Explanatory Context: Organisational Statutory Responsibilities related to SI2018/1055

Home Office

Misuse of Drugs Act 1971
Purpose:
To determine:
- Drug Classes (A, B, C)
- seriousness of an offence (possession,
- supply, production)
- maximum penalties
- police powers

Misuse of Drugs Regulations 2001 (and amendments)
Purpose:
To determine scheduling for:
- medical and scientific use
- prescribing rights
- Product licensing
- storage, record-keeping, destruction

DHSC
Purpose:
To oversee the **clinical, therapeutic, and public-health implications** of policies affecting medicines and patient care.

DHSC responsibilities include:
- ensuring clinical safety and therapeutic appropriateness
- overseeing prescribing frameworks and specialist access rules
- assessing impacts on patient safety and treatment effectiveness
- aligning policy with MHRA medicines regulation
- discharging the **Public Sector Equality Duty** for health-related decisions
- evaluating impacts on disabled and clinically vulnerable patients

ACMD
Purpose:
To provide **independent scientific, medical, and social-harm advice** to the Home Secretary on drug control.

ACMD responsibilities include:
- assessing physiological, psychological, and social harms
- evaluating therapeutic or medical value
- advising on Class (A/B/C) placement
- advising on Schedule (1–5) suitability and medical legitimacy
- reviewing evidence for policy changes
- advising on risks of criminalisation and misuse patterns
- advising on unintended consequences, misuse patterns, and proportionality of proposed controls

MoJ
Purpose:
To regulate and oversee the **criminal justice consequences** of any change to offences, penalties, or criminalised conduct.

MoJ responsibilities include:
- assessing new or amended criminal offences
- evaluating sentencing impacts
- modelling prison, probation, and court workload
- assessing prosecution and legal aid implications
- ensuring proportionality of criminalisation
- ensuring compliance with human rights law (ECHR)
- identifying discriminatory or unequal justice impacts

Cabinet Office (including the Equality Hub / Better Regulation Unit)

Purpose:
To ensure **constitutional, regulatory, and cross-government compliance** in policy-making.

Cabinet Office responsibilities include:
- enforcing the Better Regulation Framework
- ensuring Impact Assessments are completed where required
- ensuring Public Sector Equality Duty compliance
- coordinating cross-departmental policy alignment
- ensuring SIs follow correct procedural routes
- reviewing whether policy choices are proportionate and evidence-based
- preventing departments from bypassing scrutiny

Department for Education (DfE)
Purpose:
To uphold statutory duties relating to **education, safeguarding, and equality**, including responsibilities that extend beyond the school system.

DfE responsibilities include:
- discharging the Public Sector Equality Duty across all protected groups assessing disability, health, and inclusion impacts of government policy safeguarding children and young people affected by cross-government decisions
- ensuring non-discrimination in access to services and public functions providing guidance on public health messaging in educational settings contributing to cross-government equality analysis where health, disability, or children's welfare are affected

*(Note: DfE's PSED responsibilities apply **even when DfE is not the lead department**.)*

Regulatory Options for the Home Office for the making of SI2018/1055 - Consequences & Impacts

Option 1: Move Cannabis to Schedule 2 (Normal UK Model)
- Aligns with existing medicines regulation
- Removes logical contradiction between "no medical use" and prescribing
- Enables plant-based prescribing without discrimination
- Used by most countries with medical regimes

Option 2: Create New Sub-Schedule (2A)
Bespoke but coherent framework
- Allows tight, bespoke controls without misclassifying medical cannabis
- Provides legal clarity without inventing narrow product-based definitions
- Supports consistent clinical guidance and predictable prescribing rules
- Maintains political caution while avoiding structural contradictions

Option 3 (Home OfficeChoice): Leave Cannabis in Schedule 1 + Create 'CBPM' Category + Add Reg. 16A(3)
- Leaves cannabis incorrectly classified as "no medical use"
- Creates internal contradiction once prescriptions are allowed
- Imposes criminal liability for a route of administration
- Restricts access through narrow, artificial product definitions
- Generates Equality Act, PSED, and Better Regulation vulnerabilities

Regulatory coherence restored
Cannabis plant and cannabis medicines sit within the same therapeutic framework; no contradiction between "medical use" and Schedule placement.

Regulatory coherence restored
A bespoke Schedule 2A creates a clear, internally consistent framework for cannabis-based medicines without misclassifying the plant or creating artificial product categories.

Regulatory coherence lost
Cannabis remains "no medical use" in Schedule 1 while cannabis medicines are permitted in Schedule 2, creating a structural contradiction at the heart of the framework.

Access pathway stabilised
Clinicians and pharmacists operate within familiar Schedule 2 CD processes; prescribing becomes technically straightforward.

Access pathway stabilised
Clinicians and pharmacists operate within predictable, rule-based prescribing and dispensing processes; guidance is consistent and not dependent on narrow CBPM definitions.

Access pathway destabilised
Clinicians face inconsistent rules, narrow product definitions, and route-based restrictions; prescribing depends on artificial legal categories rather than clinical judgement.

Equality Act exposure reduced
Disabled patients are not singled out via route-based criminal sanctions; discrimination risks fall to baseline.

Equality Act exposure minimised
No route-specific criminalisation is required; disabled patients are not singled out for differential treatment, and discrimination risks remain low.

Equality Act exposure increased
Reg. 16A(3) uniquely criminalises a lawful route of administration, disproportionately affecting disabled patients who rely on inhaled forms for therapeutic effect.

Research and product development unlocked
Schedule 2 licensing removes major barriers to clinical trials, manufacturing, and academic work.

Research and product development unlocked
A dedicated sub-schedule provides a stable legal basis for trials, manufacturing, and academic work without the full barriers of Schedule 1 licensing.

Research and product development constrained
Schedule 1 status maintains significant barriers to clinical trials, licensing, and innovation, preventing the UK from developing or evaluating plant-based products.

International alignment achieved
Brings UK into line with jurisdictions treating medical cannabis as a controlled medicine rather than a prohibited substance.

International alignment achieved
Brings the UK closer to jurisdictions using bespoke but coherent medical cannabis schedules, offering tight control without the contradictions of the current framework.

International alignment abandoned
No other jurisdiction splits plant and product in this way or criminalises a medical route of administration; the UK becomes a clear outlier.

Why the HO chose Option 3?

Easiest parliamentary route
Option 3 could be delivered entirely by **negative resolution**, avoiding debate and scrutiny required for Options 1 and 2.

Avoided cross-government involvement
No need for agreement from **DHSC, MoJ, Cabinet Office, MHRA** by rescheduling or creating new controlled-drug categories.

Enabled fastest implementation
The negative SI allowed the Home Office to move from announcement to law in weeks, not months — crucial during political pressure in 2018.

Preserved maximum departmental control
HO retained full authority over cannabis by keeping the plant in **Schedule 1**, avoiding any shift of regulatory power toward DHSC/MHRA.

Created the appearance of medical legalisation without substantive reform
Inventing **CBPMs** allowed HO to claim "medical cannabis is now legal" while avoiding broader rescheduling, market expansion, or patient-led access.

Could the HO have made SI 2018/1055 without 16a3 and how would that affect prescribed patients?

No new criminal offence created
Removing 16A(3) would have avoided creating a unique offence for using a lawful medicine, keeping SI 2018/1055 as a technical amendment rather than criminal reform.

Reduced Equality Act exposure
Without route-based criminalisation, disabled patients are not singled out for differential treatment; discrimination risk falls to baseline.

Prescribing becomes clinically coherent
Clinicians could recommend inhaled administration when clinically appropriate without patients facing criminal liability for following medical advice.

Patient safety improves
Patients could use the most effective and fastest-acting route of administration for symptom control without fear of enforcement or legal ambiguity.

Framework becomes legally defensible
Omitting 16A(3) would preserve the HO's political caution while avoiding the structural contradiction, PSED breaches, and procedural defects generated by the offence.

A workable but tightly controlled medical regime
SI 2018/1055 would still restrict access — but without creating the incoherent, discriminatory trap that now affects prescribed patients.

Editors note: Update v2, sect 6 to reflect options and context