Pete Lindsay

Personal details redacted for privacy

16 June 2025

The Rt Hon Yvette Cooper MP
Home Secretary

Dear Home Secretary

Open Letter: Ensuring Lawful and Equitable Access to Clinically Appropriate Cannabis-Based Products for Medicinal Use (CBPMs)

I am writing to bring to your urgent attention the significant challenges faced by disabled patients, including myself, in accessing and managing prescribed cannabis-based products for medicinal use (CBPMs). As someone living with a disabling neurological condition, I experience acute symptoms daily and rely on CBPMs to manage my condition with a degree of daily normality. Without appropriate and timely access to such medication I would be largely wheelchair-bound, unable to walk or speak.

Unlike many with this condition, I am fortunate not to suffer seizures or extreme, constant pain. However, the complexity and variability of my symptoms require clinically appropriate and reliable methods of consumption to achieve effective symptom relief. For example, this may include rapid-onset forms of administration such as vaporisation or combustion (smoking) — where other oral methods are insufficiently responsive and time-critical relief is needed. Current policy effectively restricts lawful, practical access to these treatments, undermining both the purpose of the underlying legislation and the rights of disabled people to health and equality **(See Annex A)**.

One critical issue concerns the legal constraints on the administration of CBPMs. While multiple forms of CBPMs are prescribed, existing regulations limit how these medicines can be used practically by patients. Some clinically effective methods are not legally recognised for patient self-administration, complicating efforts to manage symptoms safely and effectively.

This situation undermines both the rule of law and the principle of equitable healthcare. It also exposes vulnerable patients, including those with chronic pain, neurological conditions or treatment-resistant conditions, to significant financial, legal and health risks. The current framework creates a structurally discriminatory and legally precarious two-tier system that fails to meet the UK's obligations under domestic and international law, including rights to health, private life, and non-discrimination.

Moreover, inconsistencies between the Misuse of Drugs Regulations and the Equality Act 2010 create a precarious legal environment for patients, often resulting in confusion and risk in daily medication management, healthcare interactions, and contact with law enforcement.

I also want to highlight ongoing concerns around awareness and education within the medical, policing, and disability assessment communities regarding medical cannabis use. These gaps exacerbate challenges faced by patients and may contribute to unjustified legal and social risks.

I would therefore respectfully urge your department to consider supporting the actions suggested in outline at **Annex B**, incl but not limited to:

- Address inconsistencies that place patients at legal and practical risk

and

- Ensure that disability rights legislation is fully integrated and respected within wider policy frameworks – particularly;

- Prioritise education initiatives across the NHS, policing bodies and disability assessment communities to improve understanding and support for medical cannabis patients.
- Review and update clinical guidance to reflect current evidence and patient needs, including methods of administration.
- Consider mechanisms to enable practical, safe access to clinically appropriate CBPM administration methods.

Although I'm now medically retired due to my disability, my background includes a reasonably successful career across various Government Departments. This has given me broad insight across government processes and reinforces my confidence in the importance of evidence-based, clear policy, and effective interdepartmental collaboration to address the challenges outlined.

Given that the Spending Review has now provided clarity across government on both budgets and policy priorities, the forthcoming summer recess and

subsequent conference season represent significant opportunities for cross-governmental decision-making and subsequent ministerial approval.

I also recognise that whilst providing opportunities, these timing factors may also impact Department's ability to prioritise or resource policy changes immediately. Therefore, I hope this letter and its accompanying annexes will serve as a foundation for action. I would welcome a response from your department within the usual correspondence obligations set by the Cabinet Office. I am also keen for any opportunity to contribute further to discussions on policy improvement and implementation. Following recess and the party conference season, I hope there may be further opportunities to advance these vital issues within government priorities.

Thank you for your time and consideration. I look forward to your response and the possibility of engaging further on this critical issue.

This letter has been issued concurrently to relevant ministers, departments, regulators, and public bodies in recognition of its cross-government implications. **See Annex C** for initial distribution list.

Yours sincerely

Pete Lindsay

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Annex A: Key Context, Legal Framework, and Policy Considerations on Medical Cannabis Access and Use

1. Inconsistencies Between Drug Legislation and Disability Rights

The Equality Act 2010 places a legal obligation on public bodies to make reasonable adjustments for disabled people and prohibits discrimination. As primary legislation, it has precedence over secondary legislation such as drug regulations.

However, the Misuse of Drugs Regulations and Home Office policy create a conflicting environment where patients lawfully prescribed CBPMs risk legal jeopardy for using their medicine in ways necessary to manage their disability effectively.

This legal tension is not currently addressed in either drug policy or wider Government policy, leaving patients vulnerable to enforcement actions despite being protected under disability law.

2. Driving, Policing, Education, and Enforcement

The DVLA issues medical licenses to patients who are prescribed CBPMs.

However, police forces often lack clear guidance and training on handling patients prescribed medical cannabis, resulting in inconsistent enforcement and unnecessary legal risks for patients.

There is inconsistency in assessments of fitness to drive, especially where symptoms of the underlying condition (e.g., limb weakness, stability issues) may impact impairment tests independently of medication use.

Many prescribed patients with neurological conditions (such as Functional Neurological Disorder) or musculoskeletal conditions may exhibit physical symptoms (limb weakness, balance problems) that affect their performance in standard impairment tests — regardless of whether they are impaired by medication. The legal impairment tests (e.g., walking heel-to-toe, standing on one leg) do not therefore always adequately distinguish between disability symptoms and true impairment due to CBPM use, creating significant risks in both legal and driving contexts

This means that there is currently inadequate clinical or legal differentiation between these disability symptoms and true impairment due to CBPM use.

Education initiatives for law enforcement, medical professionals and disability assessment communities are urgently needed to ensure policies are implemented with awareness of disability rights and medical necessity.

3. Medical Cannabis Prescription and Administration Challenges

The UK's legal framework permits prescription of cannabis-based products for medicinal use (CBPMs) under very limited conditions and by specialist doctors only. However, regulations such as the Misuse of Drugs Regulations 2001 (especially Regulation 16A) restrict how prescribed patients can administer these medicines themselves.

This creates a disconnect between what is medically appropriate and what is legally permitted for self-administration, especially regarding the consumption method, which can be critical to symptom relief.

Although studies show that vaporisation offers a cleaner delivery of cannabinoids than combustion, some patients report that smoking provides faster and more sustained relief. These differences in subjective efficacy may warrant further investigation into comparative pharmacokinetics and real-world outcomes across administration method.

These patient-reported outcomes suggest that, for certain disabling or acute-onset conditions, **combustion may remain the most clinically effective method** in practice — even if not the most medically desirable. Further research is needed to clarify differences in efficacy and duration between methods.

4. Clinical Guidance and NHS Prescribing Constraints

NICE Guideline NG144 (Medicinal Cannabis) sets out evidence-based recommendations but currently reflects a cautious stance, partly due to limited high-quality evidence.

NHS prescribing of CBPMs remains highly restricted compared to private clinics, resulting in access inequalities. The regulatory framework for private prescribing is established but lacks integration with NHS commissioning, causing patient confusion and inconsistent care.

Updates to clinical guidance and NHS prescribing frameworks to explicitly consider patient-centred administration methods and practicalities are essential.

5. International Travel Considerations

Patients travelling abroad with legally prescribed CBPMs face a complex landscape. While UK law allows travel with prescriptions, this is conditional on

the destination country’s laws, which vary widely. Clearer guidance is needed to support patient mobility.

6. International Comparisons and Structural Policy Issues

The UK’s approach to medical cannabis remains grounded in a "control by exception" framework, where cannabis-based products are controlled substances first and medicines second.

This contrasts with models in many other countries (e.g., Germany, Canada, Israel, parts of Australia and the USA), where medical cannabis is regulated under mainstream medicines law with appropriate clinical safeguards.

The UK’s model creates regulatory rigidity and prevents the integration of CBPMs into normal clinical pathways and patient rights frameworks, including those protected under the Equality Act 2010.

In Germany, for example, prescribed cannabis is covered under statutory health insurance, and administration methods are determined by clinical need and patient circumstances. In Canada, medical cannabis is governed by distinct but integrated legislation (Cannabis Act, 2018), balancing public health with patient rights and protections.

The UK’s regulatory stance is now a significant outlier internationally, limiting innovation, clinical development, and patient outcomes in comparison to peer countries.

References

- Misuse of Drugs Regulations 2001, Regulation 16A

- Equality Act 2010

- NICE Guideline NG144, Medicinal Cannabis

- DVLA medical standards and guidance

Annex B – Indicative Departmental Actions to Support Equitable Access to CBPMs

This annex outlines suggested areas of responsibility and potential actions across UK Government departments and key public bodies. It is intended to support a constructive, coordinated response to the concerns raised in the main letter and annex.

Home Office

- Review the impact of Regulation 16A(3), Misuse of Drugs Regulations 2001, in light of the Equality Act 2010 and the need for clinically appropriate administration. [See Annex A §1]
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- Clarify licensing implications for patients and clinics using lawful CBPMs via vaporization **OR** combustion. [See Annex A §2]
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- Lead a review of police enforcement practice relating to patients prescribed CBPMs, particularly regarding methods of consumption. [See Annex A §2]
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- Support consistent interpretation of lawful possession and administration across law enforcement bodies and regional forces. [See Annex A §2]
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Metropolitan Police Service

- Ensure clear guidance for officers on how to engage with patients lawfully prescribed CBPMs. [See Annex A §2]
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- Integrate lawful CBPM use into stop and search protocols, respecting disability rights and clinical need. [See Annex A §2]
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- Provide operational training on equality law as it relates to disabled CBPM patients. [See Annex A §1 and §2]
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- Participate in joint reviews with the CPS and Home Office to avoid discriminatory or inconsistent enforcement. [See Annex A §2]
  No current strategy or delivery plan appears to be in place.

- Support balanced use of impairment testing to ensure methods distinguish disability symptoms from intoxication. [See Annex A §2]
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Ministry of Justice / Crown Prosecution Service

- Clarify prosecutorial discretion for patients holding valid CBPM prescriptions. [See Annex A §1 and A §2]
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- Issue guidance reflecting disability rights and the clinical basis for lawful CBPM use. [See Annex A §1]
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- Coordinate with Home Office and policing bodies to reduce inconsistent charging and enforcement outcomes. [See Annex A §2] – for context, the most recent published position by this administration is was published by the previous Government in 2022. **From Harm to Hope remains the official framework** for UK drugs policy. A revised national drugs strategy hasn't yet been published, nor has a formal successor white paper been launched
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Department of Health and Social Care (DHSC)

- Review NICE guidance (e.g. NG144) to ensure equitable access to CBPMs, including for acute or rapid-onset needs. [See Annex A §4]
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- Ensure NHS protocols and digital systems support valid private prescriptions and CBPM patient records. *(data published 2023)* [See Annex A §4]
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NHS England

- Work with DHSC to remove systemic barriers to lawful prescription and delivery of CBPMs. [See Annex A §4]
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- Clarify guidance to Integrated Care Boards (ICBs) on care pathway support for CBPM patients. [See Annex A §4]
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- Address confusion in primary care prescribing for patients with lawful private CBPM prescriptions. [See Annex A §4]
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Department for Transport / DVLA

- Update official guidance on driving and cannabis, explicitly recognising lawful medical use and differentiating from misuse. [See Annex A §2]
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- Review the fairness and medical accuracy of impairment-based testing, especially for patients with neurological and / or functional disabilities.
  [See Annex A §2]
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- Promote engagement with clinicians and patient advocates to ensure assessments are lawful, evidence-based and non-discriminatory. [See Annex A §2]
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Cabinet Office / Disability Unit

- Ensure compliance with the Public Sector Equality Duty across departments. [See Annex A §1]
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- Lead cross-government coordination on disability-related implications of CBPM policy. [See Annex A §6]
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- Champion consistent policy alignment with the Equality Act and accessible healthcare obligations. [See Annex A §1 and §6]

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Department for Work and Pensions (DWP)

- Ensure that disability assessors (e.g. PIP, ESA, WCA contractors) are trained on the lawful prescription and administration of CBPMs. [See Annex A §1, §2]

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- Review existing policy to ensure that prescribed CBPM use does not lead to inappropriate benefit denial or negative scoring in functional assessments. [See Annex A §1, §2]

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- Integrate CBPM-related guidance into Access to Work decision-making, ensuring reasonable adjustments are not refused due to cannabis stigma or policy misinterpretation. [See Annex A §1, §3]

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- Audit and report on existing cases where CBPM patients have been disadvantaged due to administrative or assessor-level misapplication of [See Annex A §1, §3]

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Annex C: Initial Distribution List

Home Secretary	Rt Hon. Yvette Cooper MP
Health & Social Care Secretary	Rt Hon. Wes Streeting MP
Transport Secretary	Rt Hon. Heidi Alexander MP
Justice Secretary	Rt Hon. Shabana Mahmood KC MP
Work & Pensions Secretary	Rt Hon. Liz Kendall MP
Cabinet Office	Rt Hon. Nick Thomas-Symonds MP
Metropolitan Police Commissioner	Sir Mark Rowley QPM
Mayor of London	Sadiq Khan
Chief Executive, NHS England	Sir James Mackey