024

COURT ONLINE COVER PAGE

IN THE HIGH COURT OF SOUTH AFRICA
Gauteng Division, Pretoria

CASE NO: **2024-040119**

In the matter between:

Monica Dorothy Cromhout ,Melinda Ferguson	Plaintiff / Applicant / Appellant
and	
Minister of Justice and Constitutional Development,National Director of Public Prosecutions,Minister of Health,Minister of Police,Minister of Social Development	Defendant / Respondent

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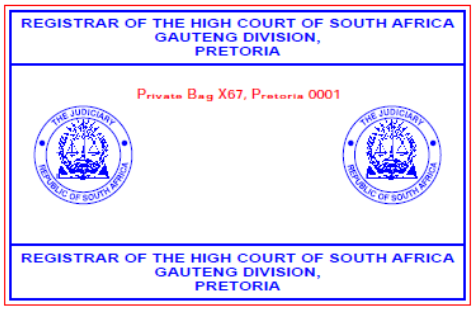
Notice of Motion (Long Form)

NOTE: **This document was filed electronically by the Registrar on 12/4/2024 at 10:54:02 AM South African Standard Time (SAST). The time and date the document was filed by the party is presented on the header of each page of this document.**



ELECTRONICALLY SIGNED BY:

Registrar of High Court of South Africa , Gauteng Division,Pretoria

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: _____

In the matter between:

MONICA CROMHOUT	First Applicant
MELINDA FERGUSON	Second Applicant

and

MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
MINISTER OF POLICE	Fourth Respondent
MINISTER OF SOCIAL DEVELOPMENT	Fifth Respondent

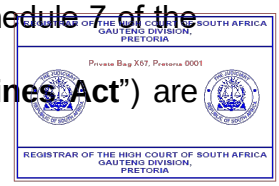
NOTICE OF MOTION

PLEASE TAKE NOTICE THAT the applicants will make an application to the above Honourable Court, on a date to be allocated by the Registrar, at 10h00, or so soon thereafter as counsel may be heard, for an order in the following terms: -

1. It is declared that the references to 'psilocybin' and 'psilocin' in Part III of Schedule 2 of the Drugs and Drugs Trafficking Act 140 of 1992 ("**the Drugs Act**") are unconstitutional and invalid.

2. The words 'psilocybin' and 'psilocin' are struck out from Part III of Schedule 2 of the Drugs Act.

3. It is declared that the references to 'psilocybin' and 'psilocin' in Schedule 7 of the Medicines and Related Substances Act 101 of 1965 ("**the Medicines Act**") are declared unconstitutional and invalid.



4. The words 'psilocybin' and 'psilocin' are struck out from Schedule 7 of the Medicines Act.

5. <u>In the alternative to paragraphs 1 to 4 above</u>:

   5.1. Sections 3, 4(b), and 5(b) of the Drugs Act are declared unconstitutional and invalid to the extent that these provisions criminalise the private use and possession of psilocybin and psilocin by adults, including but not limited to private supervised use.

   5.2. Sections 3, 4(b), and 5(b) of the Drugs Act are declared unconstitutional and invalid to the extent that these provisions criminalise: manufacturing; cultivating; collecting; possessing; selling; administering; 'dealing in' (as defined in section 1 of the Drugs Act); and/or supplying, psilocybin and psilocin - for the purposes described in paragraph 5.1 above.

   5.3. Sections 22A(9)(a)(i), 22A(9)(a)(ii) and 22A(10) of the Medicines Act are declared unconstitutional and invalid to the extent that these provisions

criminalise the private use and possession of psilocybin and psilocin by adults, including private supervised use.

5.4. Sections 22A(9)(a)(i), 22A(9)(a)(ii) and 22A(10) of the Medicines Act are declared unconstitutional and invalid to the extent that these provisions criminalise: acquiring, possessing, manufacturing, supplying, selling, and/or administering psilocybin and psilocin – for the purposes set out in paragraphs 5.3 above.

6. In the alternative to paragraphs 5 to 5.4 above, the above-mentioned provisions of both the Drugs and Drugs Trafficking Act 140 of 1992 and the Medicines and Related Substances Act 101 of 1965 must be read so as not to prohibit or criminalise the activities set out in paragraphs 5 to 5.4 above.

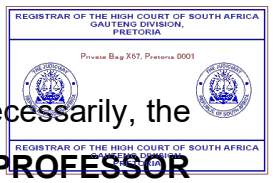
7. The declarations of constitutional invalidity (in respect of paragraphs 1 to 5.4 above, as the case may be) are suspended for a period of 24 months to allow for the constitutional defects to be remedied by Parliament and/or the relevant respondents, as the case may be.

8. From the date of this judgment, and until Parliament and/or the relevant respondents (as the case may be) remedy the aforesaid constitutional defects, a moratorium is placed on all criminal investigations, arrests, prosecutions, and/or ancillary criminal proceedings in respect of the activities set out in paragraphs 5 to 5.4 above.

9. The costs of this application are to be paid by any respondents who oppose the application, jointly and severally, including the costs of two counsel.

10. Further or alternative relief, including in accordance with sections 172 and 173 of the Constitution.

TAKE NOTICE FURTHER that the founding affidavit of **MONICA CROMHOUT,** supporting affidavit of **MELINDA FERGUSON**, and supporting *expert* affidavit of **PROFESSOR DAVID NUTT**, together with the annexures thereto, will be used in support of this application.



TAKE NOTICE FURTHER that, so as to not burden the court papers unnecessarily, the various academic papers and studies referred to in the expert affidavit of **PROFESSOR DAVID NUTT**, which are voluminous, have not been attached to the founding affidavit or the expert affidavit. They can, however, be made available electronically to any of the respondents, by written request, or to the Honourable Court.

TAKE NOTICE FURTHER that the applicants have appointed the addresses of **CULLINAN & ASSOCIATES**, 18A Ascot Road, Cape Town, 7708 care of **MACINTOSH CROSS & FARQUHARSON**, 834 Pretorius St, Arcadia, Pretoria, as the address at which they will accept notice and service of all process in these proceedings. The applicants will accept electronic service of documents at the following email addresses: **paul-michael@greencounsel.co.za** and **ricky@greencounsel.co.za**. If service is being effected electronically, please also send a text/WhatsApp message to, or call **076-273-8019** or **082-429-7084**, to confirm that the served documents have been received.

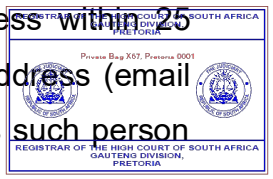
TAKE NOTICE FURTHER that, if any of the respondents intend to oppose the application, they are required to:

(a) notify the applicants' attorneys in writing of their intention to oppose the application, and file a copy of such notice with the Registrar of this Court, within **10 days** of the service of this application;

(b) deliver their answering affidavit/s (if any) within **15 days** of the date on which the notice of intention to oppose was delivered;

(c) if any of the respondents intends to raise any question of law only, such respondent shall deliver notice of intention to do so, setting forth such question, within the time stated in paragraph (b) immediately above;

(d) in terms of Rule 6(5)(d) of the Uniform Rules, appoint an address within 25 kilometres of the Office of the Registrar and an electronic mail address (email address), if available to such person, at either of which addresses such person will accept notice and service of all documents in these proceedings.



TAKE NOTICE FURTHER that, if no notice of intention to oppose the relief sought in this application is received, the relief sought in the notice of motion will be sought from this Court on the unopposed roll, on a date, and at a time, allocated by the Registrar of this Honourable Court.

DATED at Cape Town on this 12th day of April **2024**.

CULLINAN & ASSOCIATES
Applicants' Attorneys
PER: **PAUL-MICHAEL KEICHEL**
PER: **RICKY STONE**
18A Ascot Road
Cape Town
7708
Tel: 021 671 7002

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Email: **Paul-Michael@greencounsel.co.za**;

Ricky@greencounsel.co.za

Ref: C079-001

With thanks to **SEBASTIAN FOSTER**

C/O: **MACINTOSH CROSS & FARQUHARSON**

834 Pretorius St

Arcadia

Pretoria

0007

Tel: 012 342 4855

jk@macintoshcross.co.za

vm@macintoshcross.co.za

Ref: J Keus/X57/2024

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION, PRETORIA
Private Bag X67, Pretoria 0001

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**
PRETORIA

AND TO: **THE MINISTER OF JUSTICE AND**
CONSTITUTIONAL DEVELOPMENT
First Respondent
Salu Building
316 cnr Thabo Sehume and Francis Baard Streets
Private Bag X81,
Pretoria
0001
BY SHERIFF

AND TO: **THE NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS**

Second Respondent

VGM Building

123 Westlake Ave

Weavind Park

Silverton

Pretoria

0184

BY SHERIFF

AND TO: **THE MINISTER OF HEALTH**

Third Respondent

Dr AB Xuma Building

1112 Voortrekker Rd

Pretoria Townlands 351-JR

Pretoria

0187

BY SHERIFF

AND TO: **THE MINISTER OF POLICE**

Fourth Respondent

231 Pretorius Street

756-7th floor Wachthuis Building

Pretoria

0002

BY SHERIFF

AND TO: **MINISTER OF SOCIAL DEVELOPMENT**

Fifth Respondent

134 Pretorius Street

Pretoria Central

Pretoria

0002

BY SHERIFF

AND TO: **THE STATE ATTORNEY**

316 Thabo Sehume St

Pretoria Central

Pretoria

0001

Phone**: 012 309 1500**

BY SHERIFF

THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

CASE NO: 2024-040119

In the matter between:

MONICA CROMHOUT	First Applicant
MELINDA FERGUSON	Second Applicant
and	
MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
MINISTER OF POLICE	Fourth Respondent
MINISTER OF SOCIAL DEVELOPMENT	Fifth Respondent

FOUNDING AFFIDAVIT

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I, the undersigned,

MONICA CROMHOUT

state the following under oath.

1 I am an adult female, currently residing in Somerset West in the Western Cape, South Africa.

2 I am duly authorised to depose to this affidavit on behalf of the applicants.

3 The facts and allegations set out in this affidavit, save where the contrary is indicated by the context, are all within my personal knowledge and are, to the best of my knowledge and belief, both true and correct. Where I make any legal submissions, I do so on the basis of legal advice, which I believe to be correct.

THE PARTIES

4 As set out above, I am the first applicant. The application is brought:

4.1 in the applicants' own interests; as well as

4.2 in the public interest, under section 38(d) of the Constitution.

5 The second applicant is **MELINDA FERGUSON**.[1] She is an award-winning publisher, bestselling author and a freelance journalist, contributing to print and radio for various media companies, including *Cape Talk*, *City Press*, *Daily Maverick* and *Kaya FM*. A supporting affidavit from Ms Ferguson is delivered with this affidavit. In order to avoid burdening the papers, I do not in this affidavit traverse everything that Ms Ferguson

[1] The second applicant's name according to her identity document is Melinda Yazbek, but she is more commonly known by her publishing name: Melinda Ferguson. This is addressed in her supporting affidavit.

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says in her affidavit, save for emphasising particular aspects. Ms Ferguson's entire affidavit should be read as being part of the founding affidavit (and as if it had been expressly traversed in the founding affidavit).

6 The first respondent is the **MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT**, who is cited herein in their official capacity as head of the Department of Justice and Constitutional Development, with their office situated at Momentum Building, 329 Corner Prinsloo and Pretorius Streets, Pretoria. The Minister is also served care of the State Attorney in Pretoria, at 316 Thabo Sehume Street, Pretoria. The Minister is cited for any interest the Minister may have in the matter.

6.1 No order is sought against the first respondent, save for an order for costs in the event that the Minister decides to oppose the relief sought in this application.

7 The second respondent is the **NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS**, who is cited herein in their official capacity as head of the National Directorate of Public Prosecutions, with their office situated at Victoria & Griffiths Mxenge (VGM Building), 123 Westlake Avenue, Weavind Park, Silverton, Pretoria. The Minister is also served care of the State Attorney in Pretoria, at 316 Thabo Sehume Street, Pretoria. The second respondent is responsible for the institution and conduct of criminal proceedings on behalf of the State, the carrying out of any necessary functions incidental to the institution and conduct of such criminal proceedings and the discontinuance of criminal proceedings. The second respondent is cited for any interest the second respondent has in the matter.

7.1 No order is sought against the second respondent, save for an order for costs in the event that the Minister decides to oppose the relief sought in this

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application.

8 The third respondent is the **MINISTER OF HEALTH**, who is cited herein in their official capacity as head of the Department of Health, with their office situated at Civitas Building, Floor 20, corner of Struben and Andries Streets, Pretoria. The Minister is also served care of the State Attorney in Pretoria, at 316 Thabo Sehume Street, Pretoria. The third respondent is the Minister responsible for some of the legislation relevant to this matter, and is cited for any interest the Minister may have in the matter.

8.1 No order is sought against the third respondent, save for an order for costs in the event that the Minister decides to oppose the relief sought in this application.

9 The fourth respondent is the **MINISTER OF POLICE**, who is cited herein in their official capacity as head of the South African Police Services, with their office situated at Wachthuis, 7th Floor, 231 Pretorius Street, Pretoria. The Minister is also served care of the State Attorney in Pretoria, at 316 Thabo Sehume Street, Pretoria. At a national level, the fourth respondent is responsible for preventing, combatting and investigating crime, maintaining public order, and investigating crimes. The fourth respondent is cited in relation to any interest the Minister has in the matter.

9.1 No order is sought against the third respondent, save for an order for costs in the event that the Minister decides to oppose the relief sought in this application.

10 The fifth respondent is the **MINISTER OF SOCIAL DEVELOPMENT**, who is cited herein in their official capacity as head of the Department of Social Development, with their office situated at 134 Pretorius Street, HSRC Building, Pretoria. The Minister is also served care of the State Attorney in Pretoria, at 316 Thabo Sehume Street,

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Pretoria. The fifth respondent is the Minister responsible for social development, whose Department is the author of the National Drug Masterplan 2019 to 2024, and is accordingly cited in respect of any interest that the Minister has in this matter.

10.1 No order is sought against the third respondent, save for an order for costs in the event that the Minister decides to oppose the relief sought in this application.

11 I respectfully invite the respondents not to oppose the declaration of constitutional invalidity sought in this application. I am enormously proud to live in a country where the representatives of the state carefully consider the submissions of their citizens and, where the representatives agree, do not oppose applications. There are various recent examples of this admirable stance – for instance, in *EB (born S) v ER (born B) and Others; KG v Minister of Home Affairs and Others* [2023] ZACC 32; 2024 (2) SA 1 (CC).

11.1 None of the current Ministers were responsible for psilocybin being scheduled in the manner that it has been.

11.2 Moreover, even if they had been, it would certainly be legitimate and appropriate to revisit their stance in relation to psilocybin.

11.3 That is particularly so given:

11.3.1 the expert evidence set out in the founding papers from one of the world leaders in the field of psilocybin research, which demonstrates the benefits of psilocybin and that – properly used according to the correct information – psilocybin carries very few (if any) risks and harms;

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11.3.2 the positive developments around the world in relation to treating (even dangerous and harmful drugs) as a public health issue, rather than a criminal law issue; and

11.3.3 the holdings by the Constitutional Court in the 2018 ***Prince***[2] matter, in which the Constitutional Court found that certain sections of the Drugs and Drug Trafficking Act 140 of 1992 ("**the Drugs Act**") and the Medicines and Related Substances Control Act 101 of 1965 ("**the Medicines Act**") to be unconstitutional[3] on the basis that they criminalise the use or possession in private, or cultivation (in a private place) of cannabis by an adult for his or her own personal consumption in private.

12 I, accordingly, respectfully invite the state respondents to consider the contents of this affidavit, the Constitutional Court's judgment in ***Prince***, and the expert evidence. This application, then, would not be a citizen challenging state conduct, but citizens working with the state in order to approach the courts to secure needed constitutional reform in relation to a substance that is found in nature. That kind of mutual cooperation is a hallmark of what makes South Africa such a unique and impressive constitutional democracy, and as I show below would be entirely consistent with the suggested policy going forward from various state actors, and the findings of the Constitutional Court.

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[2] *Minister of Justice and Constitutional Development and Others v Prince (Clarke and Others Intervening); National Director of Public Prosecutions and Others v Rubin; National Director of Public Prosecutions and Others v Acton* [2018] ZACC 30, 2018 (6) SA 393 (CC).

[3] Sections 4(b) and 5(b) of Drugs and Drug Trafficking Act 140 of 1992 read with Part III of Schedule 2 of that Act and section 22A(9)(a)(1) of the Medicines and Related Substances Control Act 101 of 1965.

7

INTRODUCTION

13 This application concerns the constitutional validity of those sections and aspects of the Drugs Act and the Medicines Act that criminalise and prohibit the use, possession, cultivation, supply and distribution of psilocybin mushrooms and/or psilocin.[4]

14 I am 78 years old. I am a retired trauma counsellor and a grandmother.

15 In 2005, my husband passed away after a painful battle with pancreatic cancer. We were married for 16 years. His death left me in a serious struggle with depression. When modern medicines were not assisting me, after doing extensive reading and research, I decided to experiment with a few natural substances and remedies.

16 This research culminated in me experimenting with psilocybin mushrooms.

17 I emphasise, at the outset, that this was a step that was quite out of character for me at the time. I was already a pensioner. Throughout my life, I have always obeyed the law. I have never even been interested in drinking alcohol, or smoking cigarettes. But it is difficult to overstate just how much psilocybin helped me. I describe these benefits below in more detail.

18 I was sure that there must be other people in the same position I had been in: desperately depressed and not sure where to turn. After I became persuaded about the benefits of psilocybin, and had been taking psilocybin mushrooms myself for a number of months, as well as reading extensively on the topic, I decided that I would assist any other adults who wished to try it, but who wished to do so:

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[4] Psilocin is the metabolite of psilocybin (as addressed in the accompanying expert affidavit of Professor David Nutt). For the purpose of this affidavit, where I refer to psilocybin only, it is to be understood to extend equally to psilocin.

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18.1 in a safe, supervised environment;

18.2 with instructions, advice and guidance from myself and other helpers/watchers who have practical and theoretical experience of working with psilocybin; and

18.3 importantly, with safe access to the correct kind of psilocybin mushrooms.

19 But, in December 2014, I was arrested and charged, amongst other things, as a *drug dealer*. If convicted, I could face 15 years in prison.

20 The relevant sections are: section 4 and section 5 of the Drugs Act read with Part III of Schedule 2 of the Drugs Act. An extract of these provisions, together with the relevant provisions of the Medicines Act, is attached as '**FA1**' ("**the impugned provisions**").

21 I emphasise at the outset that, when I refer to "psilocybin mushrooms", or "psilocybin", throughout this affidavit, I am not referring to any synthetic human-made drug in a laboratory, like fentanyl, cocaine or heroin.

22 Quite the opposite, I am referring to actual, physical mushrooms that grow and exist in nature, some of which I understand to be uniquely indigenous to South Africa and part of our cultural heritage. If one takes a walk around certain dense forest areas in South Africa (and in many parts around the world), psilocybin mushrooms could be found growing in some places, if one knows what to look for. A few photographs of psilocybin mushrooms, both in their natural habitat, as well as dried and ready for consumption, are attached as '**FA2**'.

23 I respectfully submit that the impugned provisions:

23.1 plainly limit a number of constitutional rights (set out in detail below), including

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the right to autonomy of one's own consciousness and the right to privacy;

23.2 are premised on unfounded, outdated evidence, that allegedly supports claims that psilocybin is harmful/undesirable and dependence-producing;

23.3 are irrational and therefore inconsistent with the fundamental principles of the rule of law and the principle of legality; and

23.4 cannot be justified under the rights limitations requirements under section 36 of the Constitution.

24 Psilocybin is listed (irrationally, in my respectful submission) as an "*Undesirable Dependence-Producing Substance*".[5] Indeed, psilocybin is placed in the same category as *heroin* and *fentanyl*: widely regarded (and I do not dispute the legitimacy of this classification) as two of the most dangerous and destructive drugs of abuse in the world. The classification of psilocybin – alongside those dangerous drugs – is incorrect, irrational and unjustifiable, when the latest empirical science on these issues is considered (and, for that matter, when science that is decades old is considered).

25 On this score, the applicants file together with the founding affidavit an expert affidavit from Professor David Nutt. Professor Nutt is a Professor of Neuropsychopharmacology at Imperial College, London, and an honorary consultant psychiatrist. He is the Director the Imperial College Centre for Psychedelic Research and one of the leading experts in the field worldwide. Professor Nutt not only draws on his own research, but conducts an impressive literature review of the key research of other leading experts.

[5] In terms of Schedule 2 Part III of the Drugs Act and Schedule 7 of the Medicines Act.

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26 I would have liked to have been specific in my cross references to Professor Nutt's affidavit within this affidavit, but my worsening ill-health is such that it has become imperative that I depose to this affidavit *post haste* and prior to the finalisation of Professor Nutt's affidavit, which Professor Nutt is finalising in liaison with my legal team at the time of my deposition hereto. I am advised that cross references will be accurately provided in heads of argument.

27 Professor Nutt's expert affidavit demonstrates, *inter alia*, that psilocybin:

27.1 does not produce withdrawal symptoms;

27.2 does not increase the risk of addiction, even in people with a history of substance abuse;

27.3 is not associated with any negative long-term changes in personality or cognitive function; and

27.4 is not a substance with any high or even meaningful risk of lethal overdose (in fact, there is no known evidence of any lethal overdose caused by psilocybin).

28 Quite the opposite, the evidence that Professor Nutt highlights in his report demonstrates that the use of psilocybin has various beneficial effects and that it is effective in treating addiction, post-traumatic stress disorder, and depression (even treatment-resistant depression). Notably, psilocybin is more effective, both in the short and long terms, than medications such as SSRI anti-depressants and produces less adverse side effects for the user.

29 But – even assuming for the purposes of argument that some *minor* harms existed (though this is incorrect and denied) – that, in any event, would not justify criminalisation under our Constitutional regime. Our Parliament correctly accepts, as

most open and democratic societies do, that part of an adult person's rights to autonomy and dignity, privacy, freedom of expression, and freedom of association, means that they are free and able to choose to participate in a range of different activities, even where these activities may have *significant* risks of harm. *Volenti non fit injuria* - to which (certain) drug use seems to be an unjustified and hypocritical exception.

30 There are, for example, risks in taking commercial airline flights; and driving cars or buses on busy roads. People undertake life-threatening surgeries for purely cosmetic reasons. People participate in a range of extremely dangerous sporting activities, like skydiving, rugby, mountain climbing, big wave surfing, and base jumping. But the law permits all of this. The law also presently allows for the consumption of far more harmful substances, such as alcohol and tobacco (and, now, cannabis).

31 Indeed, during the Covid-19 pandemic, our Courts rigorously and correctly defended people's rights to sell and purchase cigarettes and alcohol. Not because cigarettes or alcohol do not cause harm or have risks, but – rather – in spite of the harms that those substances are known to cause. Why? Because adults, in a Constitutional democracy like ours, are entitled to consider those risks and decide how they will conduct themselves.[6]

32 But that is not legally so with psilocybin. I trace the growing trend of countries around the world that have decriminalised psilocybin in particular, or even harmful and addictive drugs more generally. The applicants demonstrate below that, once the private use of cannabis has been decriminalised, it is *per se* irrational that psilocybin remains criminalised.

[6] *Minister of Cooperative Governance and Traditional Affairs and Another v British American Tobacco South Africa (Pty) Ltd and Others* (case no 309/21) [2022] ZASCA 89 (14 June 2022).

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33 It is important to emphasise that it is not the case of the applicants that there could or should be no *regulation* of psilocybin whatsoever, especially because legalisation has been proven world-over to be a better means of addressing/mitigating the harms of substance abuse than decriminalisation only, *albeit* that both have proven more effective and less restrictive than criminal prohibition. The applicants' case is different.

33.1 It is that the law bluntly criminalises psilocybin and therefore does not deal with other important (more nuanced) questions about regulating it.

33.2 Regulation is an inherently less restrictive (and it transpires, more effective) means than criminalisation at reducing harms. And I am advised that the Constitutional Court has made clear in numerous cases that the State cannot "*use a sledgehammer to crack a nut*" (or Nutt).

33.3 Former-Justice of the Constitutional Court, Justice Edwin Cameron, writing in an academic capacity, has explained that the origin of criminalisation was a relic of the apartheid government. He states:

> *"Behind the misplaced use of criminal law lies a deep-rooted belief that criminal punishments should be inflicted on those considered deviant. The apartheid state was premised on this notion. South Africa has a history of using criminal law broadly and brutally, not only in minutely enforcing apartheid's misery but in persecuting sex workers and in hounding sexually and gender-diverse people."*

33.4 A copy of Justice Cameron's article, dated 19 August 2020, entitled *'Enemies of the nation: How the "war on drugs" has failed South Africa'* is attached as **'FA3'**.

34 In fact, that we ought to be moving away from using the sledgehammer of our criminal justice system to mitigate the harms of drug abuse, and towards a different way of addressing the health and social problems of substance abusers (who do not forfeit their human rights because they have found themselves in trouble) is acknowledged

and echoed within our own National Drug Master Plan, 2019 to 2024, published by the Department of Social Development (the fifth respondent).

35 In what follows, I deal with the following issues in turn:

35.1 In Part 1:

35.1.1 my pending criminal trial;

35.1.2 the nature of the act and the impugned provisions;

35.1.3 Professor Nutt's expert report which demonstrates that expert perspective: psilocybin is neither harmful, nor addictive;

35.1.4 the applicants' personal experiences regarding the harms caused by criminalisation; and

35.1.5 additional evidence supporting the applicants' case.

35.2 In Part 2:

35.2.1 the grounds of the constitutional challenge;

35.2.2 the limitations analysis;

35.2.3 the appropriate remedy; and

35.2.4 the conclusion.

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PART 1

MY PENDING CRIMINAL TRIAL

36 I have had to appear in the criminal courts related to the pending charges on four occasions. My charges were stayed in February 2016 (a copy of the Court order is attached as '**FA4**') to provide me with an opportunity to challenge the criminalisation of psilocybin, which I did, by way of launching action proceedings under case number 6819/18 out of the Western Cape Division, Cape Town, of the High Court of South Africa (**"my action proceedings"**).

37 However, in January of 2018, I was diagnosed with breast cancer. I had a double mastectomy and underwent chemotherapy and radiation. Throughout 2018, I continued with hormonal and other cancer treatments. Since then, my health has been compromised and I have been in hospital on numerous occasions. This is one of the reasons why the progress on my action proceedings, challenging the constitutionality of psilocybin, has stagnated.

38 Should it be necessary, I can deliver a notice of withdrawal in my action proceedings. I can also make available copies of the papers exchanged in my action proceedings to the Court and/or to any opposing respondents in this matter.

THE NATURE OF THE ACT AND THE IMPUGNED PROVISIONS

39 I now turn to demonstrate why the impugned provisions are unconstitutional to the extent that they prohibit the use of psilocybin. To place the offences created in context, it is necessary to sketch briefly the architecture of the Drugs Act.

40 As indicated by its long title, the Drugs Act aims to, *inter alia*, provide for the prohibition of the use or possession, or the dealing in, of drugs.

41 Section 3 of the Drugs Act provides:

> *"3 Manufacturing and supplying of scheduled substances*
>
> *No person shall manufacture any scheduled substance or supply it to any other person, knowing or suspecting that and such scheduled substance is to be used in or for the unlawful manufacture of any drug."*

42 Section 4 of the Drugs Act provides:

> *"4 Use and possession of drugs*
>
> *No person shall use or have in his possession-*
>
> *(a) any dependence-producing substance; or*
>
> *(b) any dangerous dependence-producing substance or any undesirable dependence-producing substance,*
>
> *unless-*
>
> *he is a patient who has acquired or bought any such substance-*
>
> *(aa) from a medical practitioner, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder; or*
>
> *(bb from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, dentist or practitioner,*
>
> *and uses that substance for medicinal purposes under the care or treatment of the said medical practitioner, dentist or practitioner;*
>
> *(ii) he has acquired or bought any such substance for medicinal purposes-*
>
> *(aa) from a medical practitioner, veterinarian, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder;*
>
> *(bb) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, veterinarian, dentist or practitioner; or*
>
> *(cc) from a veterinary assistant or veterinary nurse in terms of a prescription in writing of such veterinarian,*
>
> *with the intent to administer that substance to a patient or animal under the care or treatment of the said medical practitioner, veterinarian, dentist or practitioner;*
>
> *(iii) he is the Director-General: Welfare who has acquired or bought any such substance in accordance with the requirements of the Medicines Act or any regulation made thereunder;*
>
> *(iv) he, she or it is a patient, medical practitioner, veterinarian, dentist, practitioner, nurse, midwife, nursing assistant, pharmacist, veterinary assistant, veterinary nurse, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter, or any other person contemplated in the Medicines Act or any regulation made thereunder, who or which has acquired, bought, imported, cultivated, collected or manufactured, or uses or is in possession of, or intends to administer, supply, sell, transmit or export any such substance in accordance with the requirements or conditions of the said Act or regulation, or any permit issued to him, her or it under the said Act or regulation;*

(v) he is an employee of a pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter who has acquired, bought, imported, cultivated, collected or manufactured, or uses or is in possession of, or intends to supply, sell, transmit or export any such substance in the course of his employment and in accordance with the requirements or conditions of the Medicines Act or any regulation made thereunder, or any permit issued to such pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter under the said Act or regulation; or

(vi) he has otherwise come into possession of any such substance in a lawful manner.

(vii) in the case of an adult, the substance is cannabis and he or she uses it or is in possession thereof in private for his or her personal consumption in private."

43 Section 5 of the Drugs Act provides:

"5 <u>Dealing in drugs</u>

No person shall deal in-

(a) any dependence-producing substance; or

(b) any dangerous dependence-producing substance or any undesirable dependence-producing substance,

unless-

(i) he has acquired or bought any such substance for medicinal purposes-

(aa) from a medical practitioner, veterinarian, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(bb) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, veterinarian, dentist or practitioner; or

(cc) from a veterinary assistant or veterinary nurse in terms of a prescription in writing of such veterinarian,

and administers that substance to a patient or animal under the care or treatment of the said medical practitioner, veterinarian, dentist or practitioner;

(ii) he is the Director-General: Welfare who acquires, buys or sells any such substance in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(iii) he, she or it is a medical practitioner, veterinarian, dentist, practitioner, nurse, midwife, nursing assistant, pharmacist, veterinary assistant, veterinary nurse, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter, or any other person contemplated in the Medicines Act or any regulation made thereunder, who or which prescribes, administers, acquires, buys, transhipps, imports, cultivates, collects, manufactures, supplies, sells, transmits or exports any such substance in accordance with the requirements or conditions of the said Act or regulation, or any permit issued to him, her or it under the said Act or regulation; or

(iv) he is an employee of a pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter who acquires, buys, transhipps, imports, cultivates, collects, manufactures, supplies, sells, transmits or exports any such substance in the course of his employment and in accordance with the requirements or conditions of the Medicines Act or any regulation made thereunder, or any permit

> *issued to such pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter under the said Act or regulation."*

44 Part III of Schedule 2 to the Drugs Act classifies psilocybin as an *"Undesirable dependence-producing substance"*. In this way, these sections prohibit the use of psilocybin mushrooms, as they contain psilocybin, which is classified as an "*undesirable dependence-producing substance*".

45 Contrary to these provisions, the evidence contained in this affidavit, as well as the expert affidavit by Professor Nutt, demonstrates that psilocybin mushrooms are neither dependence-producing, nor undesirable (the first being a pharmacological consideration and the latter being a government policy election related to how best to deal with substances that the public use, including cigarettes, alcohol and cannabis).

EXPERT PERSPECTIVE: PSILOCYBIN IS NEITHER HARMFUL NOR ADDICTIVE

46 I have been advised and submit that any legislation which has the resultant effect of infringing or limiting upon any right in the Constitution, must be rationally related to a legitimate governmental purpose, and be reasonable and justifiable in an open and democratic society based on dignity, equality and freedom.

47 The overarching purpose of the impugned provisions appear from the long title of the Drugs Act, which states that the purpose of the Act is to:

> *"[P]rovide for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes; for the obligation to report certain information to the police; for the exercise of the powers of entry, search, seizure and detention in specified circumstances; for the recovery of the proceeds of drug trafficking; and for matters connected therewith."*

48 It is useful, at this stage, to summarise the purpose of the impugned provisions and the factual allegations and presuppositions on which they are based (which are

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unsustainable), so that I may demonstrate why the applicants submit that the impugned provisions as unconstitutionally infringing upon fundamental rights.

49 Conceptually, the impugned provisions are underpinned by the following incorrect factual propositions:

49.1 psilocybin is an undesirable substance;

49.2 psilocybin is a dependence-producing substance; and

49.3 the *'harmful'* effects of psilocybin outweigh its benefits.

50 Professor Nutt's expert affidavit demonstrates that all of these propositions are incorrect. Once that is so, there is no rational link between the prohibition and the intended purposes.

(i) Psilocybin is not an undesirable substance

51 Psilocybin has been used by human beings for millennia. As Professor Nutt's expert report points out –

> *"The Ancient Greeks are thought to have used psilocybin in their Elysian celebrations and the "soma" of ancient Indian culture also probably contained psilocybin along with other natural products such as ephedra and cannabis. The ancient Incas and Aztecs also valued psychedelic mushrooms as means of communicating with higher powers and gods. There is good evidence from rock carvings of psychedelic mushroom use in Africa over 10,000 years ago."*

52 Professor Nutt notes that, in the United Kingdom, psilocybin is widely used privately by over 1 million people every year, even though it is criminalised. It could hardly be suggested that criminalisation functions as a deterrent, which prevents members of the public from sourcing or trying it. But two things are important.

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53 First, criminalisation may mean that members of the public are at risk that the substance they are purchasing is psilocybin and has not been treated or mixed with other dangerous substances.

54 Second, the claim that psilocybin is a dangerous and abused drug is not supported by the empirical evidence.

54.1 In fact, quite the opposite: psilocybin was rated as *one of the least harmful drugs* in three independent expert group reviews using the most modern quantitative MCDA (multi-criteria decision analysis) methodology.

54.2 The first, in 2010, with UK experts, compared the harms of 20 popular recreational drugs using the most sophisticated multi-criteria decision analysis technique.

54.3 A similar finding was made in a separate study funded by the European Justice Department, with a group of European drug experts from 20 different countries.

54.4 The third study in 2018, which was conducted by Australian experts, conflated psilocybin and LSD together and still found them at the lowest end of the harm scale.

(ii) Psilocybin is not a dependence-producing substance

55 Psilocybin does not have an addictive effect, according to current (but also decades old) science.

56 As a matter of fact, many psychedelics do not have such an effect. In his expert report, Professor Nutt concludes that the use of psilocybin does not lead to dependence or addiction in humans:

> *"Psilocybin is not habit forming in animals or humans and is not capable of producing sufficient reinforcing effects to cause dependence. Animal models (i.e., self-administration, conditioned place preference) have failed to reliably demonstrate addictive liability of 5 hydroxytryptaminergic hallucinogens including psilocybin, suggesting that they do not possess the pharmacological properties to initiate or maintain dependence. This lack of dependence liability of psilocybin is in stark contrast to other drugs included in Schedule 1 such as strong opioid, crack cocaine and methamphetamine, all of which are profoundly addictive."*

(iii) The potential benefits of psilocybin outweigh any potential risks

57 In his expert affidavit – citing many other studies, authorities, and leading scientific expert – Professor Nutt explains that psilocybin use has various positive effects.

58 Again, I request that Professor Nutt's entire report be read as part of the founding affidavit. For present purposes, however, I highlight the following studies in particular.

A. Depression

59 A study conducted in 2017 by the Imperial College London, referred to in Professor Nutt's report, demonstrated the benefits of psilocybin when dealing with depression:

59.1 the study saw nineteen patients, struggling with depression, take two doses of synthesised psilocybin a week apart.

59.2 the patients had two brain scans following each dose. Thereafter, researchers examined the scans and noted that there was a decrease in blood flow to certain areas of the brain linked to emotional processing, stress, and fear.

59.3 furthermore, the research found that:

> *"psilocybin produced large and significant decreases in clinician-rated and self-rated measures of depression, anxiety or mood disturbance, and increases in measures of quality of life, life meaning, death acceptance, and optimism. These effects were sustained at 6 months."*

60 Dr Robin Carhart-Harris, one of the authors of the study, also based at Imperial College London, said that psilocybin could be a viable alternative to antidepressants, which mute emotions and have various other adverse side effects that include sexual dysfunction.

B. Addiction

61 John Hopkins University, highly regarded around the world for the standards of its medical research, conducted a study on the effects which psilocybin has on addiction. The study, which focused on smoking abstinence, found that two to three moderate to high doses (20 and 30 mg/70 kg) of psilocybin (a serotonin 2A receptor agonist), in combination with cognitive behavioural therapy for smoking cessation, resulted in substantially higher 6-month smoking abstinence rates than are typically observed with other medications or simply using cognitive behavioural therapy alone.

62 The study concluded with the researchers finding the following: -

> *"These results suggest that in the context of a structured treatment program, psilocybin holds considerable promise in promoting long-term smoking abstinence. The present study adds to recent and historical evidence suggesting high success rates when using classic psychedelics in the treatment of addiction."*[7]

63 After the study, the head researcher, Dr Matthew Johnson, stated that psilocybin has potential to treat other substance use disorders, including alcohol and cocaine addiction. This demonstrates the key benefits that psilocybin can have. The second applicant, Melinda Ferguson, explains that the scientific research accords with her experience in treating and managing her own addition to serious drugs (including

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5641975/

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heroin). But it is also ironic, given that psilocybin is presently classified in South Africa as *'dependence producing'* and *'undesirable'*.

64 Additional to a pre-journey questionnaire that asks would-be attendees for things like contact details and drug history, I also note that I also ask (but do not require) every person who undertakes a supervised psilocybin experience at my home to fill out a detailed questionnaire after the experience. An overwhelming majority of responders not only found the experience to be enlightening and beneficial immediately after the experience but who have reported similar benefits to me – *i.e.*, that following their experience with psilocybin, they found it easier to refrain from substances that they had previously been extremely addicted to.

65 I pause to mention, *albeit* that this might be out-of-place, that my door is also always open to (and in fact attendees at my home are invited to seek) follow-up support with me to assist with constructively integrating their entheogenic experience into their lives. I could say more on this, but do not wish to burden the Court with unnecessary details.

C. Cancer-related psychiatric distress

66 In a study published by Agin-Liebes et al in the *Journal of Psychopharmacology,*[8] researchers found that psychotherapy involving psilocybin may aid in long-term relief from cancer-related psychiatric distress.

67 An earlier randomised controlled trial compared the effectiveness of single-dose psilocybin vs niacin (a form of vitamin B3) plus psychotherapy in patients with cancer-

[8] Agin-Liebes GI, Malone T, Yalch MM, et al. Long-term follow-up of psilocybin-assisted psychotherapy for psychiatric and existential distress in patients with life-threatening cancer. Journal of Psychopharmacology. 2020

related psychiatric distress. Findings from the earlier trial found that psychotherapy plus psilocybin mitigated psychiatric and existential distress and improved quality of life, and spiritual well-being, up to 7 weeks prior to the experience. At almost 7 months after crossover, 60% to 80% of participants still reported clinically significant antidepressant and anxiety-reducing responses.

68 In the recent study, self-reported symptomatology[9] was followed up over the long term in a group of patients who were included in the earlier parent trial. Fifteen participants agreed to follow-ups at an average of 3.2 and 4.5 years after the administration of psilocybin.

69 The following findings were reported by the researchers:

> *"At both first and second follow-ups, participants reported reductions in feelings of anxiety, depression, hopelessness, demoralization, and anxiety about death. At 4.5-year follow-up, 60% to 80% of participants met clinically significant criteria for antidepressant or antianxiety responses. About 71% to 100% of patients included attributed positive life changes to psychotherapy plus psilocybin—with many rating it as among the "most personally meaningful and spiritually significant experiences of [their] lives."*

Conclusion on claims that psilocybin is harmful and undesirable

70 In light of the above, and in the absence of any real evidence on the harmful effects of psilocybin, it is unfathomable that the prohibition of the substance is justifiable or serves any legitimate purpose. As will be expanded upon in what follows, it is the submission of the applicants that South Africans have the constitutional right to use psilocybin. It is respectfully submitted that this right extends both to self-medication, for treatment of conditions such as depression, as well as adults taking psilocybin because of the positive changes that it can have on one's thinking, feeling and consciousness (*"self-elevation"*, as one could call it). Indeed, nothing in this application

[9] *I.e.*, the psychological and physiological effects experienced by a person.

seeks to make out a case that every adult should try psilocybin or, after trying it should be compelled to continue making use of it. Those are decisions that adults in a constitutional democracy are at liberty to make. Even if it is decriminalised, but necessarily with prohibition maintained on behaviours such as driving under the influence, there is no harm to members of the public who do not wish to try psilocybin – they are entirely at liberty not to do so and the applicants entirely respect those choices.

OUR PERSONAL EXPERIENCES: THE HARM CAUSED BY CRIMINALISATION

71 The constitutional difficulties in criminalising psilocybin are demonstrated by the personal experiences of myself and Melinda Ferguson. As I have already stated above, Ms Ferguson's affidavit should be read as being part of this founding affidavit and, accordingly, I do not repeat her experiences here.

72 It suffices to emphasise again that, as noted above, Ms Ferguson's personal experiences about the benefits of psilocybin echo the clinical research that has been done by Professor Nutt and other leading researchers. Indeed, using psilocybin has helped Ms Ferguson to conquer her stress, anxiety, and addictions to other substances.

73 In order to fully set out the practical effect of the impugned provisions on my fundamental rights, it is necessary for me to set out my personal background in some detail.

74 As will become apparent in the course of this affidavit, I – as a registered traditional healer – use psilocybin mushrooms as part of a sincere (*albeit* not formally-recognised) spiritual practice for myself, as well as for the benefit of other adults who wish to try psilocybin themselves. Accordingly, the averments made under this

heading are extremely personal and explain my religious background, my current religious and spiritual views and what matters to me now.

74.1 I am grateful to live in a constitutional democracy like South Africa, where beliefs and practices are respected even if they are considered to be different from the (sometimes majority) views or stance of others.

74.2 I also pause to note that the Traditional Health Practitioners Act 22 of 2007 excludes dependence-producing substances from the definition of *'traditional medicine'*. As psilocybin and psilocin have been incorrectly and irrationally scheduled as dependence-producing in terms of both the Drugs Act and the Medicines Act, traditional healers like me are prohibited from utilising them. I respectfully submit that this (among other things) underscores my standing to challenge the impugned provisions in the impugned provisions.

My Christian upbringing and religious studies at University

75 During my youth and young adulthood, I lived what might be referred to as a good Christian life. I was actively involved in my church. This was of my own choosing. There was no pressure from my family. From around 12 years old, my greatest pleasure was the time that I spent in private Bible study. In my teen years, I participated in Bible study groups, prayer meetings, youth meetings and outreach programs, and other church activities.

76 When I was 16, I initiated a Sunday School for children in a poverty-stricken area close to our church, but far from my home. Using my pocket money, I travelled by bus and on foot to reach the children each Sunday. At first, I went from door-to-door, speaking with parents about the value of Sunday School for their children. The number of children grew every week and the group (which was also attended by many parents of

the children) eventually became so well attended that it was too big for me to handle on my own. I called in friends from my church to help me.

77 The values that I gained through the religious studies in my younger years have stayed with me, as guiding principles for living a good and decent life, which still serve me in my old age. At approximately the age of 35, I began to study part-time at the University in Port Elizabeth (now known as the Nelson Mandela University). I chose Biblical Studies as one of my subjects for a BA degree, from which I graduated in 1985 at the age of 40. Through this process, I also discovered the value of various other ancient and modern writings, and my beliefs shifted away from a literal interpretation of the Christian Bible as the only explanation for the ultimate mysteries of life.

78 Thus, for approximately 40 years, I have not been involved with any particular organised religion. My studies in theology showed me that various reliegions have important lessons and guidance for the individuals who subscribe to them. My personal (everyday) life, and my interactions with fellow human beings, has been my spiritual practice.

79 In 1977, I trained as a crisis counsellor and, thereafter, I was employed as Director of the 24-hour Lifeline telephone counselling service, first in Port Elizabeth and then in Cape Town. This work was deeply meaningful, and it continued until 1988. During those years, in my interaction with hundreds of people – including many of whom I trained as counsellors – and also with many people from the public who were in trouble, or in pain and severe crisis – my insights became more deeply rooted in practical action, with an understanding that true service to others means enabling them to help themselves through difficult times.

80 When I moved to Cape Town towards the end of 1986, I was a single mother of two teenage children and received little help from my ex-husband, who was unemployed most of the time. Lifeline (my employer at the time) was supported by donations only, and I was paid very little. This situation became financially untenable, but a raise in salary was not an option, due to lack of funds in the organisation. Thus, in 1988, I accepted a position with Protea Assurance as Training and Strategic Planning Manager, with a significantly higher salary.

81 In the two years that I filled this position, I was given extremely useful training. I travelled around the country to fulfil training needs in the various branches of the company, and was introduced to using a computer, rather than an electric typewriter. These experiences would become immensely useful to me in the future. But the insurance industry was a completely different world. In early 1990, I decided to resign. This was a tough decision, as the high salary made it easier to manage financially as a single mother.

82 During this same period of time, a long-term interest in astronomy and other natural cycles led me into an increasingly deep study of astrology. This evolved slowly into regular work, according to which friends or members of my immediate community (knowing my knowledge of the area) would seek my guidance. It was work that was enlightening to me and I believe helpful to the people I worked with. I was invited by the Stellenbosch Hydro to present workshops and consultations for their guests. This part-time work continued for twelve years, during which time my work as an astrologer expanded. I continue to love this work, and it keeps me occupied in a meaningful way to this day.

The loss of my husband

83 At the end of 1989, I married again. We were married for 16 years. In late 2004, my husband was diagnosed with terminal pancreatic cancer. I was his sole caregiver until he passed on the 9th of March 2005. This was a catastrophic loss to me. After his death, I was inconsolably sad and depressed and longed for my own death. I withdrew from interacting with family and friends and lived alone for more than two years. During this time of relative seclusion, I continued to read and study extensively. I read a book about a plant tincture used in Amazonian shamanic cultures called *ayahuasca*. This substance, when ingested, induces a profound experience in its users and its underlying psychoactive chemical, dimethyltryptamine (DMT), has, for example, been dubbed *"The Spirit Molecule"* by author and researcher Rick Strassman. DMT occupies the same cell as psilocybin in the Drugs Act.

84 I use the phrase *"profound experience"* to refer to a subjective religious or spiritual experience, which is associated with personal changes and growth. The experience is often described as a sense of the oneness of all things, and an awareness of union with God, or the Universe, or the Absolute (something shared across most religions and belief practices). As explained by Professor Nutt in his expert affidavit, the term *"entheogens"* was proposed as a name for a subclass of psychotropic or psychoactive plants as a broad term to describe the cultural context of use, not specifically related to their chemistry or pharmacology. Entheogen refers to substances *"ingested in a religious context for a spiritual purpose"*[10] and, by *"spiritual"*, I refer to a person's personal and intimate connection and interaction with their universe, whether or not

[10] Jonathan Ott, 'Entheogens II: On Entheology and Entheobotany" Journal of Psychoactive Drugs, Vol 28 1996 – Issue 2, available at:
https://www.tandfonline.com/doi/epdf/10.1080/02791072.1996.10524393?needAccess=true

that could be classed as *"religious"*. I note that the focus of this application is only psilocybin but similar points might also be made in favour of other entheogens.[11]

85 Like dreaming when we sleep, these profound experiences[12] are complementary to the ordinary waking consciousness. I believe that these experiences allow us to transcend the ordinary self in a conscious state, and to examine the unfathomable miracle of existence. It brings about changes of world view and behaviour, with a strengthened conscience and heightened sense of responsibility and direction.

86 Having read about a certain tincture, ayahuasca, I decided to try it. I yearned to find God, and I needed also to find a way out of my grief after the death of my husband almost 3 years earlier. I had never used addictive or illegal drugs, nor even tobacco or alcohol. So, this was a significant decision for me. I was 62 years old at the time.

87 In February 2008, I joined a small group of people who attended four ayahuasca ceremonies over a period of about 6 weeks, all of which were led by a shaman from Peru. This was a life-changing time for me. Over the weeks in which I attended these ceremonies, I began to break free of the depression that was dragging me down, and I had a renewed desire for even deeper spiritual development and understanding. Through continued spiritual practices and development and the use of ayahuasca over time, my mental health improved greatly, the dark cloud of depression lifted, and my heartbreak eased.

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[11] An entheogen has also been defined as *"any substance that, when ingested, catalyzes or generates an altered state of consciousness deemed to have spiritual significance"*. - https://www.sciencedirect.com/topics/neuroscience/entheogen

[12] Some literature uses the term *"mystical experiences"*.

My experiences with psilocybin

88 As I continued to research and work with ayahuasca, I also became active again in my community and regained social confidence and energy. In October 2009, I organised a celebration for my 64th birthday which marked a return to being part of the world around me. One night in October 2009, shortly after my 64th birthday, and alone in my garden, I experienced psilocybin mushrooms for the first time. In some ways, it was like my experience with ayahuasca – but even more personally unifying, profound, informative, and transformative.

89 I consumed the psilocybin mushrooms in the privacy of my own garden. I was alone at home. I did not bother or affect anyone and there was no harm to myself or to others (which I understand to be the case with the overwhelming majority of mushroom users). The experience lasted several hours, and it is difficult to put into words.

90 I am mindful that explaining this kind of experience to a person with no frame of reference may be difficult, like explaining a colour to a blind person. The appropriate term often used is *'ineffable'*. The precise experiences may be somewhat unique to the people experiencing them.

91 Professor Nutt's affidavit explains the scientific position. I instead want to explain in lay terms what the experience might be like. The experience of taking psilocybin does not feel very different from night-time dreaming, but happens in an awake state. From monitoring the experiences of people over the last 14 years (with a two-year break during the Covid pandemic lockdown), it seems to me that one of the benefits of psilocybin is that the human brain attempts to avoid pain as much as possible, and that psilocybin can therefore assist a person to viably face (in this somewhat dream-like state) what would do more harm if it remained hidden. Our brains prevent us from

thinking about traumatic experiences. These traumatic experiences in our lives tend to become suppressed and, often, we do not deal with them, meaning that they can grow in hiding and present themselves bigger and stronger later in life.

92 While having an experience with psilocybin, one is often confronted with suppressed trauma – for instance, the death of a loved one, physical or sexual abuse, the fear of death after learning one has a terminal illness – but in a visceral and visual way, with vibrant colours and visual and other sensory metaphors. Thus, again, it is similar to the dreams one may have at night – where what one sees or experiences may not be literal or possible. When faced with these issues in a non-threatening manner and in a safe and secure environment, a lot of positive *'self-work'* can be undertaken.

93 In the years that I have been supervising people taking psilocybin mushrooms, it seems to me that people often become addicted to substances because they are trying to escape an empty, unpleasant feeling that they have inside, and the substance temporarily assists them in escaping that feeling (but then they need to repeat the behaviour by taking the substance daily or every few hours).

94 Psilocybin is different. It assists a person to address their own underlying trauma that causes the empty, unpleasant feeling. It is a tool, which is most effective if used correctly. Again, I refer to the affidavit by the second applicant, Melinda Ferguson, for her vivid account of this benefit of psilocybin.

95 I emphasise that I not only felt that my first psilocybin experience healed my psyche, but I also regard it as the deepest religious/spiritual experience that I have ever had. When it was over, I was left in a state of absolute awe and reverence. I was deeply happy and content, in sharp contrast to how I had felt only a few hours before.

96 My spiritual practice thus has a long history and, for now over 15 years, psilocybin mushrooms have been an integral part of my spiritual practice. It is respectfully submitted that no law should prevent me from continuing my spiritual experience with psilocybin mushrooms. Our personal spirituality, in whatever way each of us manifests and experiences it, or how we define God, is a belief system which includes an element of faith. I take my spiritual life seriously and cannot abandon my beliefs. As my deteriorating health means that I may soon be facing the end of my time on planet earth, I consider this application my legacy and my final spiritual contribution to those who will survive me in this dimension.

97 I have a deep respect for the rule of law and my life has been evidence of that. The current legal position forces me (and many people similarly placed to me) to make an election between our spiritual conscience and living our lives in accordance with the law. I respectfully submit that this limits our constitutional rights. Knowing that what I (and others like me) am/are doing is regarded as *"criminal"* causes me significant stress, because the law and my Christian upbringing have trained me to think that *"criminal"* activities are necessarily nefarious.

98 As I demonstrate elsewhere in this affidavit, the applicants respectfully submit that the criminalisation of psilocybin mushrooms is based on outdated knowledge and, with respect, an incorrect understanding or moral judgement.

99 I wish to emphasise that, while my personal experience with psilocybin has been personally both deeply therapeutic and spiritual, the people who approach me to ask for supervision while they undertake a guided psilocybin experience are not all spiritually inclined. Their reasons all differ. But it is worth noting that these people come from all walks of life and – while I would never disclose the identities of any of the people who have asked me to supervise their psilocybin experiences – the people

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are not simply (as one might expect) artists, hippies, or other creatives. They include high-powered businessmen and women, politicians, doctors, lawyers, engineers, and former members of the military and SAPS.

100 Many of these people are forced to hide the fact that they have elected to undertake a psilocybin experience, which they found deeply helpful to them because, if it was discovered that they were involved in unlawful conduct, this could have a significant impact on their careers, livelihoods, and even personal freedoms. But that is not so if the same people use and abuse cigarettes, alcohol, gambling, or cannabis. Importantly, again I emphasise that the irony (demonstrated by the empirical research) is that, unlike these other substances, psilocybin does not carry the same level of risks or harms to the person taking psilocybin, or to their family members, or society more generally.

ADDITIONAL EVIDENCE SUPPORTING THE APPLICANTS' CASE

(i) Numerous democratic societies have decriminalised / legalised psilocybin

101 It is true that South Africa has previously signed various international documents which commit to taking certain stances on particular substances. The three major drug-control conventions, to which South Africa are signatories, are:

101.1 The Single Convention on Narcotic Drugs of 1961 (Narcotic Drugs Convention);

101.2 The Convention on Psychotropic Substances of 1971 (Psychotropic Substances Convention); and

101.3 The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988 (Illicit Traffic Convention).

102 These conventions constitute the international community's instruments in conducting the so-called *'war on drugs'* (the history of which has already been noted by the Courts to have been founded in racism, prejudice and non-science – but I will not burden the Court with an essay on this).

103 The Narcotic Drugs Convention constituted the first coordinated international action against drug abuse by the international community, seeking to limit the legal and illicit supply of drugs. The Psychotropic Substances Convention established an international control system for psychotropic substances and is the only convention to specifically refer to psilocybin – categorising it as a substance with a high potential for abuse which has no recognised medical uses. The Illicit Traffic Convention was a hardening of the previous two conventions, enacted with the intention to prevent the growing illicit substance trafficking industry and further harmonise international cooperation in the war on drugs.

104 It is in accordance with these conventions that South Africa enacted its domestic drug laws. In *Prince v The President of the Law Society of the Cape of Good Hope*,[13] the State proffered that the reason for the enactment of the domestic criminalising legislation was to *"bring South Africa into line with inter-national drug norms"*. This was echoed in *Prince v President, Cape Law Society*,[14] where the state at the time claimed that the purpose of the criminalisation is partly required in order to adhere to South Africa's *"international legal obligations"*.

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[13] 1998 JDR 0368 (C) p15

[14] 2002 (2) SA 794 (CC) para 141.

105 Importantly, however, the Constitutional Court has since emphasised that this was not a legitimate basis because:

105.1 South Africa's international obligations are subject to South Africa's constitutional obligations.

105.2 The Constitution is the supreme law of the Republic and, in entering into international agreements, South Africa must ensure that its obligations in terms of those agreements are not in breach of its constitutional obligations.

105.3 Our Courts cannot be precluded by an international agreement to which South Africa may be a signatory from declaring a statutory provision to be inconsistent with the Constitution.

106 In any event, I emphasise that various cities, states and countries around the world have reached the conclusion that criminalisation is not an effective method of addressing the social ills associated with the sale of illegal *'drugs'*. Indeed, reliable expert research demonstrates that the social ills that the state seeks to curb are actually very often the product of criminalisation/prohibition, not the product of the substance itself.

107 Additionally, in the 2018 ***Prince*** decision, the Constitutional Court recently re-emphasised that international obligations must still be tested against our own constitutional obligations and might be circumvented if an obvious contradiction exists:

> "[82] Counsel for the State referred to various *international* agreements to which South Africa is a signatory and submitted that South Africa is obliged to give effect to these *international* agreements. The answer to the submission is that South Africa's *international* obligations are subject to South Africa's constitutional obligations. The Constitution is the supreme law of the Republic and, in entering into *international* agreements, South Africa must ensure that its obligations in terms of those agreements are not in breach of its constitutional obligations. This Court cannot be precluded by an *international* agreement to which South Africa may be a signatory from declaring a statutory provision to be inconsistent with the Constitution. Of course,

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> it is correct that, in interpreting legislation, an interpretation that allows South Africa to comply with its *international* obligations would be preferred to one that does not, provided this does not strain the language of the statutory provision."[15]

108 More and more governments around the world are opting to decriminalise the sale of psilocybin (in particular) as well as other substances. I refer to a few of these key examples below.

108.1 **Brazil**: has no laws prohibiting the distribution, use or sale of psilocybin.

108.2 **Canada**: in October 2021, exemptions were granted to four organizations to conduct clinical trials using psilocybin-assisted therapy.

108.3 **Columbia**: in May 2022, the Columbian government decriminalized the possession of up to 20 grams of psilocybin for personal use.

108.4 **Mexico**: in December 2020, the Mexican Supreme Court handed down judgment in which it found that the possession of up to 0.05 grams of psilocybin is not a crime.

108.5 **Netherlands**: psilocybin – referred to locally as 'magic truffles' (which is part of the psilocybin mushroom) are legal to purchase and use in the Netherlands.

108.6 **Australia**: in mid-2023, the country's health regulator decided to commence allowing doctors to prescribe, and pharmacists to dispense, psilocybin for conditions such as depression and post-traumatic stress disorder.

108.7 **United States of America**: while psilocybin is not legal under United States

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[15] Minister of Justice and Constitutional Development and Others v Prince; National Director of Public Prosecutions and Others v Rubin; National Director of Public Prosecutions and Others v Acton and Others [2018] ZACC 30.

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federal law, various states have decriminalised psilocybin:

108.7.1 California;

108.7.2 Massachusetts;

108.7.3 Washington;

108.7.4 **Oregon** – see the Oregon Psilocybin Services Act (which came into effect on 1 January 2023); and

108.7.5 **Colorado** – see the Colorado Psilocybin Decriminalization Initiative (which came into effect on 1 January 2023).

109 Other states have decriminalised drugs more generally:

109.1 **Portugal**: in 2001, Portugal decriminalised the possession of all drugs for personal use. This means that people caught with small amounts of drugs for personal use are not arrested or fined but are instead referred to a commission that will assess their needs and provide them with treatment or other services if necessary. The evidence shows that decriminalisation of all drugs in Portugal has *reduced* (not magnified) the harmful effects that are mooted as the rationale for prohibiting drugs. As Justice Cameron explains:

> *"Portugal has seen the way, and taken it. In 2001, it abolished all criminal penalties for personal drug use. On our continent, the West African Commission on Drugs called for similar action. It cited evidence that the 'war on drugs' exacerbates health and social insecurity. Following this recommendation, Ghana has become the first African state to rely on alternatives to incarceration to address personal drug use."*

109.2 **Uruguay**: in 2013, Uruguay became the first country in the world to legalize the production, sale, and consumption of cannabis for adults over the age of 18. The law also allows for the home cultivation of up to six plants per adult.

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109.3 **Bolivia**: in 2019, Bolivia's new president, Luis Arce, decriminalized the possession of small amounts of coca leaves for personal use. Coca leaves are a traditional crop in Bolivia and are used for chewing, tea, and other purposes.

109.4 **Ghana**: in 2023, Ghana published laws allowing for cannabis to be cultivated for industrial and medicinal uses.

(ii) South African entities assisting the government agree

110 Justice Edwin Cameron, who is presently the Inspectorate of Prisons and thus well placed to speak on the topic (*albeit* writing in a personal academic capacity) has emphasised that criminalisation makes social ills associated with drug use worse – not better:[16]

> *"Drug use is a social and health issue. It is not a criminal justice issue – and it certainly is not a national security issue. There is no health rationale for invoking criminal law sanctions.*
>
> *Beyond decriminalisation, intelligent legal regulation for drug use will go a long way to removing the drug-related harms suffered by people who use drugs and the communities they live in."*

111 Similarly, the Central Drug Authority ('CDA'), in response to Justice Cameron's stance – on 24 August 2020 – released a media statement, attached as '**FA5**'. The statement provides as follows:

> *"The Central Drug Authority (CDA) is a statutory body that advises government on drug policies and strategies. There are better approaches to solving the problem than any failed war on drugs and the criminalisation and incarceration of users and addicted people. We state this clearly in the National Drug Master Plan 2019 – 2024 (NDMP) which was launched on 26 June 2020. (a copy is available on request)."*

112 In order to avoid burdening the papers, I only attach the relevant extract of the National Drug Master Plan for 2019 – 2024 as '**FA6**'.

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[16] GroundUp August 2020.

(iii) The alleged social ills are aggravated – not curbed – by criminalisation

113 As regards the purported social ills, even assuming, for the purposes of argument only, that psilocybin was a meaningfully harmful drug (which it is not) the State would also need to demonstrate that criminalisation is an effective way of dealing with any associated harms. Justice Cameron makes the point that:[17]

> *"Criminalisation fosters criminal networks and gangs, it pollutes the world of high finance, makes a sham of border controls, and subverts the criminal process and the courts of justice."*

114 Criminalisation impairs curing:

> *"There is no doubt that drug use can be a problem, and can lead to devastating consequences that must be countered. It spawns social ills – just like cigarette smoking and alcohol use. All three are social and public health problems. None of them are matters for the criminal law. We must counter-act drug use with public information, education, counselling and treatment – not with the big blunt stick of the criminal law. … Not only do criminal laws not work, they also impair proper management of the problem and dissuade people from seeking the support and services they need."*[18]

115 Moreover, those approaches pertain to drugs like heroin that are demonstrably harmful and plainly addictive. Psilocybin mushrooms are – quite literally – at the opposite end of the spectrum as set out above: they are not addictive, not harmful, and they have significant benefits. To treat heroin and psilocybin the same under the law is irrational (as they are presently in the same listed schedules). On that basis alone, the laws fall to be declared constitutionally invalid because there is no rational reason for the classification of psilocybin in that manner.

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[17] GroundUp August 2020.

[18] GroundUp August 2020.

PART 2

CONSTITUTIONAL CHALLENGES TO THE IMPUGNED PROVISIONS

116 The body of scientific evidence summarised above (and, more specifically, detailed in the supporting expert affidavit of Professor Nutt) demonstrates that psilocybin is neither undesirable, nor addictive, nor harmful. Quite the opposite, it has numerous positive benefits, including the treatment of substance addiction.

117 I now turn to demonstrate that the criminal prohibition outlined by the impugned provisions (namely the use, possession and distribution of psilocybin) is inconsistent with the legality principle and limits various constitutional rights.

(i) The irrationality of the criminalising classification of psilocybin

118 As pointed out above and in the expert affidavit of Professor Nutt, psilocybin is not a dependence-producing substance.

119 It follows that the classification of psilocybin in Part III of Schedule 2 to the Drugs Act as an undesirable dependence-producing substance is objectively irrational and inconsistent with the legality principle in section 1(c) of the Constitution.

120 Similarly, the same logic can apply to the scheduling of psilocybin in terms of the Medicines Act.

(ii) The violation of fundamental rights

121 The applicants submit that the impugned provisions and criminalisation of psilocybin plainly limit the following rights in the Constitution. I am advised that all that the

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applicants are required to demonstrate is the limitation of their rights. Then, the state respondents – only if one or more of the Ministers oppose the application – bear the onus to demonstrate that the limitations are justified under section 36 of the Constitution.

122 As submitted in this affidavit, the applicants have shown that the limitation of rights caused by the impugned provisions fails to meet the requirements of the limitations clause in section 36 of the Constitution, because there are plainly less restrictive means available (as canvassed elsewhere in this affidavit) and because the classification of psilocybin is premised on a series of incorrect factual allegations and presuppositions.

Section 14: the right to privacy

123 I am advised that our Courts have held that:

123.1 The right to privacy is the right to be left alone.

123.2 The right to privacy essentially consists of the right to live one's own life with a minimum amount of interference from the state or others, who do not have the permission or reasonable justification to be in our private space.

123.3 The right to privacy operates in a dynamic and mutually limiting manner: the right to privacy can be seen as a sliding scale between the interests of the individual and the interests of society.

124 I am advised that the Constitutional Court has held that the scope of a person's privacy extends *a fortiori* only to those aspects in regard to which a legitimate expectation of privacy can be harboured. I understand that this provides that the scope of the right to privacy is one that is present to an applicant where there is a subjective expectation of

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privacy and such an expectation is deemed objectively reasonable in the eyes of society.

125 In addition, our courts have held that privacy enables individuals to create barriers and boundaries to protect themselves from unwarranted interference in their lives and that it is an essential way to protect individuals and society against arbitrary and unjustified use of power by reducing what can be known about and done to them.

126 There can hardly be a more sacred private space than one's own home. It cannot be questioned that, in the eyes of society, what one chooses to do in the confines of their own home, removed deliberately from the private eye, attracts the subjective expectation of privacy, and the protection which flows with it.

127 It must follow that the right to privacy includes the right to be left alone, from state interference, when in the confines of one's private sphere, and when consuming illicit substances that effect one's mind. The privacy right, I am told, is such a strong guardian that it has, in instances, protected individuals from the grasp of the law, even in instances of adults acting illegally within their private realm. In *Prince v Minister of Justice and Others* it was said that:

> *"[It is now] established law, insofar as privacy is concerned, that this right becomes more powerful and deserving of greater protection the more intimate the personal sphere of the life of a human being which comes into legal play."*

128 Separately, it is worth noting that, out of a number of legal substances, adults may consume within the confines of their private dwelling, it is psilocybin – being one of, if not the least dangerous of the substances – which is criminalised. For example: to drink alcohol and caffeine, smoke cigarettes or cannabis, or to eat sugar or psilocybin mushrooms. Indeed, the research data set out by Professor Nutt and others has shown that it is strongly arguable that psilocybin is the *least* dangerous substance out

of the above listed (and other relevant) substances. Yet it is the only one that it is criminalised.

129 I am advised that the Constitutional Court in *Minister of Justice and Constitutional Development and Others v Prince and Others*[19] found that the right to privacy entitles an adult person to *use* or *cultivate* or *possess* cannabis in private for their personal consumption. Once that is so, I am advised that – *a fortiori* – this reasoning applies to psilocybin, because psilocybin is less harmful than cannabis (or at the very least not demonstrably more harmful) and there is no other legitimate government interest in differentiating psilocybin from cannabis.

130 The state respondents bear the onus to justify the limitation of the right to privacy (if the state entities cited are minded to oppose the application).

Section 10: the right to dignity

131 Section 10 of the Constitution provides that "*[e]veryone has inherent dignity and the right to have their dignity respected and protected*". Our courts have made clear that the right to dignity includes personal autonomy – in other words, adults have the right to make their own choices and regulate their own affairs even to their own detriment.

132 I am advised that, when the Government banned the sale of cigarettes during the Covid-19 pandemic, the Courts held that the ban:

132.1 denied people their right to exercise their free will (autonomy) because they were prevented from buying these products during the lockdown;

132.2 infringed the right to personal autonomy, *i.e.*, the ability to regulate one's own

[19] 2019 (1) SACR 14 (CC)

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affairs; and

132.3 accordingly, was an unconstitutional limitation of the right to dignity.

133 I am advised that what underlies the Supreme Court of Appeal's reasoning is the legal principle that adults are permitted to consider risks and consent to those risks aligned as captured by the Latin principle: *volenti non fit injuria.* I highlighted various key examples of this that the law permits in paragraph 30 of this affidavit.

134 I understand that prominent legal theorists (including Joel Feinberg) have argued that if the state limits competent adults' freedom to assume the risk of consuming psilocybin mushrooms and further punishes them criminally for doing so, it would have the effect of reducing adults to *'children'* of the paternalistic state. This paternalistic approach was the hallmark of apartheid society – where those running the government imposed their particular sense of what was right or wrong on the entire country. I am advised that this kind of approach is not appropriate in a diverse constitutional democracy like ours and that the Constitutional Court has emphasised that diversity should be celebrated, and different views (even those some may disagree with or find to be abhorrent) should be tolerated and even accommodated.

135 Those adults who wish to use psilocybin are denied the right to make their own choice about the matter. The right to autonomy and thus dignity is plainly limited, and the state respondents bear the onus to justify the limitation, should they wish to oppose the application.

136 Dignity is also limited because the <u>effect</u> of the criminalisation of psilocybin is that users of mushrooms which contain psilocybin are stigmatised as criminals in the eyes of society. As a result of the criminal offence, people who wish to consume psilocybin,

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even in their own homes or other suitably private spaces, are at risk of being stigmatised, arrested, prosecuted, and incarcerated. Justice Cameron makes the point that the system is responsible for the stigma and discrimination against the users.[20]

> *"People who use drugs are exposed to a systematic process of dehumanisation and discrimination. Additionally, the rhetoric prevents us from engaging with the structural causes of drug use. And it obscures how criminalisation lends support to vicious cycles of poverty that target the most vulnerable and marginalised in society. … Too often, the war on drugs is, in reality, a war on 'marginalised communities'."*[21]

137 Yale Professor Steven Duke and attorney Albert Gross, in their book, *America's Longest War: Rethinking Our Tragic Crusade Against Drugs*,[22] succinctly support the above sentiment:

> *"[I]t is the modern stigma attached to drugs – not any inherent quality of the chemicals – that makes their use shocking".*

138 This opinion is further supported by South African academics within the context of the criminalisation of psilocybin mushrooms:

> *"The criminalisation [of psilocybin mushrooms] is still heavily linked to reasons dissociated with the reality presented by scientific evidence. The war on drugs agenda remains an unpersuasive, yet persistent, justification to uphold the prohibition, despite the evidence suggesting that psilocybin mushrooms are not toxic and deadly to the user or society, but could rather be beneficial if utilised correctly."*[23]

139 Accordingly, it appears apparent that there is a significant correlation between the criminalisation of psilocybin and the stigma attached to the substance, and the consequent infringement of the dignity of those who safely engage in psilocybin-related activities.

140 Again, the state would bear the onus of demonstrating that this limitation is justified (if the state entities cited are minded to oppose the application).

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[20] GroundUp August 2020.

[21] GroundUp August 2020.

[22] A Gross & S Duke America's Longest War: Rethinking Our Tragic Crusade Against Drugs (2014) 4.

[23] Foster SW (2023) "Cognitive liberty and the constitutionality of criminalising psilocybin mushrooms in South Africa", South African Journal on Human Rights, 39:1, p23.

Section 12(2): the right to bodily and psychological integrity

141 Section 12(2) of the Constitution provides, in relevant part, that "*[e]veryone has the right to bodily and psychological integrity*". This right includes:

141.1 the right to control over their own body and mind (some might say, their most intimate and indeed sacred *'private spaces'*);

141.2 the right to be protected from non-consensual interferences with one's mind – *i.e.*, the right protects the inviolability of the mind;

141.3 the right of one's autonomy and self-determination against state interference; and

141.4 the right of an individual to decide what they will and will not ingest, including if what they ingest alters their consciousness.

142 The freedom to make decisions about one's own body and mind is closely linked with the rights to autonomy (dignity) and privacy (what happens in one's own mind is the inner sanctum of privacy).

143 The Supreme Court of Appeal found (in relation to the Covid-19 smoking ban) that the prohibition limited the freedom and autonomy of adults to choose tobacco and vaping products, which they enjoyed and found relaxing when coping with stress, particularly during the lockdown. It followed (according to the Court) that the prohibition limited the rights in section 12(2) and the state would bear the onus to show that the limitation is justifiable (if the state deemed it necessary to oppose the relief sought in this matter). Precisely the same reasoning would apply – I am advised – in the case of psilocybin.

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144 Again, then, it falls to the state to justify the limitation (if the state entities cited are minded to oppose the application).

Section 15(1): The right to freedom of conscience, religion, belief and opinion

145 Section 15(1) protects the freedom of conscience, belief, thought and religion. I submit that I have the right to express my conscience, religion, beliefs and thought, and to practice as I see fit, conditional that I do so in a safe responsible manner. This is related to section 12 of the Constitution, in that I am permitted to alter my beliefs and experience of the world through the ingestion of low-harm entheogens.

146 Above, I have set out the manner in which psilocybin is part of my spiritual practice. This is not the position just for me but, I submit, for many others who are similarly placed. I submit that the current legislative regime seeks to prosecute and criminalise me if I practise these principles and practices through my use of psilocybin. This plainly limits section 15, and the state would need to demonstrate that the limitation satisfies the limitations clause (if the state opposed this matter).

Section 9: the right to equality / PEPUDA

147 Section 9 of the Constitution provides that:

147.1 everyone is equal before the law and has the right to equal protection and benefit of the law;

147.2 equality includes the full and equal enjoyment of all rights and freedoms; and

147.3 the state may not unfairly discriminate directly or indirectly against anyone.

148 I am advised that my rights to equality are infringed in at least three respects.

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149 First, the present status of the law is unlawfully differentiating without a rational basis, alternatively unjustifiably discriminating against me on the ground of what substance I choose to consume – psilocybin mushrooms – when compared to the likes of alcohol and tobacco. Users of the latter two substances are legally enabled, through regulations, to use, possess, and purchase these substances, without the fear of criminal prosecution – despite these substances being largely accepted as being harmful and toxic. However, those, such as myself, who choose to use, possess, and purchase psilocybin mushrooms – a substance which is considerably less harmful and toxic to the body and society – are at risk of criminal prosecution.

150 Secondly, the present status of the law is unlawfully differentiating without a rational basis, alternatively unjustifiably discriminating against me (and those who wish to cultivate/manufacture and supply psilocybin mushrooms), in comparison to those who are cultivating/manufacturing and supplying, for example, alcohol and tobacco. The same logic applies in this instance, insofar as the latter substances are regularly accepted to be harmful and toxic, yet they are not criminalised. Psilocybin cultivation/manufacturing and supply, however, is harshly criminalised, despite the substance being proven to be considerably less harmful, but arguably beneficial.

151 Thirdly, the impugned provisions unfairly discriminate against me and others in my position on the basis of religion, coscience, belief, culture and social origin. In this regard I refer to what I have set out above, both in my account of my personal religious and spiritual practice, as well as under the limitation of section 15.

152 I respectfully submit that the impugned provisions, equally, fall foul of the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 ("**PEPUDA**"). On this score I emphasise that:

152.1 *"discrimination"* in PEPUDA is defined as:

> *"any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly –*
>
> *(a) imposes burdens, obligations or disadvantage on ; or*
>
> *(b) withholds benefits, opportunities or advantages from,*
>
> *Any person on one or more of the prohibited grounds."*

152.2 The prohibited grounds, include the listed grounds of religion, conscience, belief, culture and social origin (which I have already dealt with above). But also include:

> *"any other ground where discrimination based on that other ground –*
>
> *(i) causes or perpetuates systemic disadvantage;*
>
> *(ii) undermines human dignity; or*
>
> *(iii) adversely affects the equal enjoyment of a person's rights and freedoms in a serious manner that is comparable to discrimination on [one of the listed grounds]."*

153 I understand that, in terms of section 13 of PEPUDA, I carry the burden of proving unfair discrimination on an unlisted ground. I respectfully submit that there is a *prima facie* case of discrimination set out above, under the other rights I have dealt with above – in particular the right to dignity, equality under the Constitution, privacy and section 15. This is particularly so:

153.1 given the nature of the consequences set out above, including the stigma and criminal consequences that persons wishing to try psilocybin are exposed to (particularly where in some instances this forms part of their spiritual practice and belief); and

153.2 when compared to alcohol / tobacco users who attract no criminal consequences and no legally-mandated stigma or impairment of their dignity.

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154 The applicants, accordingly, respectfully submit that the discrimination is unfair, in accordance with the factors listed in section 14 of PEPUDA.

155 On these grounds, the applicants have shown that the impugned provisions limit the right to equality and are inconsistent with the provisions of PEPUDA. Again, it would be for the state respondents to show the opposite (if they opposed this application).

Section 27(1)(a) and (2) – The right to access health care services

156 As pointed out above and in the expert affidavit of Professor Nutt:

156.1 psilocybin has proven and well-documented therapeutic effects, *inter alia*, combatting mental health disorders like depression and anxiety, treating alcoholism and tobacco addiction, and alleviating the symptoms of post-traumatic stress disorder;

156.2 psilocybin is not a dependence producing substance; and

156.3 psilocybin has no material safety risks of a nature that would justify a refusal to allow it to be used therapeutically, even if as part of a self-medication regime.

157 It follows that the criminalisation of psilocybin limits the fundamental right to access health care services.

158 Furthermore, in line with section 27(2) of the Constitution, it is submitted that the state's failure to take reasonable legislative and other measures to enable the use of psilocybin for health care reasons – especially considering that doing so is within the state's resources – constitutes a failure in the progressive realisation of the associated

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health care rights and reinforces the right of a person to self-medicate and/or self-elevate (*i.e.*, to treat oneself when services do not exist to outsource that).

CONSEQUENT RELIEF NECESSARY TO FACILITATE THE INFRINGED RIGHTS

159 Once it is clear, as the applicants submit it is, that adults have the right to autonomy and privacy (amongst others) to experience psilocybin, it follows that at a minimum an order akin to the type set out by the Constitutional Court in relation to cannabis must follow.

160 But the applicants respectfully submit that this Court's order should go further.

161 Professor Nutt's expert report essentially shows that there are only two rare potential harms in an adult utilising psilocybin. Either:

161.1 the person becomes overwhelmed (usually temporarily) by the sensory experiences after ingesting psilocybin; or

161.2 the person is not given, or does not take, a psilocybin mushroom at all, but some form of poisonous mushroom or some other form of substance (which harm is not actual one of psilocybin's).

162 I am advised that, where the law provides adult citizens with a right to use a particular substance, the law needs to facilitate those rights being exercised safely. The applicants submit that it is well established by the Constitutional Court that the state has obligations not only to avoid negatively interfering with people's rights, but also to positively foster those rights.

163 In the context of psilocybin, the applicants submit that there are two key consequences:

163.1 first, supervised use should be permissible (but not necessarily mandatory); and

163.2 second, the law should ensure that there is a safe (legal) supply of psilocybin.

164 The applicants respectfully submit that the developments in the cannabis sector by the executive and Parliament are to be welcomed – as they illustrate that a right to personal use is merely the starting point and it cannot be properly exercised in the absence of means for private users to try psilocybin: (i) in a safe environment (including via supervised use); and (ii) with confidence that the substance they are ingesting is indeed psilocybin (rather than something else) from a reliable source.

THE PROHIBITION OF SUPERVISED USE IN A PRIVATE SETTING

165 In relation to supervision – Professor Nutt's report refers to various sources that make it clear that the setting and mindset of people is important when they take psilocybin mushrooms.

165.1 Setting is understood to be the physical environment in which psilocybin mushrooms are consumed. A calming and familiar environment – whether it's a recreational, sacred, or clinical setting – greatly reduces the likelihood of a dysphoric experience, whereas an overstimulating, anxiety-inducing environment can increase the likelihood thereof. The evidence is that being in a familial recreational setting promotes the likelihood of a positive and open-minded expectation of the experience.

165.2 The mindset or mental state of the individual when consuming psilocybin mushrooms is directly related to that individual's psychoactive experience, so the evidence shows. Individuals who have neuroticism, difficulty regulating

their stress levels and a propensity towards negative emotionality are more inclined to a bad or challenging psychoactive experience, *albeit* that a certain irony exists insofar as psilocybin can assist them to break-free from those exact patterns. Accordingly, those who lack positive coping mechanisms and have a negative inclination to the experience or their current state of mind, are more likely to have an initially negative experience, *albeit* that, upon later reflection, they might come to view the experience as overall positive.

166 It is therefore no surprise that some users of psilocybin mushrooms prefer to gather as a group to promote a positive setting and mindset. The prohibition infringes the right to freedom of association in section 18 of the Constitution (in addition to the rights set out above).

167 I have hosted psilocybin experiences at my home for the last **15** years. I pause at this juncture to explain how the experience typically unfolds.

168 Importantly, a few days prior to the psilocybin experience, attendees receive information about the experience.

168.1 This includes a recommendation (although not requirement) that, for two or three days before the experience, they either fast or eat only vegetables, preferably raw. This assists to ensure that any minor digestive side effects are avoided.

168.2 Attendees are advised to refrain from alcohol and other intoxicating substances and drugs, leading up to the experience.

168.3 On the day of the psilocybin experience, no one will be allowed to attend the evening if they have consumed any intoxicating substances.

169 On the day of the psilocybin experience, attendees arrive at my residence anytime from 17h00 to 19h00 and are greeted by me and a team of up to ten trained supervisors (which we call *"watchers"*).

169.1 The watchers are individuals who have, on several previous occasions, consumed psilocybin mushrooms themselves and so are well acquainted with what the attendees will experience during the ceremony (allowing, of course, for the unique personal journey that is prompted by the consumption of mushrooms). As the term suggests, their purpose is to watch over the attendees for the full duration of the experience, and to gently support their experience, holding space for any difficult or profound emotions that may arise during the person's experience. Their sole purpose is to offer support to the attendees, if needed. Indeed, even in a clinical setting, supervision is – more often than not – a key ingredient of the research.

169.2 Upon arrival, the attendees find a place in the dedicated room made comfortable with mattresses, pillows and blankets.

169.3 After making themselves comfortable, they have the opportunity to interact with fellow attendees and with the watchers. Some may choose to have a time of quiet reflection on their own.

169.4 At approximately 20h00, the attendees and the watchers gather around for an introduction, where each watcher and attendee introduces themselves, giving as much detail as they wish.

169.5 The watchers then explain practical arrangements such as bathrooms, meals, the general programme for the night, and the need to remain peaceful and silent in their places in the room.

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169.6 After the introductions, each participant receives a small cup of dried and ground entheogenic mushrooms.

169.7 Generally, each participant may be given approximately 5g of dried entheogenic mushrooms. We provide guidance about possibly using less than 5g – for example, to someone who is particularly anxious, or in frail health.

169.8 Participants return to their chosen place of comfort for the evening, and together they drink their cup of dried, crushed psilocybin mushrooms mixed with honey and lemon tea. Soft music is played and will continue for the rest of the night.

169.9 Between five and thirty minutes later, the psychotropic effects of entheogenic mushrooms start to take effect.

169.10 During the psychedelic experiences, each participant has a deeply personal and uniquely subjective heightened state of consciousness, which may include a variety of dream-like experiences.

169.11 During this period, participants are more likely to be reflective and introspective, feel deeply connected to the universe, nature, and familial love. Additionally, and importantly, they become more open to addressing personal trials and tribulations, difficulties and regrets, which enables the participants to engage with themselves and their troubles in a meaningful and positive manner.

169.12 After 6 hours, the effects start to wear off. A meal of vegetable soup and bread is available from around midnight. Weather permitting, some participants go into the garden outside where they sit or lie under the trees and stars. During

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the entire experience the watchers are nearby, with the participants.

169.13 Participants are provided with a comfortable and safe sleeping space. In the morning, the participants have breakfast together and there is a time of sharing among each other, and with the watchers, about their experience of the night (should they wish to do so). Usually, by midday, all the participants have returned to their homes, each one leaving in their own time. The watchers then meet together to reflect on the night, their own experience, and on any deeper learnings they have received.

170 I emphasise three important points.

171 First, the people who have attended the psilocybin experiences are law-abiding, tax-paying citizens, coming from all walks of life, all racial groups, and a variety of religious traditions. Psychologists and psychiatrists, medical doctors, ministers of religion, journalists, lawyers, authors and publishers, teachers, and business people. Often couples, and even whole families attend together. They are all responsible adults. A large number of visitors join us from overseas, having planned their trip to South Africa for that specific purpose.

171.1 At least 50% of those who attend are over the age of 40. A significant number are over the age of 60. Young adults, below the age of 25, make up a small percentage. Roughly 60% of each group have come for their first experience with psilocybin mushrooms.

171.2 Some of the participants have been having struggles with depression or grief, with addiction, and some with suicidal thoughts or terminal illness.

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171.3 Some have physical difficulties and handicaps. What they have in common is a desire for deeper spiritual and psychological connection, for peace of mind, for relief from old habits that are destructive, or from regrets, fear, and self-defeating attitudes.

172 Second, as is apparent from what I have set out above, a supervised psilocybin experience is a very quiet experience where the participants are lying down. It is, thus, not too different from an individual receiving a spa treatment from a commercial spa. The supervisors watch and ensure the safety of the participants for the entire duration of the experience. The participants do not pose any notable risk to themselves or to other members of society.

173 Third, if the state's primary concern is the safety of the psilocybin user, then supervision of the user's experience is something that reduces – not raises – the potential for harm, *albeit* that my services have (ironically) had me labelled as a drug dealer and criminal. That said, on the basis of the maxim of *volenti non fit inuria*, supervision ought to be encouraged, but not made mandatory.

173.1 Virtually the only risk (rare as it may be) is that an individual may experience what is colloquially referred to as a *"bad trip"*. This essentially just means that a person becomes confused and anxious about the effect that the psilocybin is having on their sensory information. Importantly, it is well documented (as set out by Professor Nutt's report) that these experiences predominantly occur when psilocybin is taken unsupervised or by underinformed persons. For that very reason, before anyone has psilocybin mushrooms at my home, they are given a full picture of what they can expect. It is a scenario in which the persons with experience (myself and the supervisors) ensure the safety of the user. In my entire 15 years of experience hosting the experiences at my

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home – as far as I am aware – only two or three participants showed signs of the so-called "bad trip" but were comforted by myself and the supervisors and thus they were only temporary moments of unease. Over time, those who initially reported a *'bad experience'* are often the ones who later report the most improvement and easing of symptoms.

174 The applicants submit that prohibiting supervision is at odds with the rationale underlying the Constitutional Court's judgment in ***Prince***:

> *"[100] It seems to me that, indeed, there was no persuasive reason why the High Court confined its declaration of invalidity to the use or possession or cultivation of cannabis at a home or in a private dwelling. In my view, as long as the use or possession of cannabis is in private and not in public and the use or possession of cannabis is for the personal consumption of an adult, it is protected. Therefore, provided the use or possession of cannabis is by an adult person in private for his or her personal consumption, it is protected by the right to privacy entrenched in section 14 of our Constitution."*

175 When adults elect to come to my home and for me and my assistants to monitor them as they ingest psilocybin, it takes place in a private space. It is safer for the individuals to do so in that environment than by themselves – the law should permit that as a matter of mitigating potential harms.

THE PROHIBITION OF GROWING AND/OR SUPPLYING PSILOCYBIN

176 The applicants respectfully submit that we have demonstrated that the impugned provisions infringe the rights of adults wishing to use psilocybin. The limitations of those rights do not satisfy section 36 of the Constitution.

177 Importantly, once that is so, if the state's primary concern is safety of the public, then a scenario in which it is legal for individuals to use psilocybin privately but a criminal offence to grow or supply, creates an untenable scenario because individuals have no clear route to access legitimate and safe psilocybin. Such a scenario would simply be arbitrary and irrational.

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178 The applicants accept that, when a Government regulates certain substances, the Government may have an interest in deciding to put in place hurdles to control the amount of products, or for that matter, the quality of products, that citizens may acquire. For instance:

178.1 advertising and promotion restrictions on cigarettes;

178.2 raising a *"sin tax"* on cigarettes and alcohol; and

178.3 ensuring that there is some verification that the products sold are what the products purport to be (for instance, the regime applicable to sugar inspections).

179 Critically, however, it is patently irrational to recognise a right to personally cultivate, use and possess psilocybin, but to criminalise the (the applicants presume regulated) third party or outsourced growing and/or supplying of psilocybin mushrooms.

179.1 In the first place, it magnifies the risk of harm. Professor Nutt's report makes it clear that the biggest risk in relation to psilocybin mushrooms is that the user is not given psilocybin mushrooms at all. That requires that users are able to access a proper, clean supply of the substance that they are intending to purchase. The cultivation process requires a sterile environment and controlled temperatures and humidity. It is important that members of the public can access psilocybin mushrooms that have been properly cultivated from reliable sources. Unreliable sources could, further, wish to mix the psilocybin mushrooms with other addictive or harmful substances.

179.2 In the second place, that prohibition will have a discriminatory effect operating against poorer members of society. Those members of society who do not

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have the luxury of wealth and time to *"cultivate"* their own psilocybin are prevented from experiencing the benefits that those substances may offer them. I respectfully submit that even members of the middle class who are gainfully employed are unlikely to have sufficient time, knowledge and expertise in order to enable them to cultivate their own psilocybin mushrooms.

180 As set out above, the ongoing legislative developments in the area of cannabis are to be welcomed and show that the government and Parliament correctly appreciate that the Constitutional Court's decision in ***Prince*** – understandably – did not deal with all of the practical difficulties of ensuring that a member of the public wishing to use cannabis can do so in a safe environment and with cannabis that has been sourced from a reliable provider. The relief sought under this heading simply ensures that the state takes active steps within an appropriate time period to ensure that there is practical regulation in place.

LIMITATIONS ANALYSIS

181 The applicants have, I submit, at the very least demonstrated that the various impugned provisions limit the rights guaranteed by sections 9, 10, 12(2), 14, 15, 18, and 27 of the Constitution, as well as the rule of law enshrined under section 1(c) of the Constitution.

182 Once that is so, if the state respondents wished to oppose this application and to defend the limitations of rights, they would bear the onus to do so. Thus, if any state respondents opposed the relief sought and attempt to show that the limitations are justifiable under section 36 in their answering affidavits, the applicants will deal with that in reply. However, the applicants again invite the state respondents not to oppose

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the application – or merely to abide and furnish the court with information regarding appropriate timeframes for regulating the safe supply of psilocybin.

183 I have been advised that, in terms of section 36 of the Constitution, where a right in the Bill of Rights has been infringed, such an infringement will only be justifiable – and therefore limitable – to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human rights, equality and freedom, taking into consideration, *inter alia*: the nature of the right; the importance of the purpose of the limitation; the nature and extent of the limitation; the relation between the limitation and its purpose; and whether there are less restrictive means to achieve the purpose of the limitation.

184 As has been echoed above, the rights associated with the use, possession, cultivation, and supply of psilocybin mushrooms are all of a fundamental and crucial nature. To a large extent, these impugned rights provide individuals with the necessary rights which enable them to be free-thinking, free-acting, autonomous individuals, in pursuit of a better understanding of their own selves or for addressing conditions like addiction or depression where other means have already been unsuccessful, or are inappropriate, for them.

185 This stands in major contrast to the importance of the purpose of the limitation – the purpose of the Drugs Act and Medicines Act, as they relate to psilocybin, are to prevent and deter individuals from the use possession, cultivation, and supplying of an *'undesirable dependence-producing substance'*.

185.1 This was echoed in *Prince v President, Cape Law Society*, where the purpose of the limitation was stated to be based in state *'control'* over the use,

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consumption, and dealing in, of a *dependence-producing substance*.[24] However, this is not what the Drugs and Medicines Acts are achieving, insofar as they are not preventing acts associated with a '*dependence-producing substance*'. Rather, as I say above and as is confirmed in the affidavit of Professor Nutt, psilocybin is simply not dependence-producing, but rather beneficial in treating issues related to addiction and dependence. The importance of the limitations purpose is therefore, so I am advised, misaligned.

186 There are considerably less restrictive means to achieve the purpose, however, the purpose in and of itself is outdated and harmful. However, in respect of this factor, a far more effective and yet less restrictive means would be to provide regulations to psilocybin use, possession, cultivation, and supply – similar to those applicable to substances such as alcohol and tobacco. This would provide the state with control over psilocybin, but also give effect to the rights individuals have in respect of psilocybin.

187 At this stage, I emphasise only that any attempt by the respondents to justify the limitations concerned would have to demonstrate at least why less restrictive means are not available and feasible, in the form of provisions that, *inter alia*, *regulate* psilocybin – without criminalising the use of it.

APPROPRIATE REMEDY

188 If this Court upholds the contention that the relevant provisions are invalid, the question of an appropriate remedy arises. I am advised that, in that event, this Court

[24] Prince v President, Cape Law Society2002 (2) SA 794 (CC) para 141.

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may wish to grant a suspension of the order of invalidity to allow the relevant decision-makers time to craft appropriate provisions to remedy the defects concerned.

189 The applicants would have no difficulty with this occurring, provided that this is coupled with an order granting interim relief in order to cure the constitutional defects during the period of suspension. I am advised and submit that this is necessary to render the relief granted appropriate, effective, just and equitable.

190 The applicants respectfully submit that a just and equitable remedy combines the remedies handed down in the *Prince* decision and the *Teddy Bear Clinic* decision.[25]

190.1 In *Prince*, the Constitutional Court ordered: an immediate reading-in should be provided which decriminalised the private cultivation and personal use of cannabis. This would need to be expanded along the lines suggested above to include the supervision and safe supply of psilocybin mushrooms.

190.2 In addition, in *Teddy Bear Clinic*, the Constitutional Court made the following additional order:

> *"3. From the date of this judgment, a moratorium is placed on all investigations into, arrests of, prosecutions of, and criminal and ancillary proceedings against children under the age of 16 years in relation to sections 15 and 16 of the Act, pending Parliament's correction of the defects in the Act."*[26]

191 There should therefore be a moratorium on any existing or new prosecutions based on the impugned provisions. I pause to mention that this would also prevent abuse by rogue members of the SAPS, who may move from user of cannabis to users of psilocybin as the next *'low hanging fruit'* to solicit bribes and/or meet arrest quotas.

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[25] Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another 2014 (2) SA 168 (CC).

[26] Ibid at para 117.

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192 Furthermore, the applicants (as emphasised above) only challenge the constitutionality of the impugned provisions insofar as they limit the rights of adults. No part of the applicants' case seeks to encourage or submit that children should have the same access or right to use psilocybin. However, to the extent that this court grants an order which decriminalises psilocybin, the applicants submit that the court should still be cognisant of the rights of children and *'the best interests of the child'* standard not to be exposed unduly or too hastily to the criminal justice system. And for children to be dealt with appropriately and with care, including under the Child Justice Act 75 of 2008. I reiterate, that no part of the applicants' case seeks to promote or protect the use of psilocybin by minors – the applicants' case only deals with use by adults. That being said, it may be that this Court considers and order akin to that in *Centre for Child Law v Director of Public Prosecutions: Johannesburg and Others*[27] in order to ensure that children are protected from undue prosecutions and unwarranted exposure to the criminal justice system.

[27] *Centre For Child Law v Director Of Public Prosecutions, Johannesburg And Others* 2022 (2) SACR 629 (CC).

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CONCLUSION

193 In light of the above, the applicants pray for the relief sought in the notice of motion.

MONICA CROMHOUT

I hereby certify that the deponent has acknowledged that the deponent knows and understands the contents of this affidavit, which was signed and sworn before me at Somerset West on 28 **MARCH 2024**, the regulations contained in Government Notice No R1258 of 21 July 1972, as amended, and Government Notice No R1648 of 19 August 1977, as amended, having been complied with.

COMMISSIONER OF OATHS

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"FA1"

DRUGS AND DRUG TRAFFICKING ACT NO. 140 OF 1992

[ASSENTED TO 2 JULY, 1992]
[DATE OF COMMENCEMENT: 30 APRIL, 1993]

(English text signed by the State President)

This Act has been updated to *Government Gazette* 33601 dated 8 October, 2010.

as amended by

Justice Laws Rationalisation Act, No. 18 of 1996
[with effect from 1 April, 1997]

International Co-operation in Criminal Matters Act, No. 75 of 1996
[with effect from 1 January, 1998]

Proceeds of Crime Act,

Prevention of Organised Crime Act, No. 121 of 1998

Financial Advisory and Intermediary Services Act, No. 37 of 2002
[with effect from 15 November, 2002, unless otherwise indicated]

Regulation of Interception of Communications and Provision of Communication-related Information Act, No. 70 of 2002
[with effect from 30 September, 2005, unless otherwise indicated]

EDITORIAL NOTE

Please note that details of Government Notices published in the *Government Gazettes* that amend the Schedules to the Act are annotated at the beginning of the Schedules.

ACT

To provide for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes; for the obligation to report certain information to the police; for the exercise of the powers of entry, search, seizure and detention in specified circumstances; for the recovery of the proceeds of drug trafficking; and for matters connected therewith.

ARRANGEMENT OF SECTIONS

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CHAPTER I
APPLICATION OF ACT

1. Definitions.—(1) In this Act, unless the context indicates otherwise—

"convert" . . . . . .

[Definition of "convert" deleted by s. 79 (*b*) of Act No. 121 of 1998.]

"dangerous dependence-producing substance" means any substance or any plant from which a substance can be manufactured included in Part II of Schedule 2;

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"deal in", in relation to a drug, includes performing any act in connection with the transshipment, importation, cultivation, collection, manufacture, supply, prescription, administration, sale, transmission or exportation of the drug;

"declaration of forfeiture" means a declaration of forfeiture made in terms of section 25 (1);

"defined crime" . . . . . .

[Definition of "defined crime" deleted by s. 79 (*b*) of Act No. 121 of 1998.]

"dependence-producing substance" means any substance or any plant from which a substance can be manufactured included in Part I of Schedule 2;

"designated officer" means any officer referred to in section 8;

"drug" means any dependence-producing substance, any dangerous dependenceproducing substance or any undesirable dependence-producing substance;

"drug offence"—

(*a*) in relation to a drug offence committed in the Republic, means an offence referred to in section 13 (*f*);

(*b*) in relation to a drug offence committed outside the Republic, means any act or omission which, if it had occurred within the Republic, would have constituted an offence referred to in that section;

"economic offence" . . . . . .

[Definition of "economic offence" deleted by s. 79 (*b*) of Act No. 121 of 1998.]

"financial institution" . . . . . .

[Definition of "financial institution" deleted by s. 79 (*b*) of Act No. 121 of 1998.]

"interest" includes any right;

"manufacture", in relation to a substance, includes the preparing, extraction or producing of the substance;

"medicinal purposes", in relation to a particular drug, means the treatment or prevention of a disease or for some other definite curative or therapeutic purpose, but does not include the satisfaction or relief of a habit or of a craving for the particular drug or for any other drug;

"Medicines Act" means the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965);

"Minister" means the Minister of Justice;

"place of entertainment" includes any premises, vehicle, vessel or aircraft, or any part thereof, used for or in connection with any exhibition, show, performance, dance, amusement, game, competition or sport;

"plant" includes any portion of a plant;

"police official" means any member of the Force as defined in of the Police Act, 1958 ();

"possess", in relation to a drug, includes to keep or to store the drug, or to have it in custody or under control or supervision;

"premises" means land or any building, dwelling, flat, room, shop, office or other structure;

"proceeds" . . . . . .

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[Definition of "proceeds" deleted by s. 79 (*b*) of Act No. 121 of 1998.]

"property" means money or any other movable, immovable, corporeal or incorporeal thing;

"record" includes any information contained in a computer or reproduced by a computer print-out, as the case may be;

"scheduled substance" means any substance included in Part I or II of Schedule 1;

"sell", in relation to a drug, includes to offer, advertise, possess or expose the drug for sale, to dispose of it, whether for consideration or otherwise, or to exchange it;

"undesirable dependence-producing substance" means any substance or any plant from which a substance can be manufactured included in Part III of Schedule 2.

(2) In this Act—

(*a*) except where it is inconsistent with the context or clearly inappropriate, any reference to property shall be construed as a reference also to property which is situate outside the Republic;

(*b*) any reference to a person practising any health service or cognate profession shall be construed as a reference to a person practising any health service or cognate profession as defined in the Medicines Act.

2. Operation of Act with regard to Medicines Act.—The provisions of this Act shall apply in addition to, and not in substitution for, the provisions of the Medicines Act or any regulation made thereunder.

CHAPTER II
ILLEGAL ACTS

Acts relating to scheduled substances and drugs

3. Manufacture and supply of scheduled substances.—No person shall manufacture any scheduled substance or supply it to any other person, knowing or suspecting that any such scheduled substance is to be used in or for the unlawful manufacture of any drug.

4. Use and possession of drugs.—No person shall use or have in his possession—

(*a*) any dependence-producing substance; or

(*b*) any dangerous dependence-producing substance or any undesirable dependence-producing substance,

unless—

(i) he is a patient who has acquired or bought any such substance—

(*aa*) from a medical practitioner, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder; or

(*bb*) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, dentist or practitioner,

and uses that substance for medicinal purposes under the care or treatment of the said medical practitioner, dentist or practitioner;

(ii) he has acquired or bought any such substance for medicinal purposes—

(*aa*) from a medical practitioner, veterinarian, dentist or practitioner acting in his

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professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(*bb*) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, veterinarian, dentist or practitioner; or

(*cc*) from a veterinary assistant or veterinary nurse in terms of a prescription in writing of such veterinarian,

with the intent to administer that substance to a patient or animal under the care or treatment of the said medical practitioner, veterinarian, dentist or practitioner;

(iii) he is the Director-General: Welfare who has acquired or bought any such substance in accordance with the requirements of the Medicines Act or any regulation made thereunder;

[Sub-para. (iii) amended by s. 4 of Act No. 18 of 1996.]

(iv) he, she or it is a patient, medical practitioner, veterinarian, dentist, practitioner, nurse, midwife, nursing assistant, pharmacist, veterinary assistant, veterinary nurse, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter, or any other person contemplated in the Medicines Act or any regulation made thereunder, who or which has acquired, bought, imported, cultivated, collected or manufactured, or uses or is in possession of, or intends to administer, supply, sell, transmit or export any such substance in accordance with the requirements or conditions of the said Act or regulation, or any permit issued to him, her or it under the said Act or regulation;

(v) he is an employee of a pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter who has acquired, bought, imported, cultivated, collected or manufactured, or uses or is in possession of, or intends to supply, sell, transmit or export any such substance in the course of his employment and in accordance with the requirements or conditions of the Medicines Act or any regulation made thereunder, or any permit issued to such pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter under the said Act or regulation; or

(vi) he has otherwise come into possession of any such substance in a lawful manner.

5. Dealing in drugs.—No person shall deal in—

(*a*) any dependence-producing substance; or

(*b*) any dangerous dependence-producing substance or any undesirable dependence-producing substance,

unless—

(i) he has acquired or bought any such substance for medicinal purposes—

(*aa*) from a medical practitioner, veterinarian, dentist or practitioner acting in his professional capacity and in accordance with the requirements of the Medicines Act or any regulation made thereunder;

(*bb*) from a pharmacist in terms of an oral instruction or a prescription in writing of such medical practitioner, veterinarian, dentist or practitioner; or

(*cc*) from a veterinary assistant or veterinary nurse in terms of a prescription in writing of such veterinarian,

and administers that substance to a patient or animal under the care or treatment of the said medical practitioner, veterinarian, dentist or practitioner;

(ii) he is the Director-General: Welfare who acquires, buys or sells any such substance in accordance with the requirements of the Medicines Act or any regulation made thereunder;

[Sub-para. (ii) amended by s. 4 of Act No. 18 of 1996.]

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(iii) he, she or it is a medical practitioner, veterinarian, dentist, practitioner, nurse, midwife, nursing assistant, pharmacist, veterinary assistant, veterinary nurse, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter, or any other person contemplated in the Medicines Act or any regulation made thereunder, who or which prescribes, administers, acquires, buys, transships, imports, cultivates, collects, manufactures, supplies, sells, transmits or exports any such substance in accordance with the requirements or conditions of the said Act or regulation, or any permit issued to him, her or it under the said Act or regulation; or

(iv) he is an employee of a pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter who acquires, buys, transships, imports, cultivates, collects, manufactures, supplies, sells, transmits or exports any such substance in the course of his employment and in accordance with the requirements or conditions of the Medicines Act or any regulation made thereunder, or any permit issued to such pharmacist, manufacturer of, or wholesale dealer in, pharmaceutical products, importer or exporter under the said Act or regulation.

Acts relating to proceeds of defined crime

6. . . . . . .

[S. 6 repealed by s. 79 (*b*) of Act No. 121 of 1998.]

7. . . . . . .

[S. 7 repealed by s. 79 (*b*) of Act No. 121 of 1998.]

CHAPTER III
REPORTING OF INFORMATION, AND INVESTIGATIONS

Reporting of information

8. Designated officers.—For the purposes of this Chapter, every commissioned officer of the South African Police Service assigned to the South African Narcotics Bureau shall be a designated officer.

[S. 8 amended by s. 4 of Act No. 18 of 1996.]

9. Relaxation of restrictions on disclosure of information.—(1) Any person may, notwithstanding anything to the contrary contained in any law which prohibits him or her—

(*a*) from disclosing any information relating to the affairs or business of any other person; or

(*b*) from permitting any person to have access to any registers, records or other documents which have a bearing on the said affairs or business,

disclose to any attorneygeneral or designated officer such information as he or she may consider necessary for the prevention or combating, whether in the Republic or elsewhere, of a drug offence.

[Sub-s. (1) substituted by s. 79 (*b*) of Act No. 121 of 1998.]

(2) The provisions of subsection (1) shall not be construed as prohibiting any Minister by whom or any other authority by which, or under the control of whom or which, any law referred to in that subsection is administered, or any board, institution or body established by or under any such law, from making any other arrangement with regard to the furnishing of information or the granting of access contemplated in that subsection, according to which the information or access shall be furnished or granted—

(*a*) by, or on the authority or with the approval of, any such Minister, authority, board,

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PART III

Undesirable Dependence-Producing Substances

1. The following substances or plants, namely—

Amphetamine.

Brolamfetamine.

4-bromo-2,5-dimethoxyphenethylamine (2C-B), ("Nexus").

Bufotenine (N,N-dimethylserotonin).

Cannibis (dagga), the whole plant or any portion thereof, except dronabinol [(-)-transdelta-9 tetrahydrocannabinol].

Cathinone.

Dexamphetamine.

Diethyltryptamine [3-(2-(diethylamino)-ethyl)-indole;cb.

2,5-dimethoxyamphetamine (DMA).

2,5-dimethoxy-4-ethylamphetamine (DOET).

(±)-N,∝- dimethyl-3,4-(methylenedioxy) phenethylamine (3,4-methylenedioxymetamfetamine (MDMA).

3-(1,2-dimethylheptyl)-7,8,9,10-tetrahydro-6,6,9-trimethyl-6*H*-dibenzo [*b*, *d*] pyran-1-ol (DMHP).

Dimethyltryptamine [3-(2-(dimethylamino)-ethyl)-indole].

Etryptamine (3-(2-aminobutyl)indole).

Fenetylline.

Fentanyl-analogues:

acetyl-alpha-methyl-fentanyl;

alpha-methyl-fentanyl;

alpha-methyl-fentanyl-acetanilide;

alpha-methyl-thio-fentanyl;

benzyl-fentanyl;

beta-hydroxy-fentanyl;

beta-hydroxy-3-methyl-fentanyl;

3-methyl-fentanyl and the two isomeric forms thereof, namely,

cis-N-(3-methyl-1-(2-phenethyl)-4-piperidyl)propionanilide and trans-N-(3-methyl-1-(2-phenethyl)-4-piperidyl)propionanilide;

3-methyl-thio-fentanyl;

para-fluoro-fentanyl; and

thiofentanyl.

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Gamma-hydroxybutyrate (GHB).

Harmaline (3,4-dihydroharmine).

Harmine [7-methoxy-1-methyl-9H-pyrido (3,4-b)-indole].

Herion (diacetylmorphine).

Levamphetamine.

Levomethamphetamine.

Lysergide (lysergic acid diethylamide).

Mescaline (3,4,5-trimethoxyphenethylamine).

Methamphetamine and methamphetamine racemate.

Methaqualone, including Mandrax, Isonox, Quaalude, or any other preparation containing methaqualone and known by any other trade name.

Methcathinone (2-(methylamino)-1-phenylpropan-1-one).

2-methoxy-4,5-methylenedioxyamphetamine (MMDA).

4-methylaminorex.

4-methyl-2,5-dimethoxyamphetamine (DOM) and the derivatives thereof.

Methylenedioxyamphetamine (MDA):

N-ethyl-methylenedioxyamphetamine; and

N-hydroxy-methylenedioxyamphetamine.

Nabilone.

Parahexyl.

Paramethoxyamphetamine (PMA).

Phencyclidine and the congeners thereof, namely, N-ethyl-1-phenylcyclohexylamine (PCE), 1-(1-phenylcyclohexyl) pyrrolidine (PHP or PCPY) and 1- [1-(2-thienyl) cycohexyl] piperidine (TCP).

Pethidine-analogues:

1-methyl-4-phenyl-4-propionoxy-piperidine (MPPP);

1-methyl-4-phenyl-1,2,5,6-tetrahydropiperidine (MPTP); and

1-phenylethyl-4-phenyl-4-acetyloxy-piperidine (PEPAP).

Phenmetrazine.

Psilocin (4-hydroxydimethyltryptamine).

Psilocybin (4-phosphoryloxy-N,N-dimethyltryptamine).

Tetrahydrocannabinol.

3,4,5-trimethoxy amphetamine (TMA).

2. Unless expressly excluded, all substances or plants included in this Part include the following:

(*a*) The isomers of the specified substances or plants, where the existence of such isomers is possible;

(*b*) the esters and ethers of the specified substances or plants and of the isomers referred to in

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subparagraph (*a*), as well as the isomers of such esters and ethers, where the existence of such esters, ethers and isomers is possible;

(*c*) the salts of the specified substances or plants, of the isomers referred to in subparagraph (*a*) and of the esters, ethers and isomers referred to in subparagraph (*b*), as well as the isomers of such salts, where the existence of such salts and isomers is possible; and

(*d*) all preparations and mixtures of the specified substances or plants and of the isomers, esters, ethers and salts referred to in this paragraph.

Schedule 3

LAWS REPEALED (SECTION 66)

No. and yearof law	*Short title*	*Extent of repeal*
	Abuse of Dependence-producing Substances and Rehabilitation Centres Act, 1971	So much as is unrepealed.
	Abuse of Dependence-producing Substances and Rehabilitation Centres Amendment Act, 1973	So much as is unrepealed.
	Abuse of Dependence-producing Substances and Rehabilitation Centres Amendment Act, 1977	So much as is unrepealed.
	Abuse of Dependence-producing Substances and Rehabilitation Centres Amendment Act, 1978	The whole.
Act No. 97 of 1986	Transfer of Powers and Duties of the State President Act, 1986	Section 40.
	Abuse of Dependence-producing Substances and Rehabilitation Centres Amendment Act, 1986	The whole.
	Abuse of Dependence-producing Substances and Rehabilitation Centres Amendment Act, 1990	The whole.

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MEDICINES AND RELATED SUBSTANCES ACT NO. 101 OF 1965

[View Regulation]

[ASSENTED TO 19 JUNE, 1965]
[DATE OF COMMENCEMENT: 1 APRIL, 1966]

(Afrikaans text signed by the State President)

This Act was published in *Government Gazette* 40869 dated 26 May, 2017.

as amended by

Drugs Control Amendment Act, No. 29 of 1968

Drugs Control Amendment Act, No. 88 of 1970

Drugs Laws Amendment Act, No. 95 of 1971

Drugs Control Amendment Act, No. 65 of 1974

Medicines and Related Substances Control Amendment Act, No. 19 of 1976

Health Laws Amendment Act, No. 36 of 1977

Medicines and Related Substances Control Amendment Act, No. 17 of 1979

Medicines and Related Substances Control Amendment Act, No. 20 of 1981

Transfer of Powers and Duties of the State President Act, No. 97 of 1986
[with effect from 3 October, 1986]

Businesses Act, No. 71 of 1991
[with effect from 24 May, 1991]

Medicines and Related Substances Control Amendment Act, No. 94 of 1991

General Law Amendment Act, No. 49 of 1996
[with effect from 4 October, 1996]

Abolition of Restrictions on the Jurisdiction of Courts Act, No. 88 of 1996
[with effect from 22 November, 1996]

Medicines and Related Substances Control Amendment Act, No. 90 of 1997

Medicines and Related Substances Amendment Act, No. 59 of 2002

Judicial Matters Amendment Act, No. 66 of 2008
[with effect from 17 February, 2009]

Medicines and Related Substances Amendment Act No. 72 of 2008

Medicines and Related Substances Amendment Act, No. 14 of 2015

GENERAL NOTE

There is a discrepancy between the English and Afrikaans texts of section 1 of Act No. 94 of 1991, which affects section 1 of this Act.

The definition of "landdros" in section 1 of the Afrikaans text of this Act has been amended by the Judicial Matters Amendment Act, No. 66 of 2008. We suggest that reference be made to the Afrikaans Act for this definition.

In terms of s. 24 of Act No. 14 of 2015, the words "product" and "products", wherever they occur except in sections 2, 22A, 22F (4) (c) and 22H (1) (a) and Schedules 0 up to and including 6, are substituted by the words "medicine" and "medicines", respectively.

EDITORIAL NOTE

21. Authority may authorize sale of unregistered medicines, medical devices or IVDs for certain purposes.—(1) The Authority may in writing authorize any person to sell during a specified period to any specified person or institution a specified quantity of any particular medicine, medical device or IVD which is not registered.

(2) Any medicine, medical device or IVD sold in pursuance of any authority granted under subsection (1) may be used for such purposes and in such manner and during such period as the Authority may in writing determine.

(3) The Authority may at any time by notice in writing withdraw any authority granted in terms of subsection (1) if effect is not given to any determination made in terms of subsection (2).

[S. 21 amended by s. 19 of Act No. 65 of 1974 (English only) and substituted by s. 20 of Act No. 72 of 2008.]

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22. Authority to cause certain information to be furnished.—(1) The Chief Executive Officer shall cause, in such manner as he or she considers most suitable—

(*a*) as soon as practicable after any medicine, medical device or IVD, other than a veterinary medicine, has been registered, medical practitioners, dentists, pharmacists and the person who applied for the registration of such medicine, medical device or IVD to be informed—

(i) of the name and number under which such medicine, medical device or IVD is registered and the conditions, if any, subject to which such medicine, medical device or IVD is registered;

(ii) of the therapeutic efficacy and effect of such medicine;

(iii) of the purpose for which, the circumstances under which and the manner in which such medicine, medical device or IVD should be used; and

(iv) regarding any other matter concerning such medicine, medical device or IVD which, in the opinion of the Chief Executive Officer, may be of value to them;

(*b*) as soon as practicable after the registration of any medicine, medical device or IVD, other than a veterinary medicine, has been cancelled in terms of section 16, medical practitioners, dentists, pharmacists, the public in general and the holder of the certificate of registration issued in respect of such medicine, medical device or IVD to be informed of the cancellation of such registration.

(2) The provisions of subsection (1) shall apply *mutatis mutandis* in respect of any veterinary medicine, and for the purposes of such application the reference in that subsection to medical practitioners and dentists shall be deemed to be a reference to veterinarians.

[S. 22 substituted by s. 20 of Act No. 65 of 1974, by s. 8 of Act No. 17 of 1979 amended by s. 6 of Act No. 20 of 1981 and substituted by s. 21 of Act No. 72 of 2008.]

22A. Control of medicines, Scheduled substances, medical devices and IVDs.—(1) Subject to this section, no person shall sell, have in his or her possession or manufacture any medicine, Scheduled substance, medical device or IVD, except in accordance with the prescribed conditions.

[Sub-s. (1) substituted by s. 14 (b) of Act No. 14 of 2015.]

(2) The Minister may, on the recommendation of the Authority, prescribe the Scheduled substances referred to in this section.

[Sub-s. (2) substituted by s. 22 (a) of Act No. 72 of 2008.]

(3) Any Schedule 0 substance may be sold in an open shop.

(4) Any Schedule 1 substance shall not be sold—

(*a*) by any person other than—

(i) a pharmacist, or a pharmacist intern or pharmacist's assistant acting under the personal supervision of a pharmacist;

(ii) a manufacturer of or wholesale dealer in pharmaceutical products for sale to any person who may lawfully possess such substance;

(iii) a medical practitioner or dentist, who may—

(*aa*) prescribe such substance;

(*bb*) compound and dispense such substance only if he or she is the holder of a licence as contemplated in section 22C (1) (a);

(iv) a veterinarian who may prescribe, compound or dispense such substance;

(v) a practitioner, nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist, who may—

(*aa*) prescribe only the Scheduled substances identified in the Schedule for that purpose;

(*bb*) compound and dispense the Scheduled substances referred to in item (aa) only if he or she is the holder of a licence contemplated in section 22C (1) (a);

(*b*) to any person apparently under the age of 12 years except upon a prescription issued by an authorised prescriber and dispensed by a pharmacist, pharmacist intern or pharmacist's assistant or by a veterinarian or a person who is the holder of a licence as contemplated in section 22C (1) (a), or on a written order disclosing the purpose for which such substance is to be used and bears a signature known to the seller as the signature of a person known to such seller and who is apparently over the age of 12 years;

[Para. (b) substituted by s. 22 (b) of Act No. 72 of 2008.]

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(*c*) unless the seller, other than a manufacturer or wholesale dealer in pharmaceutical products, enters in a prescription book required to be kept in the prescribed manner, the prescribed particulars of such sale.

(5) Any Schedule 2, Schedule 3, Schedule 4, Schedule 5 or Schedule 6 substance shall not be sold by any person other than—

(*a*) a pharmacist, pharmacist intern or a pharmacist's assistant acting under the personal supervision of a pharmacist, who may sell only Schedule 2 substances without a prescription;

(*b*) a pharmacist or a pharmacist intern or pharmacist's assistant acting under the personal supervision of a pharmacist, upon a written prescription issued by an authorised prescriber or on the verbal instructions of an authorised prescriber who is known to such pharmacist;

(*c*) a manufacturer of or wholesale dealer in pharmaceutical products for sale to any person who may lawfully possess such substance;

(*d*) a medical practitioner or dentist, who may—

(i) prescribe such substance;

(ii) compound or dispense such substance only if he or she is the holder of a licence as contemplated in section 22C (1) (a);

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(*e*) a veterinarian who may prescribe, compound or dispense such substance;

(*f*) a practitioner, a nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist, who may—

(i) prescribe only the Scheduled substances identified in the Schedule for that purpose;

(ii) compound and dispense the Scheduled substances referred to in subparagraph (i) only if he or she is the holder of a licence contemplated in section 22C (1) (a).

(6) Any sale under subsection (5) shall only take place on condition that—

(*a*) all the prescribed particulars of every sale shall be recorded in the prescribed manner in a prescription book or other permanent record required to be kept in the prescribed manner;

(*b*) the authorised prescriber who has given verbal instructions to a pharmacist to dispense a prescription shall within seven days after giving such instructions furnish such pharmacist with a prescription confirming such instructions;

(*c*) in the case of verbal instructions the treatment period shall not exceed seven days;

(*d*) if a prescription is not presented for dispensing within 30 days of issue it shall not be dispensed;

(*e*) in the case of a Schedule 2 substance, such substance may not be supplied to any person apparently under the age of 12 years except upon a prescription issued by an authorised prescriber and dispensed by a pharmacist, pharmacist intern or pharmacist's assistant or by a veterinarian or a person who is the holder of a licence as contemplated in section 22C (1) (a), or on a written order disclosing the purpose for which such substance is to be used and bears a signature known to the seller as the signature of a person known to such seller and who is apparently over the age of 12 years;

[Para. (e) substituted by s. 22 (c) of Act No. 72 of 2008.]

(*f*) in the case of a Schedule 2, Schedule 3 or Schedule 4 substance, such sale may be repeated if the person who issued the prescription has indicated thereon the number of times it may be dispensed, but not for longer than six months;

(*g*) in the case of a Schedule 5 substance, such sale shall not be repeated for longer than six months, and then only if the authorised prescriber has indicated on the prescription the number of times and the intervals at which it may be dispensed;

(*h*) where a Schedule 5 substance is used for—

(i) its anxiolytic, anti-depressant or tranquillising properties it shall not be prescribed for longer than six months unless the authorised prescriber has consulted a registered psychiatrist, or, in the case of a psychiatrist, another psychiatrist before issuing a new prescription;

(ii) its analgesic properties it shall not be prescribed for longer than six months unless the authorised prescriber has consulted another medical practitioner, before issuing a new

prescription;

(*i*) in the case of a Schedule 6 substance, it shall not be repeated without a new prescription being issued;

(*j*) in an emergency in which the health or life of a patient is at stake, a pharmacist engaged in wholesale practice may, on receipt of a telephonic or telefaxed or other electronic request, supply a Schedule 6 substance to a pharmacist, medical practitioner, dentist, veterinarian, practitioner, nurse or other person registered under the Health Professions Act, 1974, without a written order: Provided that—

(i) it shall be the responsibility of such pharmacist, medical practitioner, dentist, veterinarian, practitioner, nurse or other person to ensure that such pharmacist receives a written order within seven days;

(ii) the Schedule 6 substance shall be supplied in the smallest unit sales pack available;

(iii) a permanent record is made and kept of such supply;

(*k*) in an emergency a pharmacist may sell any Schedule 5 or Schedule 6 substance in a quantity not greater than that required for continuous use for a period of 48 hours, on the verbal instructions of a medical practitioner, dentist, veterinarian, practitioner, nurse or other person registered under the Health Professions Act, 1974, who is known to such pharmacist, but the prescriber who has given such verbal instructions shall within 72 hours after giving such instructions furnish to such pharmacist a written prescription confirming the instructions;

(*l*) in an emergency a pharmacist may sell a Schedule 2, Schedule 3 or Schedule 4 substance on a non-recurring basis for a period not exceeding 30 days in accordance with the original prescription in order to ensure that therapy is not disrupted if he or she is satisfied that an authorised prescriber initiated the therapy, with the intention that the therapy be continued, and that the particulars of such sale are recorded in a prescription book or other prescribed permanent record;

(*m*) a pharmacist may sell a greater or a lesser quantity of a Schedule 1, Schedule 2, Schedule 3 or Schedule 4 substance than the quantity prescribed or ordered, according to the therapeutic pack in the original container of such substance as supplied to him or her, but the quantity so sold shall not exceed or be less than, 25 percent of the quantity specified in the prescription or order in question;

(*n*) any seller referred to in this subsection shall retain the prescription or order concerned for a period of not less than five years as from the date of such sale;

(*o*) a Schedule 6 substance may only be sold if the course of treatment does not exceed 30 consecutive days;

(*p*) the sale of a specified Schedule 5 or Schedule 6 substance by a manufacturer of or wholesale dealer in pharmaceutical products shall be recorded in a register which shall be kept in the prescribed manner, and shall be balanced so as to show clearly the quantity of every specified Schedule 5 or Schedule 6 substance remaining in stock as on the last day of March, June, September and December of each year, and such balancing shall be completed within the 14 days following each of the said dates;

[Para. (p) substituted by s. 5 (a) of Act No. 59 of 2002.]

(*q*) a pharmacist shall endorse on the prescription the date of sale and the quantity of the substance sold, and when it is repeated, the date of sale and the quantity of the said substance sold, and the last seller shall retain the prescription for a period of not less than five years as from the date of the last sale;

(*r*) any Schedule 1, Schedule 2, Schedule 3 or Schedule 4 substance for the treatment of any animal may be supplied by any person practising a para-veterinary profession within the meaning of the Veterinary and Para-Veterinary Professions Act, 1982 (Act No. 19 of 1982), upon a written prescription issued by a veterinarian or on the verbal instructions of a veterinarian.

(7) (*a*) No person, other than a pharmacist, pharmacist intern or pharmacist's assistant acting under the personal supervision of a pharmacist, shall sell or export a Schedule 1, Schedule 2, Schedule 3, Schedule 4, Schedule 5 or Schedule 6 substance for analytical purposes, manufacture of foods, cosmetics, educational or scientific purposes, unless a permit, issued in accordance with the prescribed conditions has, subject to paragraph (b), been obtained from the Director-General for such purpose.

(*b*) The Director-General may revoke any permit referred to in paragraph (a) if the conditions on which such permit was issued, are not complied with or if it is not in the public interest that the particular action be continued.

(8) Subject to subsection (9), a Schedule 8 substance shall not be acquired by any person other than the Director-General for the purpose of providing a medical practitioner therewith, on the prescribed conditions, for the treatment of a particular patient of that medical practitioner upon such conditions as the Director-General, on the recommendation of the council, may determine.

[Sub-s. (8) substituted by s. 5 (b) of Act No. 59 of 2002.]

(9) (*a*) No person shall—

(i) acquire, use, possess, manufacture or supply any Schedule 7 or Schedule 8 substance, or

manufacture any specified Schedule 5 or Schedule 6 substance unless he or she has been issued with a permit by the Director-General for such acquisition, use, possession, manufacture or supply: Provided that the Director-General may, subject to such conditions as he or she may determine, acquire or authorise the use of any Schedule 7 or Schedule 8 substance in order to provide a medical practitioner, analyst, researcher or veterinarian therewith on the prescribed conditions for the treatment or prevention of a medical condition in a particular patient, or for the purposes of education, analysis or research;

[Sub-para. (i) substituted by s. 5 (c) of Act No. 59 of 2002.]

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(ii) manufacture, use or supply any Schedule 5 or Schedule 6 substance for other than medicinal purposes, unless he or she has been issued by the Director-General with a permit for such manufacture, use or supply upon the prescribed conditions.

(*b*) Notwithstanding paragraph (a), the Director-General may at any time revoke any permit issued in terms of that paragraph if any condition on which the permit was issued is not being complied with.

(*c*) A permit issued in terms of this subsection shall be valid for a period of 12 calendar months after the date of issue thereof.

(10) Notwithstanding anything to the contrary contained in this section, no person shall sell or administer any Scheduled substance or medicine for other than medicinal purposes: Provided that the Minister may, subject to the conditions or requirements stated in such authority, authorise the administration outside any hospital of any Scheduled substance or medicine for the satisfaction or relief of a habit or craving to the person referred to in such authority.

(11) (*a*) No person shall import or export any specified Schedule 5, Schedule 6, Schedule 7 or Schedule 8 substance or other substance or medicine prescribed for that purpose unless a permit has been issued to him or her by the Director-General in the prescribed manner and subject to such conditions as may be determined by the Director-General.

[Para. (a) substituted by s. 5 (d) of Act No. 59 of 2002.]

(*b*) A permit referred to in paragraph (a) may be issued for any purpose other than the satisfaction or relief of a habit or craving in respect of such substance or medicine.

(*c*) The issue of a permit referred to in paragraph (a) may be refused if—

(i) the Director-General is not convinced that the applicant is capable of keeping or storing the substance or medicine in a satisfactory manner in order to prevent the loss thereof;

(ii) the use of such substance or medicine has not been authorised in terms of this Act;

(iii) the Director-General is of the opinion that the annual importation quota for such substance has been exceeded or will be exceeded;

(iv) the Director-General is of the opinion that such substance or medicine, of an acceptable quality, is already available in the Republic; or

(v) the applicant did not comply with the conditions under which a previous permit was issued to him or her.

(*d*) If an application is refused, the applicant shall be furnished with the reasons for such refusal.

(*e*) A permit issued in terms of this subsection shall be valid for a period of six months from the date of issue thereof.

(12) (*a*) The control on the importation of Scheduled substances shall relate to—

(i) any specified Schedule 5, Schedule 6, Schedule 7 or Schedule 8 substance;

[Sub-para. (i) substituted by s. 5 (e) of Act No. 59 of 2002.]

(ii) such substances irrespective of the scheduling status allocated thereto, as the Minister may prescribe;

(iii) any other substance which becomes subject to international control in terms of the 1961 Single Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances entered into by the Republic.

(*b*) The obtaining of import or export permits as required in terms of subsection (11) shall not apply to any preparation which contains a substance as prescribed which is specifically exempted from all control measures for the obtaining of such import or export permits by the 1961 Single Convention on Narcotic Drugs referred to in paragraph (a).

[Para. (b) substituted by s. 5 (f) of Act No. 59 of 2002.]

(*c*) Notwithstanding paragraph (b), no such importation or exportation shall take place unless authorised by the Director-General.

[Para. (c) substituted by s. 5 (g) of Act No. 59 of 2002.]

(13) Any permit issued under subsection (11) shall be subject—

(a) to the applicant's furnishing the Chief Executive Officer annually with the prescribed information;

[Para. (a) substituted by s. 22 (d) of Act No. 72 of 2008.]

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(b) to the requirement that there shall be no deviation from the particulars reflected on the permit: Provided that if the quantity of such substance or medicine to be imported is less than that provided for in the permit, the Director-General shall be informed in writing thereof within 10 days after the importation of such substance or medicine; and

(c) to the conditions, as detailed on the permit, having been complied with, the triplicate copy of the permit having been certified by a customs officer or an employee of the S.A. Post Office Limited.

(14) Notwithstanding anything to the contrary contained in this section—

(a) a pharmacist's assistant shall not handle any specified Schedule 5 or Schedule 6 substance except as contemplated in subsection (5) (a) and (b); and

[Para. (a) substituted by s. 5 (h) of Act No. 59 of 2002.]

(b) no nurse or a person registered under the Health Professions Act, 1974, other than a medical practitioner or dentist, may prescribe a medicine or Scheduled substance unless he or she has been authorised to do so by his or her professional council concerned.

(15) Notwithstanding anything to the contrary contained in this section, the Director-General may, after consultation with the South African Pharmacy Council as referred to in section 2 of the Pharmacy Act, 1974 (Act No. 53 of 1974), issue a permit to any person or organisation performing a health service, authorising such person or organisation to acquire, possess, use or supply any specified Schedule 1, Schedule 2, Schedule 3, Schedule 4 or Schedule 5 substance, and such permit shall be subject to such conditions as the Director-General may determine.

[Sub-s. (15) substituted by s. 22 (e) of Act No. 72 of 2008.]

(16) Notwithstanding anything to the contrary contained in this section—

(a) any person may possess a Schedule 0, Schedule 1 or Schedule 2 substance for medicinal purposes;

(b) any person may possess a Schedule 3, Schedule 4, Schedule 5 or Schedule 6 substance if he or she is in possession of a prescription issued by an authorised prescriber;

[Para. (b) substituted by s. 5 (i) of Act No. 59 of 2002.]

(c) any medicine or scheduled substance may be possessed by a medical practitioner, dentist, veterinarian, practitioner, nurse or other person registered under the Health Professions Act, 1974, or under the Veterinary and Para-Veterinary Professions Act, 1982, for the purposes of administering it in accordance with his or her scope of practice;

(d) any medicine or scheduled substance may be possessed for sale by a pharmacist, a person licenced to own a pharmacy in terms of the Pharmacy Act, 1974, or a person who is the holder of a licence as contemplated in section 22C.

(17) For the purposes of this section—

(a) **"authorised prescriber"** means a medical practitioner, dentist, veterinarian, practitioner, nurse or other person registered under the Health Professions Act, 1974; and

(b) **"medicinal purpose"** means for the purposes of the treatment or prevention of a disease or some other definite curative or therapeutic purpose, but does not include the satisfaction or relief of a habit or craving for the substance used or for any other such substance, except where the substance is administered or used in a hospital or similar institution maintained wholly or partly by the Government or a provincial government or approved for such purpose by the Minister.

[S. 22A inserted by s. 21 of Act No. 65 of 1974, amended by s. 9 of Act No. 17 of 1979 and by s. 7 of Act No. 71 of 1991, substituted, and subsequently re-substituted (after amendment), by s. 9 of Act No. 94 of 1991 and by s. 13 of Act No. 90 of 1997 and amended by s. 14 (a) of Act No. 14 of 2015.]

22B. Publication of information relating to medicines, Scheduled substances, medical devices or IVDs.—(1) Notwithstanding the provisions of section 34 the Authority may, if it deems it expedient and in the public interest, disclose information in respect of the prescribing, dispensing, administration and use of a medicine, Scheduled substance, medical device or IVD.

[Sub-s. (1) substituted by s. 15 (b) of Act No. 14 of 2015.]

(2) The Director-General may publish the information referred to in section (1) or release it to the public in a manner which he or she thinks fit.".

[S. 22B inserted by s. 10 of Act No. 94 of 1991, substituted by s. 23 of Act No. 72 of 2008 and amended by s. 15 (a) of Act No. 14 of 2015.]

22C. Licensing.—(1) Subject to the provisions of this section—

(a) the Director-General may on application in the prescribed manner and on payment of the prescribed

(b) except oral preparations and mixtures registered in terms of the Act and intended for the symptomatic relief of nasal and sinus congestion, where the recommended daily dose for adults is 50 milligrams or less and for children 6 to 12 years is 25 milligrams or less, with a maximum pack size of 5 days; (S1)

(c) except oral preparations and mixtures registered in terms of the Act and intended for the symptomatic relief of nasal and sinus congestion, where the recommended daily dose for adults is more than 50 milligrams and for children 6 to 12 years is more than 25 milligrams. (S2)

Tapentadol.

Thebacon.

Thebaine.

Thiafentanyl.

Tilidine.

((minus)transdelta-9-tetrahydrocannabinol - see dronabinol).

Trimeperidine.

Zipeprol.

ANNEXURE 1A: EMERGENCY CARE PROVIDER (PARAMEDIC)

[Annex 1A ins by GoN R674 in G. 36827.]

(Please note that copies of the above Annexures will be provided upon request. Kindly refer to our website for our contact details.)

- END SCHEDULE 6 -

[Sch 6 am by GoN R1230 in G. 32838, GoN R227 in G. 35149, GoN R104 in G. 37318, GoN R352 in G. 37622, GoN R234 in G. 38586, GoN 254 in G. 39815, GoN 620 in G. 40041, GoN 748 in G. 41009, GoN 1261 in G. 41256.]

SCHEDULE 7

All preparations or mixture of such substances containing or purporting to contain substances referred to in this Schedule include the following (unless expressly excluded or unless listed in another Schedule)—

(i) the isomers of such substances, where the existence of such isomers is possible within the chemical designation;

(ii) the esters and ethers of such substances and of the isomers referred to in (i), as well as the isomers of such esters and ethers, where the existence of isomers of such esters, or ethers is possible;

(iii) the salts of such substances and of the isomers referred to in (i), as well as the salts of the esters, ethers and isomers referred to in (ii), where the existence of such salts is possible;

(iv) the isomers of any of the salts referred to in (iii), where the existence of such isomers is possible;

(v) all preparations and mixtures of any of the above;

(vi) all homologues of listed substances (being any chemically related substances that incorporate a structural fragment into their structures that is similar to the structure of a listed substance and / or exhibit pharmacodynamic properties similar to the listed substance in the schedules), unless listed separately in the Schedules.

(Trivial or unofficial names are marked *)

AH-7921.

AM-2201.

Aminorex.

Amfetamine (Amphetamine) and its salts; preparations thereof. (S8)

5F- APINACA (5f AKB-48)

Acetylfentanyl.

1-Benzylpiperazine (BZP).

Beta-aminopropylbenzene and beta-aminoisopropylbenzene, except any compound structurally derived from either beta-aminopropylbenzene or beta- aminoisopropvlbenzene by substitution in the side chain or by ring closure therein (or by both such substitution and such ring closure); and presented as—

(a) preparations and mixtures when used as vasoconstrictors and decongestants in antihistamine nose and eye preparations; (S1) and

(b) appliances for inhalation in which the substance is absorbed onto solid material; (S1)

(c) excluding cathine {(+)-norpseudoephedrine}, ephedrine, etafedrine, N-methylephedrine, N-diethylaminoethylephedrine, phenylpropanolamine, prepylamine; (S1, S2, S5)

(d) except substances listed in S1, S2, S5, and S6.

Brolamfetamine {(+)-4-bromo-2,5-dimethoxy-α-methylphenethylamine} *(DOB).

4-bromo-2,5-dimethoxyphenethylamine (2C-B) *(Nexus).

Bufotenine (N, N-dimethylserotonin).

Butyrfentanyl.

Cannabidiol, except when intended for therapeutic purposes. (S4)

Cannabis (dagga), the whole plant or any portion or product thereof, except—

(a) when separately specified in the Schedules; (S6) or

(b) processed hemp fibre containing 0.1 per cent or less of tetrahydrocannabinol and products manufactured from such fibre, provided that the product does not contain whole cannabis seeds and is in a form not suitable for ingestion, smoking or inhaling purposes; or

(c) processed product made from cannabis seeds containing not more than 10 milligram per kilogram (0,001 per cent) of tetrahydrocannabinol and does not contain whole cannabis seeds.

("Processed" means treated by mechanical, chemical or other artificial means but does not include— (a) harvesting; or (b) the natural process of decay").

Catha edulis ("khat"), the whole plant or any portion or product thereof.

Cathinone ((minus)-(S)-2-aminopropiophenone).

Dexamfetamine (Dexamphetamine) and it salts; preparations thereof. (S8)

Diethyltryptamine (3-(2-(diethylamino) ethyl) indole) *(DET).

1,3 Dimethylamylamine also known as (1,3 DMAA/1,3 dimethylpentylamine/2-amino-4-methylhexane/2-hexanamine/4-methylhexane-2-amine/4-methyl-2-hexanamine/4-methyl-2-hexylamine/4-methyl-(9C1)/dimethylamylamine/geranamine/methylhexeanamine/methylhexaneamine)

(+)- 2,5-dimethoxy-α-methylphenethylamine *(DMA).

2,5-dimethoxy-α-4-dimethylphenethylamine *(DOM, STP) and its derivatives.

2,5-dimethoxy-4- (n)-propylthiophenethylamine (2C-T-7)

3-(1,2-dimethylheptyl)-7,8,9,10-tetrahydro-6,6,9-trimethyl-6H- dibenzo[b,d]pyran-1-ol*(DMHP).

(+)-N,α-dimethyl-3, 4-(methylenedioxy) phenethylamine *(MDMA).

Dimethyltryptamine (3-(2-(dimethylamino) ethyl) indole) *(DMT).

(+)-4-ethyl-2,5-dimethoxy-α-phenethylamine *(DOET).

Dronabinol ((minus)-transdelta-9-tetrahydrocannabinol). (S6)

Ethylone.

Etilamfetamine (N-ethylamphetamine).

Etryptamine.

Ethylphenidate.

Fenetylline.

Fentanyl-analogues (unless listed in another Schedule) including—

(i) acetyl-alpha-methylfentanyl;

(ii) alpha-methylfentanyl;

(iii) alpha-methylfentanyl- acetanilide;

(iv) alpha-methylthiofentanyl;

(v) benzyl-fentanyl;

(vi) beta-hydroxyfentanyl;

(vii) beta-hydroxy-3-methylfentanyl;

(viii) 3-methylfentanyl and its two isomeric forms—

cis-N-(3- methyl-1-(2-phenethyl)-4-piperidyl) propionanilide; and

trans-N-(3-methyl-1 -(2-phenethylH-piperidyl) propionanilide;

(ix) 3-methylthiofentanyl;

(x) para-fluorofentanyl; and

(xi) thiofentanyl. (S6)

(xii) 4-anilino-N-phenethylpiperidine (ANPP);

(xiii) N-phenethyl-4-piperidone (NPP).

Gamma-hydroxybutyrate *(GHB).

Harmaline (3,4-dihydroharmine).

Harmine (7-methoxy-1-methyl-9H-pyrido (3,4-b)-indole).

Heroin (diacetylmorphine).

3-hexyl-7, 8, 9, 10-tetrahydro-6, 6, 0-trimethyl-6H-dibenzo (b,d)- pyran-1-o1 *(Parahexyl).

Lefetamine *(SPA).

Lisdexamfetamine (lisdexamphetamine), except in medicines registered in terms of the Act and intended for the treatment of Attention-Deficit Hyperactivity Disorder. (S7)

Lysergide (Lysergic acid diethylamide) *(LSD).

MDMB – CHMICA.

4-MEC

Mephedrone.

Mescaline (3,4,5-trimethoxyphenethylamine).

Mesocarb.

Methamphetamine and methamphetamine racemate.

Methaqualone and any preparation containing methaqualone.

Methcathinone.

Methiopropamine (MPA).

Methoxetamine (MXE).

2-methoxy-α-methyl-4,5-(methylenedk)xy)phenethylamine *(MMDA).

p-methoxy-α-methylphenethylamine *(PMA).

4 methylaminorex, ((Methylenedioxyamphetamine *(MDA) and its analogues - see tenamphetamine).

3,4-methylenedoxypyrovalerone (MDPV).

Methylone (beta-keto-MDMA).

Methyprylon.

MT-45

Nabilone. (S8)

25B-NBOMe (2C-B-NBOMe).

25C-NBOMe (2C-C-NBOMe).

25I-NBOMe (2C-I-NBOMe).

Para-methoxymethylamphetamine (PMMA).

Para-methyl-4-methylaminorex (4,4-DMAR).

Pentedrone.

Pethidine-analogues, including—

(i) 1-methyl-4-phenyl-4-propionoxy-piperidine "(MPPP);

(ii) 1-methyl-4 phenyl-1,2,5,6-tetrahydropiperidine *(MPTP); and

(iii) 1-phenylethyl-4-phenyl-4-acetyloxy-piperidine *(PEPAP),

except pethidine-intermediate A, pethidine-intermediate B and pethidine-intermediate C. (S6)

Phencyclidine *(PCP) and its congeners, including—

(i) eticyclidine (N-ethyl-1-phenylcyclohexylamine) *(PCE);

(ii) rolycyclidine (1-(1-phenylcyclohexyl) pyrrolidine) *(PHP or PCPY); and

(iii) tenocyclidine (1-(1-(2-thienyl) cyclohexyl) piperidine) *(TCP).

Phenmetrazine.

Psilocin (4-hydroxy-NN-dimethyltryptamine).

Psilocybine (4- phosphoryloxy-NN-dimethyltryptamine).

α-pyrrolidinovalerophenone (α-PVP).

Pyrovalerone (4'-methyl-2-(1-pyrrolidinyl) valerophenone).

Synthetic cannabinoids (synthetic substances with cannabis-like effects), including but not limited to—

- cannabicyciohexanol;
- JWH-018;
- JWH-073;
- JWH-200;
- CP-47, 497;
- CP47, 497-C6;
- CP 47, 497-C7;
- CP47,497-C6;
- CP 47, 497-C9;
- HU-210

Tenamfetamine (methylenedioxyamphetamine) *(MDA) and its analogues—

(i) (+)-N-ethyl-α-methyl-3,4-(methylenedioxy) phenethylamine *(N-ethyl MDA);

(ii) (+)-N-(α-methyl-3,4-(methylenedioxy) phenethyl) hydroxylamine *(N-hydroxy MDA).

Tetrahydrocannabinol and their alkyl homotogues, except—

(a) when separately specified in the Schedules;

(b) dronabinol ((minus)-transdelta-9-tetrahydrocannabinol), when intended for therapeutic purposes; (S6)

(c) in hemp seed oil, containing 10 milligram per kilogram or less of tetrahydrocannabinols, when labelled "Not to be taken" or "Not for internal human use"; or

(d) in products for purposes other than internal human use containing 10 milligram per kilogram or less of tetrahydrocannabinols.

("Hemp seed oil" means the oil obtained by cold expression from the ripened fruits (seeds) of Cannabis sativa)

1 -(3-trifluoromethylphenyl) piperazine *(TFMPP),

(±)-3, 4, 5- trimethoxy-α-methylphenethylamine *(TMA).

U47700.

XLR-11

- END SCHEDULE 7 -

[Sch 7 am by GoN R227 in G. 35149, GoN R690 in G. 36850, GoN R352 in G. 37622, GoN R234 in G. 38586, GoN 254 in G. 39815; GoN 748 in G. 41009, GoN 1261 in G. 41256.]

SCHEDULE 8

All preparations or mixture of such substances containing or purporting to contain substances referred to in this Schedule include the following (unless expressly excluded or unless listed in another Schedule)—

(i) the isomers of such substances, where the existence of such isomers is possible within the chemical designation;

(ii) the esters and ethers of such substances and of the isomers referred to in (i), as well as the isomers of such esters and ethers, where the existence of such isomers of esters and ethers is possible;

FA2

"FA2"

Enemies of the nation: How the "war on drugs" has failed South Africa

Drug use is a social and health issue. It is not a criminal justice issue

19 August 2020 | By Edwin Cameron (/author/71/)

Opinion (/category/opinion/) | South Africa (/region/South%20Africa)

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How did the world come to blunder so badly on drugs? asks the writer. Photo: Brenton Geach (reprinted with permission of Geach, exclusive copyright, not Creative Commons)

The global "war on drugs" has failed. The decades during which it has been waged have inflicted devastating consequences on societies in both hemispheres. These are no longer fringe advocacy assertions. They are an increasingly obvious truth. A series of authoritative international reports (https://www.globalcommissionondrugs.org/wp-content/themes/gcdp_v1/pdf/Global_Commission_Report_English.pdf) has documented the calamitous mistakes and catastrophic impact of "warring" on drug use and drug users. There is a much better way to deal with drug use and dependency: mounting evidence indicates that these are best addressed as a social and public health issue, and not as crimes (https://www.globalcommissionondrugs.org/about-usmission-and-history).

Our own former President Kgalema Motlanthe has added his name to the call for reason. Recently he joined the Global Commission on Drug Policy (DCDP) in condemning the misplaced strategy of the "war on drugs" (https://www.globalcommissionondrugs.org/about-usmission-and-history).

In 2018 the United Nations (UN) finally conceded that its policies had failed to eliminate drug use. Instead, they had spawned monster off-shoots. The harms include a multi-billion dollar black market (https://transformdrugs.org) in drugs and the catastrophic weakening of justice and financial systems and political structures. These result from massive amounts of drug money that bend politicians, lawyers, prosecutors, jailors, even judges, and – of course, always – banks.

In addition, treating drug users as criminals denies them counselling, information, education and medical help and support.

In the wake of the UN's turnabout, UN Chief Executives, representing 31 UN agencies, in March 2019 expressed (https://transformdrugs.org/wp-content/uploads/2019/03/UN-CEB-Briefing-2019.pdf) "strong and unanimous support" for decriminalising possession and use of drugs.

Recently, South Africa took a small but significant step vindicating this approach. In September 2018, the Constitutional Court's Prince judgment (http://www.saflii.org/za/cases/ZACC/2018/30.html), to which I was party, struck down criminal laws preventing the use and possession of small amounts of cannabis for personal consumption in private.

How did the world come to blunder so badly on drugs? "War" talk – futile, brash, misplaced macho-speak – has been with us since President Richard Nixon declared (https://www.iracm.com/wp-content/uploads/2013/01/makarenko-global-crime-5399.pdf;%20https://www.diplomatie.gouv.fr/IMG/pdf/drogue-terreur.pdf) drug abuse "public enemy number one". The notion that drug use and distribution can be stopped by macho talk and guns has proved catastrophically wrong.

Locally, drug-war rhetoric still dominates (https://www.iracm.com/wp-content/uploads/2013/01/makarenko-global-crime-5399.pdf). Communities with high levels of drug use are "war zones". Drug use is wrongly conflated with gangsterism (https://voteanc.org.za/assets/manifesto-summaries/A5_Manifesto_English.pdf;%20Eff%20manifesto:%20https://www.dailymaverick.co.za/wp-content/uploads/2019-EFF-MANIFESTO-FINAL.pdf). And drug trafficking "and its associated challenges" are described as a threat that "undermines [our] national safety and security (http://www.sadrugpolicyweek.com/uploads/6/6/2/3/66238155/s-africa.pdf)".

But who are the enemies against whom are we warring with this militarised campaign of policing, criminal law and incarceration? Not alien invaders, but our people.

More importantly: what has this "war" achieved?

Globally, every year perhaps $100 billion is spilt down the drain of drug-related law enforcement — an estimated $50 billion by the US alone. Millions of people are arrested for non-violent drug-related offences (https://www.amazon.com/Ending-War-Drugs-Richard-Branson/dp/0753557460). Many who use drugs, and subsistence sellers, receive extremely harsh sentences.

And there is a class dimension to all of this. Sandton or Constantia cocaine users, inside their gated communities, are seldom if ever targeted. Nor are the kingpins who profit from artificial margins that only prohibition can create – enough to buy allies in law enforcement and at the borders, who ensure ready continuing supply.

It is the mules, the small-scale subsistence sellers, the small-time suppliers, who are sacrificed to police action to make it seem there is effective action – or to strike a blow against the competition.

In South Africa, minimum sentences criminalising dagga and other drugs have long scarred our courts and police and the administration of justice. The apartheid ideologue Dr Connie Mulder introduced these measures in 1971. They continue to burden criminal trial-court rolls – and exacerbate prison overcrowding.

FA3

Current statutory provisions stipulate the same minimum sentence (https://www.concourt.org.za/images/phocadownload/justice_cameron/UWC-Deans-distinguished-lecture-19-October-2017--Minimum-Sentences.pdf) – 15 years – for non-violent drug trafficking as for certain categories of murder. This reveals, shockingly, how badly wrong both our theory and practice of drug use have gone in trying to curb it.

Over-use of incarceration has led to choked-full prisons and inhumane and degrading conditions of detention. Paradoxically, these produce an environment for gangs and drug use to flourish (https://www.academia.edu/40529695/The_Crisis_of_Criminal_Justice_in_South_Africa).

There is no doubt that drug use can be a problem, and can lead to devastating consequences that must be countered. It spawns social ills – just like cigarette smoking and alcohol use. All three are social and public health problems. None of them are matters for the criminal law. We must counter-act drug use with public information, education, counselling and treatment – not with the big blunt stick of the criminal law.

Not only do criminal laws not work, they also impair proper management of the problem and dissuade people from seeking the support and services they need (https://www.rsph.org.uk/about-us/news/stop-criminalising-drug-users.html).

The prisons system is not equipped to offer treatment for drug use. And, despite the highly controlled environment, illicit drugs are readily available in prisons (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2681083/). Criminalisation fosters criminal networks and gangs, it pollutes the world of high finance, makes a sham of border controls, and subverts the criminal process and the courts of justice.

Behind the misplaced use of criminal law lies a deep-rooted belief that criminal punishments should be inflicted on those considered deviant. The apartheid state was premised on this notion. South Africa has a history of using criminal law broadly and brutally, not only in minutely enforcing apartheid's misery but in persecuting sex workers and in hounding sexually and gender-diverse people.

However, voices of reason are growing louder. Portugal has seen the way, and taken it. In 2001, it abolished all criminal penalties for personal drug use. On our continent, the West African Commission on Drugs called for similar action. It cited evidence that the "war on drugs" exacerbates health and social insecurity (http://www.wacommissionondrugs.org/WACD_report_June_2014_english.pdf). Following this recommendation, Ghana has become the first African state to rely on alternatives to incarceration to address personal drug use.

For long, I have spoken out against criminal punishments being used in the HIV epidemic. There is no doubt that HIV infection is a bad thing, something to be countered and avoided. But we do not help contain or treat it by criminalising people with HIV (https://www.hivlawandpolicy.org/resources/criminalization-hiv-transmission-poor-public-health-policy-edwin-cameron-hivaids-policy). Instead, we drive people away from education and treatment, and we undermine proper public health management of social problems that don't belong in the criminal courts.

That lesson we embraced in the AIDS epidemic. Unlike many African countries, our Parliament decided, wisely, that new criminal remedies targeting people with HIV and AIDS would boomerang.

The same applies to drug-use. Instead of applying harsh criminal penalties, our country should embrace a supportive, not punitive, approach.

Criminal laws target already vulnerable groups. The risks of drug use often intersect with, and are exacerbated by, the risks other vulnerable groups face, like sex workers, homeless people and those subjected to gender based violence.

The "war on drugs" disproportionately (https://www.concourt.org.za/images/phocadownload/justice_cameron/UWC-Deans-distinguished-lecture-19-October-2017--Minimum-Sentences.pdf) affects economically marginalised, Black and Coloured people. Women who use drugs are subjected to gender-specific discrimination and social exclusion. They tend to have less access to harm reduction or other services. They experience far higher rates of intimate partner violence and are more vulnerable to contracting (http://www.unodc.org/documents/ungass2016/Contributions/Civil/INPUD/DUPI-A_War_on_Women_who_Use_Drugs-Web.pdf) sexually transmitted infections.

Criminalisation assumes that the vulnerable are enemies of society and punishes them for that. Language is potent. When we speak about wars, we invoke the image of the Enemy, of the Outsider, who threatens our security and prosperity. When we slip between Criminal and Drug User, we do more than create a criminal offence – we criminalise a significant sector of our society, including many in our circles or families.

The consequences of this rhetoric go damagingly far. People who use drugs are exposed to a systematic process of dehumanisation and discrimination. Additionally, the rhetoric prevents us from engaging with the structural causes of drug use. And it obscures how criminalisation lends support to vicious cycles of poverty that target the most vulnerable and marginalised in society.

Too often, the war on drugs is, in reality, a war on "marginalised communities (https://www.swansea.ac.uk/media/South-Africa%C3%A2%C2%80%C2%99s-National-Drug-Master-Plan-Influenced--Ignored.pdf)".

Drug use is a social and health issue. It is not a criminal justice issue – and it certainly is not a national security issue. There is no health rationale for invoking criminal law sanctions.

However, as the abolition movement so often reminds us, abolishing criminal penalties on its own is never enough. What we need is an evidence-based continuum of care and support that prioritises the effective prevention and resolution of drug dependence and protection against stigma.

Beyond decriminalisation, intelligent legal regulation for drug use will go a long way to removing the drug-related harms suffered by people who use drugs and the communities they live in.

We are a long way from properly managing the effects of drug use. However, a reassuring international shift is happening. It points us to better solutions. War-talk increasingly is displaced by social and public health models that focus on the vulnerabilities of people who use drugs, rather than the "threat" they pose.

The threat, instead, comes from the misplaced, and dangerous, use of criminal justice remedies to social problems. It is not too late for us to learn, and to do better.

Former Constitutional Court justice Edwin Cameron is the Inspecting Judge of the Judicial Inspectorate for Correctional Services (JICS). He is also on GroundUp's board.

Views expressed are not necessarily those of GroundUp.

< (https://www.facebook.com/sharer.php?u=https://groundup.org.za/article/enemies-of-the-nation-how-the-war-on-drugs-has-failed-south-africa/) (https://twitter.com/share?url=https://groundup.org.za/article/enemies-of-the-nation-how-the-war-on-drugs-has-failed-south-africa/&text=Enemies%20of%20the%20nation%3A%20How%20the%20%E2%80%9Cwar%20on%20drugs%E2%80%9D%20has%20failed%20S%20via%20@groundup_news) (mailto:?Subject=I%20recommend%20an%20article%20published%20on%20GroundUp&Body=Here%20is%20an%20article%20on%20GroundUp%20tha of-the-nation-how-the-war-on-drugs-has-failed-south-africa/) (/article-print/enemies-of-the-nation-how-the-war-on-drugs-has-failed-south-africa/) (/copy_article/enemies-of-the-nation-how-the-war-on-drugs-has-failed-south-africa/)

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IN THE HIGH COURT OF SOUTH AFRICA
(WESTERN CAPE DIVISION, CAPE TOWN)

CASE NO.: 1942/16

ON 26 FEBRUARY 2016 AT CAPE TOWN
BEFORE THE HONOURABLE JUSTICE SALIE-HLOPHE

In the matter between :

MONICA CROMHOUT	Applicant
and	
TSHILILO MICHAEL MASHUTA N.O.	First Respondent
THE DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
THE DEPARTMENT OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	Third Respondent

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DRAFT ORDER

Having heard counsel on behalf of the Applicant, it is ordered that :

1. The matter in the Somerset West Magistrate's Court (case number A1383/2015) in which the Applicant stands arraigned on charges of possession and dealing in a prohibited substance be stayed, pending the

outcome of an application and/or action, and if necessary, appeals thereto, to be instituted by the Applicant against the Respondents, in which action the Applicant challenges the constitutionality of certain provisions of Act 140 of 1992, and in particular, insofar as it deals with the use, possession and dealing in Psilocybin and the presumptions that arise in respect thereof;

2. The Applicant is directed to institute the aforesaid action within 60 days from date of this order failing which, the order will automatically lapse and the Second Respondent will be entitled to proceed with criminal action against the Applicant.

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
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WESTERN CAPE HIGH COURT
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BY ORDER OF COURT

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Social Development Repatriates A Toddler From Senegal

Department of Social Development Leaders

Ms. Lindiwe Zulu (http://www.dsd.gov.za/index.php/about/ministry/minister)
Minister for Social Development

If the matter of any 'war on drugs' and legislation in South Africa were a nail, then Edwin Cameron has hit the nail on the head. (Daily Maverick 2020/08/19) https://www.dailymaverick.co.za/article/2020-08-19-enemies-of-the-nation-how-the-war-on-drugs-has-failed-south-africa/ (https://www.dailymaverick.co.za/article/2020-08-19-enemies-of-the-nation-how-the-war-on-drugs-has-failed-south-africa/) (https:

"FA5"

The Central Drug Authority (CDA) is a statutory body that advises government on drug policies and strategies. There are better approaches to solving the problem than any failed war on drugs and the criminalisation and incarceration of users and addicted people. We state this clearly in the National Drug Master Plan 2019 – 2024 (NDMP) which was launched on 26 June 2020. (a copy is available on request). (https:

What Edwin Cameron mentions is what the CDA has achieved in the NDMP. In developing the NDMP the CDA adopted a new strategy. For the first time we engaged in a consultative process with people with Substance use disorders (SUD). Those people who use drugs (PWUD) and inject drugs (PWID). The findings, used together with the latest research on treatment options for people with SUD, ensured that the proposals and plans were aligned and all inclusive. One of the Seven Pillars on the NDMP is the reduction of the bio-socio-economic impact of SUD and related illnesses on the South African Population. (Harm reduction) (https: annel/

In order to ensure harmonisation and enforcement of policies and laws, the CDA further consulted with the Justice cluster and the National Prosecuting Authority to facilitate effective governance of the alcohol, tobacco and other drugs supply chain (supply reduction). The consultations included the Departments of Social Development and Health to improve recreational facilities and diversion programs to prevent populations from becoming substance dependant. (Demand reduction). Substitution therapy is recommended and implemented with methadone made available for treatment. Applying the recognised triangle model of Agent, Host and Environment is helpful in building skills development strategies and involves studying cause and effect approaches. The model of Treatment, Cessation, Maintenance and Reintegration is used and repeated where necessary. (https:

Edwin Cameron says that it is never too late for us to learn. Our maxim is rather that it is never too soon to learn. Cameron hasn't recognised that we have indeed learned, investigated and consulted and have applied what knowledge we garnered, as stated above and in the NDMP.

The CDA adopted the concept in 2015 that the outdated demeaning terms such as junkie, coke-head, alcoholic, addict and other insulting names should no longer exist. Addiction is now regarded as 'A recurring chronic disease of the brain which is treatable but not curable'. The CDA recognises the changing landscape and stated its position on cannabis in 2015. This was three years prior to the Constitutional Court Ruling.

First, data on smoking cannabis indicates that this practice is unhealthy; it is linked to cardiovascular and respiratory disorders, as well as to cognitive impairment and mental disorders.

Second, given the significant public health problem represented by cannabis, particularly highly potent cannabis, its use should be prevented, and its continued use treated, using evidence-based approaches.

Third, components of cannabis have been suggested effective in a few medical conditions such as refractory seizures, and access to medical marijuana may therefore be needed.

Fourth, cannabis is safer than alcohol and many other substances and policy regarding cannabis should reflect this key point.

This position was confirmed, expanded on and published in the SA Medical Journal in June 2016. (Vol. 106. No. 6 page 579)

It is imperative that Parliament finalises their current work on amending certain sections of the Drugs and Drug Trafficking Act 140 of 1992, this month. The Constitutional Court ruling of Sept 2018 stipulated that changes must be made within two years. If Parliament fails to complete the legislative process and ensure that the President signs the amendments into law, then chaos is likely to reign.

It remains important that we pursue all the avenues open to us in order to achieve our objectives of Harm reduction, Demand reduction and Supply reduction. One of the avenues which must be investigated is the model successfully adopted by Portugal in the decriminalisation of drug use (as mentioned by Edwin Cameron). This recommendation

was table by ExCo member Peter Ucko (Chairman of Communications and Marketing) and supported with further recommendations by David Bayever (CDA Chairman), in 2014. No progress was made and efforts of the CDA were hampered by bureaucratic processes, lack of commitment within the department and lack of funding. As a result many people whose lives might have been saved, have died. Ghana was the first African country to introduce a similar model.

There are two major solutions to this problem. Most importantly the separating on the Central Drug Authority from administrative control within the DSD and its establishment as a separate independent entity, and full funding to cover all the activities are the responsibility of the CDA. The establishment of the CDA was first recommended by independent consultants Deloitte and Touche in July 2010. Proposed amendments to the current Act started in 2017, and at this time it seems unlikely that amendments to, or the introduction of a replacement Act, will be complete before the end of 2021. Speed is of the essence. To address all the severe drug problems which we face and to answer the many questions raised in the joint meeting of the Portfolio Committees on Social Development and Health in order to save lives, requires quick and decisive actions by the legislators.

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Links

- COVID-19 Rapid Needs Assessment Report - South Africa - 2020-07-08 (/index.php/component/jdownloads/?task=download.send&id=221:covid-19-rapid-needs-assessment-report-south-africa-2020-07-08&catid=18&m=0&Itemid=101)
- Population Documents (/index.php/documents/category/55-population-documents)
- Bills (/index.php/documents/category/13-bills)
- Media Statement (/index.php/documents/category/32-media-statement)
- No War on Drugs (/index.php/21-latest-news/294-no-war-on-drugs)

The following are the activities conducted during early intervention:

Initiatives directed at reducing the incidence of substance use related risks and harm through universal, selective and indicated prevention. Universal prevention refers to interventions that are targeted at the general public or to a whole population group that has not been identified on the basis of increased risk. Selective prevention targets individuals or subgroups of the population whose risk of developing a particular debility is significantly higher than average, as evidenced by biological, psychological or social risk factors. Indicated prevention targets high-risk people who are identified as having minimal but detectable signs or symptoms foreshadowing predisposition for a particular debility but who do not yet meet diagnostic criteria for the debility.

Treatment

Treatment means the provision of specialised social, psychological, and medical services to service users and to persons affected by substance use and abuse with a view to addressing the social and health consequences associated therewith (Act No. 70 of 2008). It is important to acknowledge that family may enhance recovery from SUD; family members were involved with the client before treatment; they need to be involved with the client after treatment and changes in family functioning can be a positive influence to recovery.

Approximately 10% of individuals who begin to use drugs will over time develop changes in their behaviour and other symptoms that constitute SUD in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) diagnostic system. The goal of treating SUD is to reverse the negative impact that persisting drug use has on the individual and to help them resolve the disorder as possible and to become a productive member of their society (53).

SUDs are the result of a confluence of factors that lie both within individual vulnerabilities and the ecology or system in which the person finds themselves. The continued use of drugs despite negative consequences is best addressed accordingly.

Historically, most nations' strategies for addressing SUD centred on punishment ('war on drugs'). This has been shown to have almost no effect on the levels of the use or supply of drugs and has resulted in collateral harms. The recognition of the need to shift from criminal justice to a public health approach represents a major shift in mentality (54). The public health approach further recognises that people who use drugs are often conflicted between wanting to stop and continue to use.

The continued desire or craving for substances is one of the criteria for a SUD as described in the DSM-5. Interventions that help to address the desire for the drugs are therefore helpful in resolving the dependent, and habitual use of drugs. The role of drug treatment should therefore:

1) address the factors that increase the drive to use drugs compulsively, including individual biological and psychosocial vulnerabilities such as co-occurring mental health issues and diseases, lack of coping strategies, lack of life purpose and meaning and clinical withdrawal symptoms;
2) consider ways of reducing social exclusion, improving functioning and reducing the impact of structural drivers; and
3) reduce the current and future risks and potential harms related to drug use.

Drug demand in a community

Drug demand in a community depends on the extent to which certain socio-cultural conditions or pressures prevail. These factors provide social support towards drug use. A lack of (or limited) social discrimination against drug use, and high social exposure to drug use, promote uptake of drugs in a community. The extent to which social pressures in a community exist therefore depends on community tolerance towards drug use; a belief that discrimination against drug use is mild or non-existent; a belief in the rewarding nature of drug use, and a personal attraction to drug use.

The supply or accessibility of drugs in a community depends on the opportunities available for using drugs, the knowledge and awareness of drug use, and the ways of in which substances are offered.

The demand for drugs in a community tends to agree with the level of drug use and harm in that community. Certain drug use patterns, such as binge drinking, poly-drug use, and injection drug use, contribute to community harm.

The social public health approach explicitly recognises the complexity and variability across place and time of drug use, as well as the link between drug uses, the people who use drugs, and conditions within which these individuals live. This complexity can be influenced by:

- How drug use is organised and happens during social interaction in a community;
- The interdependency between people and their economic and cultural environments;
- The influence of power relations on individual behaviour, and
- The structural constraints on individual decision making and action, such as unemployment.

Prevention strategies to protect people from drug use initiation must be based on scientific evidence, working with families, schools, and communities to ensure that especially children, young people, the most marginalised, and the poor, grow and stay healthy and safe into adulthood and old age (59). The problems linked to drug use and SUD exists at the local community level, necessitating an understanding about both the causes and system dysfunctions at that level. Local level solutions should inform local drug master plan (DMP) implementation plans, which are aligned with the NDMP 2019 - 2024.

Reducing drug-related harms

Reducing the harms associated with drug use is a pragmatic approach and aims to reduce the harmful effects of drug or alcohol use and/or other high-risk activities. It incorporates various strategies, and could include both managed use and abstinence. Most harm reduction strategies have the primary goal of meeting individuals 'where they are at'. Rather than ignoring or condemning harmful behaviour, it seeks to work with the individual or community to minimise the harmful effects of specific behaviours (60,61).

It is also important to focus strategies to reduce harm for people who use drugs (including alcohol) in a recreational setting. For example, responsible beverage service training teaches liquor sellers to recognise and respond to under-aged or intoxicated patrons at risk from harm associated with heavy alcohol consumption. Patrons themselves can be educated, and the installation of breathalysers, or the availability of drinks that are alcohol

THE HIGH COURT OF SOUTH AFRICA

(GAUTENG DIVISION, PRETORIA)

CASE NO: 2024-040119

In the matter between:

MONICA CROMHOUT	First Applicant
MELINDA FERGUSON	Second Applicant

and

MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
MINISTER OF POLICE	Fourth Respondent
MINISTER OF SOCIAL DEVELOPMENT	Fifth Respondent

SECOND APPLICANT'S SUPPORTING AFFIDAVIT

I, the undersigned,

MELINDA YAZBEK

state the following under oath.

1. I am an adult female with identity number 660820 0040081, currently residing in Cape Town.

2. The facts set out in this affidavit, save where the contrary appears from the context, are within my personal knowledge and are, to the best of my knowledge and belief, true and correct.

3. I am the second applicant. I have read the founding affidavit of the first applicant, Monica Cromhout, and confirm the contents thereof insofar as they relate to me. I also expressly endorse the legal points set out in the founding affidavit, as well as the benefits of psilocybin highlighted by Ms Cromhout and Professor David Nutt's expert affidavit.

4. What follows supplements what is stated in those affidavits. I set out certain facts from my unique perspective, as well as explaining why the criminalisation and incorrect classification of psilocybin matter dearly to me, and to many other people in my (or analogous) position.

5. Like the founding affidavit, for ease of reference, where I refer to "psilocybin", I am also referring to "psilocin", and I also use the terms "psilocybin" and "psilocybin mushrooms" interchangeably.

INTRODUCTION

6. This case is about the legal classification of psilocybin mushrooms. In South African law, as things stand – in 2024 – psilocybin is still classified alongside heroin as a Schedule 7 substance.

7. That classification matters. An adult in possession of psilocybin mushrooms, or growing them or sourcing them, entirely for private use in the comfort of someone's home, is a criminal in the eyes of the law.

8. I believe I am uniquely placed to assist this Court, and the state respondents as they (together with their lawyers) consider whether to oppose the relief sought in this case.

9. I respectfully submit that I am uniquely placed to assist for three reasons.

10. In the first place, I was addicted to heroin and crack cocaine for approximately nine years;

11. In the second place, unlike many people who, sadly, never manage to escape the clutches of heroin and crack cocaine, on 1 September 1999, I had my first day of sobriety. When I started the recovery process I had no money, no bank account, no job, no home, no ID book. Fortunately, over the last 24 years, I gradually managed to piece my life back together.

11.1. I am now far better known publicly by my publishing name: *"Melinda Ferguson"*. I am an award-winning publisher, having published close to a hundred books, one of which was the recipient of the prestigious Alan Paton Award for non-fiction.

11.2. I am also a bestselling author and have been a freelance journalist since 2003, contributing to print and radio for various media companies, including Cape Talk, City Press, Daily Maverick and Kaya FM. In particular, in 2005, I wrote a bestselling memoir called *'Smacked'*, which,

in summary, was a harsh look at the ways in which *'hard'* drugs had destroyed my life, but it was also a testimony to my recovery.

11.3. The book inspired thousands of addicts and, since then, I have had the privilege of being invited to be a guest speaker at countless events, including at schools, businesses and functions for captains of industry.

11.4. In 2011, I went back to university and walked out proudly in 2013 with an Honours Degree in publishing.

12. In the third place, I began taking psilocybin in 2015, based on the recommendation of a psychiatrist. I made a conscious and free adult decision to try psilocybin under supervision, for my mental well-being. In particular:

12.1. to continue to address post-traumatic stress disorder ("**PTSD**") from a near-fatal car accident in 2013;

12.2. to confront the internal feelings and trauma that aided and abetted my addiction to heroin and crack cocaine;

12.3. to heal from the many wounds that I carried from the days of my addiction; and

12.4. to manage my stress as a recovering addict as well as in a safe – non-addictive way – to handle the more general of life's stresses that befall each and every one of us, as human beings.

13. I can state – without equivocation – that from the age of nine, I was an addict, when I had my first drink of alcohol. It just manifested itself in different ways:

bulimia, exercise, cigarettes, alcohol, heroin.

14. But psilocybin mushrooms are not on that list. Psilocybin mushrooms are fundamentally different. Psilocybin mushrooms are something I take approximately three times a year on special occasions for their therapeutic benefits, not to get *"high"* or *"out of it"* (as I did with all the other drugs I consumed in my past). Taking Psilocybin mushrooms is not part of any relapse in my life-long battle against addiction. Quite the opposite, psilocybin is an antidote for addiction.

15. The classification of psilocybin alongside heroin is, with respect, plainly irrational for all of the reasons set out in the founding affidavit and the expert affidavit.

16. But the classification also matters deeply to me on a personal level. It means that in the eyes of South African law:

16.1. I am not an addict in recovery.

16.2. I am not someone who managed to piece their life back together.

16.3. I am just an addict – and a criminal – who merely *shifted* my addiction from heroin to another substance. Another substance that is equally undesirable and equally harmful. Why else would both substances be legally classified in Schedule 7?

17. The criminalisation and incorrect classification of psilocybin, thus, significantly encroaches on my right to dignity and self-worth in section 10 of the

Constitution.

18. I am not the only recovering addict in this position – there are many other people who have turned to psilocybin for its unique (scientifically proven) benefits, which Professor David Nutt's expert affidavit explains can be effective in helping people even where traditional medications and treatments such as antidepressants (SSRIs) and cognitive behavioural psychotherapy have failed.

19. There are, undoubtedly, many people in South Africa who remain suffering, where established treatments and methods have failed, but who do not wish to try psilocybin mushrooms because it is a criminal offence to do so.

20. What I aim to demonstrate in this affidavit is that the route of addiction is about *avoiding* internal feelings, thoughts, problems and trauma. Alcohol, heroin and crack cocaine are the vehicles to escape.

21. Psilocybin is fundamentally different, because it is not a substance used to escape those internal feelings, thoughts, problems, and trauma. Psilocybin is a unique method of confronting them.

22. I address the following topics in this affidavit: -

22.1. My history of addiction;

22.2. my relationship with psilocybin and the first applicant;

22.3. why psilocybin is fundamentally different to drugs like alcohol, crack cocaine and heroin;

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22.4. how psilocybin has already helped me and why I believe it is my right to use it in my continued journey of recovery;

22.5. how psilocybin has helped me to help others; and

22.6. how the impugned provisions limit my constitutional rights.

MY HISTORY OF ADDICTION

23. At the age of 9, I had my first sip of alcohol and, from that moment, I wanted more. By the time that I was a teenager, I was drinking alcohol regularly, often daily. At the age of 14, one of my teachers scolded me and told me I needed to lose weight – this triggered an obsession with food and being 'thin enough'. I lost 21 kilograms in three months, and my struggle with bulimia began. By the age of 23, I was addicted to heroin and crack cocaine.

24. A dark relationship with both legal substances (alcohol) and illicit substances (heroin, crack cocaine) unfolded, which would destroy my life for many years. Along the way, my rampant addiction damaged my relationships with my mother, my siblings, my two young sons, my friends, numerous acquaintances and even strangers. As part of the Narcotics Anonymous programme, they presented us with research which estimated that an addict negatively impacts at least 40 other people's lives. I am sure that the number of people who I hurt as an addict is much higher.

25. In 1999, at the age of 32 and then destitute, I trawled the streets of Hillbrow, searching for my next hit of crack cocaine and heroin. I resorted to selling my body for drugs. While attempting to buy drugs, I suffered sexual abuse more

than once, including being gang raped by three men, who were part of the criminal underworld. Suicide seemed to be my only alternative, or way out.

26. However, through a set of (I believe) miraculous circumstances, I was rescued from the streets by my brother and sister and left at a farm, called *'Enoch's Walk'*, which catered to homeless people and other social derelicts in the Magaliesberg. It was here that I rediscovered sobriety and, on 1 September 1999, I experienced my first day *'clean'* and sober in almost 20 years. I pause here to note that the opposite of *'clean'* is *'dirty'* and would submit that this connotation speaks to the stigma attached by society to drug users.

27. I have, since that day, refrained from using any drugs or alcohol, apart from psilocybin. I began working with psilocybin medicinally in 2015. While I am advised that psilocybin satisfies the broad legal definition of a *"drug"* – I do not regard it as one. I firmly believe that psilocybin is fundamentally different to *'hard'* drugs like alcohol, heroin and crack cocaine. Psilocybin is a substance that aids in recovery and confronting the internal routes of addiction.

28. The road to becoming a productive member of society was long and challenging. The first few years of abstention and rebuilding my shattered life were brutal.

29. But, in 2003, I managed to get a job as a journalist in the most successful local women's publication at the time, True Love Magazine. I began to flourish. I wrote a number of award-winning articles and was soon promoted to Features Editor.

30. As set out above, in 2005, I wrote my bestselling memoir called *'Smacked'*. After its success, I have had the privilege of being invited to be a guest speaker at countless events, including at schools, at businesses and for captains of industry, to share my story in the hope that others draw inspiration from it.

31. By 2009, I added *'Motoring Editor'* to my job title, attending launches, test-driving cars and writing car reviews. But, in 2013, while test driving a Ferrari, I had a near-fatal car accident.

32. After the accident, I suffered from extreme PTSD. Showing strong symptoms of being on the brink of a nervous breakdown, I booked myself into three weeks of hospitalisation at Crescent Clinic, in Randburg. My treatment included taking prescribed pharmaceutical medications, including Seroquel and Epitec, for my PTSD.

33. The medication was meant to assist with my extreme anxiety caused by the accident. Instead, I found that the medication impaired my cognitive abilities: I had nightmares; I became extremely forgetful; and my energy levels dropped. The medication did not help me to feel better and I understand this to be the unfortunate experience of many millions of sufferers around the world. After three months of taking the prescribed mediation, I had lost all of my energy, I experienced debilitating nightmares and became uncharacteristically forgetful. The prescribed medications also inhibited my creativity and, as a writer and publisher, I rely on my creativity to earn a living.

34. I decided that I did not want to keep taking that medication, as it was more harmful to my physical and psychological wellbeing than it did any good. On the

advice of a well-respected psychiatrist (I do not name them for obvious reasons):

34.1. I was guided to wean myself off the negative side-effects-inducing *'legal'* psychiatric medications that I had been taking; and

34.2. additionally, the psychiatrist encouraged me to try taking psilocybin mushrooms, based on the various positive effects that they may have for me and the wealth of research (including clinical studies) which demonstrated that psilocybin was not an addictive substance.

MY RELATIONSHIP WITH PSILOCYBIN AND THE FIRST APPLICANT

35. Being a recovering addict, the idea of taking psilocybin mushrooms terrified me. At that stage, before I had done my own research into psilocybin, I had thought that psilocybin was another addictive and dangerous drug. I deeply feared that my debilitating addiction to drugs like heroin and crack cocaine may be triggered. But, as I explain below, these fears were entirely unwarranted.

36. Even though I was anxious about trying psilocybin, the more that I read about it, the more that I learnt of its potential benefits as well as the tested lack of enduring side effects. Much of the learning on psilocybin emphasised (as Ms Cromhout and Professor Nutt's affidavits also emphasise) that taking psilocybin mushrooms in a relaxed setting is important in order to minimise any potential feelings of anxiety.

37. Thus, the best avenue for me was to approach a known expert with psilocybin, who would be able to ensure that: (i) what I was being given was only pure,

natural psilocybin mushrooms and not something mixed with other substances, which could be devastating for me in my continued recovery from addiction; and (ii) I wanted to have a supervised experience with people who knew what they were doing and who understood what I might be going through as the substance entered my system.

38. I was aware of Ms Cromhout (the first applicant) from when the psychiatrist (who introduced me to the idea of using psilocybin to help me with my PTSD) introduced me to her, in December 2014. I was in all honesty nervous to meet this woman who was working with illicit *"magic mushrooms"*. I was surprised to discover that this so called *"criminal"* in the eyes of the law was actually a sweet, smiling, elderly woman, who had the kindest that eyes I had ever seen.

39. After much independent reading, and on the recommendation from the psychiatrist, in March of 2015, I had my first, carefully guided and supervised, psilocybin experience in Somerset West, under the responsible guidance of Ms Cromhout and her team of supervisors.

40. The applicants respectfully submit (as set out in detail in the founding affidavit) that after the Constitutional Court has found that adults have a right to the private use and possession of cannabis, it should follow that they also have a right to the private use and possession of psilocybin. Once that is so, I respectfully submit that it should plainly not be unlawful or criminalised for the same adult seeking to exercise their constitutional right to use psilocybin privately, to do so while being supervised by a person like Ms Cromhout, who

has extensive experience in working with psilocybin and in facilitating psilocybin experiences.

41. Knowing that Ms Cromhout and her team had a wealth of experience put my mind at ease. I suppose, in some ways, it is similar to people attending a gym for the first time and seeking guidance from a personal trainer. In that context, as a beginner, it may be difficult to know if you are doing the various exercises correctly (in a manner that avoids injury) and when you become short of breath, the trainer better understands whether it is normal and to be expected or something out of the ordinary.

42. Ms Cromhout explained the entire procedure to me: what to expect; how long it would last; that I may feel my pulse increase, or I may become slightly anxious as the psilocybin began to work – but even if these effects did occur, they were quite normal; as well as assuring me that they would be supervising me for the entire duration. As Ms Cromhout explains in the founding affidavit, she explained that the experience of taking psilocybin does not feel very different from night-time dreaming, *albeit* that it happens while you are in an awake state.

43. If I had not been able to undertake a guided and supervised psilocybin experience, I may never have tried it on my own. I would have been too anxious.

44. That would have been most unfortunate. Because, in that dream-like state, I received profound insights about myself and the prior unsettled feeling I had as a young girl growing up in a home with an alcoholic mother, which continued throughout my years of addiction. It is somewhat difficult to explain in words, but the insights felt like something that had been unattainable when using

addictive drugs as well as legal medications prescribed by doctors, and difficult to attain even during my years of sobriety. What unfolded was a night of deep connection to my previously shattered self. It is not an overstatement to say that it was a night that changed my life. It inspired me to embark on a long and profound journey of healing.

45. I decided that I would go back to do another journey with Ms Cromhout in Somerset West, six months later. I had been to many therapists during my life, as well as to new age healers and churches, trying to get to grips and understand:

45.1. what had led to all my self-destructive behaviour as a drug addict; and

45.2. what lay behind the deep sadness and discomfort I had felt in my body and mind since I was a small child.

46. But nothing had at that stage been able to enlighten or heal me. My second psilocybin experience revealed many deep wounds and delusions that I had been feeding myself almost my entire life. It was as if the scales of denial were removed from my eyes and heart. It may sound somewhat esoteric, but it was as if, in that dream-like state, I was able to connect with my true self and take profound steps towards healing the pain and anxiety that had been holding me hostage for all of my life up until then.

47. My personal experience thus echoes the clinical studies referred to in Professor Nutt's expert affidavit. I refer in particular to the evidence highlighted by Professor Nutt which demonstrates, amongst other things, that:

47.1. Psilocybin was able profoundly to reduce alcohol consumption in alcoholics.

47.2. Psilocybin was able significantly to reduce anxiety and depression.

47.3. Psilocybin has various positive benefits to a person's mood.

47.4. Indeed, a single dose of 25mg resulted in profound and enduring positive alterations in mood, in people who were interested in exploring their potential for increased self-awareness and insights. The same study showed that 33% of the participants in the study ranked the psilocybin experience as being *"the single most spiritually significant experience"* of their entire lives.

48. Professor Nutt's own research included taking images of the brain using a functional magnetic resonance imaging (**"fMRI"**) machine – which demonstrated that psilocybin has unique effects on the brain – including suppression of an area of the brain that drives depression (the pre-frontal cortex).

49. For the past nine or so years, I have taken psilocybin – in a supervised setting – approximately three times a year to continue with my healing.

WHY PSILOCYBIN IS FUNDAMENTALLY DIFFERENT TO DRUGS LIKE ALCOHOL, CRACK COCAINE AND HEROIN

50. Professor Nutt's expert affidavit explains that the wealth of scientific evidence demonstrates that psilocybin (if properly sourced and used in a proper setting)

typically has (at worst) mild temporary side effects: it is not harmful, it is not addictive, and the risks of having a *"bad trip"* are minimised further when the proper steps are taken. Even those mild side effects are far outweighed by its benefits.

51. Having once been an addict, for approximately 20 years, I believe that I am an expert at knowing what an addictive drug feels like.

52. Ms Cromhout's explanation in the founding affidavit of what underlies addiction to substances like alcohol, heroin and crack cocaine closely aligns with my personal experience of addiction. Ms Cromhout explains that –

> *"[P]eople often become addicted to substances because they are trying to escape an empty, unpleasant feeling that they have inside, and the substance temporarily assists them in escaping that feeling (but then they need to repeat the behaviour by taking the substance daily or every few hours)".*

53. Heroin and crack cocaine are a means of escaping *'the real world'*: feelings of anxiety, a fear of failure, marital problems, jobs, the death of loved ones. They start a feedback loop:

53.1. Heroin and crack cocaine cause one to withdraw from the real world.

53.2. In turn, withdrawing means you are not actually confronting any of the underlying problems or issues – they just continue to snowball in the background, growing exponentially with compound interest.

53.3. Each time you briefly sober up, you feel even more ashamed that you have, once again, failed. And the feelings of anxiety, pain and self-hatred (which I believe lie at the heart of addiction) are amplified each day.

53.4. That cycle of avoidance and pain continues every four to six hours as soon as the effects wear off. One small hit of heroin and I would, once again, feel anaesthetised and oblivious to everything.

53.5. Once the problems are stacked up and have become seemingly insurmountable, and there seems to be no prospect of correcting them, then the only avenue that seems available is to continue ignoring them and to use more hard drugs.

54. Heroin is a peculiar drug – it causes you so much pain. But, simultaneously, it is the only thing that can take that persistent ache away. First thing in the morning, you awake to the feeling of your body screaming from withdrawal and craving. You will do just about anything to get it.

55. Substances like heroin or crack cocaine do not treat underlying trauma, feelings or problems. They just provide a temporary means by which to escape them. Your mind takes up temporary residence elsewhere for a few hours.

56. Psilocybin is different for at least two key reasons.

56.1. First, a signal feature of heroin and crack cocaine is that immediately after the effects have faded, you crave more. Psilocybin is the opposite: rather than wanting more after a psilocybin experience, I was left with a feeling of fullness. In the days and weeks that followed, not a single cell

in my being wanted more. My personal experience thus, again, echoes the research that Professor Nutt's expert affidavit highlights: rather than being addictive, psilocybin was able profoundly to reduce alcohol consumption in alcoholics.

56.2. Second, psilocybin – in its unique way – helps one to confront and treat the underlying trauma and anxiety that causes the empty, unpleasant feelings. Again, the underlying scientific basis is set out in detail in Professor Nutt's expert affidavit. As I understand the position, one of the benefits of psilocybin is that it appears to increase the brain's *'neuroplasticity'* — which refers to the ability for neural networks to shift and rewire. In lay terms, the research shows that psilocybin use makes it easier to break out of established habits and become more adaptive. This makes it easier for addicts to break out of the negative feedback loop created by substances like alcohol, crack cocaine and heroin.

57. When my mother was dying, for example, even though I had been *"clean"* for about four years, all I wanted to do was escape the hurt and pain. However, the reason I have managed to remain clean and sober for approximately 24 years is because I learnt to sit with the unpleasant feelings and, like waves in the ocean, allow them to ebb and flow. My use of Psilocybin (only approximately three times a year) has greatly assisted in that process. My personal experience reflects what the experts have discovered in their scientific research: with substances like heroin and crack cocaine, in the brief moments when you are sober, all you can think about is how your life has already fallen apart, what you do not have, together with indescribably powerful feelings of craving to use the

substance again. With psilocybin use, after the experience, I have a feeling that what I already have is enough, I do not crave psilocybin and, instead, I feel a sense of personal growth and that the brief time in that dream-like state has been helpful in addressing some form of either my PTSD or the trauma and pain that I inflicted on myself and people I loved during my years as an addict.

58. We learn in the Narcotics Anonymous programme that an addiction to heroin and crack cocaine is like an insidious cancer that stays hidden. It lurks, waiting. Sometimes it slides into remission. But there are people who have been clean and sober for many years (even a decade or two) who explain that, unless they stay connected to the fellowship and the Narcotics Anonymous programme, they fear that they will use heroin again.

59. I respectfully submit that my experience demonstrates why it is patently irrational for psilocybin to be criminalised or to be placed in the same schedule as heroin and fentanyl – when the substances could not be more different.

PSILOCYBIN HAS ALREADY HELPED ME AND WHY I BELIEVE IT IS MY RIGHT TO USE IT IN MY JOURNEY OF RECOVERY

60. I believe and respectfully submit that using psilocybin in a supervised setting, approximately three times a year, since 2015, has made a significant, positive contribution to my psychological and physical wellbeing, as it has helped me to heal from these wounds of my addiction to hard drugs. It has aided me in my spiritual journey. It has helped me to deal with general life stresses, as well as the serious PTSD that I suffered from the car accident in 2013. I submit that it has made me a better person to myself and to others and, therefore, contrary

to incorrect, moralistic notions that someone taking psilocybin may be a menace to society – psilocybin has actually contributed to me becoming a better member of society, by raising my own and the collective consciousness.

61. As a result of the work that I have been doing with psilocybin, I have been shown a way to confront many of the traumas that I suffered during my active addiction to heroin and crack cocaine.

62. In 1999, I was gang raped by three men in Hillbrow, while I was trying to acquire crack cocaine. I had tried to heal from this trauma by partaking in decades of face-to-face therapy, yet I was unable to do so. During my work with psilocybin, as Ms Cromhout explains in the founding affidavit, I have been able to go back in time to that night, in the dream-like state and successfully deal with this traumatic experience by deeply connecting to the event, to why I was there, to what really happened. Subsequently, I have been able to release the stranglehold of the experience, to deeply understand it and to finally *"let it go"* in a profound way, that I was unable to do in all the years of conventional therapy.

HOW PSILOCYBIN HAS HELPED ME TO HELP OTHERS

63. What has unfolded since my first experience with psilocybin in 2015 has been an incredible journey of helping myself and others.

64. I have been able to share my profound and healing experiences with others both personally and in public. I have written a book called *"Bamboozled"*, published in 2022, which in part deals with my experience of using psilocybin.

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As a result, I have spoken about psilocybin at book launches, in interviews and other events. I was asked to be a speaker at the Cannabis / Mushrooms Expo in 2022, 2023 and in 2024.

65. After I spoke to a large crowd of people, I had a long queue of curious souls, aching to discuss their addictions, their depression and pain, many of whom were interested in using psilocybin to heal. But, again, some of these individuals may never try a method that has been scientifically proven to assist, because, at least in the eyes of the law, doing so means that they would be using a substance that is criminalised: a substance that is – according to the law – as harmful and undesirable as heroin.

66. There have also been times that I have helped to facilitate and supervise small psilocybin sessions with people who have asked me for their help.

67. One thing that I have learnt over the years is that you can only keep what you have by giving it away. And part of *'giving it away'* is sponsoring (or mentoring) people who need help in their recovery. I have sponsored many people over the years. There is of course a benefit to them – my sponsors were an integral part of my recovery. But there is also an enormous benefit to the sponsor themselves, because you begin to see your own sobriety and place as a mentor as an important connection to the larger world (the world that substances like heroin and crack cocaine turn you away from).

LIMITATION OF CONSTITUTIONAL RIGHTS

68. I generally invoke and endorse the same allegations of rights violations that have been detailed in Ms Cromhout's founding affidavit. That said, the following stand out to me the most, from my own, unique, perspective.

69. Section 10 of the Constitution of South Africa provides that *"[e]veryone has inherent dignity and the right to have their dignity respected and protected*". I am advised and submit that the right to dignity, which encompasses the respect for the autonomy and inherent worth of each person, is both a self-standing right and a value that informs other rights, such as the right to freedom of person.

70. Section 12(2) of the Constitution, which forms part of the right to freedom and security of person, provides that "*[e]veryone has the right to bodily and psychological integrity*", which includes the right to "*security in and control over their body.*"

70.1. I am advised and submit that *'psychological integrity'* includes protection against undue stress or shock, as well as the right to change one's own mind through the ingestion of law-harm entheogens. I am also advised that *'control'* includes the protection of one's autonomy, or bodily self-determination, against interference.

70.2. Any law that limits this autonomy (and, in particular, the autonomy to take steps to manage one's own stress, or elevate one's own

consciousness, or give colour to one's lived experience) constitutes a *prima facie* infringement of this right, which must then be justified by the state through this prism of section 36 of the Constitution.

71. Section 9(3) of the Constitution prohibits – direct or indirect – discrimination on any of the listed grounds. I respectfully submit that the criminalisation of psilocybin indirectly discriminates along the lines of sex and gender (against women). The reason that this is so is because – assuming that psilocybin is treated like heroin and remains in Schedule 7 – and people in Ms Cromhout's position are arrested, simply for attempting to help adults source safe psilocybin and supervise them during the experience, it means that the law expects that only the criminal underworld will be responsible for people accessing psilocybin.

72. I refer to what I have said above, particularly in paragraph 62 above. I emphasise that this was just one example. The illegal drug trade is typified by the sexual abuse of women.

73. Importantly, I respectfully submit that the criminalisation of acquiring harmful drugs like heroin and crack cocaine does not prevent users acquiring them. My 10 or so years of successfully acquiring them while being in active addiction illustrates this. The drug market appears to be run and conducted by large syndicates and thus arresting the person dealing on the corner does nothing to prevent the operation as a whole. In any event, even if one syndicate is stopped, they are replaced by another which sees a *'gap in the market'* (in fact, syndicates often tip-off the police against competing syndicates). I emphasise that the purpose of this case is not to suggest that heroin should be legalised –

but that psilocybin (a substance that bears no resemblance whatsoever to heroin, and is clinically proven to be helpful rather than harmful) should not be criminalised or placed in the same category as heroin. I respectfully submit that, if there is a concern about psilocybin use, then the focus should be on ensuring: (i) that people have proper information about it; and (ii) that people are able to source it safely. As I have said above, it could be the end of over 20 years of recovery if I were to acquire psilocybin mushrooms from the illegal drug trade, which had been laced with another substance.

74. I also refer to what Ms Cromhout has set out in the founding affidavit regarding the need for private individuals to be able to source psilocybin safely. Criminalisation prevents this. This is particularly risky and harmful for individuals like me, who are recovering addicts, seeking to make use of psilocybin – not unthinkingly – but on the advice of therapists. Purchasing psilocybin on the street means there is no guarantee that it is safe. In addition, and although I speculate here, it is in the interests of drug dealers to sell psilocybin mushrooms that have been laced or combined with other drugs, for reason that psilocybin itself is not addictive (as set out by Professor Nutt's expert affidavit). Addicts wishing to take psilocybin for the clear benefits it offers should not be placed at risk of acquiring it from dubious or unknown sources.

75. I was very fortunate to have been led and supervised by Ms Cromhout. Ms Cromhout has significant experience, as well as honest, reliable suppliers of psilocybin mushrooms. If Ms Cromhout and those like her are arrested, it means that those adults who wish to acquire psilocybin would need to turn to *traditional* and often dubious drug dealers.

76. That amplifies risk in three different ways.

76.1. First, there are risks in the practical exercise of purchasing it. I submit that these risks are heightened and more significant for women.

76.2. Second, there is a risk that the substance is not psilocybin mushrooms at all, but something else.

76.3. Third, there is a risk for former addicts like myself that the substance is laced or combined with other *'hard'* drugs.

77. Thus, I firmly believe that the work being done by Ms Cromhout in supervising and sourcing clean, natural, reliable psilocybin mushrooms, is a service to society. She is a caring and kind, elderly lady, who merely wishes to empower other people who take an adult decision to try psilocybin, and ensure that they can do so safely. It is irrational and unconstitutional, with respect, that the law seeks to have this caring elderly lady thrown in jail. On this score, I note that there are still pending charges against Ms Cromhout – they have never been withdrawn, but are subject to a stay in prosecution, by way of an Order of the High Court.

78. Adults have the right to choose a substance like psilocybin that has proven scientific successes in the arena of mental health and in the life-long endeavour of recovery from addiction.

79. Knowing that I am breaking the law by imbibing psilocybin has a severe impact on my psychological and emotional wellbeing. While I have used psilocybin responsibly and embarked on healing journeys, approximately three times a

year since 2015 up until the present, knowing that what I am doing is regarded as criminal causes me undue stress and is in contravention of my constitutional rights.

80. As a result, the continued criminalisation of psilocybin prejudices me by putting my mental health and wellbeing at risk, or at least subordinate to irrational laws, and the limitations of my constitutional rights do not satisfy the requirements of the limitations clause. There are plainly less restrictive means available to the state than criminalising psilocybin and classing it (irrationally) in the same category as heroin, which is actually one of the most dangerous and addictive drugs in existence.

CONCLUSION

81. During my 24 years in recovery I have learnt that, sometimes in the eye of the storm, just when things look the bleakest and most hopelessly hellish, a little cloud breaks golden and the storm delivers another, more promising horizon. I firmly believe that psilocybin can be an important part of that more promising horizon for many people.

82. For the reasons set out in this affidavit, as well as those set out in Ms Cromhout's founding affidavit, read together with the expert affidavit from Professor David Nutt, I pray for an order in terms of the notice of motion.

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MELINDA YAZBEK

I hereby certify that the deponent has acknowledged that the deponent knows and understands the contents of this affidavit, which was signed and sworn before me at _____ on ____ **APRIL 2024**, the regulations contained in Government Notice No R1258 of 21 July 1972, as amended, and Government Notice No R1648 of 19 August 1977, as amended, having been complied with.

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
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Capacity: Constable

SUID-AFRIKAANSE POLISIEDIENS
FORENSIESEWETENSKAPLABORATORIUM
WES-KAAP
2024 -04- 08
FORENSIC SCIENCE LABORATORY
WESTERN CAPE
SOUTH AFRICAN POLICE SERVICE

THE HIGH COURT OF SOUTH AFRICA
(GAUTENG DIVISION, PRETORIA)

CASE NO: 2024-040119

In the matter between:

MONICA CROMHOUT	First Applicant
MELINDA FERGUSON	Second Applicant
and	
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	First Respondent
MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	Second Respondent
MINISTER OF HEALTH	Third Respondent
MINISTER OF POLICE	Fourth Respondent
MINISTER OF SOCIAL DEVELOPMENT	Fifth Respondent

EXPERT AFFIDAVIT BY PROFESSOR DAVID NUTT

I, the undersigned,

DAVID JOHN NUTT

state the following under oath:

1. I am an adult male professor of Neuropsychopharmacology at Imperial College London, as well as an honorary consultant psychiatrist. I am also the Director for the Imperial College Centre for Psychedelic Research, the first such in the world. My training and previous appointments are set out in my attached *curriculum vitae*, marked "**E1**".

2. The facts contained in this affidavit are, save where the contrary appears from the context, within my personal knowledge and are, to the best of knowledge and belief, both true and correct.

3. Where I set out, or rely on, any legal propositions - I do so based on guidance that I have received from the applicants' legal representatives, regarding the legal position.

INTRODUCTION AND EXPERTISE

4. I have worked for almost all my professional life (of 48 years) in psychiatry, with a particular interest in the addictions and on the effects, both beneficial and harmful, of drugs and substances on the brain. I have extensive clinical and research experience in this field.

5. I am a Fellow of the Royal College of Physicians and of Psychiatry and of the Academy of Medical Sciences of the UK. I also chaired the UK government Advisory Council on the Misuse of Drugs sub-committee for the assessment of drug harms from 1999 to 2007 before being appointed to chair of the full Advisory Council for the Misuse of Drugs ("**ACMD**") Council in 2008.

6. In 2004 and 2005, I was the medical lead on the UK government's Foresight committee that provided a 25-year future vision of addiction and brain science. The report was so well received that it was published as a book.

7. I have published over 500 research papers, as well as several hundred specialist reviews and 40 books in this field, including many on the effects of drugs on the brain. These are listed in my attached CV. One of my books – written for the general public rather than experts - "Drugs: without the hot air" (UIT press) has sold over 30,000 copies. It was also awarded the UK Transmission prize for science communication in 2014, and has now been re-issued in a 2nd revised edition.

8. Several of my research papers have been extensively cited and have been used as the basis of which to produce evidence-based changes to national drug policies in several countries. As a result of this work, I have been asked to speak on comparative drug harms in a number of important locations including at the United Nations Office on Drugs and Crime ("**UNODC**"), the Houses of Parliament in the United Kingdom, the European Commission, and in both the Dutch and New Zealand legislatures. I was also invited to speak at Oxford University at the largest trauma and mental health conference in Europe – The Master Series – held from 31 August to 3 September 2023.

9. For over 25 years (until 2021), I was the editor of the *Journal of Psychopharmacology* one of the top journals in the world on the effects of drugs and the brain.

10. In 2013, I was awarded the Nature/Sense About Science annual John Maddox prize for standing up for science by pursuing research of public interest with perseverance and courage.

11. My status as an expert in the field has been recognised with a number of prestigious appointments, including Presidencies of the European Brain Council, the European College of Neuropsychopharmacology, the British Association of Psychopharmacology and the British Neuroscience Association. I have served on the Medical Research Council

Neuroscience ("**MRC**") board and, for 16 years, I held programme grant funding from the MRC for the study of addictions and the effects of drugs on the brain. I currently chair the UK National Institute of Health research grants committee on new treatments for opioid and cocaine addiction.

SCOPE OF REPORT

12. I have been requested by the applicants' attorneys of record to prepare a report, in the form of this affidavit, explaining the pharmacology of psilocybin, as well as expressing my expert opinion on psilocybin's potential therapeutic and harmful effects.

13. Throughout this report, I refer to various academic studies and literature – some of which were not authored by me. However, I have considered the underlying studies and papers and I attempt to give a summary of the most consistent conclusions drawn in relation to the benefits of psilocybin and the alleged harms (which I demonstrate below are relatively minor when compared with other drugs or substances, such as alcohol or tobacco).

14. I consider myself able to do so based on my prior research, qualifications, and consideration of a wide range of literature related to psilocybin (in particular), other psychedelic medicines in addition and psychoactive drugs (more generally).

15. I have been informed that, in constitutional challenges, particularly if the government respondents oppose the application, an important task that the Court will have to consider is whether a limitation on a right is reasonable and justifiable in an open and democratic society in terms of section 36 of the Constitution. I have been guided on that this enquiry involves considering all relevant factors including the following, non-exhaustive list, of factors:

15.1. The nature of the right;

15.2. The importance of the purpose of the limitation;

15.3. The nature and extent of the limitation;

15.4. The relation between the limitation and its purpose; and

15.5. Less restrictive means to achieve the purpose.

16. I am further informed that, it is only if the government respondents decided to oppose the relief sought by the applicants, that they would deliver an answering affidavit in which they set out, amongst other things, the purpose of the limitation (i.e. criminalisation) and the purpose that criminalisation is intended to achieve.

17. While I am not a lawyer or politician, one assumes that the government's criminalisation of psilocybin would either be:

17.1. historical (i.e. it was criminalised based on research at a particular time and the question has not been revisited); or

17.2. based (at least partly) on the notion that psilocybin use is harmful.

HISTORICAL USE OF PSILOCYBIN MUSHROOMS

18. Psilocybin is a natural substance that is produced by many species of mushrooms.

19. The history of psilocybin falls outside of my clinical and expert experience, but, while studying the topic over the years, I have read much literature about the topic. As fully addressed in my latest book -

"Psychedelics: The Revolutionary Drugs That Could Change Your Life - A Guide from the Expert" - the literature appears to make it clear that:

19.1. Psilocybin containing mushrooms have been consumed by many human societies across the world for millennia as part of bonding and right-of passage celebrations.[1]

19.2. Indeed, the Ancient Greek are thought to have used psilocybin in their Elysian celebrations and the "soma" of ancient Indian culture also probably contained psilocybin along with other natural products such as ephedra and cannabis.[2]

19.3. The ancient Incas and Aztecs also valued psychedelic mushrooms as means of communicating with higher powers and gods. There is good evidence from rock carvings of psychedelic mushroom use in Africa over 10,000 years ago.[3]

CLINICAL FEATURES OF PSILOCYBIN

20. Psilocybin is a precursor to the active ingredient psilocin that is released when psilocybin is broken down in the body. Psilocin acts on a certain type of serotonin receptor in the brain (the 5-HT2A receptor) that is involved in the regulation of mood and other aspects of consciousness.

21. Psilocybin is usually taken orally, but can be given via the intravenous route for research purposes. There are no reports of intravenous recreational use of psilocybin.

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[1] https://chacruna.net/mazatec-shamanism-and-psilocybin-mushrooms/

[2] https://chacruna.net/soma-and-the-sacred-feminine-reflections-from-ancient-vedic-myth/

[3] https://www.atlasobscura.com/articles/psychedelic-mushroom-algeria

22. Psilocybin produces a short-lived change in consciousness in most people that is colloquially called a "trip". The formal term for a “trip” is a psychedelic experience. This is dose-related with true psychedelic effects emerging at doses of 20mg or above when given orally. A dose of 20mg is roughly equivalent to the active contents of four psilocybin-containing mushrooms.

23. Psilocybin can elevate mood during the "trip" and this can endure for weeks or months. In our depression study[4] many patients stayed in recovery and free of depression for months after a single 25mg dose.

CLINICAL UTILITY OF PSILOCYBIN

24. In the 1950 and 1960s, with the rise of psychedelic science, there were a number of studies conducted exploring the value of psilocybin in the treatment of mental illnesses. For a period in the late 1950s to the late 1960s, the company Sandoz sold psilocybin as a medicine for use by psychiatrists under the trade name Indocybin.

25. In addition to my work already mentioned, there are now many studies that have shown that psilocybin used once or twice only can markedly improve mental state and reduce mental illness. The first of these was from Moreno and colleagues, who, having noted individual use of psychedelics could ameliorate obsessive compulsive disorder (**“OCD”**) and body-dysmorphic disorder, then conducted a controlled trial in patients with OCD and found a significant therapeutic effect.[5]

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[4] Carhart-Harris RL, Bolstridge M, Rucker J, Day CM, Erritzoe D, Kaelen M, Bloomfield M, Rickard JA, Forbes B, Feilding A, Taylor D, Pilling S, Curran VH, Nutt DJ. 2016. Psilocybin with psychological support for treatment-resistant depression: an open-label feasibility study. Lancet Psychiatry 3(7): 619-627.

[5] Moreno FA, Wiegand CB, Taitano EK, Delgado PL. 2006. Safety, tolerability, and efficacy of psilocybin in 9 patients with obsessive-compulsive disorder. J Clin Psychiatry 67(11): 1735-1740.

26. The Johns Hopkins University group has shown that as single 25mg psilocybin can profoundly alter a smoker's dependence on tobacco so that the majority are able to successfully quit smoking and stay abstinent for months or years.[6] In other words, this is strong evidence that supports the conclusion that psilocybin has beneficial effects in treating addiction.

27. A group led by Dr Bogenschutz[7] in Arizona found that a 25mg dose of psilocybin was able to profoundly reduce alcohol consumption in alcoholics. This is an exciting finding that replicates early work with another psychedelic – lysergic acid diethylamide [**"LSD"**] – that was shown in the 1960s to have powerful effects to promote abstinence in alcoholics. A more detailed replication placebo-controlled study of psilocybin is currently underway by the same group. This finding has recently been replicated in a major double-blind randomised control trial [**"RCT"**] using an active placebo.[8]

28. Another study found that a single psilocybin administration could result in significantly reduced anxiety and depression in people with a diagnosis of

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[6] Johnson, M. W., Garcia-Romeu, A., & Griffiths, R. R. (2017). Long-term follow-up of psilocybin-facilitated smoking cessation. *The American Journal of Drug and Alcohol Abuse*, *43*(1), 55–60. https://doi.org/10.3109/00952990.2016.1170135; Johnson MW, Garcia-Romeu A, Cosimano MP, Griffiths RR. (2014) Pilot study of the 5-HT2AR agonist psilocybin in the treatment of tobacco addiction. Psychopharmacol. 2014 Nov; 28(11):983-92. doi: 10.1177/0269881114548296. Epub 2014 Sep 11.PMID: 25213996

[7] Bogenschutz MP, Forcehimes AA, Pommy JA, Wilcox CE, Barbosa PC, Strassman RJ. 2015. Psilocybin-assisted treatment for alcohol dependence: a proof-of-concept study. J Psychopharmacol 29(3):289-299.

[8] Bogenschutz et al 2022. Bogenschutz, M. P., Ross, S., Bhatt, S., Baron, T., Forcehimes, A. A., Laska, E., Mennenga, S. E., O'Donnell, K., Owens, L. T., & Podrebarac, S. (2022). Percentage of heavy drinking days following psilocybin-assisted psychotherapy vs placebo in the treatment of adult patients with alcohol use disorder: a randomized clinical trial. *JAMA Psychiatry, 79*(10), 953-962.

terminal illness (mostly cancer).[9]

29. Since then, there have been two placebo-controlled trials of psilocybin in people with life-threatening diagnoses (mostly terminal illness from cancer). These are the largest psilocybin studies ever conducted and both showed good benefits on mood and anxiety.[10]

30. Psilocybin is also effective in neurological disorders, especially in the treatment of cluster headaches (Horton's headache).[11] These are the most severe headaches known and for which there are no really effective licensed treatments. When chronic in occurrence, they often lead to patients committing suicide.

31. In the non-medical psychotherapeutic setting, Professor Griffiths and other colleagues at Johns Hopkins University in Baltimore have explored the impact of psilocybin on people who were interested in exploring their

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[9] Grob CS, Danforth AL, Chopra GS, Hagerty M, McKay CR, Halberstadt AL, Greer GR. 2011. Pilot study of psilocybin treatment for anxiety in patients with advanced-stage cancer. Arch Gen Psychiatry 68(1):71-78.

[10] Ross, S., Bossis, A., Guss, J., Agin-Liebes, G., Malone, T., Cohen, B., Mennenga, S. E., Belser, A., Kalliontzi, K., Babb, J., Su, Z., Corby, P., & Schmidt, B. L. 2016. Rapid and sustained symptom reduction following psilocybin treatment for anxiety and depression in patients with life-threatening cancer: A randomized controlled trial. *J. Psychopharmacol.*, 30(12), 1165–1180. https://doi.org/10.1177/0269881116675512. See also: Griffiths, R. R., Johnson, M. W., Carducci, M. A., Umbricht, A., Richards, W. A., Richards, B. D., Cosimano, M. P., & Klinedinst, M. A. (2016). Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial. *J. Psychopharmacol.*, 30(12), 1181–1197. https://doi.org/10.1177/0269881116675513.

[11] Madsen, M.K., Petersen, A.S., Stenbæk, D.S., Sørensen, I.M., Schiønning, H., Fjeld, T., Nykjær, C.H., Ulv Larsen, S.M., Grzywacz, M., Mathiesen, T. and Klausen, I.L., 2022. Psilocybin-induced reduction in chronic cluster headache attack frequency correlates with changes in hypothalamic functional connectivity. *medRxiv*, 2022-07.

potential for increased self-awareness and insights. They found that a single exposure of 25mg can result in profound and enduring positive alterations in mood.[12] This study reported that 38% of the volunteers rated the psilocybin experience as being one of the top five most *"spiritually significant experiences"* of their lives, with 33% ranking the psilocybin experiences as being *"the single most spiritually significant experience of [their lives]"*.[13] These data support our and others' clinical data that find psilocybin improves wellbeing as well as decreasing depression and provides scientific evidence that would justify non-medical use in psychotherapeutic settings.

32. In 2012, my research group published the first-ever functional magnetic resonance imaging ("**fMRI**") brain imaging studies of psilocybin. These were published in the leading journal Proceedings of the National Academy of Sciences USA.[14] Subsequently, I led the team that conducted the first-ever magnetoencephalography ("**MEG**") study with psilocybin.[15] These two studies revealed psilocybin to have unique

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[12] Griffiths RR, Richards WA, McCann U, Jesse R. 2006. Psilocybin can occasion mystical-type experiences having substantial and sustained personal meaning and spiritual significance. Psychopharmacology (Berl) 187(3):268-283; discussion 284-292. See also: Griffiths RR, Johnson MW, Richards WA, Richards BD, McCann U, Jesse R. 2011. Psilocybin occasioned mystical-type experiences: immediate and persisting dose-related effects. Psychopharmacology (Berl) 218(4):649-665.

[13] Griffiths RR, Richards WA, McCann U, Jesse R. 2006. Psilocybin can occasion mystical-type experiences having substantial and sustained personal meaning and spiritual significance. Psychopharmacology (Berl) 187(3):268-283; discussion 284-292 (see, in particular, page 10).

[14] Carhart-Harris RL, Erritzoe D, Williams T, Stone JM, Reed LJ, Colasanti A, Tyacke RJ, Leech R, Malizia AL, Murphy K, Hobden P, Evans J, Feilding A, Wise RG, Nutt DJ. 2012. Neural correlates of the psychedelic state as determined by fMRI studies with psilocybin. Proc Natl Acad Sci U S A 109(6):2138-2143.

[15] Muthukumaraswamy SD, Carhart-Harris RL, Moran RJ, Brookes MJ, Williams TM, Errtizoe D, Sessa B, Papadopoulos A, Bolstridge M, Singh KD, Feilding A, Friston KJ, Nutt DJ. 2013.

J.C.B.

effects on the brain (which we have since replicated with other psychedelics - LSD and dimethyltryptamine [**"DMT"**]).

32.1. These brain effects included suppression of activity in an area of the brain that had been shown to drive depression (the pre-frontal cortex). Many proven antidepressant treatments had by that time been shown to similarly supress activity in this region.

32.2. Also found was the dampening of a major brain network that is overactive in depression, which is called the default mode network (**"DMN"**).

33. These neuroscience discoveries suggested that psilocybin might have so-called *'antidepressant'* effects and, to test this hypothesis, I obtained a UK MRC grant to conduct the first modern trial of psilocybin, plus psychotherapy, in treatment-resistant depression. This found that a single 25mg dose of psilocybin was well tolerated and very effective in relieving depression symptoms in these patients in whom previous antidepressant treatments (they had tried at least 2 other antidepressants) as well as cognitive behavioural psychotherapy ("**CBT**") had failed. This effect was fast in onset and quite enduring, with some of the patients staying well until this day. The study was published in Lancet Psychiatry - a leading psychiatry journal.[16]

34. Since then, I have conducted a comparative study of psilocybin plus psychotherapy treatment versus the gold-standard conventional selective

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Broadband cortical desynchronization underlies the human psychedelic state. J Neurosci 33(38):15171-15183.

[16] Carhart-Harris RL, Bolstridge M, Rucker J, Day CM, Erritzoe D, Kaelen M, Bloomfield M, Rickard JA, Forbes B, Feilding A, Taylor D, Pilling S, Curran VH, Nutt DJ. 2016. Psilocybin with psychological support for treatment-resistant depression: an open-label feasibility study. Lancet Psychiatry 3(7):619-627.

serotonin re-uptake inhibitor ("**SSRI**") antidepressant *'Escitalopram'*, in patients with depression. I believe this was the world's first study of this kind. This was published last year in the leading medical journal the *New England journal of Medicine.*[17] We found two 25mg doses of psilocybin, given three weeks apart, to have greater antidepressant benefits than a high dose of Escitalopram. Escitalopram is used to treat depression and generalised anxiety disorder – it is sold in South Africa under the brand names *Lexapro* and *Cipralex*. Moreover, psilocybin worked faster and had less adverse effects.

35. On top of this, psilocybin enhanced wellbeing much more than escitalopram, as demonstrated by higher scores on the Warwick-Edinburgh mental wellbeing scores. By *'enhancing wellbeing'*, I mean that it improved patients' energy, engagement with the world, optimism, enjoyment of life etc. more than escitalopram did. This was an effect that patients found satisfying. Some patients using traditional SSRI treatments feel like the medication impairs their cognitive abilities: some people have vivid nightmares; become extremely forgetful; and their energy levels dropped.

36. In this, we were also able to conduct brain imaging studies before and after treatment with the two medicines. We found that psilocybin had a very different brain profile to Escitalopram. It increased connectivity across the brain, whereas Escitalopram did not.[18] Greater connectivity across the brain is a positive effect, because in practical terms it means

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[17] Carhart-Harris, R., Giribaldi, B., Watts, R., Baker-Jones, M., Murphy-Beiner, A., Murphy, R., Martell, J., Blemings, A., Erritzoe, D. and Nutt, D.J., 2021. Trial of psilocybin versus escitalopram for depression. *New England Journal of Medicine*, 384(15), pp.1402-1411.

[18] Daws, R.E., Timmermann, C., Giribaldi, B. *et al.* Increased global integration in the brain after psilocybin therapy for depression. *Nat Med* 28, 844–851 (2022). https://doi.org/10.1038/s41591-022-01744-z

that brain processing is more flexible and able to respond in a more adaptive and effective manner. Patients are able to escape from their deeply entrenched negative thought processes. This change in brain physiological measures is paralleled by our patients descriptions of the positive effects of psilocybin. One quote from a patient shows this: "*My mind works differently now. I ruminate much less, and my thoughts feel ordered, contextualized. Rumination was like thoughts out of context, out of time; now my thoughts feel like they make sense, with context and logical flow*".[19]

37. By contrast, Escitalopram blunted activity in the emotional circuits of the brain, whereas psilocybin did not.[20] This study provided the first strong evidence that psilocybin works in a quite different way and in quite different brain regions to traditional antidepressants, as we had hypothesised in a 2017 paper.[21] Put simply, while escitalopram blunted both positive as well as negative emotional responses , psilocybin did not affect either.

38. Other groups in the USA have since reported psilocybin in a single 25mg dose, plus psychotherapy, to have meaningful antidepressant effects[22]

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[19] Watts, R., Day, C., Krzanowski, J., Nutt, D., & Carhart-Harris, R. (2017). Patients' accounts of increased "connectedness" and "acceptance" after psilocybin for treatment-resistant depression. *J. Humanist. Psychol.*, *57*(5), 520–564. https://doi.org/10.1177/0022167817709585, at p11.

[20] Wall, M.B., Demetriou, L., Giribaldi, B., Roseman, L., Ertl, N., Erritzoe, D., Nutt, D.J. and Carhart-Harris, R.L., 2023. Reduced brain responsiveness to emotional stimuli with escitalopram but not psilocybin therapy for depression. *medRxiv*, pp.2023-05.

[21] Carhart-Harris, R., & Nutt, D. (2017). Serotonin and brain function: A tale of two receptors. *Journal of Psychopharmacology*, *31*(9), 1091–1120. https://doi.org/10.1177/0269881117725915.

[22] Davis, A. K., Barrett, F. S., May, D. G., Cosimano, M. P., Sepeda, N. D., Johnson, M. W., Finan, P. H., & Griffiths, R. R. (2021). Effects of Psilocybin-Assisted Therapy on Major Depressive Disorder: A Randomized Clinical Trial. *JAMA Psychiatry*, *78*(5), 481–489. https://doi.org/10.1001/jamapsychiatry.2020.3285. See also: Raison CL, Sanacora G, Woolley J,

and to have therapeutic benefit in other forms of psychiatric distress such as anxiety after receiving a diagnosis of a terminal illness (most of the research relates to patients discovering they had cancer).

39. Our treatment-resistant depression study has now been replicated by a pharmaceutical company, *COMPASS Pathways*. These results are very similar to, and consistent with, those in our original Lancet Psychiatry study, in that the same 25mg psilocybin oral dose given just once produced fast and very significant improvements in mood. They also had groups of patients that received lower (placebo) doses and these experienced less effects. One quarter of the treatment-resistant depression patients that received the 25mg dose were in remission (i.e. free from depression) at 3 months.[23]

40. Moreover, in June 2023, I was amongst a team of other experts, who published a study which found that psilocybin has the potential to be a cost-effective therapy for severe depression.[24] There is growing evidence to support the use of the psychedelic drug psilocybin for difficult-to-treat depression. The paper compares the cost-effectiveness of psilocybin-assisted psychotherapy ("**PAP**") with conventional medication, cognitive behavioural therapy ("**CBT**"), and the combination of conventional medication and CBT.

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et al. Single-Dose Psilocybin Treatment for Major Depressive Disorder: A Randomized Clinical Trial. *JAMA*. 2023;330(9):843–853. doi:10.1001/jama.2023.14530

[23] Goodwin, G.M., Aaronson, S.T., Alvarez, O., Arden, P.C., Baker, A., Bennett, J.C., Bird, C., Blom, R.E., Brennan, C., Brusch, D. and Burke, L., 2022. Single-dose psilocybin for a treatment-resistant episode of major depression. *New England Journal of Medicine*, *387*(18), pp.1637-1648.

[24] McCrone, P., Fisher, H., Knight, C., Harding, R., Schlag, A.K., Nutt, D.J. and Neill, J.C., 2023. Cost-effectiveness of psilocybin-assisted therapy for severe depression: exploratory findings from a decision analytic model. *Psychological Medicine*, *53*(16), pp.7619-7626.

41. In practical terms, for instance, psilocybin could make a huge difference. This is particularly so because I understand that – presently in South Africa – many people do not have private medical healthcare and the public health system is overburdened. Greater (regulated) psilocybin use in this context may well lead to significant savings for individuals (in relation to their medical expenses for medical care, or medical aid benefits where they subscribe to a private medical aid) and for the state (where individuals make use of public healthcare).

42. On the bases of these findings, as well as conducting a detailed literature review of the material in this field (including the works listed in the bibliography) – I have concluded that psilocybin offers a unique, beneficial approach to alleviating mental disorders such as depression and anxiety.

43. It has a different pharmacology and brain mechanisms to conventional antidepressants: these explain how it works, and why it can prove effective where other current antidepressant and anxiolytic treatments do not and why it has an improved tolerability profile.

44. For instance, current antidepressant and anxiolytic treatments are not effective in about 40% of patients but the studies referenced above in treatment-resistant depression show that psilocybin can be. This I believe is because psilocybin works in a different way to traditional antidepressants. It works on different receptors in different brain regions.

    44.1. Psilocybin acts on a certain type of serotonin receptor in the brain (the 5-HT2A receptor) that is involved in the regulation of mood and other aspects of consciousness; whereas

44.2. Traditional antidepressants work by enhancing serotonin levels to stimulate a different type of serotonin receptor the 5-HT1A receptor.

45. Taken together, these multiple studies from different groups in different countries provide a powerful body of evidence regarding the benefits of psilocybin in improving an individual's wellbeing as well as being an effective treatment of the efficacy of psilocybin in treating depression.

SAFETY PROFILE OF PSILOCYBIN

46. Preclinical studies indicate that psilocybin has extremely low toxicity.[25] Studies of the "lethality" of psilocybin defined as the dose required to kill 50% of animals receiving it (LD50) find values ranging from 280 mg/kg in rats and mice to 12.5 mg/kg in rabbits.[26] Obtaining human data is obviously not possible, but if we extrapolate from the rat, then 17 kg of fresh mushrooms would have to be consumed, in a single sitting of a few hours, in order to reach this dose in an adult human subject. A paper estimating the ratio of active dose to lethal dose of a range of commonly used drugs concluded that psychedelics like psilocybin were amongst the safest.[27] According to the study: the ratio between lethal dose and treatment/effective dose was estimated as 1,000 times, which betters that for the antidepressant fluoxetine [Prosac] which was 100.

46.1. The ratio for Alcohol was only 10, for heroin 8, and cocaine 15.

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[25] Nichols, D.E., 2004. Hallucinogens. *Pharmacology & therapeutics*, *101*(2), pp.131-181. See also: Passie, T., Seifert, J., Schneider, U. and Emrich, H.M., 2002. The pharmacology of psilocybin. *Addiction biology*, *7*(4), pp.357-364.

[26] Efron, D.H. and Usdin, D., 1972. *Psychotropic drugs and related compounds*. National Institute of Mental Health.

[27] Gable R. S. Comparison of acute lethal toxicity of commonly abused psychoactive substances. Addiction 99, 686–696 (2004).

46.2. Caffeine was around 100.

46.3. Other drugs and also many licensed medicines have ratios that are much lower than that for psilocybin, e.g. morphine 20, and amitriptyline (another widely used antidepressant) 10.

47. Psilocybin has now been taken through regulatory pre-clinical safety testing by the pharmaceutical company COMPASS Pathways as a prelude to its being developed as a medicine. This has led to its being given fast-track status by the FDA (USA food and drug administration) and the EMA (European Medicines Agency) to be used in multiple studies, which proves that it meets the necessary safety criteria to become a medicine should the clinical data prove positive. In July 2023 the Australian regulator approved psilocybin for treatment-resistant depression for patients with serious illness in whom two prior approved treatments had failed.

48. Psilocybin is remarkably safe in humans. Evidence of this was already apparent from psilocybin's use in the 1950s and 1960s as a medicine without reported harms.

49. Several reviews of the harms of psilocybin have been conducted.[28] They conclude that it is very safe. Since then, in the clinical trials detailed above, including ours, many hundreds of patients have been treated with psilocybin without any reported serious adverse effects of statistical significance. In addition, studies in healthy volunteers have included

[28] These include, for example: Strassman RJ. 1984. Adverse reactions to psychedelic drugs. A review of the literature. J Nerv Ment Dis 172(10):577-595. 46; and Van Amsterdam J, Opperhuizen A, van den Brink W. 2011. Harm potential of magic mushroom use: a review. Regul Toxicol Pharmacol 59(3):423-429.

many thousands of participants and no serious adverse effects have so far been reported.

50. The most common adverse effects are extremely minor:

50.1. nausea at the start of the experience;

50.2. some anxiety at the start of the experience; or

50.3. a headache which usually remits within a few hours of the experience ending;

51. Over the last 15 years, psilocybin has been given to several hundred patients and volunteers in many studies. In a thorough review of dosing sessions in 110 healthy subjects, dysphoric experiences/bad trips were rare (i.e. 2 out of 110 subjects) and dose-dependent and, importantly, there was no evidence of subsequent drug abuse, flashback phenomena or prolonged psychoses.[29] Our own work has involved several hundred people without serious adverse effects being noted either during the experience, or afterwards, at follow up for 6 months.

52. There have been some unverified claims that psychedelics (and so by inference psilocybin) can cause people to behave irrationally and thus come to harm. Almost all of these claims relate to LSD and even those claims about LSD are either exaggerated or made up as scare stories designed to deter use and to justify the harsh treatment of psychedelics in international regulatory and legal systems.

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[29] Studerus E, Kometer M, Hasler F, Vollenweider FX. 2011. Acute, subacute and long-term subjective effects of psilocybin in healthy humans: a pooled analysis of experimental studies. J Psychopharmacol 25(11):1434-1452].

53. Notably, the UK national poisons database has recorded just one death *possibly* associated with psilocybin in the past ten years, an exceptional safety record considering that it is estimated that about one million young people use it every year.[30] In contrast, alcohol, with an estimated 30 million users in the UK, is associated with over 8,900 directly related deaths *per* year.

54. Psilocybin can produce a mild elevation of blood pressure and heart rate; these are equivalent to the changes produced by walking up a couple of flights of stairs and are rarely - if ever - of clinical relevance, even in elderly or medically ill people who have been treated with the drug.

55. It is debatable if psilocybin has ever caused a death or even serious harms when used medically (the source and quality being assured) or in a supervised therapy session (supervision almost eliminates the risk of confusion or disorientation resulting in harm to self). Consider the difference with medicinal opiates that are responsible for tens of thousands of deaths each year, some even when administered under strict medical supervision.

56. The majority of psilocybin mushroom users described their experiences as enriching, insightful and beneficial, but not something they would regularly repeat. These opinions have been verified in a controlled trial.[31] Our own experience using psilocybin as a treatment for depression has

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[30] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2020.

[31] MacLean KA, Johnson MW, Griffiths RR. 2011. Mystical experiences occasioned by the hallucinogen psilocybin lead to increases in the personality domain of openness. J Psychopharmacol 25(11):1453-1461.

revealed powerful and enduring positive insights associated with its therapeutic effects.[32]

57. For the reasons explained in the above paragraphs, psilocybin was rated as one of the least-harmful drugs in three independent expert group reviews using the most modern quantitative MCDA (multi-criteria decision analysis) methodology. The first, in 2010 with UK experts, compared the harms of 20 popular recreational drugs using the most sophisticated multi-criteria decision analysis technique.[33] A similar judgement was made in a separate study funded by the European Justice Department, with a group of European drug experts from 20 different countries.[34] The third study in 2018, which was conducted by Australian experts, conflated psilocybin and LSD together and still found them at the lowest end of the harm scale.

58. For the purpose of legibility, tables summarising the results of these studies follow on the next few pages.

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[32] Watts, R., Day, C., Krzanowski, J., Nutt, D., & Carhart-Harris, R. (2017). Patients' accounts of increased "connectedness" and "acceptance" after psilocybin for treatment-resistant depression. *J. Humanist. Psychol.*, *57*(5), 520–564. https://doi.org/10.1177/0022167817709585.

[33] Nutt DJ, King LA, Phillips LD, Independent Scientific Committee on D. (2010) Drug harms in the UK: a multicriteria decision analysis. Lancet 376(9752):1558-1565.

[34] Van Amsterdam J, Nutt D, Phillips L, van den Brink W (2014) European rating of drug harms. Journal of Psychopharmacology 2015 Apr 28. pii: 0269881115581980.

36 = Bonomo Y, Norman A, Biondo S, Bruno R, Daglish M, Dawe S, Egerton-Warburton D, Karro J, Kim C, Lenton S, Lubman DI, Pastor A, Rundle J, Ryan J, Gordon P, Sharry P, Nutt D, Castle D. The Australian drug harms ranking study. J Psychopharmacol. 2019 Jul;33(7):759-768. doi: 10.1177/0269881119841569. Epub 2019 May 13. Erratum in: J Psychopharmacol. 2019 Nov;33(11):1471. PMID: 31081439.

UK drug ranking data

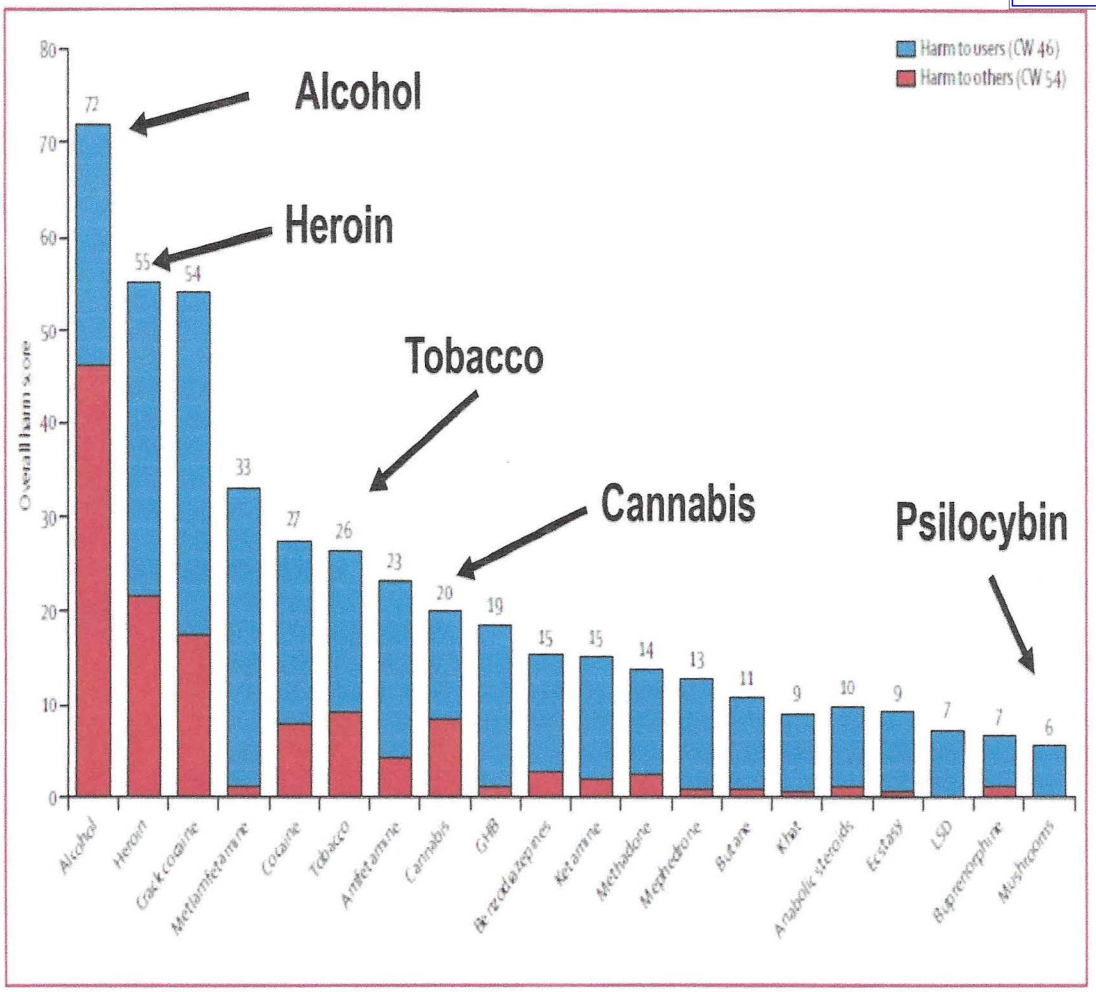
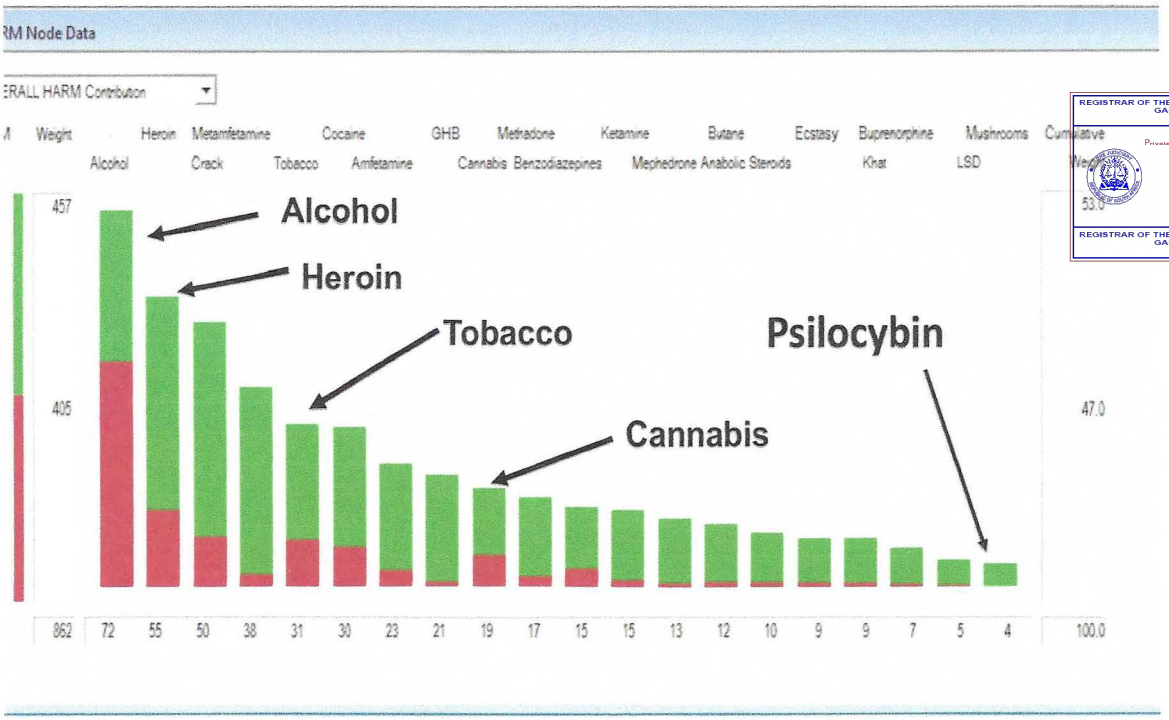


Figure 2: Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others
The weights after normalisation (0-100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

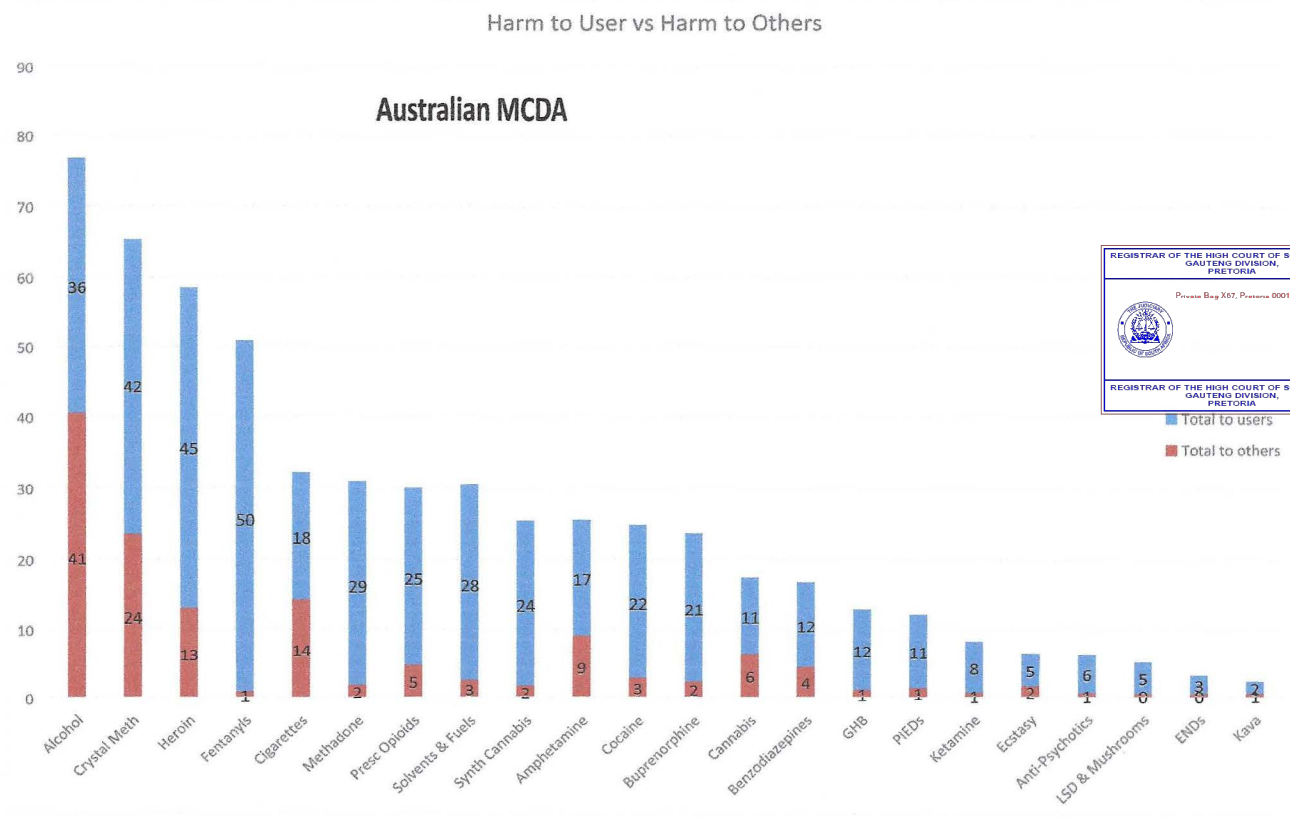
Nutt King & Phillips Lancet Nov 2010

New European MCDA data – 2013



ISCD European study FP7 2013

Figure 2: Contribution of Harm to User and Harm to Others to Overall Harm



59. Psychiatric sequelae (such as severe agitation, psychosis; paranoia, delusions, confusion, and excited delirium – and some others commonly invoked that are more fictional than factual) are also very rare, though are more likely in individuals with a history of prior psychotic episodes or a family history of psychosis. We have not had a single person, either a healthy volunteer or patient, experience this in over 300 psilocybin doses. It is worth reflecting on how very rarely psilocybin does lead to disturbed behaviour compared with intoxicating doses of alcohol.

60. Psychiatric sequelae are also very rare, though are more likely in individuals with a history of prior psychotic episodes or a family history of psychosis. We have not had a single person, either a healthy volunteer or patient, experience this in over 300 psilocybin doses. It is thus worth considering how rarely psilocybin leads to disturbed behaviour with substances that are legal – such as alcohol.

61. Notably, even the non-medical use of psilocybin at (for example) a nightclub or music festival, which increases the risk of the user becoming anxious or having a "bad trip" can be quickly delt with by supportive care and rarely do they need medical intervention. In addition, the evidence does not support the conclusion that these bad experiences lead to any enduring mental health issues.[35]

62. *"Bad trips"*, should they occur with psilocybin:

62.1. In the first place, can be simply dealt with using calm reassurance from an experienced sitter or guide. This will deal with most cases.

62.2. If this does not prove adequate, then benzodiazepine sedative or a serotonin 5-HT2A receptor blocker such as risperidone, as would have to be administered by a medical professional.

62.3. In any event, these effects do not last for more than a few hours in most instances.

63. I emphasise that thoughtful and considered psilocybin use by adults – under supervision (such as that conducted by Ms Cromhout and her team

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[35] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/13746drugrelateddeathregistrationsmentioninglsdorpsilocybinenglandandwales1993to2020.

of watchers) – is likely to reduce even further the relatively low risks of the users becoming anxious or having a "bad trip".

64. In relation to placing side effects in context, aspirin (when consumed in high dosages) can produce hallucinations – but it is available to members of the public in South Africa *'off-the-shelf'*. I understand from the applicant's attorneys that the following products are available 'off-the-shelf' in a pharmacy (without a prescription or any indication that the person has seen a doctor). The side effects listed include a variety of conditions that are fatal.

64.1. Aspirin – gastric bleeding and anaphylaxis;

64.2. Panadol – liver failure;

64.3. Valoid – stopping breathing;

64.4. Imodium - stopping breathing; and

64.5. Allergex - stopping breathing.

65. The point is that every substance that people use to treat conditions has potential side effects, allergic reactions and some risk involved. In the case of the medications listed above none are criminalised.

DEPENDENCE-PRODUCING QUALITIES

66. Any claims that psilocybin is a dangerous and abused drug are not supported by the body of evidence. Psilocybin may be used as a medicine, as a means of self-elevation and self-analysis, or intermittently as a recreational drug (without any more grand purpose than youths taking it to see how it affects them). Users often describe psychedelic

experiences as challenging, rather than fun, and are often relieved when the experience comes to an end.[36]

67. The use of psilocybin-containing mushrooms tends to be occasional, e.g. monthly or yearly rather than weekly or daily. However, regular use of psilocybin is very rare, and use does not lead to dose escalation because these drugs are not classically rewarding or reinforcing. They do not produce a feeling of "wanting more" or craving.[37]

68. Psilocybin is not habit forming in animals or humans and is not capable of producing sufficient reinforcing effects to cause dependence.[38] Animal models (i.e., self-administration, conditioned place preference) have failed to reliably demonstrate addictive liability of 5 hydroxytryptaminergic psychedelics including psilocybin, suggesting that these drugs do not possess the pharmacological properties to initiate or maintain dependence.

69. This lack of dependence liability of psilocybin is in stark contrast to other drugs, including those in the same Schedule as psilocybin, such a strong opioid, crack cocaine and methamphetamine, all of which are profoundly addictive (both to animals and humans).

70. The use of psilocybin does not lead to dependence or addiction in humans and indeed, as illustrated by reliable studies, it can be used to treat addiction to other substances.

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[36] Van Amsterdam J, Opperhuizen A, van den Brink W. 2011. Harm potential of magic mushroom use: a review. Regul Toxicol Pharmacol 59(3):423-429.

[37] In addition, as with all classical hallucinogens, regular use of psilocybin is very rare, because complete tolerance to the effects rapidly develops if someone were to take repeated daily doses.

[38] Hoffmeister F. 1975. Negative reinforcing properties of some psychotropic drugs in drug-naive rhesus monkeys. J Pharmacol Exp Ther 192(2):468-477.

71. My group recently asked a large sample of 93 experienced drug users to rank the relative harms and benefits of 11 of the most widely used recreational drugs in the United Kingdom. Users were considered 'experience drug users' if they had used each of these drugs. Users ranked psilocybin mushrooms as the least harmful and one of the most mentally beneficial drugs.[39] The most commonly cited benefits were facilitated psychological insight and improved wellbeing.

72. In a separate survey, without being explicitly cued, 5% of 503 psilocybin users reported that psilocybin mushrooms had alleviated their depressive symptoms, and 3.6% of 247 ketamine users reported this for ketamine.[40] Ketamine is currently being used as a treatment for resistant depression, with evidence of short-term efficacy. Our survey results imply that psilocybin was "at least as, if not more, *effective*" than ketamine but - because of what is said elsewhere in research literature – including, for instance, the UK, Australian and European MCDA ranking data – it is known that psilocybin is safer than ketamine.

73. In my view, the listing of psilocybin in the United Nations' ("**UN**") and South African drug schedules as highly dangerous (or at least undesirable) and dependence producing is based on incorrect and/or outdated evidence. The almost complete lack of any person reporting psilocybin dependence, when millions of doses per year are consumed, demonstrates that its use does not lead to dependence.

74. The statement in the Schedules that psilocybin causes dependence is - and always has been - incorrect. The most recent WHO report on drug

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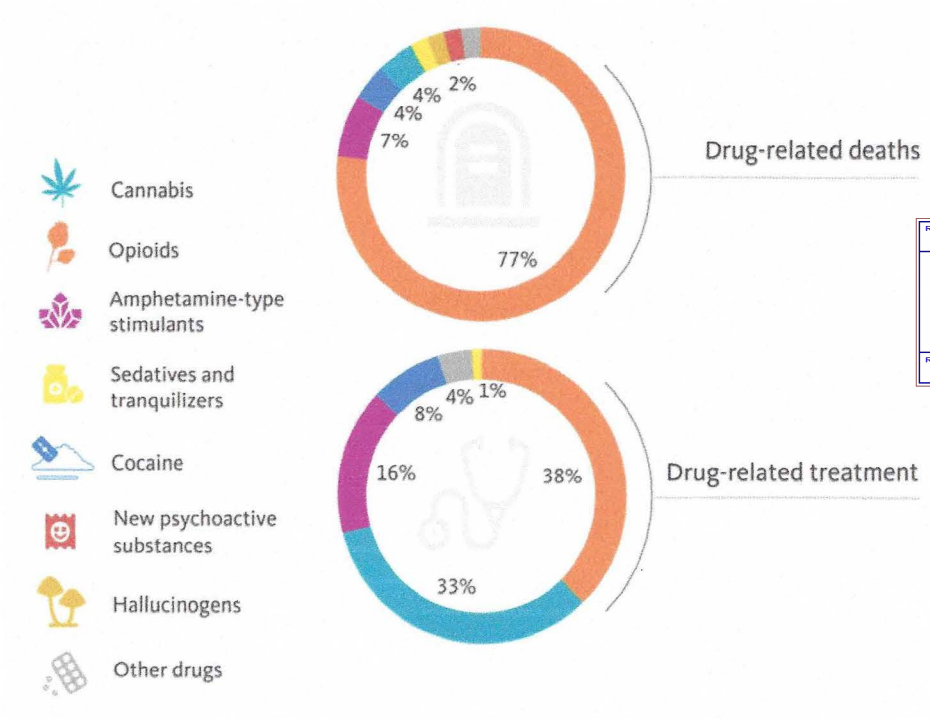
[39] Carhart-Harris RL, Nutt DJ. 2013. Experienced drug users assess the relative harms and benefits of drugs: a web-based survey. J Psychoactive Drugs 45(4): 322-328.

[40] Carhart-Harris RL, Nutt DJ. 2010. User perceptions of the benefits and harms of hallucinogenic drug use: A web-based questionnaire study. J Subst Use 15(4):283-300.

harms and dependence failed to find any significant deaths, dependence (as indicated by treatment requirements) to psilocybin (or other hallucinogens) - see following figure from said WHO report.



75. Psilocybin is currently placed in Schedule 2 of the SA Drugs Act along with fentanyl and heroin. This would suggest to the public (who do not have expertise in these fields) that psilocybin is as dangerous/undesirable or addictive (or both) as these two drugs. In my professional and expert opinion, this demonstrates the serious error of the Drug and Drug Trafficking Act of 1992, as the scheduling clearly has not been based on the evidence related to psilocybin – nor any rational analysis of the comparative harms of the drugs in the same schedule. Heroin and fentanyl are among the most dangerous, whereas psilocybin, even when in psilocybin mushrooms, is one of the safest.[41]

[41] Bonomo Y, Norman A, Biondo S, Bruno R, Daglish M, Dawe S, Egerton-Warburton D, Karro J, Kim C, Lenton S, Lubman DI, Pastor A, Rundle J, Ryan J, Gordon P, Sharry P, Nutt D, Castle D.

76. I have been informed that it is repeatedly invoked that SA is a signatory to the UN conventions on drugs that have put psilocybin in Schedule 1. However, many international experts now agree that this Scheduling is inappropriate and many countries have chosen to exempt psilocybin and or magic mushrooms from their own national Drugs Acts, yet still comply with the UN Conventions. Of particular relevance is the recent Australian regulatory decision to move psilocybin out of their equivalent of the UN Conventions Schedule 1 for treatment-resistant depression.[42]

77. The fact that the UK signed the 1971 UN Convention on Psychoactive Drugs, yet allowed magic mushrooms to be legal for a further 35 years shows how little harm magic mushrooms cause. They only became controlled in the UK in 2005, when freeze-drying techniques allowed them to be sold in *'head-shops'* in London. This led to a frenzied media campaign to get magic mushrooms banned – to which the UK government succumbed for political reasons.[43] In the past few years, however, various countries around the world have decriminalised or legalised psilocybin.

THE RISKS AND HARMS ASSOCIATED WITH PSILOCYBIN USE AND HOW THEY CAN BE MANAGED/MITIGATED

78. The first impact of ingesting psilocybin mushrooms and psilocybin is on the stomach where mild nausea and stomach cramps are reported, though only rarely with vomiting. These effects are self-limiting and, in my clinical experience, of not of much concern either to patients or healthy

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The Australian drug harms ranking study. J Psychopharmacol. 2019 Jul;33(7):759-768. doi: 10.1177/0269881119841569. Epub 2019 May 13. Erratum in: J Psychopharmacol. 2019 Nov;33(11):1471. PMID: 31081439.

[42] https://www.tga.gov.au/resources/publication/scheduling-decisions-final/notice-final-decision-amend-or-not-amend-current-poisons-standard-june-2022-acms-38-psilocybine-and-mdma.

[43] Nutt DJ; Drugs: without the hot air (2012) UIT press ISBN 13: 9781906860165.

volunteers. Evidence of such is reflected in the Table of Adverse Events reported by Carhart-Harris et al,[44] which showcases the effects of psilocybin in comparison to escitalopram. It is worth noting that this study showed that none of the adverse effects of psilocybin were significantly greater than for Escitalopram.

79. During the rising phase of the drug, effects such as a slight increase in anxiety is reported by a small proportion of people, possibly because of anxiety about the likely experience or because the heart rate begins to elevate. A small increase in breathing rate is also seen. This is almost always self-limiting and disappears as the "trip" starts.[45] During treatment with psilocybin, patients are warned of these effects, and this minimises their reaction to them.

80. The acute psychological effects of psilocybin are short-lived, lasting just a few hours, so rarely require any treatment, even if people have a *'bad trip"*.[46] When used in clinical or spiritual/guided practice, during the trip phase, the person should be overseen in a safe and secure environment. This minimises the risk of a *"bad trip"* and any negative consequences that might ensue from one. Experienced supervisors are able to talk attendees through troubling experiences and make them feel secure

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[44] Carhart-Harris, R., & Nutt, D. (2017). Serotonin and brain function: A tale of two receptors. *Journal of Psychopharmacology*, *31*(9), 1091–1120. https://doi.org/10.1177/0269881117725915.

[45]14. Hasler F, Grimberg U, Benz MA, Huber T, Vollenweider FX. 2004. Acute psychological and physiological effects of psilocybin in healthy humans: a double-blind, placebo-controlled dose-effect study. Psychopharmacology (Berl) 172(2):145-156. See also: Carhart-Harris RL, Bolstridge M, Rucker J, Day CM, Erritzoe D, Kaelen M, Bloomfield M, Rickard JA, Forbes B, Feilding A, Taylor D, Pilling S, Curran VH, Nutt DJ. 2016. Psilocybin with psychological support for treatment-resistant depression: an open-label feasibility study. Lancet Psychiatry 3(7):619-627.

[46] Passie, T., Seifert, J., Schneider, U. and Emrich, H.M., 2002. The pharmacology of psilocybin. *Addiction biology*, *7*(4), pp.357-364.

about where they are, what they are doing, and that effects are temporary.

81. Thus, outside of a clinical setting, the impact of a *"bad trip"* can be minimised by careful preparation beforehand, reassurance and other interventions (e.g. hand-holding, if agreed beforehand).

82. In the very rare case of a trip requiring early termination (i.e. not waiting for the trip to end) this can easily be achieved either by using a tranquillizer such as a benzodiazepine or a newer drug for psychosis such as risperidone or olanzapine. These are potent antagonists of the serotonin 5-HT2A receptor, through which psilocybin produces its effects. In instances where *'watchers'* or supervisors cannot administer prescription medications, a over-the-counter sedative antihistamine, or sleeping aid, should usually assist.

83. I also emphasise that subjects do retain a degree of control over the experience and, for example, can minimise some aspects voluntarily (e.g. opening the eyes and turning on the lights will reduce visual hallucinations).

84. Some users of serotoninergic psychedelics report visual perceptual disturbances that can last from weeks to (in extremely rare cases) years after use. This condition is now called hallucinogen persistent perception disorder (HPPD). There have been very few cases reported after use of psilocybin-containing mushrooms.[47]

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[47] Hyde, C., Glancy, G., Omerod, P., Hall, D. and Taylor, G.S., 1978. Abuse of indigenous psilocybin mushrooms: a new fashion and some psychiatric complications. *The British Journal of Psychiatry*, *132*(6), pp.602-604; Benjamin, C., 1979. Persistent psychiatric symptoms after eating psilocybin mushrooms. *British medical journal*, *1*(6174), p.1319; Schlag, A.K., Aday, J., Salam, I., Neill, J.C. and Nutt, D.J., 2022. Adverse effects of psychedelics: From anecdotes and misinformation to systematic science. *Journal of Psychopharmacology*, *36*(3), pp.258-272.

85. An examination of previous reports and estimates of psychedelic use in the United States suggests that HPPD is very rare.[48] Moreover, even people who had not used hallucinogens sometimes report similar perceptual disturbances. The two largest surveys on this phenomenon found that very few psychedelic drug users (3-4%) report perceptual changes that are distressing to them.[49]

86. There have been no cases of HPPD symptoms occurring in modern clinical studies with psilocybin.[50] In our last decade of clinical research with psilocybin, we have not had a case of HPPD in over 300 administrations of a psychedelic dose.

87. Population studies have shown that the use of psychedelic drugs including psilocybin is associated with less psychiatric illness than that found in a control group that had not used such drugs.[51] Similarly,

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[48] Halpern JH, Pope HG, Jr. 1999. Do hallucinogens cause residual neuropsychological toxicity? Drug Alcohol Depend 53(3):247-256; Johnston LD, O'Malley PM, Bachman JG, Schulenberg JE. 2004. Monitoring the Future national survey results on drug use, 1975-2003: Volume II, College students and adults ages 19-45. Bethesda, MD: National Institute on Drug Abuse.: (NIH Publication No. 04-5508); Schlag, A.K., Aday, J., Salam, I., Neill, J.C. and Nutt, D.J., 2022. Adverse effects of psychedelics: From anecdotes and misinformation to systematic science. *Journal of Psychopharmacology*, *36*(3), pp.258-272.

[49] Carhart-Harris RL, Nutt DJ. 2010. User perceptions of the benefits and harms of hallucinogenic drug use: A web-based questionnaire study. J Subst Use 15(4):283-300.

[50] Studerus E, Kometer M, Hasler F, Vollenweider FX. 2011. Acute, subacute and long-term subjective effects of psilocybin in healthy humans: a pooled analysis of experimental studies. J Psychopharmacol 25(11):1434-1452.

[51] Hendricks PS, Thorne CB, Clark CB, Coombs DW, Johnson MW. 2015. Classic psychedelic use is associated with reduced psychological distress and suicidality in the United States adult population. J Psychopharmacol 29(3):280-288. See also: Johansen PO, Krebs TS. 2015. Psychedelics not linked to mental health problems or suicidal behavior: a population study. J Psychopharmacol 29(3):270-279.

prisoners who used psychedelics after leaving prison were less likely to re-offend suggesting these drugs improve social cohesion.[52]

88. There is no population data suggesting that psilocybin can lead to enduring psychosis such as schizophrenia. For the purposes of the studies in which I have been involved, we have excluded people with risk factors for schizophrenia or other psychosis. That is so because there is some possibility that any psychedelic used at a dose that produces a trip might exacerbate ongoing psychosis or precipitate an episode in someone with genetic vulnerability.

89. Importantly, that potential would not rationally demand criminalising or restricting access to the entire population of people in a state. As demonstrated above, people may, for instance, have a severe allergic reaction to ordinary medication that is available off-the-shelf in a pharmacy (i.e. without a doctor being consulted and without any prescription). Similarly, people may have a deadly peanut allergy. But that does not mean it is rational or appropriate to criminalise any person (even those without any adverse effect) consuming peanuts. In fact, in relation to peanuts – some people may have such an acute allergy that being in the presence of peanuts may cause a severe allergic reaction including anaphylaxis. This has led to some school systems banning students from having peanuts in their lunches. But buying peanuts is not a criminal offence. Safety is achieved in various other ways that do not involve criminalisation. With all substances, it is primarily a question about individuals understanding their particular medical history or (if they do not know their history) then educating them(selves) about the potential risks associated with a particular activity or consuming a particular

[52] Hendricks PS, Clark CB, Johnson MW, Fontaine KR, Cropsey KL. 2014. Hallucinogen use predicts reduced recidivism among substance-involved offenders under community corrections supervision. J Psychopharmacol 28(1):62-66.

substance and then deciding for themselves whether they wish to undertake that activity. I am told by the applicants' legal team that this underlies the legal maxim of *volenti non fit injuria*.

90. Again, with peanuts and tree nuts, because producing, selling and consuming them are not criminal activities there are health advantages in regulating the conditions under which all of that is done. In the same way, the possible risks to a small number of people could be dealt with by individuals or entities supplying psilocybin or mushrooms to consumers being trained in, and obliged to discuss and mitigate, those risks.

91. As with all drugs – including alcohol, nicotine and caffeine – psilocybin overdose can theoretically occur. However, in the case of psilocybin there are few, if any, proven deaths from such. Even when several hundred mushrooms are taken, few physical sequelae are noted, though a profound and long-lasting "trip" might ensue.

92. Unquestionably the biggest danger with amateur psilocybin mushroom use is taking the wrong species of mushrooms that contain toxic substances, or acquiring mushrooms from an unreliable source where the mushrooms are laced or combined with other harder drugs. That, however, does not speak to the risk of psilocybin containing mushrooms themselves. Rather, it speaks to an individual wishing to use psilocybin privately having proper access to a safe and reputable supply of psilocybin. This demonstrates that criminalisation – from a clinical and expert perspective – would aggravate any risks of private individuals using psilocybin – since they may be unable to source genuine psilocybin mushrooms. Moreover, provision by people with expertise of wild-picked plants or specific cultivation for therapeutic use minimises these risks to negligible.

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93. Guidelines for use have been developed,[53] which include:

93.1. mindful selection of volunteers;

93.2. correct interactions with study personnel;

93.3. ensuring a good physical environment;

93.4. preparing volunteers adequately;

93.5. considering the presence of a physician;

93.6. ensuring correct procedure during the experience; and

93.7. post-session procedures.

94. Overall, the data are clear that psilocybin is very likely the least harmful of all commonly used "illegal" drugs. And, certainly, the most up-to-date analyses conducted in 30 European countries and in Australia have shown it to be very significantly less harmful than alcohol, tobacco and cannabis[54] – none of which are now criminalised in South Africa.

95. As I have worked in this field for over 30 years, I am familiar with various common objections and claims that are raised in relation to the safety and utility of psilocybin.

96. I understand that section 22A(9)(a)(i) of the SA Medicines Act states that: *"No person shall - acquire, use, possess, manufacture, or supply any*

[53] Johnson M, Richards W, Griffiths R. 2008. Human hallucinogen research: guidelines for safety. J Psychopharmacol 22(6):603-620.

[54] Van Amsterdam J, Opperhuizen A, van den Brink W. 2011. Harm potential of magic mushroom use: a review. Regul Toxicol Pharmacol 59(3):423-429.

Schedule 7 or Schedule 8 substance, or manufacture any specified Schedule 5 or Schedule 6 substance unless he or she has been issued with a permit by the Director General for such acquisition, use, possession, manufacture, or supply: Provided that the Director-General may, subject to such conditions as he or she may determine, acquire or authorise the use of any Schedule 7 or Schedule 8 substance in order to provide a medical practitioner, analyst, researcher or veterinarian therewith on the prescribed conditions for the treatment or prevention of a medical condition in a particular patient, or for the purposes of education, analysis or research". This suggests that the experts making this legislation understood the potential medical value of the drugs that they had made *"illegal"*.

97. In relation to potential adverse effects of psilocybin use, I make three points. First, such effects are rare. Secondly, the same or similar risks are also listed side effects of many prescribed medications. For example, SSRI antidepressants, anaesthetics, as well as pain killers such as tramadol and ketamine. As detailed above, these effects of psilocybin are almost always self-limiting and can readily be managed by support and, in extreme cases, other medicines.

98. Psilocybin has a short half-life of 3 hours (standard deviation of 1.1). A common misconception is that this may lead to an increase in repeated use (i.e. the notion that once the person is no longer under the effects of the substance, they will then seek out more – what is sometimes referred to in common parlance as *"chasing the next high"*). That is not the case with psilocybin. In the first place, the half-life of a drug is an entirely separate metric from whether the substance is dependence-producing. In other words, it is not the case that short half-life substances – used occasionally – lead to greater dependence than longer half-life substances: indeed the opposite is sometime seen. In the second place,

and more importantly, psilocybin (like other serotoninergic psychedelics) does not lead to repeated using.

99. Individuals may develop some form of tolerance to the effects of psilocybin, but this does not lead to an increase in use. Rather, it decreases use.

CONCLUSION

100. For the reasons set out above, based on the consistent evidence from clinical studies, my considered expert view is that:

100.1. Psilocybin has various potential benefits for those who take it. This includes treating depression and anxiety as well as helping individuals deal with forms of trauma including addictions.

100.2. Psilocybin is one of the least harmful drugs. It is not addictive (and in fact helps to tackle addiction to other substances).

100.3. The rare and minor risks associated with psilocybin can be addressed by:

100.3.1. ensuring that first-time users are supervised by people with experience of psilocybin and its effects; and

100.3.2. similarly, by psilocybin mushrooms being sourced from reliable suppliers – to ensure that psilocybin mushrooms (rather than poisonous mushrooms, or mushrooms laced with another substance) are used.

100.4. Thus, the few, minor and rare risks of psilocybin use are aggravated by its criminalisation (not mitigated).

DEPONENT

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA

REGISTRAR OF THE HIGH COURT OF SOUTH AFRICA
GAUTENG DIVISION,
PRETORIA

I certify that the deponent has acknowledged that the deponent knows and understands the contents of this affidavit which was signed and sworn to before me at 12:45 at 12 York Gardens, Clayton, Midrand on this 11 day of **APRIL 2024**, the regulations contained in Government Gazette Notice No. R1258 of 21 July 1972, as amended, and Government Notice No. R1648 of 19 August 1977, as amended, having been complied with.

COMMISSIONER OF OATHS
Notary Public

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E1 Nutt CURRICULUM VITAE

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Overview

David is currently the Edmund J Safra Professor of Neuropsychopharmacology and Head of the Centre for Psychedelic Research in the Division of Psychiatry, Dept of Medicine, Imperial College London.

After 11+ entry to Bristol Grammar he won an Open Scholarship to Downing College Cambridge, then completed his clinical training at Guy's Hospital London. After a period in neurology to MRCP he moved to Oxford to a research position in psychiatry at the MRC Clinical Pharmacology Unit where he obtained his DM. On completing his psychiatric training in Oxford, he continued there as a lecturer and then later as a Wellcome Senior Fellow in psychiatry. He then spent two years as Chief of the Section of Clinical Science in the National Institute of Alcohol Abuse and Alcoholism in NIH, Bethesda, USA. He returned to England in 1988 to set up the Psychopharmacology Unit in Bristol University, an interdisciplinary research grouping spanning the departments of Psychiatry and Pharmacology before moving to Imperial College London in December 2008 where he leads a similar group with a particular focus on brain imaging especially PET and fMRI in the study of psychedelic medicines. In 2018 he co-founded the first academic psychedelic research centre in the world.

He is founder and scientific chair of the charity DrugScience. He has been President of major national and international organisations: the British Neuroscience Association, the British Association for Psychopharmacology, the European Brain Council and the European College of Neuropsychopharmacology. In recognition of his research success he has been made a Fellow of the Royal Colleges of Physicians, of Psychiatrists, of the Academy of Medical Sciences and the British Pharmacological Society. He edited the Journal of Psychopharmacology for over twenty-five years and now edits the journal Drugscience policy and law. For 2o years he was a psychiatry drugs advisor to the British National Formulary. He has published over 500 original research papers, a similar number of reviews and books chapters, eight government reports on drugs, nearly 40 books including five for the general public, and one, Drugs without the hot air, won the Transmission book prize in 2014.

He has held significant government positions as member and Chair of the Advisory Committee on the Misuse of Drugs (ACMD – 1998-2009, member of the HEFCE/NHS Senior Lecturer Selection Panel and

member of the MRC Neuroscience Board. Other previous national contributions include serving as the medical expert on the Independent Inquiry into the Misuse of Drugs Act (2000 Runciman report), and membership of the Committee on Safety of Medicines, the Committee on NHS drugs and the Ministry of Defence Science Advisory Board. He was the clinical scientific lead on the 2004/5 UK Government Foresight initiative "Brain science, addiction and drugs" that provided a 25-year vision for this area of science and public policy.

He broadcasts widely to the general public both on radio and television. Highlights include being a subject for The Life Scientific on BBC radio 4, several BBC Horizon programs and the Channel 4 documentaries Ecstasy-live and Cannabis live and the BBC documentary "The psychedelic drug trial". His research has been featured as a play "All you need is LSD". Additionally is much in demand for public affairs programs on therapeutic as well as illicit drugs, their harms and their classification. His also lecturers widely to the public as well as to the scientific and medical communities at the Cheltenham the How The Light Gets In science festivals and at Glastonbury and other music festivals. In 2010 The Times Eureka science magazine voted him one of the 100 most important figures in British Science, and the only psychiatrist in the list and in 2013 he was awarded the John Maddox Prize from Nature/Sense about Science for standing up for science in the face of hostility and intimidation.

Career Overview

SCHOOL: Bristol Grammar School

UNIVERSITY:
1969 - 1972 Downing College, Cambridge - Open Scholarship
1972 - 1975 Guy's Hospital, London

QUALIFICATIONS:

1972	BA (Cantab)
1975	MB BChir (Cantab)
1977	MRCP (London)
1981	MA, MB, BChir (Oxon) (by Incorporation).
1982	DM (Oxon)
1983	MRCPsych (UK)
1994	FRCPsych (UK)
2002	FMedSci
2002	FRCP
2016	Doctor of Laws honoris causa (Bath university)
2022	FBPhS (hon) Fellow of the British Pharmacological Society

GENERAL MEDICAL COUNCIL REGISTRATION 2251774

Academic POSITIONS HELD

1978-1982	Clinical Scientist in the MRC Unit of Clinical Pharmacology, Radcliffe Infirmary, Oxford (Professor D G Grahame-Smith).
1982-1983	Registrar in Psychiatry on the Oxford Rotational Training Scheme.
1983-1985	Lecturer in Psychiatry, University of Oxford, attached to the Psychopharmacology Research Unit, Littlemore Hospital, Oxford.
1985-1986	Wellcome Senior Fellow in Clinical Science; University Department of Psychiatry, Warneford Hospital, Oxford. Honorary Consultant Psychiatrist.
1986-1988	Fogarty Visiting Scientist NIH and Chief of the Section of Clinical Science, National Institute on Alcohol Abuse and Alcoholism, Bethesda, Maryland.

1988-date	Director, Psychopharmacology Unit, University of Bristol; Senior Research Fellow in Pharmacology and in Mental Health; Honorary Consultant Psychiatrist, United Bristol Healthcare Trust.
1994	Professor of Psychopharmacology, University of Bristol
1996-1997	Head, Division of Psychiatry, University of Bristol
1997-2003	Head of Department of Clinical Medicine
2000-2003	Dean of Clinical Medicine and Dentistry
2003- 2008	Head of the Department of Community Based Medicine
2008- 2016	Edmond J Safra Chair of Neuropsychopharmacology Imperial College London

COLLEGE APPOINTMENT

1983-1988 Research Fellow in Medical Sciences, Corpus Christi College, Oxford

LEARNED SOCIETIES by examination or election

Royal College of Physicians
Royal College of Psychiatrists
British Association for Psychopharmacology – Past President - 2000-2002 (BAP)
European College of Neuro-Psychopharmacology (ECNP) – President 2007-2010
Collegium Internationale Neuro-Psychopharmacologicum (CINP)
British Pharmacological Society (BPS)

Editor: Journal of Psychopharmacology since 1989
Drug Science, Policy and Law since 2013

UNIVERSITY AWARDS

Visiting Professor University of Maastricht	2004-date
Visiting Professor Imperial College University of London	2006 -2011
Visiting Professor University of Otago, New Zealand	2004-2008
Raine visiting professor, University of Western Australia	2006
Visiting Professor The Open University	2014

ROYAL COLLEGE OF PSYCHIATRY

Basic Sciences Exam Committee (Part II)	1990-date
Psychopharmacology Sub-Committee	1994-1997
Steering group of Biological Psychiatry Special Interest Group	1996- 2000

MRC

Subcommittee for site visit - Institute of Psychiatry	1991
Neuroscience Approach to Mental Health steering group	1992-1993
Addiction Field Review working party	1992-94
Neuroscience Project Grant Committee	1993-1997
Alcohol Treatment Research Working Group	1994
Suicide and Parasuicide Review Panel	1994
Neuroscience Advisory Board	1998-2005
Neuroscience and Mental Health Board	2006 -2009
Lead (with Robbins Cambridge) MRC ICCAM research cluster in Addiction	2009-2012
Addiction Initiative Stakeholder group	2009-2012

ESRC

UK Psychology Benchmarking Review Steering Group Member	2010

REF – Neuroscience Psychiatry and Psychology panel member 2013-2014

President British Neuroscience Association 2011-2013

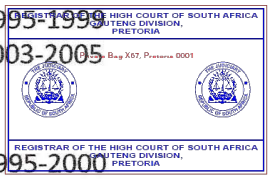
GOVERNMENT RESPONSIBILITIES

Home office

Advisory Council on the Misuse of Drugs	1996-2008
Chair: Advisory Council on the Misuse of Drugs	2008 -2009
Chair of Technical Committee, ACMD	2000-2008
Cross departmental research group	2008
Home Office Scientific Advisory Committee	2008

Science and technology/ DTI/OSI

Parliamentary Office of Science and Technology 'Soft' Drugs Steering Committee	1995-1999
Scientific Lead DTI Foresight Program "Brain Science Addiction and Drugs"	2003-2005



Dept of health

Advisory Committee on NHS Drugs	1995-2000
British National Formulary (BNF) Adviser	2000-date
Committee on Safety of Medicines	2000-2005
NICE reviewer for depression, panic and social anxiety disorders and the Z-drug hypnotics	1999-date

Ministry of Defence

Consultant	1990 - 2004
Member Defence Sciences Advisory Council - DSAC	2005- 2007

Parliamentary evidence

To House of Lords committee on cannabis	2000
Home Affairs committee on drugs	2004
Evidence to All part drugs interest group	2005
Evidence to the Select Committee on Science and Technology;	
Scientific Advice, Risk and Evidence:	2006
Cocaine and related drugs	2009
Home affairs Select Committee review of the drug laws	2012

MISCELLANEOUS:

Police Foundation	1997-2000
UBHT - Medicines Advisory committee	1993-2000
UBHT - Medical Research committee	1993-1997
District psychiatric training committee	1993-2000
External Examiner, University of Birmingham	1994-1997
British Pharmacological Society, Clinical Pharmacology Section Expert	1996-date
British Association of Psychopharmacology - President	2000-2001
Trustee of the Sir Robert Mond Memorial Trust	1998-2004
BBSRC Functional Imaging Course Board Member	1999-2001

INTERNATIONAL POSITIONS

Faculty Member, European Certificate in Anxiety Disorder	1993-1995
Director of the European Certificate of Affective disorders course	1995-date

CINP International Scientific Program Committee member	1996-1998
ECNP Council Member	1998-2017
ECNP President	2007 - 2010
World Psychiatric Association, Co-Chair Section on Biological Psychiatry	1999-2001
Member of the EC Working Party on PET and SPECT ligands	1992
Council member European Brain Council	2007 –2011
Vice President European Brain Council	2011-2013
President - European Brain Council	2013 - 2017
Adviser Grand Challenges in Mental Health	2010
Advisor to Swedish government review on drug alcohol and tobacco research	2011-2012
EU scientific committee for Month of the Brain 2013	2012-2013

Charitable work

Founder and current Chair DrugScience.org.uk (formerly ISCD)	2010 - on
Founder/Chair London Joint Working Group on Drug Abuse and Hepatitis C	2009 - 2014

Refereeing for grants and fellowships: MRC, BBSRC, ESRC, Wellcome Trust, The Netherlands MRC, NIHR, INSERM, German-Israel research fund, NIH

Official reports and books

Drugs and the Law: Report of the Independent Inquiry into the Misuse of Drugs Act 1971. Members of Inquiry: Viscountess Runciman (Chairman), A Chesney, R Fortson, J Hamilton PQPM, S Jenkins, A Maynard, L G Murray, DJ Nutt, D O'Connor QPM, G Pearson, I Wardle, B Williams, A Zera. Report published in 2000.

Advisory Council on the Misuse of Drugs (2002) The Classification of Cannabis under the Misuse of Drugs Act 1971. London: Home Office.

Nutt DJ and Nash J 2002 Cannabis- an update. Home Office publications http://www.drugs.gov.uk/ReportsandPublications/Communities/1034165905/Cannabis_update_1999to2002.pdf

Nutt DJ and Williams T 2004 Ketamine – an update http://www.drugs.gov.uk/ReportsandPublications

Williams T and Nutt DJ 2005 – Khat (qat): assessment of risk to the individual and communities in the UK – Home Office on-line publication http://drugs.homeoffice.gov.uk

Rawlins M et al 2005 Further considerations of the classification of cannabis under the Misuse of Drugs Act 1971

Rawlins M et al 2008 Cannabis; classification and public health. Home Office on line publication http://drugs.homeoffice.gov.uk/publication-search/acmd/acmd-cannabis-report-2008

Nutt DJ et al (2009) MDMA (ecstasy): A review of its harms and classification under Misuse of Drugs Act 1971 http://drugs.homeoffice.gov.uk/publication-search/acmd/acmd-MDMA-report-2009

EMCDDA monograph 2009. Addiction neurobiology: ethical and social implications http://www.emcdda.europa.eu/publications/monographs/neurobiology ISBN 978–92–9168–347–5 doi: 10.2810/48676

ISCD publication 2011. A minimum data set for the control of new drugs http://drugscience.org.uk/minimumdataset.html

WHO pre-review on cannabis 2016 http://www.drugscience.org.uk/legislation/whocannabis

EMCDDA monograph 2009. Addiction neurobiology: ethical and social implications http://www.emcdda.europa.eu/publications/monographs/neurobiology ISBN 978–92–9168–347–5 doi: 10.2810/48676

ISCD publication 2011. A minimum data set for the control of new drugs http://drugscience.org.uk/external-resources/novel-drugs-concern-minimum-dataset/

Drugscience Cannabis report for 38th Expert Committee meetig 2016 p://www.drugscience.org.uk/assets/WHOcannabisreport.pdf

Rolles S et al (2017) A framework for a regulated market for cannabis in the UK: Recommendations from an expert panel https://d3n8a8pro7vhmx.cloudfront.net/libdems/pages/10794/attachments/original/1457398164/A_framework_for_a_regulated_market_for_cannabis_in_the_UK.pdf?1457398164

Publications
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38 books
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IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: 2024-040119

In the matter between:

MONICA CROMHOUT	First Applicant
MELINDA FERGUSON	Second Applicant

and

MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
MINISTER OF POLICE	Fourth Respondent
MINISTER OF SOCIAL DEVELOPMENT	Fifth Respondent

APPLICANTS' RULE 41A NOTICE

KINDLY TAKE NOTICE THAT – given that this matter prays for orders of constitutional invalidity – the applicants do not consider that this matter is one capable of being mediated.

KINDLY TAKE NOTICE FURTHER THAT (any opposing) respondents are hereby invited to record their agreement or disagreement with the above.

1

DATED at Cape Town on this 12th day of April **2024**.

CULLINAN & ASSOCIATES

Applicants' Attorneys

PER: **PAUL-MICHAEL KEICHEL**

PER: **RICKY STONE**

18A Ascot Road

Cape Town

7708

Tel: 021 671 7002

Email: **Paul-Michael@greencounsel.co.za**;

Ricky@greencounsel.co.za

Ref: C079-001

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834 Pretorius St

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jk@macintoshcross.co.za

vm@macintoshcross.co.za

Ref: J Keus/X57/2024

2

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**
PRETORIA

AND TO: **THE MINISTER OF JUSTICE AND**
CONSTITUTIONAL DEVELOPMENT
First Respondent
Salu Building
316 cnr Thabo Sehume and Francis Baard Streets
Private Bag X81,
Pretoria
0001
BY SHERIFF

AND TO: **THE NATIONAL DIRECTOR OF PUBLIC**
PROSECUTIONS
Second Respondent
VGM Building
123 Westlake Ave
Weavind Park
Silverton
Pretoria
0184
BY SHERIFF

AND TO: **THE MINISTER OF HEALTH**
Third Respondent
Dr AB Xuma Building
1112 Voortrekker Rd

Pretoria Townlands 351-JR

Pretoria

0187

BY SHERIFF

AND TO: **THE MINISTER OF POLICE**

Fourth Respondent

231 Pretorius Street

756-7th floor Wachthuis Building

Pretoria

0002

BY SHERIFF

AND TO: **MINISTER OF SOCIAL DEVELOPMENT**

Fifth Respondent

134 Pretorius Street

Pretoria Central

Pretoria

0002

BY SHERIFF

AND TO: **THE STATE ATTORNEY**

316 Thabo Sehume St

Pretoria Central

Pretoria

0001

Phone**: 012 309 1500**

BY SHERIFF

IN THE HIGH COURT OF SOUTH AFRICA

GAUTENG DIVISION, PRETORIA

CASE NO: 2024-040119

In the matter between:

MONICA CROMHOUT	First Applicant
MELINDA FERGUSON	Second Applicant

and

MINISTER OF JUSTICE AND CONSTITUTIONAL DEVELOPMENT	First Respondent
NATIONAL DIRECTOR OF PUBLIC PROSECUTIONS	Second Respondent
MINISTER OF HEALTH	Third Respondent
MINISTER OF POLICE	Fourth Respondent
MINISTER OF SOCIAL DEVELOPMENT	Fifth Respondent

APPLICANTS' RULE 16A NOTICE

KINDLY TAKE NOTICE THAT the applicants in the above matter raise constitutional issues, as set out below.

1. The applicants challenge the constitutionality of various aspects of the Medicines and Related Substances Act 101 of 1965 ("**the Medicines Act**") and the Drugs and Drugs Trafficking Act 140 of 1992 ("**the Drugs Act**") to the extent that the provisions:

   1.1. list psilocybin and psilocin in Part III of Schedule 2 of the Drugs Act and Schedule 7 of the Medicines Act;

   1.2. criminalise the manufacturing, supply, use, possession, cultivation and dealing in, of psilocybin and psilocin.

2. The applicants seek an order in the following terms:

   "1. It is declared that the references to 'psilocybin' and 'psilocin' in Part III of Schedule 2 of the Drugs and Drugs Trafficking Act 140 of 1992 ("**the Drugs Act**") are unconstitutional and invalid.

   2. The words 'psilocybin' and 'psilocin' are struck out from Part III of Schedule 2 of the Drugs Act.

   3. It is declared that the references to 'psilocybin' and 'psilocin' in Schedule 7 of the Medicines and Related Substances Act 101 of 1965 ("**the Medicines Act**") are declared unconstitutional and invalid.

   4. The words 'psilocybin' and 'psilocin' are struck out from Schedule 7 of the Medicines Act.

   5. <u>In the alternative to paragraphs 1 to 4 above</u>:

      5.1 Sections 3, 4(b), and 5(b) of the Drugs Act are declared unconstitutional and invalid to the extent that these provisions

criminalise the private use and possession of psilocybin and psilocin by adults, including private supervised use.

5.2 Sections 3, 4(b), and 5(b) of the Drugs Act are declared unconstitutional and invalid to the extent that these provisions criminalise: manufacturing; cultivating; collecting; possessing; selling; administering; 'dealing in' (as defined in section 1 of the Drugs Act); and/or supplying, psilocybin and psilocin – for the purposes described in paragraph 5.1 above.

5.3 Sections 22A(9)(a)(i), 22A(9)(a)(ii) and 22A(10) of the Medicines Act are declared unconstitutional and invalid to the extent that these provisions criminalise the private use and possession of psilocybin and psilocin by adults, including private supervised use.

5.4 Sections 22A(9)(a)(i), 22A(9)(a)(ii) and 22A(10) of the Medicines Act are declared unconstitutional and invalid to the extent that these provisions criminalise: acquiring, possessing, manufacturing, supplying, selling, and/or administering psilocybin and psilocin – for the purposes set out in paragraphs 5.3 above.

6. In the alternative to paragraphs 5 to 5.4 above, the above-mentioned provisions of both the Drugs and Drugs Trafficking Act 140 of 1992 and the Medicines and Related Substances Act 101 of 1965 must be read so as not to prohibit or criminalise the activities set out in paragraphs 5 to 5.4 above.

7. The declarations of constitutional invalidity (in respect of paragraphs 1 to 5.4 above, as the case may be) are suspended for a period of 24 months to allow for the constitutional defects to be remedied by Parliament and/or the relevant respondents, as the case may be.

8. From the date of this judgment, and until Parliament and/or the relevant respondents (as the case may be) remedy the aforesaid constitutional defects, a moratorium is placed on all criminal investigations, arrests, prosecutions, and/or ancillary criminal proceedings in respect of the activities set out in paragraphs 5 to 5.4 above.

9. The costs of this application are to be paid by any respondents who oppose the application, jointly and severally, including the costs of two counsel.

10. Further or alternative relief, including in accordance with sections 172 and 173 of the Constitution."

3. The applicants submit that the impugned provisions of the Drugs Act and Medicines Act limit various constitutional rights, including: the rights to privacy (section 14), the right to dignity and autonomy (section 10), the right to bodily and psychological integrity (section 12(2)), the right to freedom of conscience, religion, belief and opinion (section 15), the right to equality (section 9), the right to access to health care services (section 27)and that the limitations are not justified by section 36 of the Constitution.

4. In support of their application, the applicants deliver an expert affidavit by Professor David Nutt, a Professor of Neuropsychopharmacology at Imperial College, London, and an honorary consultant psychiatrist. He is the Director of the Imperial College Centre for Psychedelic Research and one of the leading experts in the field

worldwide. Professor Nutt's expert affidavit draws on his own research, and a literature review of the key research of other leading experts.

5. The expert affidavit demonstrates, inter alia, that psilocybin:

5.1. does not produce withdrawal symptoms;

5.2. does not increase the risk of addiction, even in people with a history of substance abuse;

5.3. is not associated with any negative long-term changes in personality or cognitive function; and

5.4. is not a substance with any high or even meaningful risk of lethal overdose.

6. Quite the opposite, the expert affidavit highlights evidence that the use of psilocybin has various beneficial effects and that it is effective in treating addiction, post-traumatic stress disorder, and depression (even treatment-resistant depression). Notably, psilocybin is arguably more effective, both in the short and long terms, than medications such as SSRI anti-depressants and produces less adverse side effects for the user.

7. In any event, the applicants respectfully submit that – even assuming for the purposes of argument that some minor harms existed (though this is incorrect and denied) – that would still not justify criminalisation under our Constitutional regime. Part of an adult person's rights to autonomy and dignity, privacy, freedom of expression, and freedom of association, means that they are free and able to choose to participate in a range of different activities, even where these activities may have significant risks of harm (*volenti non fit injuria*).

8. It is not the case of the applicants that there could or should be no *regulation* of psilocybin whatsoever. The applicants' case is different. It is that the law bluntly criminalises psilocybin and therefore does not deal with other important (more nuanced) questions about regulating it.

9. Regulation is an inherently less restrictive (and it transpires, more effective) means than criminalisation at reducing harms. And I am advised that the Constitutional Court has made clear in numerous cases that the State cannot "*use a sledgehammer to crack a nut*" (or Nutt). Former-Justice of the Constitutional Court, Justice Edwin Cameron, writing in an academic capacity, has explained that the origin of criminalisation was a relic of the apartheid government. He states:

> *"Behind the misplaced use of criminal law lies a deep-rooted belief that criminal punishments should be inflicted on those considered deviant. The apartheid state was premised on this notion. South Africa has a history of using criminal law broadly and brutally, not only in minutely enforcing apartheid's misery but in persecuting sex workers and in hounding sexually and gender-diverse people."*

KINDLY TAKE NOTICE FURTHER THAT any party interested in the aforementioned constitutional issues may, within the time periods set out in Rule 16A, request the consent of all of the above parties to be admitted as *amicus curiae*, upon such terms and conditions as may be agreed upon between the parties.

KINDLY TAKE NOTICE FURTHER THAT, in the event of a refusal or failure of the above parties to agree as aforesaid, any party interested in the aforementioned constitutional issues may make application to the above Honourable Court to be admitted as *amicus curiae*, upon such terms and conditions as may be imposed by said Court.

TO THE REGISTRAR: KINDLY place this Notice on a board designated for the purpose recorded in Rule 16A(1)(c) and place your date stamp upon the Notice to indicate the date upon which it is placed on the board, in accordance with Rule 16A(1)(d).

DATED at Cape Town on this 12th day of April **2024**.

CULLINAN & ASSOCIATES

Applicants' Attorneys

PER: **PAUL-MICHAEL KEICHEL**

PER: **RICKY STONE**

18A Ascot Road

Cape Town

7708

Tel: 021 671 7002

Email: **Paul-Michael@greencounsel.co.za**;

Ricky@greencounsel.co.za

Ref: C079-001

With thanks to **SEBASTIAN FOSTER**

C/O: **MACINTOSH CROSS & FARQUHARSON**

834 Pretorius St

Arcadia

Pretoria

0007

Tel: **012 342 4855**

jk@macintoshcross.co.za

vm@macintoshcross.co.za

7

Ref: J Keus/X57/2024

TO: **THE REGISTRAR OF THE ABOVE HONOURABLE COURT**

PRETORIA

AND TO: **THE MINISTER OF JUSTICE AND**

CONSTITUTIONAL DEVELOPMENT

First Respondent

Salu Building

316 cnr Thabo Sehume and Francis Baard Streets

Private Bag X81,

Pretoria

0001

BY SHERIFF

AND TO: **THE NATIONAL DIRECTOR OF PUBLIC**

PROSECUTIONS

Second Respondent

VGM Building

123 Westlake Ave

Weavind Park

Silverton

Pretoria

0184

BY SHERIFF

AND TO: **THE MINISTER OF HEALTH**

8

Third Respondent

Dr AB Xuma Building

1112 Voortrekker Rd

Pretoria Townlands 351-JR

Pretoria

0187

BY SHERIFF

AND TO: **THE MINISTER OF POLICE**

Fourth Respondent

231 Pretorius Street

756-7th floor Wachthuis Building

Pretoria

0002

BY SHERIFF

AND TO: **MINISTER OF SOCIAL DEVELOPMENT**

Fifth Respondent

134 Pretorius Street

Pretoria Central

Pretoria

0002

BY SHERIFF

AND TO: **THE STATE ATTORNEY**

316 Thabo Sehume St

Pretoria Central

Pretoria

0001

Phone: **012 309 1500**

BY SHERIFF