CAMBRIDGE-STANFORD ADDICTION POLICY FORUM

Establishing the Cambridge-Stanford Addiction Policy Forum

FORUM 1: APRIL 2026

THE POLICE FOUNDATION
The UK's policing think tank

ABOUT THE FORUM

The Stanford Network on Addiction Policy (SNAP) is a philanthropically-supported initiative that brings scientists, policymakers, and the public together to design and implement policies that prevent and treat substance use disorders, support long-term recovery from addiction, and protect public health and safety. SNAP is primarily focused on US, Canadian, and British addiction-focused policy, but also provides consultation to policymakers in other nations and within international bodies.

The Police Foundation is the only independent think tank focused exclusively on improving policing and developing knowledge and understanding of policing and crime reduction. Our mission is to generate evidence and develop ideas which deliver better policing and a safer society. We do this by producing trusted, impartial research and by working with the police and their partners to create change.

BACKGROUND

In spring 2026, founding members of the Stanford Network on Addiction Policy were invited by colleagues at Cambridge University to collaborate on a new British forum that would share the same focus and mission as the US forerunner. The inaugural meeting was held at King's College in April 2026, with the support of the Police Foundation.

This summary captures the key topics and evidence discussed at that meeting, without attribution to individual speakers. Attendees were invited to contribute under the Chatham House Rule and the meeting achieved a cross-party balance and was designed to ensure that a range of academic experts, policy-makers, and legislators were able to share the same room and hear each other's perspectives.

The seminar discussions covered a broad terrain, specifically focusing on the operational philosophy of the SNAP network and emerging 'new' addictions; addiction mechanisms and prevention; police diversion and the use of Naxolone, and the next steps for influencing addiction policy. A thematic discussion summary can be found below.

THE VALUE OF THE FORUM

The discussion dinner and seminar were convened with a range of experts including scientists, academic researchers, clinicians, police officers and Members of Parliament. The Chair of the meeting, Professor Keith Humphreys of Stanford University, opened the gathering by explaining how the launch of a UK policy-science network was envisaged, modelled on the SNAP (Stanford Network on Addiction Policy) initiative in the US.

SNAP was established in 2018 as a philanthropically funded, non-partisan network of scientists and practitioners. The unique benefit of SNAP has been its unusual mixture of practitioners, legislators, scientists and researchers, who all share an interest in finding solutions to addiction and the policy challenges that flow from it, but who also each bring different perspectives of science, law, politics and civic adminstration.

The SNAP network operated with no fixed agenda and with no employed members. Instead of a committee or board with standing membership, SNAP came together as a network that would meet virtually and in-person, leveraging the "strength of weak ties" to connect each other and to exert influence on decision-makers.

After 10 years of focusing on the opioid crisis, cannabis legalisation, youth mental health, and criminal justice, the group decided to reconvene this year to establish a new agenda with partners in the UK.

The new group – the Cambridge-Stanford Addiction Policy Forum (CSAPF) was based on this model and aims to establish a respected network to address addiction by translating neuroscientific research and population-level evidence into actionable policy.

The strength of the SNAP model lies in the connections between participants, drawn from outside each other's immediate networks, and from diverse sectors such as policing, local government and academia. The diversity of participants (not members) prevents the group from becoming an echo-chamber and enables participants to provide rapid, cross-sector policy related synthesis rather than academic output.

The network will continue to invite new individuals to participate, and to convene three specific archetypes: 'Monks' (pure scientists), 'Wonks' (academics with government roles), and 'Mockers' (practitioners/policymakers, such as mayors or city officials).

It was agreed to preserve financial neutrality. Funding will continue to be derived exclusively from philanthropic sources (e.g. the current unrestricted gift from a Stanford-affiliated family) and research grants like the Bootstrap Project (Horizon Europe).

THE CASE FOR A UK POLICY-SCIENCE NETWORK ON ADDICTION

Addiction challenges are shared across many jurisdictions, even if the specific drivers of harms might differ. In the UK, the context is an addiction policy landscape currently defined by one participant as the "holy trinity of death", being:

- austerity, which has seen sustained cuts to social support budgets against the backdrop of a rising cost of living;
- the fragmentation of health and treatment services following the Health and Social Care Act which created disruption for service users, and
- workforce erosion, with skilled staff leaving and recruitment challenges in many treatment and recovery services and community-based settings.

In this context, we see addiction-related harms rising in many areas. Illicit drugs and alcohol remain the two biggest drivers of health and crime related social harms, but recent governments have not been consistent in developing a holistic policy agenda for addictions of all types.

Addiction policy in Whitehall has struggled to gain traction. It remains siloed, underpowered in terms of policy attention and influence, and largely reactive. Meanwhile, exposure and harms are increasingly systemic and addiction is becoming a more complex social problem.

For example, new addictions such as 'digital' or process addictions are beginning to represent a systemic public health crisis. Weak or poorly enforced regulatory frameworks have allowed problematic online behaviours to spread, while more traditional addiction harms, like gaming and gambling, have extended their reach with internet platforms, consumer apps and smartphone use. And the transition from human-generated to AI generated content is expected to further accelerate addictive engagement loops in these areas.

The group agreed that while there is plentiful evidence available to policy-makers – and in areas like alcohol policy we now have alternative models to review from similar jurisdictions – the real issue is the ability to identify good quality, non-commercial and non-partisan studies and then to bridge the gap between scientific evidence and political mandates or legislative windows.

AREAS OF DISCUSSION

1. ADDICTION AS A SYSTEMIC ISSUE

Practitioners debated the emergence of 'digital addiction' as a systemic public health crisis. The core thesis is that modern tech such as social media, online pornography and gambling platforms are designed to exploit dopamine reward mechanisms which traditional addiction frameworks (ICD/DSM) fail to capture. This requires a shift from individual clinical diagnosis to population-level regulation, not just education or clinical intervention. Participants went as far as arguing that digital addiction should be viewed as an emerging public health crisis.

One participant highlighted how reward-system research has been co-opted by product designers resulting in 'neuro-addiction' from digital platforms. From a medical perspective, design could be viewed as a pathogen: specific examples include features like 'loot boxes' in gaming, 'TikTokisation' (infinite scrolling on smartphones) and 'variable rewards'. These are not accidental side effects but intentional design features applying reward science to maximise user-engagement.

Another useful medical analogy is 'metabolic syndrome' which describes a cluster of conditions (such as diabetes or hypertension) driven by the food environment. It could be argued that digital addiction should be viewed as a syndromic construct resulting from population-level exposure to technology.

Emphasis on willpower and individual responsibility is particularly unhelpful for the younger generation who have had the most sustained exposure during a key window of adolescent brain development (unlike Millennials and older generations), and when the smartphone has become a prerequisite for 'normal' social existence. Opting out is therefore a 'social death' creating a problem that individual will power alone cannot be expected to solve.

Other new forms of substance misuse

In addition to online pornography, gambling and 'TikTokisation of experiences, mentioned above, concern was raised about the five per cent prevalence rate of ADHD and the subsequent mass exposure of the population to prescribed stimulants such as methylphenidate or methamphetamine, both of which are used to treat the disorder. Participants discussed how there should be more emphasis on the long-term prevention of substance use disorders within this medicated cohort.

The rise in use of alternative substances (new psychoactive substances and vaping) due to declining alcohol use, particularly among younger demographics was also raised. Unfortunately, there is insufficient data on the new 'in-vogue' substances replacing alcohol among younger cohorts, and regulation governing vaping and other 'recreational' products containing nicotine or THC is still playing catch-up.

2. NEUROSCIENCE, BRAIN DEVELOPMENT AND PREVENTION

The group noted the systemic failure in both the US and Britain to translate neuroscientific evidence into effective addiction and prevention policy. Participants highlighted the critical gap in understanding adolescent brain development, noting that the brain's frontal lobes do not mature until the age of 25 rendering the current 16-to-18-year-old policy thresholds inadequate.

Participants noted the tension between the need for regulation and allowing choice for teenagers in a free society. While some preferred school phone bans or Australian-style age restrictions as measures to mitigate the harms of 'digital addictions', others feared these would infringe young people's autonomy and be largely ineffectual in practice. A participant reflected on the difficulty of passing protective legislation in England compared to Wales and Scotland.

There was firm agreement that current prevention efforts are failing because they start too late. It was agreed to revisit the 'Future Generations Act' model from Wales and explore opportunities to exploit quirks of public sector commissioning such as year-end budget flushing (e.g. filling potholes using funds that must be allocated or otherwise surrendered by 31 March each year) and redirect it towards long-term but low-cost prevention activities such as school-based music and sports.

Participants also noted the significant gap in addressing the neuroscience of addiction and the plasticity of the brain - restoring normal brain function remains a primary challenge that current policy under-serves. They agreed that specific attention should be given to trauma-induced addiction, particularly occupational stress, for example train drivers witnessing suicides and victims of abuse who rely on substances to manage flashbacks.

3. STRUCTURAL WEAKNESSES IN TREATMENT AND PREVENTION SYSTEMS

A big structural weakness is the shift from national (NHS) to local authority commissioning and tendering out of substance misuse services in England which has led to a significant de-skilling of the workforce. The medical model has been eroded leaving staff with minimal clinical training managing complex physical and mental health comorbidities and unable to refer patients back to GPs for primary care issues.

Highly trained clinical staff (doctors, nurses, psychologists) have largely left the sector, replaced by a recruitment challenge and a lower paid workforce that often lacks clinical supervision and is driven by 'traffic light' key performance indicators rather than patient outcomes. There was a consensus among a number of participants that if additional funding (a theoretical £100 million) were available, the priority would be to improve the quality of the workforce and invest in professional skills, rather than just increasing staff numbers.

4. DATA DEFICITS

The addiction landscape also suffers from major deficiencies in terms of data and information flows. Voluntary data sharing is insufficient for safeguarding, and prevention and treatment and policing datasets which are capturing mandatory information by law, were described as incomplete, misaligned, or unusable. Currently there is a strategic push to move from voluntary to mandated data sharing from coroners, but even in this domain, the lack of centralised or shareable data meant that drug mortality was not properly understood.

Additionally, the National Drug Treatment Monitoring System (NDTMS) was considered no longer fit for purpose, based on old definitions and often filled with 'rubbish data' driven by administrative departments. Participants agreed that there was a critical need for an independent research body (similar to an IDA) to commission high quality actionable research.

One participant estimated that currently, 30 per cent of patients lack diagnostic coding because there is no financial incentive (unlike the US DRG system) to capture this information regularly and accurately. It was agreed to advocate for better diagnostic formulation to ensure substance use disorders are not relegated to 'hidden notes' but are coded to trigger proper analysis and ultimately the appropriate resource allocation.

5. POLICING, HARM REDUCTION AND DIVERSION

Preventative approaches

Participants heard that the police-led Naloxone opioid antidote rollout has demonstrated measurable impact, despite initial cultural resistance and concerns from regulators like the Independent Office for Police Conduct, with one in four forces now using it. This “fantastic antidote” has already saved lives in areas like South Yorkshire and its use is now endorsed by the Police Federation (who represent rank and file officers). It was agreed that there should be a wholesale roll-out of Naxolone across police forces in England and Wales, as there already had been in Scotland.

In terms of diversion, and with regard to mental health, policing leadership is shifting toward a model where police officers’ roles are strictly defined (as part of ‘Right Care, Right Person’), with the police moving away from acting as primary first responders for mental health crises unless there is a specific policing requirement. Participants raised concerns about whether this would eventually drive more demand that was hard to manage.

Unfortunately, efforts to implement evidence-based addiction policies in other sectors, such as among university students (for example the Birmingham collegiate recovery programme) continue to face internal pushback within institutions which view such initiatives as ‘promoting drugs’ rather than addressing existing harms. Conversely the national ‘alert system’ for high strength synthetic drugs often acts as ‘advertising’, drawing users to specific locations to seek out higher-potency batches, as seen in recent overdose clusters in Camden.

A debate emerged regarding the framing of harm reduction as separate from treatment. Some argued this creates unnecessary conflict, whereas others maintained that preventing overdose (harm reduction) is a distinct, uniting public health goal that can bring together disparate stakeholders.

The police response to drugs misuse

Participants heard about how the Metropolitan Police in London uses the ADDER model (Addiction, Diversion, Disruption, Enforcement and Recovery) as part of the Government’s programme to combat drugs misuse. The strategy has been expanded city-wide and transitioned from simply targeting illicit drugs supply and dealers to focusing on demand reduction and multi-agency partnerships offering treatment support for users.

Participants were briefed on the police implementation of a ‘4P’ plan (Pursue, Prevent, Protect, Prepare) specifically for Ketamine to address long-term health issues and rising use. The Met Police has also formally rolled out a voluntary referral app (developed by a serving Met Inspector) which has already facilitated 1,200 referrals. This has been very successful, however data sharing remains a barrier to tracking treatment conversion, limiting evaluation and continuity of care.

Drug testing

Participants agreed it was unfortunate that drug testing on arrest (DTOA), restored as part of the From Harm to Hope strategy launched in 2021, was recently defunded by central government at the end of the financial year. This has forced local forces and elected Police and Crime Commissioners (PCCs) to decide whether to fund these programmes locally or allow them to end. Participants expressed grave concern that this critical intervention point will decline as local funding is exhausted, removing a primary trigger point for identifying individuals with substance use disorders as well as key data to support policy analysis of illicit drug use. Waste-water testing was briefly discussed as one developing area that might help to improve surveillance of the consumer market.

6. CRIMINAL JUSTICE OVERLAP

Substance misuse, digital abuse, and domestic violence increasingly intersect. A participant noted the 'domestic violence aspect' of digital addiction and the increasing cross-contamination in the drug market (e.g. synthetic opioids in cannabis), which complicates the policing of these intersecting harms.

Participants also heard how enforcement tools lag behind emerging harms, like impaired driving. For example, police now argue that there is a critical need for 'drug-driving' detection technology with magistrates reporting that fatal accidents and life-changing injuries are increasingly linked to drug impairment, yet roadside testing lags far behind established technology like alcohol breathalysers.

7. STIGMA AND SOCIAL CAPITAL

Institutional stigma and discrimination against treating addiction as a chronic health condition persists; participants noted that addiction is not afforded the same clinical rigour as other chronic diseases like diabetes. There is also evidence of institutions such as prisons or local areas arbitrarily limiting treatment options.

A strategic move towards peer-led Lived Experience Recovery Organisations (LEROs) was endorsed. These organisations were seen to be more effective than traditional clinical models although they are likely to be constrained by professional risk aversion and a safeguarding culture.

Additionally, trusted intermediaries can reduce stigma where formal services are rejected. Faith-based engagement is proving effective in breaking down barriers and helping to build social capital in specific communities (e.g. Alberta and British Columbia in Canada) where users of traditional addiction services face high stigma.

8. GOVERNANCE AND LEVERS FOR CHANGE

Participants debated the best way to make practical progress given the system we were working in and the funding constraints already mentioned. Despite the rhetoric of partnership, services remain delivered in silos. The lack of organisational memory means when funding for an initiative ends the learning and data often vanish with it. The group collectively decided that the 'Combating Drug Partnerships' (CDPs) - now the main organisational tier for addiction services involving drugs – must move beyond fragmented delivery to a whole system approach, specifically bringing education and housing to the table as fundamental partners.

Mayors and PCCs and the devolved administrations (Scotland and Wales) are ideally placed to deliver a 'whole-system approach' to tackling drug misuse in their areas that integrates education, health, and criminal justice due to their arms-length, or full autonomy, from central government (and residual budgets).

To gain traction within five-year election cycles for 20-year prevention goals, the group agreed that 'economics speaks to politicians. To justify future long-term investment the social side effects - domestic abuse, educational under-attainment, and family breakdown must be made clear.

Sometimes the barriers can be addressed by changing how the problem is perceived. By framing drug and gambling-related mortality data as a 'safeguarding and public health' necessity rather than a 'research project', the group could bypass Ministry of Justice funding hurdles and seek to get coroners' data collated and federated.

Unlike cardiovascular or obesity policy, addiction lacks a narrative of 'things getting better'. Highlighting the recovery movement is essential to counter the 'can't arrest/treat our way out' defeatism. Recovery could be reframed as 'connection' and 'recovery capital' as housing, jobs and life purpose rather than just abstinence.

In addition to direct policy campaigning, other legislative mechanisms such as Private Members' Bills were discussed as a way to highlight one narrow issue where a practical change was achievable, and use that as a way to push addiction up the national agenda despite tightening fiscal constraints and ongoing geopolitical crises.

Next steps for addiction policy

The final session focused on transitioning from theoretical policy analysis to tangible legislative and local action.

A number of blind spots were identified for immediate evidence-gathering:

- trauma-informed recovery (specifically abused children and traumatised professionals);
- neuroscience – bridging the gap between brain plasticity research and practical recovery models;
- training teachers and school staff to identify and approach parents with addiction issues and
- developing solutions for robust roadside drug detection.

With economic analysis seen as the strongest influencer to engage politicians, participants called for a shift in the advocacy narrative from moral failing to economic impact and safeguarding. In addition, they wanted to re-centre the prevention agenda on the 'developing brain' (up to age 25) to counter traditional punitive approaches.

There was a consensus on bypassing central government bottlenecks by engaging mayors, PCCs and devolved administrations and to seek to have allies for policy change from the bottom up. In Westminster, the group decided to explore ways to use Private Members' Bills as a primary tool for change, with the aim of 'nudging' addiction up the political agenda.

Three main areas for policy action in the next 12 months were identified:

- Explore mandating data supply from coroners via the Ministry of Justice.
- Pursue a Naloxone rollout expansion, moving from a 'stealth' pilot phase to a large-scale rollout.
- Seek to exploit year-end budget flushing and redirect money in budgets towards long-term and low-cost prevention activities.