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Criminal Policy of Iran and the United Kingdom Regarding the Offense of Drug Use

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ABSTRACT

This study conducts a comparative analysis of the criminal policy of Iran and the United Kingdom concerning the use of narcotic drugs, and explains the logic behind integrating punishment with health-oriented interventions. The research follows a descriptive–analytical approach and relies on primary legal sources, sentencing guidelines, and executive documents. For comparison, the study employs a three-dimensional matrix—legislative, judicial, and executive—against four policy criteria: proportionality, deterrent effectiveness, alignment with public health, and enforceability. The findings indicate that Iran criminalizes "use/addiction" but Articles 15 and 16 of the Anti-Narcotics Law provide treatment-oriented pathways for exemption or suspension of prosecution, thereby facilitating the legal exit of the user from the criminal cycle. In the United Kingdom, "use" per se is not criminalized, and criminal policy exerts its practical effect through the criminalization of "possession" under the Misuse of Drugs Act 1971 and the focus on production and supply under the Psychoactive Substances Act 2016. Sentencing is calibrated through binding guidelines of the Sentencing Council, and treatment-oriented community orders offer an alternative to short-term imprisonment. The executive analysis reveals that Iran, in order to enhance the effectiveness of its response to drug use, requires standardization of criminal decision-making, continuity of treatment from prison to community, and integration of health–justice data systems. Conversely, the United Kingdom—through its "From Harm to Hope" strategy, mandatory treatment requirements in community orders, and expanded access to naloxone—presents a more coherent model. Accordingly, the article recommends developing criteria-based sentencing guidelines, institutionalizing diversion from prosecution conditional on treatment, implementing the "Take-Home Naloxone" protocol, and establishing online dashboards for monitoring coverage and outcomes as key policy implications.

Keywords: *criminal policy; drug use offense; Anti-Narcotics Law (Iran); Misuse of Drugs Act 1971; Psychoactive Substances Act 2016; proportionality of punishment; Iran; United Kingdom.*

Introduction

Addiction to narcotic and psychotropic substances today represents one of the most complex social and public health challenges, producing multidimensional economic, social, and legal consequences, and is rightly regarded as a "global concern" (1). In policy discourse, the connection between drugs and criminality has often been treated as an obvious axiom and used as the basis for adopting stringent legislation; however, when such a link is generalized without precise empirical evidence, it can result in inefficient and costly penal policies (2). On the

individual level, dependency resulting from repeated use creates serious physical and psychological risks and provokes social and institutional reactions (1).

Within the legal framework of the Islamic Republic of Iran, the responsibility to combat manifestations of corruption—including addiction—is explicitly assigned to the state. The legislative memory of the country reflects the adoption of severe and sometimes differential reactions; nevertheless, within the framework of a "rational criminal policy," punishment is justified not as retribution but through its preventive and deterrent functions (3). Furthermore, criminal policy constitutes a network of legislative, judicial, and executive safeguards that may contain conflicting objectives or inconsistent instruments (4). In recent years, alongside punitive approaches, there have been efforts to render interventions treatment-oriented and to facilitate the social reintegration of dependent individuals; however, persistent conflicts and inconsistencies at the implementation level may diminish policy effectiveness (5).

In the United Kingdom, the legal framework governing controlled and psychoactive substances has been strengthened through gradual reforms, and alongside continuous criminalization of production and supply, health-oriented and harm reduction approaches have also emerged. Thus, the rigor applied to the supply chain is combined with therapeutic and social innovations within the domain of consumption (6). This institutional coexistence of "supply control" and "demand/harm reduction," rather than relying solely on punishment, seeks to balance deterrent efficiency with the imperatives of public health (7).

This study, adopting a descriptive–analytical approach, comparatively examines the criminal policy of Iran and the United Kingdom regarding the offense of drug use. The guiding questions are: (1) What measures have been adopted in the two systems to address "use"? (2) What are the points of convergence and divergence? (3) To what extent are these measures consistent with the goals of prevention, proportionality of punishment, dignity of stakeholders, and social reintegration? The innovation of this article lies in constructing a three-dimensional comparative matrix and proposing evaluation criteria—*proportionality, deterrent effectiveness, alignment with public health, and enforceability*—to guide future policymaking. The structure of the paper proceeds as follows: theoretical foundations of drug criminal policy; description of the legal frameworks of both countries; comparative analysis; and finally, policy implications for enhancing penal governance and harm reduction (8).

Theoretical Framework

Criminal policy may be conceptualized as a *multi-level architecture* of responses to criminality that integrates intelligent legislation, fair adjudication, evidence-based policing/execution, and social prevention—an architecture simultaneously advancing two objectives: "reducing social harm" and "limiting/legitimizing penal power" (9).

Accordingly, an effective criminal policy links the multi-level structure of prevention and penal response under two principles—*legitimacy* and *evidence-based efficiency*. On the one hand, the theory and evidence of *procedural justice* demonstrate that perceptions of neutrality, respect, and explainability in interactions with police and courts enhance legitimacy and, consequently, strengthen compliance with the law and cooperation with authorities, even more effectively than fear of punishment (10). On the other hand, the *UN/UNODC Crime Prevention Guidelines* emphasize that national criminal policy must be designed and implemented with clear leadership, intersectoral coordination among justice, health, education, and housing sectors, participation of civil society and business actors, and continuous evaluation (11). The synthesis of these two lines of thought implies that contemporary

criminal policy becomes sustainable and effective when it combines integrated, data-driven prevention with fair and accountable procedures—thus producing legitimacy while reducing the costs of coercive control.

From a procedural standpoint, the focal tension remains the classical dichotomy between Packer's two models: the *crime control model* emphasizing functional efficiency, versus the *due process model* emphasizing rights and fairness, which together define the policymaker's matrix of choices (speed/certainty versus accuracy/rights). Over the past three decades, a shift toward *risk governance* and *new penology* has occurred—moving the focus from rehabilitating individuals to managing high-risk populations through the language of risk assessment, classification, and population control. This evolution, captured in the "culture of control," has been reinforced by public demands for order/security and political accountability, yet in the absence of normative safeguards, it exposes defensive rights to gradual erosion (12).

Concurrently, deterrence research indicates that the *perceived certainty* of detection and arrest exerts a stronger preventive effect than the *severity* of punishment. Hence, effective policy should emphasize increasing detection probability, ensuring swift response, and designing situational strategies rather than engaging in a punitive escalation race (13). At the level of legitimacy, compliance with the law stems less from fear of sanction and more from the experiential dimensions of procedural justice—being heard, neutrality, transparency, and respect—suggesting that investment in procedural justice is as crucial as any deterrent measure (10).

In practice, evidence-based policing has demonstrated that spatial concentration ("hot spots") and targeted interventions can reduce crime without necessarily displacing it. Ultimately, the normative framework of legitimate criminal policy rests upon international standards, including the *Nelson Mandela Rules* regarding the dignity of prisoners and the *Tokyo Rules* promoting non-custodial measures and the principle of minimum intervention (11).

In conclusion, a measurable and accountable criminal policy finds its meaning in the interconnection of three key components: *fair certainty* (rather than severity), *procedural legitimacy*, and *data-driven prevention/execution*—all within the framework of *fundamental rights* and *international standards* (4).

Measures Governing the Offense of "Use of Narcotic/Psychoactive Substances" in Iran and England

Iran

In this section, the principal measures concerning the use of narcotic and psychoactive substances in Iran will be examined and analyzed.

A — Criminalization

Iran's normative framework is grounded in the *Anti-Narcotics Law*, which criminalizes production, distribution, possession, and use of substances while simultaneously embedding mechanisms for voluntary and compulsory treatment. The text enacted in 1988, as amended in 1997 and 2010, consolidated the overall structure of penal and therapeutic responses—including Article 15, which, while treating addiction as an offense, declares that "all persons with addiction are permitted to refer to the authorized centers designated by the Ministry of Health, Treatment, and Medical Education to undertake treatment and rehabilitation." Close scrutiny of this provision suggests that the legislature primarily envisioned persons who present voluntarily; this is reflected in Note 1, which states that "the aforementioned addicted persons shall be exempt from criminal prosecution for the offense of addiction during the period of treatment and rehabilitation," and in Article 16, which provides for compulsory custody of persons manifestly suffering from a substance use disorder for a specified period (usually 1 to 3 months, and in some cases

up to 6 months) in the designated centers. This design clearly indicates a legislative approach that combines criminalization with treatment-orientation and endeavors, through “suspension of prosecution conditional upon treatment,” to create a lawful exit channel from the penal cycle for users (14, 15).

B — Institutionalization

From the perspective of *institution-building*, pursuant to Article 33 of the “Law Amending the Anti-Narcotics Law and Adding Articles Thereto” (resolutions of the Expediency Council, with subsequent amendments), the *Anti-Narcotics Headquarters* (Setad) was established under the chairmanship of the President, and the concentration of “all executive and judicial operations,” as well as prevention/education programs, was provided for within it; the composition of Setad was completed in later amendments (including the 1992 revision of Article 33) with the participation of senior executive and judicial authorities (14).

The financial and budgetary backing for this centralization is also strengthened within the law: Article 29 obliges the Government to include “the funds required for implementing the programs ratified by Setad” each year in the national budget bill. In addition, Note to Article 36 obliges courts to transmit copies of all final judgments issued in narcotics cases to Setad; this requirement entrenches Setad’s position in monitoring, evaluation, and data-driven policymaking based on judicial information (14).

With respect to *regulatory powers*, Article 34 of the same law explicitly authorizes Setad “to prepare and formulate the necessary executive by-laws as required.” On this basis, the “Executive By-Law of the Law Amending the Anti-Narcotics Law and Adding Articles Thereto” (34 articles and 28 notes; adopted 1999-01-12) was approved and, in particular, provided for a network of *Provincial/County/District Coordinating Councils for Combating Narcotics* to ensure inter-agency coordination (Article 33 of the By-Law). A targeted 1992 amendment to Article 33—redefining certain membership seats—demonstrates that Setad’s composition has been updated over time to streamline the institutional architecture of suppression, prevention, and treatment, and later consolidated into its current form through the 1997/2010 amendments (14). One of the key outputs of this authority is the “Executive By-Law of Authorized Centers for Treatment and Harm Reduction of Addiction to Narcotics and Psychoactive Substances” (issued under Note 1 of Article 15), which delineates the framework for outpatient/residential treatment centers, agonist maintenance therapy (e.g., methadone), harm reduction centers (including needle and syringe program services), and national/provincial oversight mechanisms (15, 16).

C — Network-Building

At the *operational networking* level, beyond the national headquarters, the 1999 Executive By-Law (Article 33) mandates the creation of “Coordinating Councils for Combating Narcotics” at the province/county/district levels to guarantee inter-agency coordination locally. Thus, the institutional linkage of Setad with the Judiciary, law enforcement, and the Ministries of Health and Welfare at national and provincial tiers is explicitly stated and institutionalized in the regulations. The same Executive By-Law (adopted 1999-01-12) defines the status of provincial councils and extends the coordination chain down the administrative hierarchy: under Clause (c) of Article 1, the *Provincial Coordinating Council for Combating Narcotics* corresponds to the provincial councils referenced in Article 8 of the “Organization and Duties of Setad,” established by the decision of Setad’s 11th meeting (2001-02-27) and operating “directly under the Center,” thereby confirming the vertical linkage between provincial councils and the central headquarters (15, 16).

Pursuant to Article 33 of the Executive By-Law (1999-01-12), the Coordinating Councils are obligated—“in accordance with the country’s administrative divisions (county–city–district)”—to establish subsidiary anti-narcotics

councils; accordingly, the inter-agency coordination mechanism is institutionalized from the provincial level down to counties and districts (15).

For specialized functions, Article 29 of the By-Law provides for the formation of thematic committees under Setad's Secretariat—such as "Public Education," "Prevention, Treatment, and Rehabilitation," "Publicity," and "Supply Reduction"—thus adding a functional/specialized dimension to the operational network alongside its territorial dimension. As for composition and chairmanship, formal procedures stipulate that the *Governor* chairs the provincial Coordinating Council and the *County Governor* chairs the county council; formal appointment notices issued by the Ministry of Interior, Setad, and provincial governorates have consistently confirmed this structure. The Secretariat of the Provincial Council is situated within the governorate's organizational chart, and the council's secretary is appointed by Setad/the Governor—evidence of the continued institutional linkage between Setad and the executive apparatus of the province (15, 16).

The linkage with the Judiciary and the police is likewise specified and operationalized in the regulations: on the one hand, the Note to Article 36 of the Law obliges courts to send "copies of all final judgments" to Setad so that judicial data directly feeds into the policy cycle; on the other hand, the By-Law defines "detecting organizations" and judicial police within the coordination chain. Finally, to finance the operational network, Article 29 of the Law (as amended 2001-11-17) requires the Government to provide "the necessary funds for implementing Setad's approved programs" annually in the national budget—thus reinforcing the continuity of functions performed by provincial/local councils and committees (14).

The legal logic of network-building in this field rests on three pillars: (1) the definition and hierarchy of councils under the "Center" (Clause (c) of Article 1 of the 1999 By-Law), (2) the extension of councils down to the county/district levels (Article 33 of the By-Law), together with specialized committees (Article 29 of the By-Law), and (3) institutional linkage to the Judiciary and the public budget (Note to Article 36 and Article 29 of the Law), which collectively *specify* and *institutionalize* Setad's connection with the Judiciary, law enforcement, and the Ministries of Health and Welfare at national and provincial levels (14-16).

D — Therapeutic Arms

With respect to the *therapeutic arms*, Article 15 (as amended 2010-07-31) explicitly provides for "authorized centers for treatment and harm reduction," and stipulates that a person with addiction who obtains a "treatment/harm-reduction certificate" from such centers, provided that they do not *manifest addiction publicly*, shall be exempt from criminal prosecution; conversely, refusal to seek treatment or to quit is criminalized. Note 1 to Article 15 assigns the preparation of the "By-Law on Authorized Centers" to the Ministry of Health and the Ministry of Welfare, with final approval by Setad; Note 2 obliges the Ministry of Welfare to cover the treatment costs of indigent persons with addiction under basic and inpatient insurance schemes, and mandates the Government to allocate the requisite funds annually in the national budget (14-16).

On this basis, the "Executive By-Law of Authorized Centers for Treatment and Harm Reduction of Addiction… pursuant to Note 1 of Article 15" (adopted 2013-05-06; promulgated 2013-06-19) defines the types of centers and sets out the rules for establishment and oversight: outpatient treatment centers; inpatient wards/centers; medium-term residential centers; peer-run self-help residential centers; *therapeutic communities (TCs)*; units/centers for agonist pharmacotherapy in accordance with issued protocols; behavioral disease counseling centers; and harm reduction centers. The By-Law designates (depending on center type) the Ministry of Health and the State Welfare

Organization as the licensing authorities, provides for national/provincial oversight committees, and requires data registration in the *National Anti-Narcotics Information System* (15, 16).

In parallel, Article 16 (as amended 2010-07-31) stipulates *compulsory custody*—by judicial order only—of persons *without* an Article 15 certificate who *manifest addiction publicly*, for 1 to 3 months in governmental and authorized centers; a single three-month extension is permissible upon the center's request. The center must submit a *monthly treatment progress report* to the judicial authority, and, where the individual is willing to continue with *voluntary* treatment, the pathway under Article 15 may be followed. Note 1 mandates "post-release supervision obligations" upon proposal of Setad's Secretariat and approval by the Head of the Judiciary; Note 2 provides for a *six-month suspension of prosecution* (once, upon securing bail and the undertaking to present an Article 15 certificate and referral to relevant centers), with a further *three-month* extension permitted; Note 3 prescribes imprisonment of 91 days to 6 months for non-compliance without a valid excuse. The amended text of Article 15—and its rationale of "non-prosecution contingent upon treatment without public manifestation"—together with the executive/oversight frameworks of the 2013 By-Law, has fortified the legal foundation of the "network of voluntary centers," and, through the mechanisms of Article 16 (judicial order, monthly reporting, post-release care, and suspension of prosecution), has established an institutional linkage thereto (8, 14, 15).

N — International Dimension

In the *international* dimension, Iran's framework for cooperation with United Nations bodies on drugs has been incorporated into domestic law through the "Law on Accession to the 1988 Vienna Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances" (adopted 1991-11-24). This law commits the Government to the Convention's provisions and enables operational and judicial cooperation such as *mutual legal assistance*, *extradition*, *controlled delivery*, *seizure and confiscation of proceeds of crime*, and *precursor control* (Articles 3, 5, 6, 7, 9, and 12 of the Convention) (2, 11).

In addition, Iran had previously acceded to the *Single Convention on Narcotic Drugs, 1961 (New York)* (Law of Accession: 1972-07-09), the *1972 Protocol amending the 1961 Convention* (Law of Accession: 2001-08-05), and the *Convention on Psychotropic Substances, 1971* (Law of Accession: approved by Parliament 1998-06-16; confirmed by the Council 1998-06-21). Collectively, these instruments reinforce the domestic framework for *schedule control*, restriction of use to *medical/scientific purposes*, and cooperation with the relevant international bodies. In particular, the 1988 Convention, in Article 14, emphasizes *demand-reduction measures* and *rehabilitation and treatment*, thereby providing a legal basis for technical cooperation with the United Nations Office on Drugs and Crime (UNODC) in areas such as prevention, addiction treatment, and HIV/harm-reduction programs among key populations and within prisons (7, 11, 17). UNODC's country programs for Iran under the *Country Partnership Programme* during 2016–2019 and its updated 2023–2025 cycle advance operational cooperation across three main pillars: (1) counter-trafficking and border management; (2) criminal justice and anti–money laundering/financial crime; (3) health, treatment, and harm reduction (including agonist therapy and related interventions) (11).

At the regional level, the *Trilateral Initiative* among Iran, Afghanistan, and Pakistan—facilitated by UNODC since 2007—has provided a platform for joint operations, exchange of intelligence/information, and confidence-building along borders, complementing the cooperation commitments embedded in the 1988 Convention (11). Furthermore, to align domestically with the 1988 Convention's obligations regarding proceeds of trafficking, the *Anti–Money Laundering Law* (2008-01-22) and the *Law Amending the Anti–Money Laundering Law* (2019-01-23), together with their implementing by-laws, have strengthened the framework for detection, seizure, confiscation, and international

financial cooperation; these measures directly correspond to the Convention's provisions on confiscation of proceeds and financial/judicial cooperation (18, 19). Consequently, in addition to the "Law on Accession to the 1988 Vienna Convention," Iran's accession to the 1961 and 1971 treaties and the 1972 Protocol—combined with the domestic anti–money-laundering regime—has created an *internal–international legal chain* that coherently supports technical cooperation with UNODC (in prevention, treatment, and HIV/harm reduction), cross-border judicial and police cooperation, and the control of precursors and criminal proceeds (2, 11).

Y — From the Policy-Making Perspective

From the vantage point of *health-oriented policymaking and monitoring/evaluation*, Iran's legal underpinnings are explicit. First, Note 1 to Article 15 of the Law Amending the Anti-Narcotics Law led to the adoption of the *Executive By-Law on Authorized Centers for Treatment and Harm Reduction*, which institutionalizes assessment and monitoring. This By-Law (promulgated 2013-06-19) not only explicitly defines center types—including *harm reduction centers* and *behavioral disease counseling centers* that specifically target high-risk groups such as people who inject drugs—but also establishes oversight mechanisms at two levels ("National Oversight Committee" and "Provincial Oversight Committee") and mandates adherence to a "Supervision and Evaluation Guideline for Centers" (Articles 4 and 5; Notes 1 and 2) (15, 16). More importantly, Article 14 of the same By-Law obliges all relevant agencies and centers to *collect and register data in the National Anti-Narcotics Information System for treatment and harm reduction*, treating non-cooperation as grounds for *license revocation*; this provides a statutory basis for improving data quality and reducing errors such as *double counting of clients* (8, 15).

Second, the *General Policies for Combating Narcotics* (promulgated 2006-10-02) expressly mandate alignment of criminalization with "approved treatment and harm-reduction programs" (Clause 5) and the "establishment and expansion of diagnostic, treatment, and harm-reduction facilities" (Clause 6), and also stipulate the "development of fundamental, applied, and developmental research" to provide scientific support for policies (Clause 10). The normative message of this instrument prioritizes evidence-based policy and requires continuous evaluation (4, 11, 14).

Third, regarding *data integration and prevention of duplicate counting*, national planning law obliges the Government to establish the *Electronic Health Record System for Iranians* and to ensure cooperation from all public and non-public health centers (former Article 74(a); web numbering L1053–L1056). This legal requirement enables assignment of a *unique identifier* and real-time information exchange across agencies to measure the *true coverage* of services—including for people who inject drugs—and serves as the legal basis for redesigning addiction data-collection systems (8, 15).

Fourth, in *closed settings*, the *Executive By-Law of the Prisons Organization and Security–Correctional Measures* explicitly provides for the delivery of health services in cooperation with the Ministry of Health and for health insurance coverage for persons deprived of liberty (Articles 146 and 147). This legal linkage to the health sector facilitates continuity of evidence-based treatments, including *agonist therapies* pursuant to ministerial protocols, within prisons (15, 17). A review of practice indicates that Iran's penal policy in confronting drug trafficking has, in effect, focused more on *peripheral actors*, while *principal actors* have often evaded prosecution. The inaccessibility of principal actors stems from the *organized* nature of drug trafficking: masterminds plan operations at a distance and recruit weak and vulnerable individuals as couriers; consequently, counter-narcotics efforts become limited to the *lower tiers* of trafficking organizations (20).

England: Measures Governing "Use/Possession for Personal Use"

A — Sentencing Council Guidelines

In England, sentencing for drug offenses is grounded in the *legal duty of courts to follow the Sentencing Council's guidelines* and a *stepwise model for assessing offense seriousness*. Under Section 59 of the *Sentencing Act 2020*, each court must follow the relevant guideline when determining sentence unless doing so would be contrary to the interests of justice; accordingly, the revised drug offenses guidelines issued on 2021-01-27 and effective from 2021-04-01 form the operative basis. In "possession of a controlled drug" (section 5(2) of the *Misuse of Drugs Act 1971*), the initial categorization turns on the class of the drug (A/B/C), and for each class a "starting point" and "sentencing range" are specified (for example, for Class A from a fine up to 51 weeks' custody; for Class B from discharge up to 26 weeks' custody); aggravating/mitigating factors are then applied. For "supply/possession with intent," "production/cultivation," and "importation/exportation," the court assesses the offender's role (leading/significant/lesser) and the harm level (largely quantity/output/purity) and, on that basis, selects the "starting point" and "range," adjusting to the case circumstances; in some repeat Class A cases, a seven-year minimum is contemplated. Statutory maxima continue to follow the A/B/C classification (for example, possession of Class A up to 7 years, Class B up to 5 years, Class C up to 2 years; and supply/production/importation of Class A up to life, with B and C up to 14 years). Therefore, under this law, "simple possession" (except in custodial settings) is not an offense, whereas production/supply/intent to supply/import/export are criminalized with maxima up to seven years' custody. (6, 9, 13).

B — The Misuse of Drugs Act 1971

Under section 5 of the *Misuse of Drugs Act 1971* (MDA 1971), *unauthorized possession* of a controlled drug constitutes an offense; the Act criminalizes controlled drugs and sets statutory maxima by class—"for Class A up to 7 years, for Class B up to 5 years, and for Class C up to 2 years" (plus a fine). Courts sentence within the guideline ranges by reference to the class, quantity, context, and criminal history. The statute also sets the foundation for *seizure, search, and licensing*, and, together with secondary legislation, provides the licensing regime for drugs with medical uses. (13).

Put differently, historically the conviction and regulation of distribution and use of cocaine and (principally) morphine, and later cannabis, coexisted with access to prescribed cocaine and heroin for dependent users through physicians—a measure known as the *British System*, endorsed by the Rolleston Committee in 1928. This treatment system separated the management of dependent users from the punishment of unauthorized suppliers. Up to the 1980s, UK drug policy followed this distinct system; the number of users was comparatively small and prevalence remained low, while a small subset of dependent users continued to receive prescribed medications as part of treatment (21, 22).

In the 1980s, two developments produced a sharp increase in legal control over illicit drugs: first, the prescription of large amounts of heroin by a small number of physicians, which leaked into the illicit market; second, the rising consumption of cannabis, amphetamines, and LSD, which had not previously been prevalent in the UK. This led to a *third phase* of drug policy in which intensified control coincided with increased prevalence across the 1960s–1980s. In 1991, the first statutory steps toward integrating criminal justice responses with health interventions were taken. Today, there is less separation between punitive and medical responses than in the past British System (9, 22). For *possession*, the statutory maxima by class are: for Class A up to 7 years' imprisonment (plus an unlimited

fine), for Class B up to 5 years, and for Class C up to 2 years; in practice, courts sentence by applying the Sentencing Council's definitive guideline, taking account of harm/quantity, location and context, and criminal history. In "supply/offer to supply" or "possession with intent," sections 4(3) and 5(3) of the MDA 1971 apply, with a Class A maximum of life imprisonment (6, 13).

The duty on courts to *follow* these guidelines is also entrenched in statute (e.g., the modern framework reflected in subsequent legislation), requiring adherence unless doing so would be unjust. Regarding *seizure, search, and warrants*, statutory powers authorize officers to stop and search persons, inspect vehicles/vessels, and seize items evidencing an offense; warrants to search premises may be issued on reasonable suspicion. Operational use of these powers is aligned with policing codes of practice. For the *licensing and medical-use regime*, detailed rules appear in the *Misuse of Drugs Regulations 2001*: scheduling of substances (Schedules 1–5) based on therapeutic value/misuse potential, exemptions, licensing, and storage/prescribing requirements; Home Office guidance elaborates licensed uses and exemptions (including certain cannabinoid products). Updated classifications and regulatory schemata are published through the government's information services (9, 13).

C — The Psychoactive Substances Act 2016

In 2016, the *Psychoactive Substances Act* defined a "psychoactive substance" as any substance capable of producing a psychoactive effect in a person by stimulating or depressing the person's central nervous system and thereby affecting the person's mental functioning or emotional state (section 2(1)). Rather than listing specific compounds, the Act targets any substance with a "psychoactive effect" (subject to exemptions), and criminalizes production, supply/offer to supply, possession with intent to supply, and import/export; *simple possession* is criminalized only within custodial institutions (sections 4–9, 10–11). The Act sets a maximum of up to 7 years' imprisonment/unlimited fine for most offenses, and up to 2 years for possession in a custodial institution. The overall focus is thus on *production/supply/importation*, while simple possession (outside prisons) is not criminalized; however, "possession with intent to supply" attracts defined penal limits. In tandem with traditional offenses relating to classic drugs, the 2016 Act provides an agile legislative response to "new psychoactive substances." In public policy, the Government's 10-year drugs strategy proceeds on *twin pillars*: "disrupting the supply chain" and "expanding treatment and recovery." The first-year report (2022–2023) announced over £3 billion for the first three years, with clear targets to expand access to treatment, reduce overdose deaths, and strengthen justice–health linkages; from 2024, a 10-year workforce plan for addiction and alcohol treatment aims at sustainable service capacity. The Government also explicitly emphasizes expanding access to naloxone and undertaking legal changes to facilitate its distribution—measures that strengthen *treatment-oriented pathways* alongside proportionate, guideline-based criminal responses (7, 17, 23, 24).

In day-to-day operations, policing strategies that concentrate on *hot spots* and collaborate with social/health services simultaneously increase the *probability of detection* and *referral to treatment*; courts, guided by the definitive sentencing guidelines, tend—especially for users at risk of dependence—to prefer community orders with *Drug Rehabilitation Requirements* or *Alcohol Treatment Requirements* over short custodial terms, an approach aligned with evidence on reduced reoffending and cost-effectiveness (10, 23, 24). Overall, England's architecture for "possession for personal use" combines statute-based criminalization, diversion and community-based treatment, and health-oriented investment within a national 10-year strategy and standardized sentencing guidance (7, 13, 17).

Commonalities

Both systems (Iran and England) address “use/possession” within a hybrid penal–health framework such that criminalization remains the hard core of policy, while channels for “diversion from prosecution/suspension of prosecution conditional upon treatment” and “treatment-oriented community alternatives” are provided for users. In both, higher-order policy instruments and operational/judicial guidance play a decisive role in standardizing decisions, and a multilateral coordination mechanism (the national headquarters and provincial councils in Iran; the national strategy, Sentencing Council guidelines, and the justice–health nexus in England) is established to link criminal justice with treatment and to monitor outcomes.

Table 1. Common Grounds in the Criminal Policy of Iran and England on the Offense of Drug Use

Axis of Commonality	Iran	England	Regulatory Evidence / Example
Penal–health hybrid	Exemption from prosecution in voluntary treatment; possibility of compulsory custody by judicial order	Non-custodial alternatives; community-based orders/social penalties and Drug Rehabilitation Requirements for dependence	Article 15 and 16 of the Anti-Narcotics Law (Iran); sentencing practice in England
Decision standardization	Executive by-laws and a network of coordinating councils	Definitive sentencing guidelines (duty to follow unless contrary to justice)	2013 Executive By-Law (Iran); Section 59 of the Sentencing Act 2020 and definitive Sentencing Council guidelines
Linkage with health policy	Authorized treatment/harm-reduction centers and data-registration system	“From Harm to Hope” strategy and linkage between the justice system and the NHS	By-Law on Authorized Centers (2013); UK Drugs Strategy
Coordination mechanism	National headquarters and provincial/county councils	Cross-sector councils/partnerships and unified judicial practice	Article 33 of the Law and the 1999 Executive By-Law (Iran); sentencing guidance in England

Differences

The core divergence concerns the threshold of criminalization and the logic for assessing “proportionality of punishment”: in Iran, “use/addiction” is an offense but is paired with treatment-oriented paths to exemption/suspension (Articles 15 and 16); by contrast, in England “simple possession of psychoactive substances” is generally not an offense (outside custodial settings), with emphasis placed on production/supply. In sentencing, Iran relies more on statutory and by-law rules, whereas in England the “role × harm” matrix (combining offender role with quantitative/qualitative drug indicators) and “income-based fine bands” determine the starting point and range. Additionally, in Iran a hierarchical network (headquarters–province–county) with budget mandates and transmission of court judgments is institutionalized, while in England the duty to follow Sentencing Council guidelines and the use of “out-of-court” tools (warnings/cautions) at the police/prosecution level are more prominent.

Table 2. Points of Difference in the Criminal Policy of Iran and England on the Offense of Drug Use

Axis of Difference	Iran (Feature)	England (Feature)	Policy Implication
Criminalization threshold	Use/addiction is an offense, with treatment-oriented exemption	Under the 2016 framework, simple possession of psychoactive substances (outside detention) is not an offense	Iran focuses on treatment as an exit pathway; England focuses on the supply chain
Sentencing logic	Statutory and by-law rules; judicial discretion in suspension/custody	“Role × harm” matrix and income-based fine bands	Greater transparency and predictability in England for supply/offer to supply/possession with intent
Diversion tools	Suspension of prosecution conditional on treatment; compulsory custody by order	Warnings/cautions, community-based disposal, and treatment requirements	Earlier police-level intervention in the UK; greater reliance on judicial decision-making in Iran

Institutional architecture	Central headquarters and provincial/county councils with budget mandates and court-reporting	Unified national sentencing guidance plus multi-year strategy/budget	Centrality of the "Headquarters" in Iran; centrality of "guidance and strategy" in the UK
Criminalization focus	Broad criminalization of use/possession alongside concurrent treatment	Emphasis on production/supply; simple possession (under PSA) largely non-criminal	Different punitive burdens on users across the two systems

Policy Implications: Iran and England

In this section, the key policy implications on the offense of drug use for Iran and England are distilled and operationalized.

1 — Proportionality and Standardization of Sentencing Decisions

The core of effective penal governance is *proportionality*—calibrating sanction to culpability and harm. In England, the legislative and doctrinal architecture organizes seriousness assessment around the dual axes of *role/culpability* and *harm/impact*, operationalized through definitive Sentencing Council guidelines and a duty on courts to follow them unless contrary to justice, which reduces unwarranted disparity and improves predictability (9, 13). The drug guidelines (revised 2021) embed a stepwise method: classify the offense by drug class and role/harm, select a starting point and range, then adjust for aggravation/mitigation, credit for plea, totality, and ancillary orders—within statutory maxima linked to Classes A/B/C (13).

A *localized pathway* is feasible in Iran without new primary legislation. Constitutional principles of legality and prevention mandate reasoned, law-based adjudication, while ordinary statutes already supply calibration tools: graded *taʿzir* penalties (Article 19), reduction/commutation (Article 37), and totality for multiple offenses (Article 134) (19). The Anti-Narcotics Law defines offenses and limits, with later amendments raising thresholds for the most severe sanctions (14). The duty to issue *reasoned, substantiated* judgments supports the adoption—by judicial by-law—of *offense-specific sentencing guidance* for narcotics, consistent with the Judiciary's constitutional powers and conducive to Article 374's reasoning mandate (18). Concretely, a matrix mapping "drug type × quantity × role/culpability × record × violence/organization" to the taʿzir grades, with specified aggravators/mitigators and totality rules, would enhance transparency and curb penal inflation (4, 20).

2 — Diversion from Prosecution and Strengthening Treatment-Based Alternatives

In England, *treatment-oriented alternatives* are available both pre-court and at sentencing: community orders can incorporate Drug Rehabilitation Requirements and Alcohol Treatment Requirements, operationalizing the presumption of custody as a *last resort* (13, 24). Police/prosecution disposals (e.g., cautions/warnings) and *Liaison & Diversion* schemes identify vulnerability—including substance use disorder—at the police station/court and route individuals to health services; independent evaluations report increased treatment engagement and reduced short custodial episodes (23, 24). Systematic reviews show that adequate coverage of opioid agonist therapy and needle–syringe programs reduces HIV/HCV transmission and improves downstream justice and health indicators (7, 17).

Iran already possesses a legal base to institutionalize diversion *conditional on treatment*: Article 15 and the 2013 Executive By-Law establish referral pathways and continuity of care; Code of Criminal Procedure tools—file shelving, suspension of prosecution, and mediation—permit pre-trial diversion, while *deferment of sentence* and *suspension of execution* enable treatment-based alternatives post-conviction (14, 15, 19). Building on this, prosecutors could standardize *treatment-contingent suspension of prosecution* for low-level, use-related allegations

with formal referral to Article 15 centers and staged prosecutorial/judicial oversight, thereby avoiding unnecessary short custodial terms (5, 8).

3 — Preventing Overdose Deaths: Naloxone Access and Continuity of Care

Smart penal policy targets *high-risk periods*. Mortality risk from drug use surges in the first two weeks after prison release—often several-fold higher than baseline—underscoring the need for *take-home naloxone* and seamless opioid agonist therapy across custody and community (25). Health-rights guidance and harm-reduction evidence further justify broad naloxone availability and training for likely bystanders, alongside assured continuity of agonist treatment in prisons and immediately post-release (7, 17).

England's policy trajectory has progressively removed barriers to *wider naloxone supply* and embedded joined-up pathways between justice and health services, reflecting an evidence-led public health orientation within criminal policy (23, 24).

In Iran, Article 15 and the 2013 By-Law already authorize harm-reduction service packages and agonist treatment; executive clinical guidance operationalizes delivery standards (14, 15). Building on this base, we recommend: (i) a national "*Take-Home Naloxone* + *Training*" protocol under the 2013 By-Law for Article 15 centers, emergency services, detox/rehab clinics, and as a *day-of-release* kit; (ii) a *custody-to-community* OAT continuity mandate (induction/maintenance in prison, bridge prescription at release, and immediate community linkage); and (iii) dashboard indicators for continuity of care (e.g., *treatment initiation ≤ 3 weeks post-release*) to enable real-time accountability (8, 11).

Across both jurisdictions, aligning proportionality-based sentencing with routinized diversion and robust overdose prevention can reconcile deterrence with health, reduce avoidable custody, and improve public safety and legitimacy.

4 — Data Governance Reform and Evidence-Based Oversight

The *information gap* between the health sector and the criminal justice system leads to fragmented services and suboptimal policy decisions. In England, the National Institute for Health and Care Excellence (NICE) guideline on needle and syringe programs explicitly emphasizes systematic monitoring of service coverage and quality and the use of data for continuous improvement. This approach is reinforced by operational instruments such as the NICE/Exchange Supplies Audit Tool, which defines compliance indicators and measurement mechanisms.

At the data infrastructure level, NHS England's National Drug Treatment Monitoring System (NDTMS) provides a unified, person-level dataset across all providers, formally registered under national health information standards and feeding annual official statistics. In the "health and justice" domain, *performance indicators* and the Quality Assurance and Improvement Framework (QAIF) establish regular reporting, accountability, and audit mechanisms for prisons, police custody, and detention environments. In addition, the National Data Sharing Guidance for the Criminal Justice System provides a unified legal framework for data exchange between police, courts, prisons, health authorities, and other stakeholders, articulating governance and privacy safeguards.

In Iran, recent policy assessments indicate that *institutional polyphony* and the limited integration of *evidence-based policymaking* remain barriers to coherence in design and implementation. Yet, there is already a legal foundation for data registration and integration: the 2013 Executive By-Law on Authorized Treatment and Harm Reduction Centers obligates centers to collect and record required data in the National Drug Control Information System (Health and Harm Reduction Division) and establishes sanctions for noncompliance (15).

Building upon this capacity requires enhancing reporting standards and establishing a structured policy feedback loop to close the *data ↔ decision* cycle. Accordingly, four operational recommendations can be made:

1. Standardization of a National Health–Justice Dataset — defining a *minimum shared dataset* on substance use (including pseudonymized identity variables, diagnosis, service type, dosage/treatment continuity, legal case status, and transitional points such as intake/release), aligned with indicators proposed by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS.
2. Data Governance and Secure Sharing — adoption of a *memorandum of understanding* between the Ministry of Health, the Prison Organization, the Judiciary, and Police, with *Data Protection Impact Assessments (DPIAs)*, tiered access control, and pseudonymization mechanisms, modeled on UK justice sector guidance.
3. Performance Dashboard and External Audit — development of *real-time dashboards* for service coverage and quality under a QAIF-style framework, with periodic audits and *performance-based financing* linked to data completeness and accuracy.
4. Policy Feedback Loop — institutionalizing *"data → decision"* reports for the iterative redesign of treatment/harm-reduction pathways and for evaluating justice–health outcomes.

5 — Integrating Public Health Standards into Criminal Policy

The English experience demonstrates that embedding public health standards—from the governance of controlled drugs to evidence-based treatment pathways and community/pharmacy-level service coverage—can serve as *normative benchmarks* for criminal policy.

At the level of *controlled drug governance*, the Psychoactive Substances Act 2016 and related frameworks stipulate systematic requirements for safety, recordkeeping, monitoring, and accountability, ensuring management practices align with statutory law and mitigate safety risks related to controlled substances. Complementary Controlled Drugs (Supervision of Management and Use) Regulations 2013 and the designation of "Accountable Officers for Controlled Drugs" enforce mandatory reporting, auditing, and corrective action throughout the care chain.

Regarding *harm reduction*, NICE's PH52 Guideline (2014) explicitly recommends needle and syringe programs (NSPs) in pharmacies to reduce HIV/HCV transmission, emphasizing sufficient geographic and population coverage and extended pharmacy hours for accessibility. When these health standards are linked to *health–justice performance indicators* and *quality assurance frameworks*, they transform into outcome-based monitoring tools within criminal justice contexts—periodically assessing coverage, quality, and health/criminal outcomes, and feeding the results back into justice-sector decision-making (7).

Policy Implications for Iran

Iran's *Article 15 of the Anti-Narcotics Law* and the 2013 Executive By-Law on Authorized Treatment and Harm Reduction Centers already provide a basis for voluntary referral and protection from prosecution during treatment (14, 15). To narrow the *health–justice gap*, the following measures are recommended:

1. Integration of Evidence-Based Treatment Standards — explicitly incorporate evidence-based treatment protocols into judicial and policing regulations and ensure their use as the *first-line policy option* during

pretrial and trial stages (e.g., formal referrals to Article 15 centers, diversionary measures, and non-custodial alternatives).

2. Data-Driven Quality Governance — adopt *health–justice performance indicators* (continuity of treatment, care integration, health and legal outcomes) modeled on the UK framework; simultaneously, strengthen national evaluation and research systems documenting methadone maintenance, sterile syringe-exchange programs, and harm-reduction infrastructure in both community and prison settings.

This *domestic evidence base* justifies and reinforces the linkage of Article 15 mechanisms with standardized treatment and harm-reduction protocols, advancing a coherent, health-centered criminal policy.

Conclusion

This study demonstrates that both the Iranian and English legal systems rely fundamentally on a "penal–health architecture" in responding to drug-use–related offenses; however, they differ substantially in the threshold of intervention and the standardization of penal responses. The Iranian system criminalizes "use/addiction" but opens treatment-oriented paths of exemption or suspension of prosecution through Articles 15 and 16. The English system, by contrast, does not criminalize "use" itself but criminalizes "possession" of controlled substances under the 1971 law, while under the 2016 Psychoactive Substances Act, "simple possession" outside custodial settings is not considered an offense. It then calibrates the penal response through the Sentencing Council's binding guidelines, using a role/harm matrix.

At the implementation level, Iran utilizes the institutional capacity of the national headquarters and provincial council networks but faces challenges such as justice–health data fragmentation, uneven standards, and relatively high reliance on short-term imprisonment. England, through its "From Harm to Hope" strategy, community-based treatment orders (including drug and alcohol treatment requirements), expanded naloxone access, and structural linkage with national health services, advances a more cohesive "risk identification–referral–treatment–monitoring" chain.

Each system offers lessons for the other. Iran can enhance proportionality, efficiency, and legitimacy by developing benchmark-based sentencing guidelines for drug offenses, institutionalizing diversion from prosecution conditional on treatment, ensuring continuity of opioid agonist and methadone maintenance therapies in prison and post-release, standardizing health–justice data, and expanding take-home naloxone protocols. England, conversely, could strengthen coherence and procedural justice by more closely monitoring sentencing outcomes for "minor possession" under the 1971 Misuse of Drugs Act, reducing enforcement disparities, securing sustained treatment funding, and reinforcing data privacy safeguards.

In conclusion, optimal criminal policy design in this domain is achieved when systems replace ineffective punitiveness with "fair certainty of detection," "measurable treatment-based alternatives," and "auditable data governance." Such an integrated approach reduces social and penal costs while reinforcing public trust in criminal justice.

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Authors' Contributions

All authors equally contributed to this study.

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The authors of this article declared no conflict of interest.

Ethical Considerations

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Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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