

Drug Knowledge, Body Autonomy and Patient Choice

From punishment to care: lived experience, informed consent, harm reduction and accountable medicine

Discussion draft September 2026

This paper begins with a civic question: this is the situation I can see we are in, but does it have to remain this way? Could the same public tools be repurposed—from punishment to care, from secrecy to knowledge, and from uncontrolled supply to accountable control? People make safer and more legitimate decisions when scientific evidence, lived experience, product testing, professional observation and individual values can be examined together.

The position is rights based but not risk blind. Freedom means that an adult with decision making capacity should have the greatest possible control over what enters their body, supported by full and honest information. It does not mean that a clinician must certify an unknown product as safe, that driving while impaired becomes acceptable, or that one experience proves a universal truth. The task is transformation rather than abolition: retain rules that protect other people, repurpose institutions that can provide care, and remove punishments that create avoidable danger.

Reader note This is a discussion paper, not medical or legal advice and not an instruction to use illegal drugs. It does not recommend stopping prescribed medicines suddenly. Some medicines can cause dangerous withdrawal, and urgent concerns require a pharmacist, prescriber, NHS 111 or emergency care as appropriate.

Executive frame: the situation and the alternative

Every drug decision combines chemistry, circumstance and power. Dose, purity, route, interactions, health, setting and expectations all matter. So do the rules that determine which products are legal, affordable, researched, prescribed and discussed. The present pattern often divides legal medicine from illegal drugs as if legal status settled pharmacology, while patients report stigma, withdrawal and unequal access and police confront a resilient illicit market. A humane system should neither romanticise drugs nor use fear as its governing method.

People have a right to informed consent and, when they have decision making capacity, to refuse offered treatment. They have a right to information about risks, benefits and reasonable alternatives. Those rights do not create an unlimited entitlement to any chosen medicine or public funding, but they do require a meaningful voice in care. NHS and professional standards already recognise this principle. [1–3]

Lived experience belongs inside evidence, not underneath it. Patient reports can reveal pain, withdrawal, cognitive changes, stigma and failures of communication that trials may not measure well. They are especially valuable for detecting possible signals and deciding what to investigate. They are unreliable for estimating frequency or proving that a drug or clinician caused an outcome unless stronger evidence supports the connection.

Public Health England reached a similar practical conclusion in its review of prescribed medicines associated with dependence or withdrawal. It found reports of inadequate risk information, unrecognised withdrawal, insufficient review and lack of non medicinal options. It also warned that inappropriate restrictions may push people toward illicit or less regulated sources and increase harm. [4]

Regulation is also a resource question. England and Wales recorded 231,130 drug offences in the year ending March 2026, while suspected drug possession was the stated reason for about 318,000 stop and searches in the preceding year. Official statistics do not convert this activity into police hours. A transparent scenario in this paper therefore shows assumptions rather than claiming a measured saving. It also tests prison capacity, clinical workload and a publicly captured revenue model. [43, 44]

The proposed alternative is not a promise that every drug becomes harmless or every black market disappears. It is a civilised test: can the state obtain better outcomes by helping competent adults make informed choices, assuring product identity, providing supervised support and concentrating police power on violence, exploitation, children, dangerous driving and dishonest supply? Where a less coercive policy can reduce contamination, humiliation, avoidable pain or delayed rescue, refusing even to test it deserves explanation.

Core proposals

- Treat informed refusal, supported tapering and discussion of reasonable alternatives as ordinary parts of care.
- Use non judgmental language and separate physical dependence, addiction, pain relief, pleasure, coping and experimentation instead of treating them as one moral category.
- Fund drug checking, supervised settings, naloxone access and honest interaction advice wherever evidence shows that these measures reduce harm.
- Publish ownership, payments, prices, formularies, evidence submissions and conflicts so that commercial influence can be examined rather than merely alleged.
- Build research with patients, people who use drugs, pharmacists, paramedics and other frontline workers, while protecting confidentiality and testing claims against clinical and laboratory evidence.
- Pilot regulated access with standardised products, privacy safeguards, independent evaluation, a public resource ledger and continued enforcement against impaired driving, violence, sales to children and unlicensed supply.

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1 The situation I can see and the question it creates

The situation this paper can see is a contradiction. Society asks people to trust prescribed substances while sometimes discounting their reports of harm; it condemns other substances by legal category while leaving their actual supply to an unregulated market; and it spends public resources enforcing possession rules without publishing a complete ledger of the time, money, health outcomes and opportunity costs involved. None of those observations proves a conspiracy. Together they justify a public question: does it have to be this way, or can the same institutions be used differently?

The demand at the centre of this paper is straightforward. Your body is your own, and my body is mine. Healthcare should listen, explain, help and respond when a person reports pain, illness, withdrawal or harm. Government should protect people from coercion, contamination, fraud and harm to others without treating every person who uses a prohibited drug as an enemy or every person who questions a prescription as non compliant. Permission over one's own body should begin with the informed choice of the person who lives in it, subject to proportionate boundaries where conduct threatens another person.

This argument does not require the claim that all doctors are ignorant, that every company is corrupt, or that self experimentation is safe. Those claims are too broad to prove and too easy to dismiss. The stronger argument identifies the conduct that damages trust: consent obtained under pressure, known risks left unexplained, withdrawal mistaken for relapse, alternatives withheld without reasons, commercial interests hidden, individual feedback discounted, and criminal penalties that make honest disclosure dangerous.

Fear is useful as an acute alarm. It is a poor governing principle. Threats can make teenagers, patients and adults hide what they are doing. Secrecy then removes the very information that parents, clinicians and emergency workers need to reduce harm. Respectful communication does not guarantee agreement, but it makes accurate information more likely.

Transformation, not abolition

Public tool	Current punitive use	Care based use
Police power	Punish authorised adult possession	Protect against violence, coercion, exploitation, sales to children, impaired driving and dishonest supply
Clinical authority	Gatekeep through status or stigma	Explain evidence, assess material risk, support informed consent and document reasons
Regulation	Leave prohibited products unverified	Control identity, potency, manufacture, packaging, recall and truthful labelling
Emergency services	Meet people only after crisis	Use batch alerts, prepared protocols, onsite welfare and rapid non judgemental rescue
Patient reports	Dismiss stories as merely anecdotal	Treat them as signals, preserve records and test them against toxicology and population evidence
Public finance	Absorb costs across disconnected budgets	Publish a ledger and ring fence any public contribution for treatment, harm reduction and care

A six hour experience of wonder, music, movement or connection may be deeply meaningful to the person who has it. It may also involve dehydration, overheating, injury, panic, adulterants or dangerous interactions. Both statements can be true. Dismissing the meaning makes care less credible; dismissing the risk makes autonomy less informed. In this paper, 'civilised' means making that tension discussable and measurable. 'Barbaric' describes avoidable institutional humiliation, contamination, pain or delayed rescue—not the character of every doctor, police officer or public servant working inside the present system.

2 Drugs language and moral categories

A drug is a substance that changes biological function. The category includes prescription medicines, pharmacy products, alcohol, nicotine, caffeine and prohibited psychoactive substances. It also reaches many plant compounds and naturally occurring chemicals. Law and culture divide these substances into moral categories, but pharmacology does not recognise a border between respectable and disreputable molecules.

This does not mean that all drugs are equivalent. Risk depends on the substance and its potency, dose, purity, route, frequency, combinations, the person's physiology and mental state, and the physical and social setting. A regulated tablet has manufacturing controls that a powder from an illegal market may lack. A prescription may still be poorly chosen, badly monitored or difficult to stop. A familiar over the counter medicine can still cause serious harm.

Language should also be chemically accurate. Codeine is an opioid, but it is not heroin. Heroin is diamorphine. The relationship matters because both can cause dependence and respiratory depression, but calling them identical obscures important differences in potency, metabolism and use. Likewise, the anticoagulant sometimes called wolferine is warfarin. Precision helps people challenge a system without giving the system an easy reason to ignore them.

3 Science and lived experience

Science is incomplete by design. It is a method for testing claims, measuring uncertainty and correcting error. Its incompleteness is a reason to keep investigating, not a reason to place every claim on the same footing. Medicine becomes authoritarian when it presents provisional knowledge as unquestionable. Personal testimony becomes misleading when it presents one outcome as universal.

Evidence source	What it can reveal	What it cannot establish alone
Randomised trials	Average effects under controlled conditions	May exclude complex patients and miss rare or long term harms
Observational studies	Patterns in larger real world populations	Confounding can imitate causation
Pharmacovigilance	Signals after medicines enter wider use	Reports are incomplete and do not prove causation
Laboratory testing	Identity purity and contaminants	Does not predict one person's psychological or medical response
Qualitative research	Meaning context stigma and care experience	Usually cannot estimate population frequency
Experience reports	Detailed first person effects and unexpected possibilities	Identity dose memory selection and survivorship may be uncertain
Frontline observation	Acute failure modes and system gaps	Emergency work sees a selected high risk population

The best inquiry combines these forms. A patient story may generate a signal. Repeated stories may justify a formal study or regulatory review. Laboratory data can establish what was actually present. Clinical records can clarify timing and competing causes. Population studies can estimate frequency. None of this requires treating the person as a passive container for professional knowledge.

The 2026 MHRA review of gabapentin, pregabalin, benzodiazepines and Z drugs illustrates this combined approach. It considered Yellow Card reports, company data, international regulators, GP practice data and lived experience supplied by patient groups. It concluded that warnings about addiction, dependence, withdrawal and tolerance needed strengthening. [5] That is science learning from experience rather than using authority to silence it.

4 Consent refusal and patient choice

In England, valid consent must be voluntary, informed and given by a person with capacity. NHS guidance states that an adult with capacity may refuse a treatment even when refusal could result in death. Information should cover benefits, risks, reasonable alternatives and what may happen without treatment. [1] The NHS Constitution also recognises rights to accept or refuse offered treatment, receive information about options, and participate in decisions. [3] GMC guidance treats shared decision making and listening as fundamental to good medical practice. [2]

These rights are powerful but specific. A person can usually refuse an offered drug. A person can ask for another option, a second opinion, a medication review and an explanation of a funding decision. The law does not generally guarantee access to any drug a person chooses, nor does it require the NHS to fund an intervention that is unlawful, clinically inappropriate or outside commissioning rules. Emergency treatment, lack of decision making capacity and some mental health law situations create exceptions that require careful legal analysis.

The right to refuse treatment is also different from a general legal right to obtain any substance or to receive assistance in dying. Bodily autonomy remains the ethical starting point, but laws also address coercion, capacity, protection of children, dangerous supply, public safety and professional duties. A serious rights argument should confront those tensions directly.

What respectful refusal should look like

- The clinician checks that the person understands the relevant information and is deciding voluntarily.
- The record states the offered treatment, the person's reasons if they wish to give them, the alternatives discussed and the agreed safety plan.
- Refusal is not converted into a character judgement or used to deny unrelated care.
- If a medicine can cause withdrawal, refusal of continued treatment leads to a supported reduction plan rather than abrupt abandonment.
- The person is told how to seek review, complain, report a suspected adverse effect and obtain urgent help.

5 Prescribed dependence and preventable harm

The claim that legal medicine can cause dependence is not an alternative theory. It is recognised by public health authorities. Public Health England reported that 11.5 million adults in England received at least one prescription from five medicine groups associated with dependence or withdrawal in 2017 to 2018. It found 5.6 million people received opioid pain medicines and 1.5 million received gabapentinoids. It also identified 540,000 people with continuous opioid prescriptions and 160,000 with continuous gabapentinoid prescriptions from April 2015 to March 2018. [4] These historical figures describe scale, not current prevalence, but they show why supported review matters.

The same review reported that some patients lacked information about risks, felt that withdrawal was not recognised, received insufficient reviews, and were not offered non medicinal options. Its conclusion is especially important: patients seeking to stop must have appropriate advice and must never be stigmatised, while inappropriate restriction may increase suicide risk or push people toward illicit and less regulated supply. [4]

Current MHRA advice distinguishes physical dependence from addiction. It warns that abrupt stopping or dose reduction can produce withdrawal and that tapering may take weeks or months. The plan should be individual and flexible. [5] This directly challenges the idea that every request for help with a prescribed medicine proves moral failure or illicit intent.

Examples worth studying

Medicine	Established concern
Codeine	Opioid dependence withdrawal sedation and slow breathing are recognised risks. It should not be stopped suddenly after long use. [6]
Pregabalin and gabapentin	Dependence withdrawal tolerance and addiction warnings were strengthened in 2026. Pregabalin has also been linked to reports of severe respiratory depression, with higher risk in some patients and combinations. [5, 9]
Naproxen	Ulcer or gastrointestinal bleeding kidney problems and heart failure are recognised serious harms. The smallest effective dose for the shortest period is advised. [7]
Ibuprofen	This NSAID can also cause gastrointestinal kidney and cardiovascular harm, especially in susceptible people or with certain combinations. [8]

High risk combinations to ask about

Combination	Why it matters	Question to ask
Opioid plus pregabalin or gabapentin	Greater sedation and respiratory depression risk	Why is this combination needed and what monitoring or alternatives apply
Opioid plus benzodiazepine Z drug or alcohol	Additive central nervous system and breathing suppression	Which depressants should be reduced or avoided and what is the emergency plan
Naproxen plus ibuprofen or aspirin for pain	Greater ulcer bleeding and other NSAID toxicity	Am I taking two NSAIDs and which single plan is intended
NSAID plus warfarin or another anticoagulant	Bleeding risk may rise	Has the interaction been reviewed and is another pain treatment safer
NSAID plus ACE inhibitor or ARB plus diuretic	The combination can increase acute kidney injury risk	Do I need kidney tests hydration advice or an alternative
Tramadol plus serotonergic medicines	Serotonin toxicity and seizure risk may rise	Have all antidepressants migraine drugs and other medicines been checked
Methotrexate plus trimethoprim	Potentially severe bone marrow toxicity	Has the prescriber checked this specific interaction
Nitrate medicine plus sildenafil or similar drug	Dangerous fall in blood pressure	Are these medicines ever safe together for me

This table is a prompt for professional review, not a complete interaction checker. A pharmacist is often the most accessible medicines specialist. Severe sleepiness, slow or shallow breathing, collapse, vomiting blood, black stools, severe confusion or other acute danger requires urgent assessment.

6 Harm reduction and regulated care

Prohibition can create specific harms: uncertain strength, substitution, contamination, hurried use, fear of seeking help and exposure to violent markets. It does not follow that prohibition causes every drug harm or that legal supply would make every use safe. Regulation changes which risks can be measured and controlled. It can set standards for identity, potency, packaging, age, staff training, record keeping and emergency response.

A humane setting can offer sterile equipment, a calm place, water, time to recover, staff who check on people, and rapid access to emergency care. It can also provide drug checking, naloxone, wound care, housing help and a route into treatment without making abstinence the price of dignity. Systematic reviews of supervised injection facilities report prevention of on site overdose deaths and benefits such as safer practice or service connection, while population level effects and study quality vary. [21]

The Thistle in Glasgow opened in January 2025 as the United Kingdom's first sanctioned safer drug consumption facility. People bring their own drugs and use them under health supervision. The facility was designed with people who had lived experience and emphasises relationships, privacy, basic care and wider support. [20] It is an experiment that should be evaluated transparently, including benefits, unintended effects, neighbourhood impacts, cost and user experience.

Drug checking addresses a different problem. WEDINOS accepts anonymous samples and publishes analytical results so that people and services can compare what a substance was believed to be with what testing found. [22] Testing cannot make consumption safe, but it can expose mis selling and create evidence about the illegal market that prohibition otherwise hides.

7 Frontline and paramedic knowledge

Paramedics see acute consequences that may remain invisible in routine appointments: respiratory depression, panic, seizure, overheating, falls, violence, withdrawal, polypharmacy, homelessness and the results of delayed care. Their observations matter because they show how a policy or prescription behaves in uncontrolled life.

Frontline experience also has selection bias. Paramedics are called when something has gone wrong, so they cannot estimate how often uneventful use occurs. A GP or specialist sees a different part of the same person's life, including diagnosis, follow up and long term tradeoffs. Neither viewpoint should dominate. A credible system should link ambulance data, toxicology, patient accounts, primary care records and mortality review while protecting privacy.

There is no clearly credential verified, open UK forum devoted specifically to honest paramedic accounts of drug incidents. The public communities r ParamedicsUK and r Paramedics contain professional discussion, but identity and credentials are not independently guaranteed and patient identifiable details are prohibited. [34, 35] The College of Paramedics and the Journal of Paramedic Practice provide more formal professional material. Coroners' Prevention of Future Deaths reports provide named legal findings and organisational responses when a death reveals a systemic risk. [36]

A clinician checking an electronic reference during an appointment is not proof of ignorance. Current interaction guidance and formularies change, so checking can be responsible practice. The legitimate

questions are whether the source is authoritative, whether the clinician understands the person, whether alternatives and uncertainty are discussed, and whether time or access rules are replacing judgment.

8 Access control money and commercial power

Access is controlled by several institutions rather than one hidden distributor. The MHRA licenses medicines and regulates manufacturing and wholesale standards. NICE evaluates clinical and cost effectiveness for routine NHS use in England. NHS commissioners and local formularies shape implementation. Prescribers decide whether a medicine is clinically appropriate. Pharmacies dispense it. Manufacturers and wholesalers supply it. [10, 13] Each stage can protect patients, restrict them, or both.

Actor	Practical role	What should be transparent
Manufacturer	Develops or produces a medicine and usually proposes its price	Trial design selective publication patents marketing and supply
MHRA	Licenses products and regulates safety manufacturing and distribution	Regulatory decisions safety signals inspections and conflicts
NICE	Assesses clinical effectiveness and value for NHS use in England	Evidence thresholds models assumptions and patient participation
NHS commissioner or formulary	Funds services and defines local pathways	Variation waiting times exception processes and reasons
Prescriber	Recommends or refuses treatment for an individual	Consent alternatives review monitoring and declared interests
Pharmacy	Dispenses and is reimbursed or paid privately	Substitution supply continuity counselling and fees
Patient	Accepts refuses reports effects and lives with the outcome	Access to records information complaints and shared decisions

Companies influence the evidence base because they fund development and submit evidence about new products. That influence is real and should be disclosed. It does not mean that every approval was purchased. The House of Commons Library explains that manufacturers set prices within NHS purchasing and cost control mechanisms, while NICE considers cost effectiveness and the NHS may negotiate discounts. [10, 11] The Drug Tariff sets reimbursement, remuneration, fees and prices for community pharmacy in England and Wales. [12]

A private prescription is normally a private transaction. Consultation fees go to the clinic, dispensing and product charges to the relevant pharmacy and supply chain, and the NHS does not ordinarily receive that private sales revenue. An NHS organisation may separately operate a self pay service, in which case revenue belongs to that service. The ownership and payment chain should be visible before anyone labels the arrangement corruption.

Corruption is a claim about concealed payment, improper influence, conflicts or abuse of office. Unequal access, two tier care and commercial incentives can exist without meeting that definition. A responsible investigation should examine company ownership, clinician interests, clinic pharmacy manufacturer relationships, procurement records, political donations, lobbying, payments disclosed through Disclosure UK, and any commission linked to prescribing. Naming the money flow is more powerful than assuming a motive.

9 Cannabis and ketamine case studies

Medical cannabis exposes a visible gap between formal legality and practical access. NHS guidance says that very few people in England are likely to receive an NHS prescription and identifies limited circumstances involving severe epilepsy, chemotherapy related nausea and multiple sclerosis spasticity. It also says evidence for pain is not strong enough for a general recommendation. [15, 16] Private clinics may lawfully prescribe within controlled drug and professional rules, but being regulated by the Care Quality Commission or employing a doctor who also works in the NHS does not make a private prescription an NHS prescription.

The access gap raises legitimate questions about equality, research priorities and commercial incentives. It does not prove that private cannabis is universally effective or safe. A 2026 inquest concerning Oliver Robinson reported that privately prescribed medicinal cannabis probably contributed to his death and identified problems involving records, information and coordination of care. The clinic disputed aspects and described changes. [18] One case cannot estimate sector wide risk, but it shows why private care needs the same scrutiny demanded of public care.

Ketamine has established medical uses as an anaesthetic and analgesic. Ketamine for depression is generally off label, private or restricted to specialist arrangements. Esketamine is licensed for treatment resistant depression, but NICE did not recommend it for routine NHS use in its 2022 technology appraisal because of uncertainty in the clinical and economic evidence. [17] This distinction matters: legal status, marketing authorisation, NHS recommendation and individual clinical judgment are separate gates.

These case studies support a demand for consistent standards. Public and private providers should share relevant records, state the evidence and uncertainty, declare financial interests, monitor harms, publish meaningful outcome data and provide a clear route for complaints. Restricting NHS access while a private market expands may be unjust, but the remedy is transparent evaluation and accountable access rather than weaker safeguards.

10 Police time prison space and public money

A national claim needs a national ledger. No published source was found that totals all police hours spent on drug prohibition across the United Kingdom. The legal systems and health responsibilities of England and Wales, Scotland and Northern Ireland also differ. The most defensible calculation therefore uses recent England and Wales counts and makes each time assumption visible. It is an order of magnitude exercise, not an official forecast.

Official baselines and their limits

Measure	Baseline	Interpretation
Police recorded drug offences	231,130 in the year ending March 2026	157,786 possession, 73,344 trafficking and 609 other. An offence is not a unique person or a complete case. [43]
PACE stop and searches	522,670 in the year ending March 2025	60.9% were for suspected drug possession, about 318,000 searches. This is an incident count and may overlap recorded offences. [44]
Prison population	85,858 on 30 June 2026	70,003 were sentenced. Drug offences were 12% of immediate custodial sentences. Applying 12% to the whole sentenced count gives a rough ceiling of about 8,400, not an exact total. [47]
Drug offence remand estimate	About 1,700 on 30 June 2026	Calculated from 8% of 10,242 untried prisoners and 17% of 5,144 convicted unsentenced prisoners. Published percentages are rounded. [47]
Prison place cost	£56,987 in 2023 to 2024	Overall resource expenditure per certified normal place. This is an average, not the cash saved by removing one prisoner. [48]
Illicit market	£9.4 billion a year in the 2020 review	Historical estimate for England and Wales. The same review estimated more than £19 billion in wider social costs and £600 million spent on treatment and prevention. [45]

Source status matters. The offence, search, prison, cost and market baselines above are public figures from ONS, the Home Office, the Ministry of Justice or a government commissioned review. Every police hour, full time equivalent, releasable prison place and future sales contribution below is calculated by this paper from stated assumptions. Those results are scenarios for scrutiny, not statistics issued by government or promises of cash savings.

Illustrative police time

The whole case estimate multiplies 231,130 recorded drug offences by an assumed average number of officer hours covering the initial encounter, travel, recording, evidence, investigation and related administration. One full time equivalent is then set at 1,500 productive hours a year. Neither assumption is an official police measure.

Scenario	Hours per recorded offence	Officer hours	Productive FTE equivalent
Low	5	1.16 million	770
Central	10	2.31 million	1,541
High	20	4.62 million	3,082

A separate stop and search cross check reaches a smaller but visible floor. About 318,000 drug searches at an assumed 0.5 officer hour each equal about 159,000 officer hours, or 106 productive FTE. This covers only the search event assumption and excludes travel, supervision, custody, testing, case preparation and court. It must not be added to the offence based range because the same events may be counted twice.

Legal regulation would not release every hour. Police would still investigate unlicensed production, counterfeit products, diversion, sales to children, organised violence, exploitation and impaired driving. The possible gain is a shift away from authorised adult possession and supply toward those harms and toward visible community policing. Whether that happens depends on budgets and deployment decisions rather than following automatically from a change in law.

Illustrative prison capacity

Using the rough current ceiling of 10,100 sentenced and remand prisoners whose principal category is a drug offence, the table tests what would happen if 25%, 50% or 75% of those places became unnecessary after resentencing, release review and lawful supply. It is not a prediction. Serious trafficking, violence and unlicensed supply would remain offences, while some people convicted of simple possession may not be in prison at all.

Policy case	Places potentially released	Gross annual cost capacity at £56,987
25% eligible	About 2,525	About £144 million
50% eligible	About 5,050	About £288 million
75% eligible	About 7,575	About £432 million

These are gross capacity values, not bankable savings. Prisons have fixed costs, released places may be filled because the estate is crowded, and closing a wing or prison saves more than leaving scattered beds empty. Courts, probation, housing and treatment may need more funding during transition. The 2020 review also estimated that about 20,000 people on a given day were detained for offending related to their drug use rather than supply, mostly acquisitive crime. Regulation alone does not erase those convictions or the needs behind them. Accessible treatment, income, housing and continuity of care are required to reduce that wider prison churn. [45]

Illustrative publicly captured revenue

The revenue model starts with the 2020 £9.4 billion illicit market estimate because it is published alongside the £600 million treatment and prevention benchmark. Regulated sales equal market value multiplied by the share moved into the legal channel and by a legal to illicit price ratio. Public contribution equals sales multiplied by a contribution rate after production, laboratory testing, dispensing, clinical review and administration. This contribution reaches the NHS or local treatment system only if legislation creates a public supplier, levy, tax or binding ring fence.

Case	Legal share	Price ratio	Contribution	Sales	Public contribution	After £0.6bn reserve
Cautious	50%	60%	10%	£2.82bn	£0.282bn	minus £0.318bn
Central	70%	70%	20%	£4.606bn	£0.921bn	plus £0.321bn
Upper	85%	80%	25%	£6.392bn	£1.598bn	plus £0.998bn

The central illustration leaves 30% of the former market outside the legal channel and produces £321 million after the historical service reserve. It does not show that regulation would abolish the black market. Legal displacement depends on competitive price, products people actually choose, reliable availability, privacy, opening hours and eligibility rules. High tax, stigma, narrow products or slow appointments can preserve illicit demand. Conversely, a public channel priced below the illegal market may reduce contribution while displacing more illegal sales.

The £600 million reserve is retained only to keep the calculation aligned with the 2020 market estimate. It is not a current treatment budget. The 2022 drugs strategy later committed an additional £780 million over three years to rebuild treatment and recovery services, illustrating why any final model must replace the historical reserve with current local authority, NHS, justice and voluntary sector accounts. [46]

The £19 billion social cost cannot be subtracted as if it were an NHS invoice. It includes health harm, crime and wider effects, much of which is not a cash budget and would not vanish. Police, prison and court savings also accrue to different organisations. A credible law would publish a distribution rule, for example product and service costs first, a protected treatment and harm reduction allocation second, local authority and ambulance support third, and any remaining surplus to the NHS. Parliament would need current market, service and behavioural data before setting rates.

11 A regulated access model

The question can be stated plainly: could an adult ask a clinician, ‘Can I have three pills to go raving at the weekend?’ Under current law the answer cannot be a routine recreational prescription. MDMA is listed as a Class A, Schedule 1 controlled drug, and changing that position would require legislation, licensing and a new professional framework. [51] The policy question is whether Parliament should create a tightly evaluated route in which the person can ask honestly and receive an evidence based decision without being treated as a criminal.

The number three is not itself a safe dose. Tablets can differ in identity and potency, people differ in physiology and medicines, and repeated use during heat and exertion can change risk. A lawful model would authorise a standardised product and quantity under a published protocol. It would never treat an unknown street pill or a requested count as a clinical unit.

A possible event access pathway

Stage	Safeguard
1 Request	An adult asks without fear of arrest or loss of unrelated healthcare. The service explains confidentiality and its limits.
2 Review	A trained clinician or pharmacist reviews health conditions, current medicines, previous reactions, capacity, expected setting and plans for driving or safety critical work.
3 Decision	Approval is not automatic. The professional may authorise within protocol, delay, decline with reasons, seek specialist advice or offer another harm reduction plan. Risk based contraindications are clinical safeguards, not discrimination.
4 Supply	An authorised pharmacy supplies a laboratory verified product in tamper evident packaging with identity, strength, warnings, batch number and a route for recall.
5 Event support	The venue provides free water, cooling and quiet spaces, drug checking, trained welfare staff, paramedics and rapid transfer. Onsite teams receive batch alerts and protocols.
6 Public safety	The person agrees not to drive or undertake safety critical work while impaired. Police enforce impairment, violence, coercion, diversion and unlicensed sales rather than authorised possession.
7 Learning	The service records outcomes, adverse effects and near misses, invites follow up and publishes anonymised results through an independent evaluator.

Confidentiality and emergency information

Routine notification to police that a named person plans to use a drug would make honesty less likely and would conflict with the purpose of confidential care. GMC guidance treats confidentiality as an important ethical and legal duty. Disclosure is normally based on consent, a legal requirement or a justified public interest such as preventing serious harm. Only relevant information should be shared. [49] A safer design gives police aggregate operational information and gives ambulance or venue clinicians batch warnings and treatment protocols. Personal information follows the patient with explicit consent, through direct care rules, or under a clear emergency legal basis.

Drug driving remains a separate public safety boundary. Current law makes it illegal to drive when unfit because of legal or illegal drugs, and police may use impairment assessments, roadside screening and evidential tests. A future authorisation should not become permission to drive while impaired. [50] The same principle applies to operating machinery or other safety critical work.

Clinical capacity and gatekeeping

Making every recreational decision a GP appointment could reproduce scarcity and medicalise autonomy. The 2020 review estimated about 3 million adults used drugs in England and Wales. One 20 minute annual review for that population would require about 1 million clinical hours or 667 full time equivalents at 1,500 productive hours each. Four reviews a year would require 4 million hours or 2,667 full time equivalents. Monthly 30 minute support for the 300,000 higher risk opiate or crack population would be another 1.8 million hours or 1,200 equivalents. These are workload illustrations, not staffing forecasts. [45]

A more workable model would use trained pharmacists, nurses, specialist prescribers and digital records, with GPs involved when medical complexity requires them. Independent eligibility rules, an appeal route and equality monitoring would reduce arbitrary refusal. A clinician should protect a person's welfare, not act as a moral gatekeeper, but professional authorisation still carries a duty to refuse when a protocol identifies a material danger.

What a pilot must test

- Deaths emergency calls overheating respiratory depression panic injury and delayed presentations
- Product identity potency contamination diversion and unlicensed market share
- Driving and workplace impairment violence exploitation and sales to children
- Access by income ethnicity disability geography and previous contact with police or healthcare
- Patient trust disclosure consent privacy complaints and reasons for clinical refusal
- Police ambulance pharmacy primary care treatment court and prison workload in comparable hours and pounds
- Changes in frequency dose patterns dependence treatment entry and quality of life without assuming that abstinence is the only valuable outcome

The humane promise would be modest and testable: be honest, receive accurate information, use a known product if the law permits, do not drive or endanger others, and get help without punishment when something goes wrong. A pilot could show that this reduces harm, or it could reveal new harms and inequities. Either result should be published. Respect for autonomy includes respecting evidence that complicates the preferred policy.

12 A practical method for questioning treatment

Legitimate refusal is a skill. It becomes easier when a person asks specific questions, requests a written record and separates disagreement about values from disagreement about facts. The following questions can be taken to a GP, specialist or pharmacist.

1. What problem or diagnosis is this medicine intended to treat, and how certain is that diagnosis
2. What benefit should I expect, how large is it, how soon should it appear, and how will we know whether it worked
3. What common and serious harms matter for my health history, age, kidneys, liver, mental health and other medicines
4. Can this medicine cause tolerance, physical dependence, addiction or withdrawal, and what is the stopping plan before I begin
5. What reasonable alternatives exist, including another medicine, a non medicinal treatment, watchful waiting or no treatment
6. Why is this option preferred for me, and is the choice affected by a formulary, shortage, price or commissioning rule
7. What evidence supports the recommendation, who funded it, and what important uncertainty remains
8. Which combinations should I avoid, and has a pharmacist reviewed my complete list including alcohol, cannabis, supplements and non prescribed drugs
9. What monitoring is needed, who will review the results, and what symptoms mean I should seek urgent help
10. May I have time to decide, written information, access to my records, or a second opinion
11. Please record that I do not consent to this option and record the alternative or review I am requesting

A concise refusal script

I understand the purpose you have explained. I do not consent to starting or continuing this treatment at present. Please explain the reasonable alternatives, the risks of no treatment, and any withdrawal risk. Please record my decision and the reason for any alternative you cannot offer. I would like a medication review or second opinion.

A person who wants to stop codeine, pregabalin, gabapentin, benzodiazepines, Z drugs, antidepressants or another dependence forming medicine should not be forced into abrupt cessation. The request should lead to an individual plan. [4, 5] Suspected medicine harm can be reported directly through the MHRA Yellow Card scheme. [37]

13 Sources for alternative and patient perspectives

No source is neutral. Every archive reflects who contributes, who survives to write, what moderators select, what funders support and which experiences are easier to describe. The aim is therefore not to find a bias free site. It is to compare sources with different methods and incentives.

Source	Address and type	Why use it and what to watch
Erowid	Psychoactive library erowid.org/	Broad archive joining chemistry law culture health and experience. Useful for orientation. Content varies by source and date. [23]
Erowid Experience Vaults	First person reports www.erowid.org/experiences/	Positive negative and mixed reports reviewed for publication. Erowid states that reports are authors' opinions and activities are not recommendations. [24]
Erowid Chemical Vaults	Substance index www.erowid.org/chemicals/	Fast route to substance specific pages and related material. Some pages are old or incomplete and should be checked against current sources. [25]
PsychonautWiki	Community reference psychonautwiki.org/	Structured descriptions of effects and harm reduction concepts. Community edited and not a clinical authority. [26]
Bluelight	Harm reduction forum www.bluelight.org/community/	Long running peer discussion with research participation and recovery spaces. Identities and claims usually remain unverified. [27]
Drugs Forum	Peer forum drugs-forum.com/	Large discussion archive covering experience law recovery and health. Quality varies by contributor and thread. [28]
TripSit	Education and peer support tripsit.me/	Volunteer harm reduction community with factsheets and a combination chart. The site states that volunteers are not certified professionals. [29]
WEDINOS	Anonymous laboratory testing wedinos.wales/	Tests submitted substances and publishes results. Stronger for identity than a story, but a submitted sample does not describe the whole market. [22]
Release	Law and harm reduction www.release.org.uk/	UK charity providing drug law information, policy analysis and confidential legal advice. It has an explicit human rights and reform perspective. [30]
Transform	Drug policy reform transformdrugs.org/	Develops arguments and models for legal regulation. Useful advocacy analysis, not a neutral evaluator of prohibition. [31]

Source	Address and type	Why use it and what to watch
Drug Science	Independent research and commentary www.drugscience.org.uk/	Scientific charity covering harms, psychedelics and medical cannabis. It openly supports reform and should be read alongside contrary evidence. [32]
Patient Communities	Medicine experiences community.patient.info/	Patient and carer discussions about side effects, withdrawal and care. Useful for possible signals and language, not causal findings. [33]
ParamedicsUK	Public frontline discussion www.reddit.com/r/ParamedicsUK/	UK focused public forum where professional identity is not guaranteed and patient identifying details are prohibited. [34]
Prevention of Future Deaths	Coroner reports www.judiciary.uk/prevention-of-future-death-reports/	Named legal reports on risks that may cause further deaths, with responses from organisations. More accountable than anonymous claims but limited to selected deaths. [36]
MHRA Yellow Card	Suspected adverse effects yellowcard.mhra.gov.uk/	Official route for patients and professionals to report suspected medicine harms. A report is a safety signal, not proof by itself. [37]

The likely source name behind Narccount is PsychonautWiki. Its name comes from psychonaut, a person who explores altered states. The website address is psychonautwiki.org. It is useful as a community reference, but its entries should be checked against current pharmacology, toxicology and official alerts.

14 Reading experience reports responsibly

An experience report should be read as a case narrative. It can answer what this person noticed and what questions the story raises. It cannot answer how likely the result is for another person without broader data.

- **Identity** Was the substance laboratory tested, prescribed, in original packaging or merely sold under a name
- **Amount and route** Is the amount known and is the route clear without treating remembered precision as certainty
- **Timing** Did the effect begin and end in a pattern consistent with the substance and route
- **Combinations** Were alcohol, medicines, supplements or other drugs also present
- **Baseline** What pain, illness, sleep loss, diet, hydration, tolerance and mental state existed first
- **Setting** Who was present and were heat, exertion, fear, music, conflict or expectation important
- **Outcome** Was there objective evidence such as toxicology, blood tests, diagnosis or a clinical record
- **Selection** Are dramatic positive and negative reports more likely to be submitted than ordinary experiences
- **Alternatives** Could illness, adulteration, withdrawal, interaction or coincidence better explain the event
- **Transferability** What is specific to this person and what appears repeatedly across independent sources

Competent reports may contain detailed chemistry and biology. Readers should learn enough to understand basic pharmacology, metabolism, interactions and uncertainty. Technical language is not proof of accuracy, but refusing to learn it leaves decision making to whoever controls access.

15 Principles for humane drug policy

Principle	Practical meaning
Bodily autonomy	Adults with capacity should control consent to treatment and be able to express informed refusal without punishment or loss of unrelated care.
Honest risk	Legal status must not substitute for pharmacology. Information should state benefits harms uncertainty dependence and withdrawal in comparable language.
Care before stigma	Pain relief dependence experimentation and addiction require different responses. Language should describe behaviour and need rather than condemn identity.
Quality control	Where use occurs policy should reduce unknown strength contamination substitution and dangerous packaging through testing standards and alerts.
Harm reduction	Drug checking naloxone sterile supplies supervised facilities and rapid medical care should be assessed as health interventions rather than moral rewards.
Supported choice	Patients should receive reasonable alternatives and individual stopping plans. No one should be abandoned because they decline the first offer.
Transparent money	Ownership prices discounts payments lobbying research funding and prescribing interests should be visible in forms that patients can understand.
Shared evidence	Research should combine trials population data toxicology adverse event systems qualitative work and lived experience while preserving the limits of each.
Frontline learning	Paramedics pharmacists nurses peers and patients should have protected routes to report patterns without breaching confidentiality or risking retaliation.
Measured accountability	Claims of corruption negligence or benefit should be tied to records methods and evidence so that they can be investigated and corrected.
Confidential care	Personal health information should not become a police register. Share identifiable information with consent or a clear legal and proportionate justification.
Auditable resources	Publish police hours prison capacity clinical workload service costs market capture and revenue assumptions so that policy claims can be challenged.

The choice before us

This is the situation the paper can see: people will continue to seek relief, pleasure, connection, energy, sleep, altered consciousness and escape; prescribed and prohibited drugs can both help and harm; lived experience is often rich but cannot calculate population risk; science is indispensable but unfinished; and the illegal market remains resilient even while public money is spent trying to suppress it. The evidence does not require us to accept that arrangement as permanent.

It could be this way instead: adults ask honest questions without making themselves criminals; clinicians and pharmacists answer with evidence, uncertainty and respect; regulated products have known identity and strength; venues and ambulance teams prepare for foreseeable emergencies; police concentrate on violence, coercion, children, dangerous driving and fraudulent supply; patient reports become research signals; and every pound claimed as a saving or public contribution appears in an auditable ledger. That is transformation, not abolition. The tools remain—law, medicine, regulation, policing and public finance—but perspective changes their purpose.

The most defensible demand is not that medicine surrender evidence or that government approve every requested product. It is that authority stop substituting for consent and that prohibition stop pretending to be a complete safety policy. Listen when a person says a medicine is harming them. Explain rather than command. Offer reasonable alternatives. Record uncertainty. Investigate patterns. Help when help is requested. A person should be able to say no with knowledge and, within a lawful framework that protects other people, to say yes with knowledge. That is the freedom this paper asks society to test: civilised care in place of avoidable fear and punishment.

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Appendix A Patient experience threads

The twenty public threads below report possible adverse effects, withdrawal, dependence or difficulty obtaining support involving naproxen, pregabalin, gabapentin, codeine and ibuprofen. They were selected to show what lived experience can sound like. They are anonymous or pseudonymous accounts, not verified diagnoses or findings that a clinician caused harm or death. Read them as signals and questions, then compare them with official safety information and professional advice.

Number	Medicine	Thread and address
1	Naproxen	Naproxen 500 mg community.patient.info/t/naproxen-500mg/671872/2
2	Naproxen	Naproxen side effects community.patient.info/t/naproxen-side-effects/532326/2
3	Naproxen	Naproxen messed up my stomach community.patient.info/t/naproxen-messed-up-my-stomach/619331/2
4	Pregabalin	Generic pregabalin feels different to Lyrica community.patient.info/t/generic-pregabalin-feels-very-different-to-lyrica/680399/2
5	Pregabalin	Pregabalin community.patient.info/t/pregabalin/690666/2
6	Pregabalin	Pregabalin two months on advice needed community.patient.info/t/pregabalin-2-months-on-it-so-far-advice-needed-and-my-background/656366/2
7	Pregabalin	Pregabalin and gabapentin community.patient.info/t/pregabalin-and-gabapentin/771300/2
8	Pregabalin	Losing the pregabalin weight community.patient.info/t/losing-the-pregabalin-weight/738464/2
9	Gabapentin	Gabapentin for foot neuropathy community.patient.info/t/taking-gabapentin-for-neuropathy-in-feet-hardly-any-relief-now-having-muscle-and-joint-pain/642086/2
10	Gabapentin	Gabapentin and mirtazapine community.patient.info/t/gabapentin-and-mirtazapine/510400/2
11	Gabapentin	Gabapentin withdrawal continues community.patient.info/t/gabapentin-withdrawal-horror-continues/789181/2
12	Gabapentin	Gabapentin for nerve pain community.patient.info/t/gabapentin-for-genital-herpes-nerve-pain/690569/2
13	Gabapentin	Gabapentin and the FDA community.patient.info/t/gabapentin-what-the-fda-needs-to-know/649956/2
14	Codeine	Buprenorphine for codeine dependence community.patient.info/t/buprenorphine-for-codeine-addiction/665416/2

Number	Medicine	Thread and address
15	Codeine	Unexpected codeine withdrawal community.patient.info/t/unexpected-codeine-withdrawals-please-need-some-advice/584793/2
16	Codeine	Help with codeine dependence community.patient.info/t/need-help-with-codeine-addiction/618533/2
17	Codeine	Codeine withdrawals community.patient.info/t/codeine-withdrawals/504776/2
18	Codeine	Nurofen Plus and codeine dependence community.patient.info/t/nurofen-codeine-addiction/528192/2
19	Ibuprofen	Ibuprofen tablets and gel community.patient.info/t/ibuprofen-tablets-and-ibuprofen-gel/548680/2
20	Ibuprofen	Side effects of ibuprofen gel community.patient.info/t/sides-effects-of-ibuprofen-gel/553023/2

A stronger evidence trail begins when a report is dated, the product and manufacturer are identified, the medicine list and time course are recorded, an adverse event is reported through Yellow Card, and relevant records or test results are preserved. Even then, causation may remain uncertain. The purpose is to make investigation possible.

Appendix B Animal use of bioactive substances

Drug related behaviour is not uniquely human. Animals encounter and sometimes select biologically active substances. The examples below involve self medication, parasite defence or exposure to naturally fermented foods. They do not prove that animals endorse human recreational drug use, and they do not establish that domestic cats safely seek cannabis. Veterinary reports of cannabis poisoning are a reason to keep it away from pets. The narrower point is that biology contains tradeoffs in which a toxic compound can have a useful effect in a particular context.

Animal	Observed behaviour	What the evidence supports
Domestic cats	Rub and roll on catnip or silver vine iridoids	Experiments found transfer to fur and mosquito repellence. [38]
Woolly bear caterpillars	Increase ingestion of pyrrolizidine alkaloids when parasitised	The plant toxins improved survival of parasitised caterpillars but harmed unparasitised ones. [39]
Fruit fly larvae	Consume ethanol in response to parasitoid infection	Experimental work found ethanol could protect larvae against blood borne parasitoids. [40]
Monarch butterflies	Use milkweed with defensive cardenolides	Experiments and field work link some milkweeds with reduced parasite burden and maternal selection. [41]
Chimpanzees	Swallow rough leaves and chew bitter plant material	Observed behaviours are associated with intestinal parasite removal or bioactive compounds. [39, 41]
Sumatran orangutan	Applied chewed medicinal plant to a facial wound	A 2024 case report documented targeted application followed by healing. [42]
House finches and sparrows	Add cigarette fibres containing nicotine to nests	Experiments reported reduced ectoparasites, although toxic exposure also carries costs. [41]
Honeybees	Collect and incorporate antimicrobial plant resin as propolis	Colonies increase resin collection under some parasite or pathogen challenges. [41]
Wood ants	Bring antimicrobial resin into nests	Experimental literature describes colony level protection against pathogens. [39, 41]
Grazing livestock	Select tannin rich plants or other compounds under parasite pressure	Controlled and field observations support context dependent self selection. [39, 41]

The caterpillar result is particularly instructive. A toxin improved survival when parasites were present and reduced survival when they were absent. [39] The effect of a drug cannot be separated from dose, condition and context. That lesson supports careful human research, not automatic imitation of animals.