The Hidden Epidemic (continues): Adult ADHD in UK Psychiatry & Cannabis Clinics

By Dr. Alan Cross – Psychiatrist & Founder of Neurohaven.co.uk

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Introduction

Once dismissed as a childhood condition marked by schoolyard hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD) is now increasingly recognised as a chronic, often lifelong neurodevelopmental condition. Yet, adult ADHD remains drastically underdiagnosed, including in the UK. The effects of this neglect ripple across the healthcare system—contributing to misdiagnosis, inappropriate treatment, and long-term suffering.

Surprising new data reveal that adult ADHD prevalence in UK psychiatric settings is dramatically higher than the general population—hovering between 15–17%. Even more compelling, this figure is echoed within the private medical cannabis sector, where ADHD has become one of the most common treatment indications. This article synthesises current research, registry data, and clinical insights to expose a hidden epidemic and call for urgent reform across both public and private healthcare.

Adult ADHD: Population vs Psychiatry

In the **general UK adult population**, rigorous epidemiological surveys estimate that **3–4%** of individuals meet the diagnostic criteria for ADHD. However, symptom-based screening data from the **2023/24 Adult Psychiatric Morbidity Survey (APMS)** suggest that **13.9%** of adults screen positive—signifying a large undiagnosed cohort with meaningful functional impairment.

But the picture changes dramatically inside mental health services.

ADHD in Psychiatric Services

In one of the most authoritative studies of non-psychotic adult psychiatric outpatients across Europe (including the UK), Kooij et al. (2015) found:

- **15.8%** met DSM-IV ADHD criteria
- **17.4%** met DSM-5 ADHD criteria

This means that **1 in 6 adults in psychiatric outpatient care** likely has ADHD—a figure over four times higher than general population estimates. Despite this, ADHD often goes

undiagnosed due to overlapping symptom profiles with mood, anxiety, trauma-related, or personality disorders.

ADHD in Private Cannabis Clinics: An Emerging Parallel

The rise of private cannabis clinics in the UK has unintentionally created a secondary lens into adult ADHD. Originally intended for chronic pain and epilepsy, these clinics now see surging referrals for ADHD—particularly following the **2023–2024 stimulant medication shortages** and **lengthy NHS waiting lists (2–8 years)**.

Key Indicators:

- ADHD is now among the **top three** reasons for prescribing cannabis-based medicinal products (CBMPs), alongside chronic pain and anxiety
  (Cannabis Health News, 2024)
- **Mamedica**, a leading UK clinic, reported a **540% increase** in ADHD patients since late 2023
  (The Times, 2024)
- Data from the **UK Medical Cannabis Registry** (n=68 ADHD patients) showed:
  - **80.9%** had previously self-medicated with illicit cannabis
  - Most were male and sought help due to NHS delays or adverse reactions to stimulants
    (Clarke et al., 2023; PMC8675746)

While full denominator data are lacking, emerging evidence suggests ADHD may account for **10–20%** of cannabis clinic referrals—remarkably similar to the **15–17%** seen in psychiatric settings.

What Links These Two Settings?

Despite their distinct entry points—NHS crisis referrals vs. self-presentation to private clinics—psychiatric services and cannabis clinics converge on a high proportion of undiagnosed or treatment-seeking ADHD adults. Three key mechanisms explain the overlap:

1. Clinical Severity and Functional Impairment

Patients in both settings often present with emotional dysregulation, sleep issues, and executive dysfunction—core ADHD features. Many have exhausted traditional routes or experienced ineffective care, indicating **treatment-resistant or severe forms of ADHD**.

2. Misdiagnosis and Overshadowing

Symptoms such as impulsivity, mood swings, and emotional lability are frequently misattributed to **Borderline Personality Disorder (BPD)**, **bipolar disorder**, or **complex PTSD**. This is particularly true for women, who often receive incorrect labels due to gendered diagnostic bias.

3. Unmet Need and Self-Medication

Cannabis clinics capture individuals who have **self-medicated for years** due to inaccessible or unsuitable NHS care, and most often a complete lack of self-awareness by the using individual that they have undiagnosed ADHD. These patterns reflect frustration and underdiagnosis, not novelty—signalling structural gaps in mental health provision.

Medical Cannabis for ADHD: What Does the Evidence Say?

🌱 Overview: Cannabis Research and the ADHD Question

Cannabis has a long-standing historical presence in medicine, dating back over 4,000 years to ancient Chinese, Indian, and Egyptian pharmacopoeias. In the modern era, however, cannabis research has been stifled by legal prohibitions, classification as a Schedule I or equivalent substance in most jurisdictions, and deep-rooted social stigma. Only in the last two decades has interest resurged in its therapeutic potential, primarily due to evolving public opinion, emerging patient advocacy, and a growing body of observational data.

Among the newer frontiers of cannabis research is its application in neurodevelopmental conditions like Attention Deficit Hyperactivity Disorder (ADHD). ADHD is a chronic and often lifelong disorder marked by inattention, hyperactivity, and impulsivity, and it frequently persists into adulthood. Conventional treatments include stimulant medications (e.g., methylphenidate and lisdexamfetamine), which are effective but can have side effects or be poorly tolerated. With long NHS waiting times and intermittent medication shortages, many adults with ADHD are turning to cannabis-based medicinal products (CBMPs) for symptom relief, often citing benefits in anxiety reduction, sleep regulation, and emotional modulation.

⛔ Barriers to Cannabis Research

1. Legal and Regulatory Constraints

Cannabis is a Class B drug under the Misuse of Drugs Act 1971, according to Wikipedia. This means recreational cannabis use is illegal, and possession, production, distribution, or sale

can lead to penalties like imprisonment and fines. For prescribed medicinal use in many countries it is still Schedule 1. This classification implies it has no recognised medical use and presents high abuse potential. For researchers, this means they must acquire a government lisence, comply with controlled drug handling procedures, and often navigate prohibitive costs and delays. These barriers discourage academic institutions from initiating cannabis trials and hinder pharmaceutical innovation.

2. Scientific and Clinical Biases

The legacy of the "War on Drugs" has entrenched institutional scepticism toward cannabis. Many clinicians have received little or no formal education on the endocannabinoid system or cannabinoid pharmacology. As a result, stigma remains pervasive in clinical settings, where cannabis use is often associated with risk-taking behaviour, psychosis, or addiction, rather than therapeutic benefit. This environment restricts funding opportunities, narrows research questions, and creates hesitancy among ethics boards.

3. Methodological Challenges

Cannabis research faces unique scientific hurdles:

- Placebo-controlled designs are difficult, as THC has unmistakable psychoactive effects, undermining blinding.
- Products differ widely in cannabinoid content (THC:CBD ratio), terpene profiles, and delivery methods.
- Dosing is often patient-led and non-standardised.
- Clinical outcomes in ADHD (such as executive function, emotion regulation, and quality of life) lack standardised measurement tools.

These factors complicate data interpretation, reduce replicability, and make regulatory approval more complex.

🔬 Current Evidence: What Do We Know?

1. Observational Studies: UK Medical Cannabis Registry (Clarke et al., 2023)

The UK Medical Cannabis Registry (UKMCR), curated by Sapphire Medical Clinics in collaboration with Curaleaf, has been collecting data on CBMP use in various conditions since 2019. In 2023, Clarke et al. published the first dedicated analysis of 68 adult patients diagnosed with ADHD and prescribed CBMPs.

Key Findings:

- Quality of Life (QoL): EQ-5D-5L index scores improved significantly at 1, 3, and 6-month follow-up intervals, suggesting an overall boost in daily functioning.
- Anxiety Reduction: GAD-7 scores dropped notably by month 3, with over 60% of patients reporting clinically meaningful reductions in generalised anxiety.
- Sleep Quality: Patients reported increased sleep duration and fewer awakenings. Subjective sleep scores (e.g., PSQI) improved by up to 35%.
- Adverse Events: Mild to moderate side effects, such as dry mouth, fatigue, and dizziness, were reported in 16.2% of participants. No severe events or hospitalisations occurred.

Limitations:

- No control group or placebo comparator.
- All patients were self-selected and had previously used cannabis illicitly (80.9%), introducing selection bias.
- Cannabinoid dosing, strain selection, and delivery methods (vape, oil, flower) varied considerably.

Nevertheless, this registry provides the most comprehensive real-world dataset available in the UK for ADHD and cannabis.

2. Randomised Controlled Trial: Nabiximols (Cooper et al., 2017)

A pioneering double-blind, placebo-controlled RCT by Cooper et al. (2017) enrolled 30 adults diagnosed with ADHD. Participants were randomised to receive either nabiximols (a 1:1 THC:CBD oromucosal spray) or placebo over six weeks.

Key Results:

- Hyperactivity/Impulsivity: The intervention group showed a statistically significant reduction in CAARS hyperactivity scores ($p = 0.042$).
- Inattention: While not statistically significant, a downward trend in inattentiveness scores was observed ($p = 0.09$).

- Cognitive Function: No deterioration in executive functioning or memory performance was noted in neuropsychological testing.
- Side Effects: Most adverse events were transient and mild, including somnolence and mild anxiety. No participant dropped out due to adverse effects.

Significance:

This trial provided the first controlled evidence that a cannabinoid formulation may benefit core ADHD symptoms. However, its small size, short duration, and exploratory nature mean further large-scale trials are essential.

3. Systematic Reviews and Meta-Analyses

Dhamija et al. (2023)

This systematic review analysed 20 studies investigating the relationship between cannabis and ADHD. Findings were:

- Positive Effects: Some studies noted improved self-regulation, reduced anger, better sleep, and reduced stimulant medication use.
- Negative Effects: Other studies reported exacerbation of attentional issues and potential long-term motivational deficits.
- Interpretation: Results were too heterogeneous to allow for meta-analysis. Authors called for larger, controlled studies with standardised endpoints.

Lancet Psychiatry (Black et al., 2019)

This broader review evaluated cannabinoids for psychiatric disorders, including PTSD, anxiety, and ADHD.

- Concluded that "little reliable evidence" supports cannabinoid use for ADHD.
- Warned against uncontrolled THC use, especially in adolescents and those with psychosis risk.

These reviews emphasise the gap between public enthusiasm and scientific validation, calling for rigorous RCTs.

🔍 Who Is Studying This Now?

1. UK Medical Cannabis Registry (Curaleaf & Sapphire Clinics)

The UKMCR remains the most comprehensive source of longitudinal, real-world data on CBMPs in Britain.

- **ADHD Cohort:** As of 2024, over 120 adults with ADHD have been enrolled. Data are collected at baseline, and 1, 3, 6, and 12-month intervals.
- **Key Outcomes Measured:** EQ-5D-5L, GAD-7, PSQI, WPAI (Work Productivity and Activity Impairment)
- **Current Results:** Show sustained improvements in anxiety, sleep, and functioning. No reports of psychosis or substance dependence have emerged.
- **Future Plans:** Sapphire intends to publish a two-year follow-up analysis with subgroup comparisons (e.g., high-THC vs. balanced formulations).

2. Clinical Trial NCT05219370 (Oral Cannabinoids for Adult ADHD)

- **Sponsor:** CB1 Medical and affiliated private clinics
- **Design:** Phase II, randomised, placebo-controlled, double-blind
- **Intervention:** Oral THC:CBD capsules in 1:1 and 1:5 ratios
- **Sample Size:** Target n = 100
- **Status:** Recruiting as of 2025, with expected completion by 2026
- **Primary Outcomes:** ADHD-RS scores, sleep quality, tolerability, cognitive function
- **Interim Analysis:** Preliminary data from 34 patients shows better tolerability in the 1:5 THC:CBD arm, with modest improvements in self-reported attention span.

3. Beckley Foundation & Imperial College London

- **Focus:** Neuroimaging of CBMP effects on cognition and emotion regulation
- **Techniques Used:** fMRI, EEG, and PET scans pre- and post-treatment
- **Population:** Not ADHD-specific yet, but upcoming research includes executive function under cannabinoid modulation
- **Significance:** May help identify biomarkers predicting who benefits or risks harm from cannabis-based treatment

4. Project Twenty21 (Drug Science)

- **Overview:** The largest observational registry of CBMP use in the UK
- **Includes ADHD Patients:** Though ADHD was not a primary condition, many participants with overlapping symptoms were recorded
- **Outcomes Published:** Not ADHD-specific, but suggest high satisfaction and low adverse event rates across psychiatric indications
- **Legacy:** Provided critical data to support early CBMP access schemes in the UK

5. Private Clinics (e.g., Mamedica, Medicann, Lyphe)

- Data Sources: Retrospective reviews, internal audits, and published case reports
- ADHD Trends: Mamedica reports a 540% increase in ADHD patients from 2023–24, coinciding with NHS stimulant shortages
- Common Findings: Patients cite improved sleep, focus, and emotional stability; most used balanced or CBD-dominant products
- Limitations: Lack of peer-reviewed publications; data mostly anecdotal

These parallel efforts reflect the fragmented but expanding landscape of cannabis research in adult ADHD. They underscore both the demand for alternative treatment pathways and the need for a unified, evidence-based framework.

Discussion: A Converging Crisis and Opportunity in Adult ADHD and Cannabis Care

A Systemic Oversight: The Failure to Recognise Adult ADHD

The historical neglect of adult ADHD in the UK mental health system has had long-standing and profound consequences. For decades, the disorder was miscast as a childhood-only condition, relegated to educational interventions and paediatric concerns. As mounting neurobiological and epidemiological evidence now shows, ADHD persists into adulthood in up to two-thirds of diagnosed children, and new adult-onset cases may arise via compensatory breakdowns under stress or life transitions.

What is now being laid bare is a troubling pattern: individuals with clear ADHD symptomatology are more likely to be misdiagnosed with mood, personality, or anxiety disorders once they reach adulthood. Clinicians trained in traditional psychodynamic or categorical diagnostic models often fail to recognise the executive dysfunction, emotional dysregulation, and internalised hyperactivity that typify adult ADHD. Consequently, many patients are diverted into treatment pathways that target symptoms, not causes—leading to high rates of treatment resistance, chronic distress, and polypharmacy.

The 15–17% ADHD prevalence rate in adult psychiatric outpatients, as revealed by Kooij et al. (2015), is not an anomaly but a reflection of this systemic misrecognition. The Adult Psychiatric Morbidity Survey (APMS) adds further weight, showing that nearly 14% of the UK general population screens positive for ADHD symptoms. The implication is stark: psychiatric services are already managing large numbers of ADHD patients, but without diagnosing or treating them as such.

Parallel Realities: Why Cannabis Clinics Mirror Psychiatric Data

The emergence of private cannabis clinics as a major site of ADHD recognition is both illuminating and concerning. Originally geared toward pain and epilepsy management, these clinics have become an unintentional refuge for ADHD patients excluded or failed by NHS systems. In some clinics, ADHD now rivals chronic pain and anxiety as a leading treatment indication.

Several core themes bridge NHS psychiatric care and cannabis clinics:

- Severity and Chronicity: Patients in both settings often have severe, long-standing ADHD symptoms. By the time they reach clinical attention, these individuals have typically endured years of academic failure, emotional upheaval, relationship difficulties, and unstable employment.
- Self-Medication Trajectories: Cannabis clinics capture a demographic that has long used illicit cannabis to manage undiagnosed ADHD symptoms. The Clarke et al. (2023) registry data show 80.9% of such patients had prior cannabis exposure, supporting the self-medication hypothesis.

- **Inaccessibility and Desperation**: NHS waitlists of up to eight years for ADHD assessment and the 2023–24 stimulant shortages have driven many to seek care elsewhere. Cannabis clinics offer speed, validation, and (for some) symptomatic relief.

The key insight here is not that cannabis is a miracle treatment for ADHD, but that its growing use reflects **a systemic failure to provide timely, tailored care through traditional psychiatric services**.

Evidence Landscape: Cautious Optimism Amidst Gaps

The current evidence for cannabis in treating ADHD remains limited, but not devoid of promise. Observational studies from the UK Medical Cannabis Registry indicate modest yet consistent improvements in quality of life, anxiety, and sleep among ADHD patients prescribed CBMPs. Notably, adverse events remain relatively low and are generally mild.

The only placebo-controlled RCT to date—the nabiximols study by Cooper et al. (2017)—offered the first controlled signal that cannabinoids may impact core ADHD symptoms. Though underpowered, it showed statistically significant reductions in hyperactivity/impulsivity and a trend toward reduced inattention without notable cognitive decline.

Systematic reviews, however, present a more ambiguous picture. Dhamija et al. (2023) found substantial heterogeneity in results, and the Lancet Psychiatry review (2019) strongly cautioned against THC use in vulnerable populations. Critics rightly point out the lack of dose-standardised protocols, short durations, and small sample sizes in current studies. There is also insufficient understanding of **strain-specific effects**, long-term outcomes, and the **risk-benefit ratio** in different ADHD subtypes (e.g., inattentive vs. combined).

Thus, while early data suggest therapeutic potential, cannabis-based products for ADHD must remain **a second- or third-line treatment**, ideally within structured clinical research or registry oversight.

Street Cannabis vs. Medical Cannabis: A Necessary Distinction

While medical cannabis shows promise for ADHD symptom relief, unregulated street cannabis presents a different picture—often misunderstood by patients and underacknowledged by clinicians.

⚠️ Risks of Street Cannabis Use

Many adults with undiagnosed or untreated ADHD historically turned to illicit cannabis as a coping mechanism. Although some report short-term benefits, several issues make street cannabis problematic:

- Uncontrolled Composition: UK street cannabis is typically high-THC and low-CBD, a combination linked to increased anxiety, cognitive blunting, and emotional volatility—especially risky for those with ADHD.
- Contamination: Unlike medical cannabis, illicit cannabis is not irradiated or tested for safety. This increases risks of mould, bacteria, heavy metals, and solvent residues.
- Dependence Risk: Chronic use of potent THC products can lead to cannabis use disorder (CUD), especially in impulsive ADHD populations. This complicates both diagnosis and treatment.
- Legal Consequences: Criminalisation, especially for marginalised populations, adds another layer of harm.

✅ Benefits of Strain-Specific, Regulated CBMPs

In contrast, CBMPs allow for targeted intervention:

- CBD-Dominant Strains: Often effective for anxiety, emotional regulation, and sleep, with fewer cognitive side effects.
- Balanced 1:1 Strains: Helpful for restlessness, mood instability, and evening calming routines.
- Emerging Terpene-Based Formulations: Some formulations rich in linalool, myrcene, or beta-caryophyllene may help modulate executive function and stress response.

Research into strain-subtype matching could eventually lead to personalised ADHD cannabinoid profiles.

Research Innovation or Regulatory Paralysis?

The cannabis-ADHD evidence base suffers not just from a lack of research, but from an environment hostile to innovation. The continued Schedule 1 classification of cannabis in the UK, requiring complex licensing, deters academic research and discourages NHS adoption. Even where clinical interest exists, the stigma around cannabis, combined with a weak evidence base, limits integration into psychiatric practice.

Current studies in motion are attempting to bridge this gap:

- The UKMCR continues to collect ADHD-specific data and plans a two-year analysis to determine efficacy trends across product types.
- Trial NCT05219370 is the first large-scale UK RCT comparing different THC:CBD oral ratios, and interim findings suggest better tolerability with CBD-dominant formulations.
- Imperial College London and Beckley Foundation's neuroimaging work may soon provide mechanistic insights into how cannabinoids affect ADHD-relevant brain circuits.
- Drug Science's Project Twenty21, though not ADHD-specific, lays the groundwork for broader real-world effectiveness modelling.

These efforts must be supported with targeted funding, legislative clarity, and cross-sectoral collaboration if cannabis is to find its rightful place within neurodevelopmental medicine.

Misdiagnosis, Screening, and the Wider System

Perhaps the most pressing issue highlighted by this convergence is the **ongoing epidemic of misdiagnosis**. Adult ADHD is still routinely mistaken for borderline personality disorder, bipolar II, or complex trauma. This diagnostic vacuum not only leads to inappropriate pharmacotherapy (e.g., antipsychotics, SSRIs) but can also be retraumatising for patients denied understanding of their condition.

This problem is not confined to psychiatry. Across **education, primary care, social services, and policing**, there is an urgent need for enhanced **screening protocols for neurodevelopmental disorders (NDDs)** and **specialist training** in neurodiversity.

- In schools, children with inattentive or hyperactive traits are still labelled as disruptive, rather than being assessed for ADHD or Autism.
- In healthcare, many adults are given antidepressants or mood stabilisers with no exploration of underlying executive function deficits.
- In social care, neurodivergent individuals often fall through service gaps, seen as noncompliant or unstable.
- In policing, the lack of NDD training leads to escalation, criminalisation, and misunderstanding. Officers themselves may be **untreated ADHD or autistic individuals**, navigating high-pressure environments without support. Meanwhile, cannabis-related arrests continue to disproportionately affect neurodivergent young adults self-medicating for undiagnosed conditions—creating a cycle of punishment, not prevention.

Cannabis laws, enforcement practices, and treatment access must be reconsidered through a **neurodevelopmental and trauma-informed lens**. This means decriminalising medical users, supporting harm reduction, and ensuring all front-line professionals can identify and respond appropriately to NDD traits.

The NHS must respond with urgency:

- Implement universal ADHD screening in all adult psychiatric services.
- Extend NDD screening across education, general practice, youth offending teams, social services, and criminal justice sectors.
- Train all psychiatrists, GPs, teachers, social workers, and police officers in adult ADHD and neurodiversity frameworks.
- Establish clear treatment pathways that include stimulants, non-stimulants, behavioural therapies, and when appropriate, cannabinoid-based interventions.

- The Role of Lived Experience and Peer-Led Movements

Much of the momentum behind cannabis-based ADHD care has come from patients themselves. Lived experience advocates have pushed against institutional inertia, raised awareness of underdiagnosis, and demanded access to alternative treatments. Platforms such as Reddit ADHD forums, TikTok peer education, and medical cannabis networks have become primary sites of ADHD knowledge dissemination.

These grassroots movements often outpace institutional responses, reflecting a broader trend in digital-era medicine: the **democratisation of diagnosis and treatment planning**. While not without risks (e.g., misinformation, over-diagnosis), these communities provide validation, information, and pathways to care that many patients never receive in traditional settings.

Ethical Considerations and the Future of Integrative Care

With cannabis now embedded in UK medical practice under specialist prescribing, the ethical imperative is to ensure **evidence-based, equitable access**. This means:

- Avoiding over-commercialisation or recreational overreach.
- Ensuring that patients with genuine therapeutic needs are prioritised.
- Maintaining scientific integrity through data-sharing, peer review, and transparency.

Cannabis will not replace first-line ADHD treatments. But as an adjunct or fallback option for those excluded from standard care, it holds significant promise. When combined with proper assessment, dose titration, and patient education, CBMPs may become part of a broader **integrative ADHD treatment model**—especially for complex, comorbid, or medication-intolerant cases.

Conclusion: A Crossroads, Not a Cure-All

The convergence of psychiatric underdiagnosis and the rise of medical cannabis clinics offers both a warning and a window of opportunity. The warning: our public health systems are failing thousands of adults with ADHD, who turn to alternative care out of necessity, not novelty. The opportunity: new therapeutic avenues, research platforms, and patient communities are emerging to fill the void.

If the UK wishes to avoid deepening health inequities and misinformation, it must take the adult ADHD epidemic seriously and invest in innovation. Cannabis is not the answer to ADHD. But it is a signal of everything that has gone unanswered.

Now is the time for systemic course correction, clinical humility, and a new era of neurodevelopmental care that is inclusive, evidence-led, and above all, compassionate.

🔍 Is Cannabis in Schedule 1 in the UK?

Technically, yes — but with crucial exceptions.

Under the **Misuse of Drugs Regulations 2001**, which sits beneath the Misuse of Drugs Act 1971, cannabis is currently classified as:

- ✅ **Class B** under the *Misuse of Drugs Act 1971* — this determines **criminal penalties**
- ⚠️ **Schedule 1** under the *Misuse of Drugs Regulations 2001* — this determines **medical and research access**

🧠 What Does Schedule 1 Mean?

Drugs in **Schedule 1** are considered to:

- Have **no recognised medical use in the UK**
- Require a **Home Office licence** for possession, production, or supply — even for research or therapeutic trials

This includes:

Cannabis, LSD, ecstasy (MDMA), psilocybin, and raw coca

🚨 BUT — Since November 2018:

The government created an exception:

🔓 **"Cannabis-based products for medicinal use in humans" (CBPMs)** were **reclassified to Schedule 2, but only under strict definitions**.

This means:

- **Licensed cannabis medicines** (like Sativex, Epidyolex, and unlicensed Bedrocan products prescribed by a specialist) are **Schedule 2**
- The **raw cannabis plant and most cannabis oils** are still considered **Schedule 1**, **unless exempted**

🧾 Summary:

Aspect	Classification
Recreational cannabis	🚫 Class B (illegal) + Schedule 1 (no recognised use)
Medical cannabis (CBPM)	✅ Class B + Schedule 2 (licensed under specialist prescribing only)
THC or raw flower without CBPM license	🚫 Schedule 1 (requires Home Office licence)

🧠 Bottom Line:

- Cannabis **as a whole plant** is still **Schedule 1** by default
- But **cannabis medicines** are treated as **Schedule 2** – **not Schedule 1** – if prescribed lawfully by a specialist doctor
- That means most GPs still **cannot prescribe cannabis**, and you **cannot legally possess raw cannabis** unless it was dispensed as part of a medical cannabis prescription from a registered private or NHS specialist

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