

THE GREEN TANK

PART I · REVISED EVIDENCE EDITION

From Punishment to Care

A harm-reduction, autonomy and public-health case for replacing moral labels with accountable regulation

A proposal to judge psychoactive substances by evidence, context and actual harm—not by whether history first placed them inside a medicine cabinet or a criminal statute.

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

Reader's orientation

This paper does not claim that every drug is safe, that every use is wise, or that intoxication excuses harm. It asks a narrower question: when an adult's conduct does not harm or materially endanger another person, is criminal punishment the least harmful and most effective response?

The line this paper defends

Keep firm law against violence, coercion, child supply, spiking, trafficking of people, dangerous adulteration, fraud and impaired driving. Replace punishment for low-harm adult possession with health protection, honest information and proportionate regulation.

Executive summary

- The arrest that prompted this paper is verifiable as an official agency report, but it remains an allegation rather than a conviction.
- Legal status and measured harm are different variables. Alcohol and lawful medicines demonstrate that society already manages powerful benefits and serious risks without pretending either side does not exist.
- Prohibition can add harms of its own: uncertain potency, contaminated supply, organised-crime revenue, reluctance to seek help, criminal records, imprisonment and loss of work or housing.
- A credible alternative must be deliberately cautious: substance-specific tiers, age limits, dose and quantity rules, testing, traceability, treatment access, impaired-driving enforcement and independent review.
- Persuasion should respect the reader. This edition distinguishes verified facts, evidence-based inference and policy proposals; it includes counterarguments and a correction route.

1. The human event that opened the question

On 23 August 2026, Nigeria's National Drug Law Enforcement Agency reported that its officers had arrested a 101-year-old great-grandmother on 15 August in Ogun State. The agency said officers found 90 grams of cannabis in retail sachets and that she claimed to sell small quantities locally after her provisions shop burned down. It also said she was granted bail and placed in counselling because of her age. [A1]

The verified fact is that the agency published this account of an arrest. The alleged possession and sale have not been established here by a court. Her age and circumstances do not prove innocence, and they do not make cannabis harmless. They do force a serious proportionality question: what outcome was the arrest meant to produce, and could health, welfare or regulated-market responses have achieved more with less human cost?

Use the story correctly

This is a starting case, not proof of the whole policy argument. One arrest cannot establish national effects. Its value is to make the moral and administrative question visible enough to investigate with wider evidence.

2. How understanding changes without manipulation

People rarely change their minds because they are defeated or shamed. Communication research warns that facts alone do not guarantee understanding, while messages experienced as threats to freedom can produce psychological reactance. [A2][A3] This paper therefore uses an ethical persuasion discipline:

1. Name the strongest opposing concern before answering it.

- 2. Separate a person from an act, an act from its consequences, and consequences from labels.
- 3. Show benefits and harms symmetrically.
- 4. Use ordinary comparisons people already accept, especially alcohol and prescribed medicines.
- 5. Offer reversible trials and measurable stopping rules instead of demanding belief.
- 6. State uncertainty openly. Trust is damaged by confidence that outruns evidence.

The aim is not to ‘penetrate’ or override another mind. It is to make the reasoning easy to inspect, difficult to misrepresent and safe to reject until the evidence is persuasive.

3. Method, definitions and evidence rules

This is a structured policy synthesis rather than a new systematic review. It combines legislation, official guidance, government data, clinical guidance, primary or peer-reviewed research and international policy experience. Sources are graded by what they can support, not by whether they support the author’s conclusion.

Evidence label	Meaning	What it does not mean
Established	Authorised clinical use or replicated high-quality evidence for a defined purpose	Safe for every person, dose or context
Promising	Consistent early evidence or advanced trials	Ready for unrestricted use
Investigational	Active scientific study with material uncertainty	Proven treatment
Observed/social	A reported or measured effect relevant to behaviour	A medical benefit or endorsement
Proposal	A policy design offered for testing	A current legal entitlement or forecast

4. Twenty controlled substances: function, evidence and risk

The table is deliberately symmetrical. A useful function does not erase harm; a serious harm does not erase every function. ‘Social effect’ records why people may seek a substance—it is not a recommendation.

Substance	UK context	Medical/ scientific function	Reported social function	Evidence	Important harms	Sources
Cannabis / THC	Class B; Schedule 1, with specified medicines in other schedules	Selected cannabis-based medicines; modest average benefit for some indications	Relaxation, altered perception, sociability	Established for limited products; mixed by indication	Impairment, dependence, anxiety or psychosis risk in susceptible people; smoke exposure	S1,S2,S3
Ketamine	Class B; Schedule 2 medicine	Anaesthesia and analgesia; rapid antidepressant effects under specialist care	Dissociation, altered perspective and pain	Established anaesthetic; strong but protocol-dependent depression evidence	Acute impairment; dependence; urinary injury with heavy repeated use	S1,S4
MDMA	Class A; Schedule 1	Investigational MDMA-assisted therapy	Affiliation, warmth and music/dance enhancement	Advanced investigation; regulatory conclusions remain contested	Hyperthermia, cardiovascular strain, serotonergic toxicity and illicit-dose uncertainty	S1,S5
Psilocybin	Class A; Schedule 1	Investigational treatment for depression and other conditions	Introspection, connectedness and altered perspective	Promising; trial effects depend on screening and support	Acute anxiety or distress; psychiatric vulnerability and interaction risks	S1,S6

Substance	UK context	Medical/ scientific function	Reported social function	Evidence	Important harms	Sources
LSD / lysergide	Class A; Schedule 1	Psychiatric and consciousness research	Novel associations, introspection and altered perception	Investigational	Acute anxiety; prolonged distress in some people; context matters	S1,S7
Diamorphine / heroin	Class A; Schedule 2	Severe pain, palliative care and supervised dependence treatment	Analgesia and withdrawal suppression	Established medicine and specialist treatment	Dependence and respiratory depression; illicit supply increases overdose risk	S1,S8
Cocaine	Class A; Schedule 2	Topical local anaesthetic and vasoconstrictor	Stimulation, alertness and sociability	Established specialist medicine	Arrhythmia, stroke, dependence and compulsive redosing	S1,S9
Amphetamine / dexamfetamine	Class B; authorised medicines	ADHD and selected narcolepsy treatment	Wakefulness and task persistence	Established medicine	Cardiovascular effects, sleep loss and misuse/dependence potential	S1,S10
Methamphetamine	Class A	Limited medical use internationally; pharmacology research	Wakefulness and reduced fatigue	Limited medical role	High dependence potential, psychosis and cardiovascular/nutritional harm	S1,S11
GHB / sodium oxybate	Class B; pharmaceutical sodium oxybate regulated	Narcolepsy/ cataplexy treatment	Relaxation and disinhibition	Established pharmaceutical use	Steep dose-response; profound sedation; dangerous with depressants	S1,S12
Nitrous oxide	Class C outside exempt lawful contexts	Anaesthesia and analgesia	Brief euphoria and anxiety reduction	Established medicine	Neurological injury from repeated exposure; hypoxia risk	S1,S13
DMT	Class A; Schedule 1	Psychiatric, addiction and consciousness research	Introspection and altered self-experience; ritual use	Early investigation	Acute psychological distress; interaction and context risks	S1,S7
Mescaline	Class A; Schedule 1	Psychiatric and consciousness research	Traditional ceremonial use and introspection	Early or historical research	Acute anxiety, nausea and prolonged intoxication	S1,S7
PCP / phencyclidine	Class A	Historic anaesthetic; NMDA-receptor research tool	Historic anaesthetic/analgesic effects	Research and historical value	Severe behavioural and psychiatric toxicity at problematic doses	S1,S7
2C-B	Class A	Serotonergic and perception research	Sensory, emotional and social effects	Research only	Dose uncertainty, acute anxiety and limited clinical evidence	S1,S14
Mephedrone	Class B	Monoamine pharmacology research	Stimulation, euphoria and sociability	No established treatment	Dependence, cardiovascular toxicity, overheating and sleep disruption	S1,S15
Synthetic cannabinoids	Many are Class B or generically controlled	Cannabinoid-receptor research	Cannabis-like effects sought	Varies by compound	Some full agonists are far more toxic than THC; seizures, psychosis and cardiovascular harm	S1,S16
Opium	Class A preparations; opiates controlled	Historic source of morphine/codeine and analgesic pharmacology	Analgesia and sedation	Foundational historical medicine	Dependence and respiratory depression	S1,S17
Methadone	Class A; Schedule 2 medicine	Opioid substitution and analgesia	Stabilises withdrawal and craving	Established medicine	Respiratory depression, QT effects and dependence; dosing care required	S1,S17
Methylphenidate	Class B; Schedule 2 medicine	ADHD and narcolepsy	Focus, wakefulness and reduced impulsivity in responsive patients	Established medicine	Appetite, sleep and cardiovascular effects; misuse potential	S1,S10

5. Twenty-nine lawful medicines with serious recognised harms

These medicines can be indispensable. Their inclusion is not an argument against treatment. It demonstrates the ordinary medical principle that benefit, risk, dose, monitoring, consent and alternatives must be considered together.

Lawful medicine	Why it is used	Examples of serious recognised harm	Sources
Pregabalin	Neuropathic pain, epilepsy, anxiety	Dependence, withdrawal, sedation and respiratory risk with depressants	M1,M2
Gabapentin	Neuropathic pain, epilepsy	Dependence/withdrawal, sedation and respiratory risk in combinations	M1,M2
Fluoxetine	Depression, OCD and related conditions	Serotonin toxicity, hyponatraemia, sexual dysfunction and discontinuation symptoms	M3
Sertraline	Depression, anxiety, PTSD and OCD	Serotonin toxicity, bleeding interactions, hyponatraemia, sexual effects and withdrawal	M3
Paroxetine	Depression and anxiety	Sexual effects and potentially troublesome withdrawal	M3
Venlafaxine	Depression and anxiety	Withdrawal, hypertension and serotonin toxicity	M3
Amitriptyline	Depression and neuropathic pain	Cardiac and anticholinergic toxicity; overdose can be fatal	M3
Diazepam	Anxiety, seizures and muscle spasm	Dependence, tolerance, withdrawal seizures and dangerous sedative combinations	M1,M2
Zopiclone	Insomnia	Dependence, cognitive impairment, falls and withdrawal	M1,M2
Quetiapine	Psychosis and bipolar disorder	Sedation, metabolic disease, movement and cardiac effects	M4,M5
Olanzapine	Psychosis and bipolar disorder	Weight gain, diabetes/metabolic dysfunction and sedation	M4,M5
Risperidone	Psychosis and selected conditions	Movement disorders, prolactin/sexual and metabolic effects	M4
Lithium	Bipolar disorder	Kidney and thyroid effects; severe toxicity can cause neurological injury or death	M5
Sodium valproate	Epilepsy and bipolar disorder	Liver/pancreatic toxicity and major fetal/developmental risks	M5,M6
Carbamazepine	Epilepsy and neuralgia	Serious skin reactions, blood disorders, hepatic toxicity and interactions	M7
Tramadol	Pain	Dependence, seizures, respiratory depression and serotonin syndrome	M8
Morphine	Severe pain and palliative care	Dependence, constipation, sedation and respiratory depression	M8
Oxycodone	Severe pain	Dependence and potentially fatal respiratory depression	M8

Lawful medicine	Why it is used	Examples of serious recognised harm	Sources
Fentanyl	Severe pain and anaesthesia	Extreme potency, respiratory depression and fatal overdose	M8
Codeine	Pain	Dependence, constipation and respiratory depression; metabolic variation affects risk	M8
Paracetamol	Pain and fever	Overdose can cause acute liver failure and death	M9
Ibuprofen	Pain and inflammation	GI ulcer/bleeding, renal injury and cardiovascular risk	M10
Naproxen	Pain and inflammation	GI bleeding, renal injury and cardiovascular risk	M10
Diclofenac	Pain and inflammation	GI/renal harm and significant cardiovascular risk	M10
Aspirin	Antiplatelet treatment and pain	GI or intracranial bleeding and overdose toxicity	M10,M11
Warfarin	Prevention/treatment of thrombosis	Major or intracranial bleeding and extensive interactions	M11
Apixaban	Prevention/treatment of thrombosis	Serious internal or intracranial bleeding	M11
Prednisolone	Inflammatory and autoimmune disease	Infection, osteoporosis, diabetes, adrenal suppression and psychiatric effects	M12
Methotrexate	Autoimmune disease and cancer	Bone-marrow, liver and lung toxicity; severe infection; dosing errors can be fatal	M13

6. The alcohol test and responsibility

A 2010 UK multicriteria analysis ranked alcohol highest overall when harms to users and others were combined. The model is expert judgement and is not a timeless biological law, but it illustrates that legal class and measured harm are not the same variable. [A6]

Alcohol is associated with dependence, injury, violence, liver disease and cancer; the WHO states that cancer risk begins from the first drink. [A7] Yet adults are permitted to buy alcohol. A coherent system must explain why comparable or lower-harm conduct requires criminal punishment rather than proportionate regulation.

Responsibility remains

Intoxication does not excuse violence, coercion, dangerous driving, neglect of a dependent person or other harm. The reform principle is personal responsibility for conduct—not immunity because a substance was involved.

7. Pain, pleasure, connection and informed choice

Pain can constrain choice. A patient may face persistent pain, a lawful treatment that is ineffective or intolerable, and an illicit option of uncertain identity or dose. Ethical care does not mean supplying any requested drug. It means an honest review of evidence, risks, alternatives and the patient's values. The Supreme Court's Montgomery decision and GMC standards support material-risk disclosure and shared decision-making. [A8] [A9]

Pleasure and connection are also part of human welfare. Dance, sociability, relief and altered perspective are not clinical diagnoses, yet governments routinely regulate activities partly because adults value them.

Recognising a desired effect does not deny addiction or toxicity; it makes prevention more realistic because policy begins with why use occurs.

8. The cost of control

The Home Office’s June 2026 experimental wastewater analysis estimated an England retail market of approximately £12.0 billion across cocaine, ketamine, heroin, amphetamine, MDMA and methamphetamine between August 2024 and July 2025. Cannabis was not measured and the confidence intervals were wide. [A4] The figure should therefore be used as a scale indicator, not a precise tax forecast.

Criminalisation can create secondary costs: enforcement and court activity, prison bed-days, records that obstruct work and housing, fear of seeking treatment, and an unregulated market in which suppliers have no lawful quality duties. Dame Carol Black’s review documented severe treatment-system weakness and the wider costs of drug dependence. [A5]

A regulated system would not eliminate organised crime automatically. Success must be measured by illicit-market displacement, product safety, treatment access, deaths and violence—not simply by licences issued or taxes collected.

9. Strongest counterarguments—and answers

Concern	Proportionate response
Availability may increase use	It may for some products or groups. Use age controls, price floors, advertising bans, purchase limits and staged pilots; stop or tighten a tier if predefined harm thresholds are crossed.
Commercial firms may create another alcohol or tobacco industry	Use a public-health regulator, plain packaging, no lifestyle advertising, ownership transparency, potency-linked excise and limits on vertical integration.
Some substances are too dangerous for retail sale	Regulation need not mean ordinary retail. High-risk tiers may require prescription, pharmacy supply, supervised consumption or no commercial market.
Driving and workplace safety may worsen	Keep impairment offences, validated testing, safety-critical rules and employer duties. Do not equate inactive metabolites with current impairment.
International treaties constrain reform	They do. Decriminalisation, treatment and research can move faster than a nationwide non-medical market; Part II sets out a transparent treaty pathway.
Communities harmed by dealing want enforcement	Retain firm enforcement against violence, coercion, child exploitation, trafficking, dangerous adulteration and unlicensed high-risk supply.

10. A regulation matrix

Tier	Typical channel	Core controls	Examples for evaluation—not final assignments
A · Lower-risk adult products	Licensed specialist retail	Age verification, batch testing, dose labels, purchase limits, no advertising	Lower-potency cannabis products; final placement evidence-led
B · Pharmacy or trained-provider	Pharmacy / accredited specialist	Screening, interaction checks, recorded supply, stronger quantity limits	Selected stimulants or psychedelics if evidence permits

Tier	Typical channel	Core controls	Examples for evaluation—not final assignments
C · Clinical or supervised	Prescription, clinic or supervised service	Diagnosis/eligibility where relevant, observed dosing, emergency capacity	Diamorphine treatment, sodium oxybate, high-risk opioids
D · Research / exceptional licence	Accredited research or specialist licence	Protocol approval, secure storage, pharmacovigilance	Compounds without adequate safety evidence
Prohibited conduct	Criminal law	Children, coercion, spiking, dangerous adulteration, fraudulent substitution, violent debt enforcement	Conduct-based offences across all substances

11. NHS and care pathway

7. A person can disclose use without automatic punishment or loss of ordinary care.
8. Immediate triage covers overdose, withdrawal, mental state, pain and safeguarding.
9. A shared medication-and-substance review identifies interactions and alternatives.
10. Drug checking and toxicology information support harm reduction and public alerts.
11. Treatment is voluntary except where ordinary capacity, safeguarding or criminal-law principles require intervention.
12. Outcome measures include health, housing, work, relationships and the person's own goals—not abstinence alone.

12. Equality, accountability and institutional humility

Policy should publish enforcement and outcome data by geography, age, sex, ethnicity, disability and deprivation, with safeguards against re-identification. Disparities require explanation and correction. Regulators, police, clinicians and licensed businesses should disclose conflicts, publish reasons and remain reviewable.

This edition replaces the rhetorical phrase 'social psychosis' with 'institutional lock-in': a self-reinforcing policy belief maintained by sunk costs, selective evidence, status incentives and fear of admitting error. The term describes a governance mechanism, not a medical diagnosis of a person or society.

13. Findings and recommendations

- End criminal penalties for adult possession within evidence-based personal-use rules, while retaining conduct-based protections.
- Commission independent substance-by-substance risk tiers instead of treating 'drug' as one category.
- Build treatment, drug checking, product testing and data infrastructure before commercial expansion.
- Create a transparent justice-transition process for people imprisoned or burdened by conduct that becomes lawful.
- Use reversible pilots, 12- and 24-month reviews, a five-year statutory review and automatic expiry of unsupported restrictions.
- Publish an evidence register and corrections log so both supporters and critics can see what changed and why.

Appendix A. Evidence and correction register

ID	Claim	Basis	Status / limitation	Sources	Correction rule
E1	The 101-year-old arrest occurred as reported	Official agency statement	Supported as an agency report; allegation not adjudicated	A1	Correct if court or agency record changes
E2	Six-drug England market ≈ £12bn	Government experimental wastewater model	Supported with wide uncertainty; excludes cannabis	A4	Update when methodology or figures are superseded
E3	Legal status and measured harm diverge	UK comparative-harm analysis plus alcohol evidence	Supported as an analytical conclusion; rankings depend on model	A6,A7	Do not present ranking as biological fact
E4	Controlled substances can have medical/scientific functions	Official classifications, clinical guidance and trials	Supported unevenly by substance	S1-S17	Re-grade each row as evidence changes
E5	Lawful medicines can cause serious harm	NICE, MHRA and NHS guidance	Supported by medicine class; individual risk depends on dose/person	M1-M13	Use current product information in clinical decisions
E6	Regulation will reduce total harm	Policy inference from mechanisms and international experience	Plausible, not guaranteed	A5 plus Part II	Require pilots and stopping rules
E7	Respectful communication improves scrutiny	Science-communication and reactance literature	Supported at general level; not a guarantee of agreement	A2,A3	Test comprehension and trust, not compliance

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