

THE GREEN TANK

PART II · REVISED EVIDENCE EDITION

From Prohibition to Regulation

A staged UK legal, regulatory, health and justice-transition procedure

Move quickly where existing law permits; use Parliament where durable rights and markets require it; measure every stage; preserve the power to stop, correct or reverse.

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Public-interest policy paper. Not individual medical or legal advice.

Executive summary

Part I explains why reform deserves serious consideration. Part II sets out how the United Kingdom could test and implement it without pretending that ministers can create a permanent non-medical market by guidance alone.

- Immediate administrative action can reduce research barriers, improve treatment, commission drug checking and review prosecution priorities within existing legal duties.
- Durable adult possession rights, commercial licensing, taxation, conviction repair and an independent regulator require primary legislation.
- Article 8 is relevant to bodily integrity and private life but does not automatically invalidate drug controls; proportionality must be argued honestly.
- International conventions materially constrain non-medical markets. Parliament should publish the treaty pathway rather than hide it inside secondary legislation.
- The recommended market is deliberately restrained: no lifestyle advertising, strong product rules, public-health pricing and higher-risk clinical tiers.

Legal-status notice

This is a policy architecture, not a formal legal opinion. Before a Bill or statutory instrument is introduced, Parliamentary Counsel and government lawyers should verify competence, treaty effects, devolution, drafting and transitional consequences.

1. Legal starting point

The Misuse of Drugs Act 1971 creates the principal offences and classification framework. Section 7 permits regulations that authorise or control production, supply, possession and related activities for defined purposes; the Misuse of Drugs Regulations 2001 implement schedules and authorised routes. The Psychoactive Substances Act 2016 separately regulates production and supply of psychoactive substances subject to exemptions. [L1][L2][L3]

That flexibility is important but finite. Section 7 can support licences, medical/scientific routes and tightly defined pilots where lawful. It should not be stretched into an attempt to manufacture a permanent constitutional settlement that contradicts the central prohibitions Parliament enacted.

2. Two legal tracks

Track	Use it for	Authority and safeguards	Do not use it to
A · Existing powers	Research licensing, medical scheduling, treatment expansion, data, drug checking where lawfully structured, independent prosecution-guidance review	MDA regulations/licences, ACMD advice, health commissioning, DPP independence	Create an unrestricted national adult retail market by administrative assertion
B · Primary legislation	Adult possession rules, durable licensed supply, excise, regulator, justice transition, record repair, sunset and review	Act of Parliament with devolved coordination and published treaty analysis	Avoid scrutiny of rights, market design or international obligations

3. Human rights, devolution and treaties

Human rights

Article 8 protects private and family life and is relevant to bodily integrity and medical choice. It also permits lawful, necessary and proportionate interference for health, crime prevention and the rights of others. Reform should therefore be framed as a comparative proportionality exercise, not a claim that personal preference defeats regulation. [L4][L5]

Devolution

The 1971 Act is UK-wide, while health services, policing structures and justice administration vary. Misuse of and dealing in drugs is reserved in Wales. Implementation must be co-designed with Scotland, Wales and Northern Ireland, with separate operational plans where institutions and legal competence differ. [L13]

International treaties

The 1961 and 1971 conventions restrict scheduled substances principally to medical and scientific purposes; the 1988 convention requires offences around illicit production and supply and addresses personal possession subject to domestic constitutional principles. [L10][L11][L12] Decriminalisation, treatment and research can therefore move farther and faster than a national non-medical commercial market. Any broader market needs a published route involving interpretation, coordinated reform, reservations where legally available, or denunciation and re-accession considered openly.

4. First 30 days

1. Create a UK Drug Regulation Transition Commission jointly sponsored by the Home Office, DHSC, Ministry of Justice and Treasury, with devolved-government participation.
2. Commission the ACMD on research barriers, medical scheduling, personal-possession options, risk tiers, age rules and product standards.
3. Publish a harm-accounting baseline: deaths, admissions, treatment access, arrests, convictions, prison bed-days, enforcement costs, contamination and illicit-market indicators.
4. Invite the DPP—without direction—to review low-harm possession and social-supply guidance under the public-interest test; begin equivalent discussions in Scotland and Northern Ireland. [L6]
5. Begin an HMPPS/MoJ audit of prisoners and historical convictions potentially affected by reform.
6. Commission publishable legal advice on each proposed tier's treaty and devolution position.
7. Fund design work for accredited regional drug-checking and toxicology services.
8. Pause new possession penalties unless an identified urgent risk justifies them.

5. Days 30-120

9. Implement evidence-based reductions in duplicative Schedule 1 research licensing for appropriately approved institutions. [L7]
10. Expand evidence-based injectable opioid treatment where local need and clinical governance support it. [L8]
11. Create only those licensed pilots clearly within section 7 and treaty limits, with independent evaluation from day one.
12. Launch protected drug-checking services with rapid alerts for dangerous potency or contamination.
13. Publish draft risk tiers and Treasury sensitivity analysis for tax, compliance cost, illicit-market displacement and health funding.
14. Publish a Drug Harm, Autonomy and Regulation Bill and a parallel treaty strategy paper.

6. Months 4-9: the primary Bill

Bill part	Core content
1 · Principles	Autonomy, harm, child protection, evidence standards, regulated product, dependence, social and commercial supply
2 · Adult possession	No criminal offence within prescribed personal-use rules; thresholds evidential rather than automatic proof of supply
3 · Licensing	Retail, specialist, pharmacy, clinical, supervised-use, manufacturing, cultivation, import/export and research licences
4 · Product standards	Identity, dose, batch tests, contaminants, warnings, packaging, recalls and pharmacovigilance
5 · High-harm offences	Children, coercion, trafficking of people, spiking, dangerous adulteration, fraud, violent debt enforcement and serious unlicensed supply
6 · Health and research	Drug checking, Good Samaritan protection, treatment access, research exemptions and specialist pain review
7 · Justice transition	Prisoner review, resentencing/release, historical disregard and disclosure consequences
8 · Fiscal	Excise, licence charges, NHS Drug Dividend and transparent accounts
9 · Regulator	Independent authority, conflicts register, scientific panels and public evidence register
10 · Review and sunset	12-month, 24-month and five-year reviews; restrictions expire unless renewed on evidence

7. Months 9-18: commencement

15. Establish the regulator in shadow form before Royal Assent so standards and systems are ready.
16. Open a Drug Conviction Review Tribunal immediately, with automatic identification of potentially eligible prisoners.
17. Prioritise record repair for simple possession and low-level consensual adult supply without independent violence, coercion or child offences.
18. Issue first licences only where product standards, testing capacity and treaty position are settled.
19. Start the NHS Drug Dividend with the first taxable market.
20. Redeploy enforcement toward violence, exploitation, fraud, corruption, dangerous adulteration, trafficking and impaired driving.

8. Product and market design

The objective is not to maximise consumption or tax. It is to displace unsafe supply while preventing a new industry from manufacturing demand.

- No broadcast, influencer, sponsorship or lifestyle advertising.
- Plain packaging, standard dose units, ingredient and contaminant disclosure, batch identifiers and recall capability.
- Potency-linked excise and minimum public-health prices, with monitoring for displacement back to illicit supply.
- Ownership transparency, limits on vertical integration and a ban on regulator-to-industry conflicts.
- Different channels by risk: licensed retail, pharmacy, specialist service, supervised clinic or research-only.
- Criminal and civil liability for dangerous adulteration, fraudulent substitution and supply to children.

9. Healthcare and research procedure

Stage	Action	Decision gate
1 · Present	Person states goal: pain, treatment, withdrawal, safer use or information	Urgent medical or safeguarding need?
2 · Assess	Medication/substance reconciliation, capacity, interactions, dependence and mental/physical health	Can risk be reduced in ordinary care?
3 · Choose	Shared decision with evidence grade, alternatives and material uncertainty	Clinical, pharmacy, supervised or non-drug route
4 · Monitor	Outcomes, adverse effects and the person's own goals	Continue, adjust, taper or stop
5 · Learn	De-identified outcomes enter the evidence register	Does the tier or guidance need correction?

10. Justice transition and record repair

Reform is incomplete if the state permits tomorrow what keeps a person imprisoned or unemployable today. Parliament should create express review powers rather than relying on inconsistent applications. The existing statutory disregard model shows that Parliament can create targeted record-repair architecture, although drug reform requires its own criteria. [L9]

Eligibility should separate the drug conduct from independent wrongs. Violence, coercion, child exploitation, spiking, trafficking of people, dangerous adulteration and fraud remain reviewable as their own offences even where the associated substance conduct changes.

11. Workforce and police transition

Licensed workers need training in identification, dose, interactions, safeguarding, refusal of sale, emergency response and record keeping. Police transition should publish the number of hours and specialist resources redeployed from possession toward violence, exploitation, fraud, dangerous supply and impaired driving. Performance measures should reward reduced harm and illicit-market share—not arrest totals.

12. NHS Drug Dividend

A starting proposal is to ring-fence 50% of net receipts from excise and licence charges after direct regulatory costs. This percentage is a policy choice, not an evidence finding, and requires Treasury modelling. Funds should be additional, transparent and protected from replacing existing treatment budgets.

Illustrative allocation	Share of ring-fenced fund	Purpose
Treatment and recovery	35%	Rapid access, medication, psychosocial support and continuity of care
Mental health and pain	20%	Specialist review and alternatives to unsupported prescribing
Drug checking and toxicology	15%	Regional testing, alerts and surveillance
Housing and employment	15%	Stability that supports recovery and reduces reoffending
Research and evaluation	10%	Independent trials, registries and policy evaluation

Illustrative allocation	Share of ring-fenced fund	Purpose
Community repair	5%	Areas disproportionately harmed by illicit markets or enforcement

13. Independent regulation and anti-corruption

- Appointments through an open process with health, science, lived experience, justice and consumer representation.
- Published interests, gifts, meetings, lobbying submissions and reasons for decisions.
- No industry majority on scientific or licensing committees.
- Protected whistleblowing, audit access and parliamentary reporting.
- A public evidence register showing claim, source, grade, limitation, decision and next review date.
- A corrections log that preserves what changed rather than silently replacing history.

14. Monitoring, sunset and emergency correction

Domain	Minimum measure	Trigger for review
Health	Deaths, poisonings, admissions, dependence and treatment access	Predefined statistically and clinically material deterioration
Children	Use, school harms, accidental exposure and illegal supply	Any sustained worsening beyond agreed tolerance
Market	Price, potency, licensed share, illicit share and contamination	Illicit displacement stalls or licensed market promotes demand
Justice	Arrests, convictions, prison bed-days and disproportionality	Conduct-based enforcement drifts back into status offences
Economy	Regulatory cost, receipts, health allocation and organised-crime indicators	Receipts used to justify growth or promised savings fail
Trust	Complaints, conflicts, corrections and public comprehension	Undisclosed influence or repeated unsupported claims

Emergency restrictions should be time-limited, publicly reasoned and reviewable. A restriction imposed urgently expires unless confirmed through the ordinary evidence process. The regulator must be able to tighten, pause or reopen a tier—and must also remove a restriction when evidence no longer supports it.

15. Evidence register

ID	Claim	Basis	Status / limitation	Sources	Correction rule
L-E1	Current UK offences and schedules	Primary legislation and regulations	High	L1-L3,L17,L18	Update after every statutory change
L-E2	Section 7 can support defined authorisations	Text and operation of MDA framework	High for medical/scientific licensing; legal advice needed for each pilot	L1,L2	Publish pilot-specific vires opinion
L-E3	Durable adult market requires primary legislation	Constitutional/legal inference	Strong but must be settled by counsel	L1-L3	Record contrary advice openly
L-E4	Article 8 requires proportionality, not automatic invalidity	Statute and ECtHR guide	High	L4,L5	Update with relevant case law

ID	Claim	Basis	Status / limitation	Sources	Correction rule
L-E5	Treaties constrain non-medical markets	Treaty text	High; route options require specialist advice	L10-L12	Publish substance-tier treaty table
L-E6	Record repair can be legislated	UK statutory analogy	High as an architectural precedent	L9	Do not imply identical eligibility
L-E7	The 30-day/18-month timetable is achievable	Implementation proposal	Unproven	This paper	Publish critical path and delay reasons
L-E8	A regulated model will reduce total harm	Policy hypothesis	Uncertain and testable	Part I; L14-L16	Apply stopping rules and publish negative outcomes

16. Implementation checklist

- Baseline harms and costs published before reform.
- ACMD commission and independent treaty advice published.
- Bill contains child, coercion, spiking, adulteration, fraud and impaired-driving protections.
- Testing, treatment and recall capacity exists before first licence.
- Justice-transition tribunal ready at commencement.
- Police and workforce transition plans funded.
- Evidence register, conflict register and correction log live.
- Review thresholds, sunset dates and emergency-expiry rules written into law.
- Public reporting distinguishes facts, forecasts and political choices.

Conclusion

The choice is not between punishment and permissiveness. It is between systems of control. Prohibition controls through criminal status and illicit scarcity; regulation can control identity, dose, channel, age, conduct and accountability. The latter will deserve public trust only if it remains cautious, transparent, reversible and willing to admit when evidence contradicts its hopes.

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