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The prevention and treatment of drug misuse in Britain

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The prevention and treatment of drug misuse in Britain

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INTRODUCTION

DRUG misuse in the United Kingdom, as in many other countries, is seen as part of a much wider problem of society's over-reliance on alcohol, cigarettes, and sleeping pills and tranquillisers. Although a relatively small problem in terms of the numbers of people involved, and only one of a whole range faced by health and personal social services authorities, it remains a source of public concern, not least because of the great harm it can cause young people.

In the 1960s a rise in the rate of increase of young people becoming dependent on heroin and cocaine attracted much publicity and led to the establishment of new narcotic drug treatment services.[1] There was some suggestion at the time that there might be a large increase in the number of addicts. In the event, however, this has not happened, and in comparison with several other countries facing similar problems the United Kingdom appears at present to have a relatively stable situation as far as narcotic drug dependence is concerned. By the end of 1970 the number of addicts known to be receiving treatment for addiction to narcotic drugs was over 1,400; the number rose in successive years, and since 1973 has been approximately 2,000. The number of known young narcotic addicts (under 25) has been falling, from over 800 in 1972 and 1973 to 407 at the end of 1977. The figures of course provide only a guide to the number of narcotic addicts; it is not possible to quantify those who misuse narcotic, or indeed other, drugs illicitly, and who are unknown to treatment agencies.

Although the extent of narcotic drug dependence seems to have been stabilised, the problem of drug misuse as a whole is a difficult one. According to a working group report published in 1977 the problem has changed rather than diminished.[2] The report noted a number of points. Multiple drug misuse (the misuse of two or more drugs at the same time) involving a wide range of drugs, including barbiturates and other psychotropic drugs, was seen as probably the major problem of the 1970s, and was not confined to narcotic addicts. There were heavy pressures, the report recorded, on the drug treatment clinics, especially in London; some young people had difficulty in finding appropriate treatment rapidly; and there could be a lack of choice in rehabilitation facilities. The frequency with which misusers took overdoses of drugs also presented special problems to hospital accident and emergency departments, which had to provide detoxification treatment.

This pamphlet outlines the measures taken to restrict the availability and the illegal supply of drugs scheduled under the misuse of drugs legislation, and summarises the British approach to the treatment and social rehabilitation of people who misuse drugs or have become dependent upon them. The approach is based on the belief that drug misusers are people with health and social problems who must be helped accordingly. It has a multi-disciplinary basis and involves social workers as well as nurses and the medical

[1]The term 'narcotic drugs' is used generally in this pamphlet to include the narcotic analgesics – mainly opium, heroin, morphine, pethidine, dipipanone and methadone – and cocaine.

[2]*Advisory Council on the Misuse of Drugs, Treatment and Rehabilitation Working Group: First Interim Report*, September 1977.

profession. At the same time, as in all other aspects of health and social care, the approach recognises the importance of the professionals' responsibility in each individual case, and especially the responsibility of the doctor in prescribing drugs on a maintenance basis.

The drugs scheduled under the misuse of drugs legislation include the opiates—opium and its derivatives such as morphine, heroin, codeine and synthetic opiates including methadone and pethidine; cocaine; the amphetamines; cannabis, which is by far the most commonly misused drug; and hallucinogens such as LSD (lysergic acid diethylamide-25, lysergide). Barbiturates are not controlled under the legislation, but they may only be retailed by an authorised pharmacist on a prescription given by a medical practitioner.

Responsibility for administering the drugs legislation rests with the Home Office, the Scottish Home and Health Department and the Department of Health and Social Services for Northern Ireland. Provision of facilities for the treatment of misuse is a matter for the Department of Health and Social Security (in England), the Welsh Office, the Scottish Home and Health Department and the Department of Health and Social Services for Northern Ireland. Other official agencies concerned with the application of measures to prevent drug misuse and dependence include the Department of Education and Science and the other central education departments, local authorities, the police, the probation and prison services and the Board of Customs and Excise. Voluntary agencies, sometimes with the support of public funds, play an important part, especially at 'street level', and both official and voluntary bodies carry out education programmes and research, and give practical advice and help.

BACKGROUND

THE MEDICINAL use of drugs is mentioned in the works of Chaucer and Shakespeare, and opium preparations have been used in British medicine for several hundred years. Accounts of the misuse of opium and its derivatives date mainly from the eighteenth and nineteenth centuries. During the nineteenth century opium was freely supplied by chemists—as laudanum, morphine or in a wide variety of lozenges and patent medicines—as a treatment for colds, hay-fever and nervous headaches. Several leading literary figures of the nineteenth century are known to have taken opiates, and advertisements for addiction cures appeared in the Press. Heroin, first synthesised from morphine in the latter half of the century and introduced into the country as a non-addictive pain-killing drug to end morphine addiction, was found to be quite as likely to cause dependence as morphine or opium itself.

As a result of mounting concern about the problems of dependence on opiate drugs, an international conference on opium (at which the United Kingdom was represented) met in 1909, and led in 1912 to the first international convention to impose controls on the distribution and supply of the drugs (see p 31). Some provision for the control of opium and cocaine in the country was made during the first world war, and in 1920 the first dangerous drugs legislation was passed, in accordance with the 1912 convention. Further Acts were passed in the 1920s and within a few years there were various restrictions on the import, export, manufacture, sale, distribution, supply and possession of such drugs as opium, morphine, heroin, coca leaves, cocaine and cannabis. Possession of the drugs was restricted to people authorised by the Home Secretary and to patients to whom the drugs were supplied for the purposes of medical treatment.

The Rolleston Committee

In 1926 the report of the Rolleston Committee (the Report of the Departmental Committee on Morphine and Heroin Addiction) found that dependence on morphine and heroin was rare and had recently declined. Cases were more frequent in large urban centres, among people who had to handle the drugs for professional reasons, and among people especially liable to nervous and mental strain. Addiction to morphine was much more common than heroin addiction.

The Committee adopted the general view of its witnesses that addiction should be regarded as an illness and not as 'a mere form of vicious indulgence'. It recommended that doctors should be free to administer morphine and heroin as part of the treatment of addicts, and it outlined the circumstances in which the prescription of addictive drugs should be allowed. It defined patients for whom this might be done as (a) those undergoing treatment for cure of addiction by the gradual withdrawal method; and (b) those from whom, after every effort had been made for the cure of the addiction, the drug could not be completely withdrawn, either because complete withdrawal produced serious symptoms which could not be satisfactorily treated under the ordinary conditions of private practice, or because the patient, while

leading a useful and fairly normal life so long as he or she took a certain non-progressive quantity (usually small) of the addictive drug, ceased to be able to do so when the regular allowance was withdrawn.

This view was accepted by the medical profession and the government of the day. It was interpreted by both, not as giving a free hand for prescribing heroin or morphine to any addict under any circumstances, but as discouraging the prescribing of such drugs unless, in the opinion of the doctor concerned, there were overwhelming reasons for not subjecting the individual patient to complete withdrawal. A doctor's right to prescribe drugs if he judged them necessary for the treatment of his patient was not challenged, but the doctor was expected to apply the Rolleston Committee's guidance in judging whether his patient's condition would be impaired or improved by continued use.

The Rolleston Committee also gave detailed advice on the medical management of withdrawal, and proposed the constitution of a tribunal to advise the Home Secretary in cases where there was evidence of medical misuse of drugs whether to withdraw a doctor's right to supply them. The Committee's recommendations, although not incorporated into the law, were accepted, and have since formed the basis of the British approach to the problems of drug dependence.

After the passing of the first dangerous drugs legislation in 1920, the number of addicts known to the Home Office showed a gradual fall up to 1947, after which there was a slight rise. (Notification was not compulsory until 1968—see p 5—but some idea of numbers was obtained from pharmacists' registers.) Most addicts were over the age of 50, and the origin of their dependence was therapeutic—that is, they had become dependent on opiates (usually morphine or, after 1945, pethidine) in the course of medical treatment. A further group comprised 'professional' addicts such as doctors, dentists, midwives and pharmacists, who had relatively easy access to addictive drugs. By 1957 the number, although still very small, had reached 359, compared with 199 in 1947 (and 616 in 1936).

The Brain Committee

In 1961 an interdepartmental committee on drug addiction, the Brain Committee, which had been set up to review the Rolleston Committee's advice in the light of recent developments, particularly in the use of drugs other than narcotics, concluded that in relation to the misuse of narcotic drugs the situation was not one which warranted any change in existing practices. Evidence had, however, begun to emerge of a sharp increase in the incidence of heroin addiction, particularly among young people, and in 1964 the Committee was reconvened to examine the situation again.

The Committee's second report, in 1965, confirmed a substantial increase in dependence on heroin and on heroin in conjunction with cocaine. Over the years 1961–64 the total number of people known to be addicted to dangerous drugs had risen from 470 to 753; the number of known heroin addicts had increased from 132 to 342, while the incidence of addiction to other drugs had remained more or less constant. The number of cocaine addicts, however, had increased from 84 in 1961 to 211 in 1964, and virtually all of these were using the drug in conjunction with heroin. There had also

been a significant change in the age distribution and social background of addicts: by 1964 nearly 40 per cent were under 35 years of age, and some 40 heroin addicts were known to be under 20 years of age. While the new therapeutic addicts belonged mainly to the professional or middle classes the new drug takers showed a more even social distribution. The increase in addiction appeared to be centred very largely on London, although indications of similar but smaller trends had been observed in other large cities.

The Brain Committee found that the main source of supply had been over-prescribing by a very small number of doctors. It mentioned instances in which very large quantities of drugs had been prescribed on a single occasion, and commented that 'not more than six doctors have prescribed these very large amounts of dangerous drugs for individual patients and these doctors have acted within the law and according to their professional judgements'.

Faced with the problem of reconciling the practice of 'maintenance prescribing'—which was recognised as an important element both in the treatment of drug dependence and in ensuring the continued absence of an organised illicit traffic in drugs—with the need to stop the spread of addiction, the Committee's approach was to seek to establish controls which, while not violating medical responsibility for the treatment of addiction, would limit the number of doctors authorised to supply heroin and cocaine to addicts; ensure that the supply of drugs took place only in a setting where there was a comprehensive range of treatment facilities; and establish a measure of scrutiny over the problem of addiction as a whole.

With the exception of a proposal for compulsory powers to detain and treat addicts, the Committee's recommendations were accepted by the Government. Legislation was passed enabling regulations to be made requiring the compulsory notification of addicts, and restricting the supply of heroin or cocaine to addicts for the purposes of treating their addiction; licences to prescribe these drugs to treat addiction were then granted only to doctors working in hospitals or similar institutions, with the result that the treatment of addiction was removed from general practitioners to the hospital service. The regulations have since been re-enacted, essentially unchanged, as the Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973 (see p 14). Separate but comparable regulations apply in Northern Ireland.

As a further response to the Brain Committee's report, special treatment centres were set up in several National Health Service hospitals under the clinical direction of consultant psychiatrists (see p 20).

A New Framework of Law

By the end of the 1960s it had become clear that the existing piecemeal legislation, comprising a number of Acts of Parliament each passed to counter particular misuse as it arose, was no longer appropriate for the situation that had developed. The law had largely evolved before the country had experienced serious problems of drug misuse, and represented an insufficiently flexible approach to a constantly changing problem. Certain drugs were controlled under one set of legislation, others under another set; there were no powers to control the manufacture, supply or export of

certain drugs, or the number of manufacturers of, or dealers in, others; and, in particular, as the misuse of drugs spread to stimulants and hallucinogens, the current legal distinction between narcotics subject to international controls and other drugs seemed artificial and out of date.

The Misuse of Drugs Act 1971 was accordingly passed to replace the outmoded law, and to establish new and more extensive provisions for controlling certain drugs liable to misuse. The main provisions of the Act, which became fully operative in 1973, are outlined on pp 8–15.

Advisory Council on the Misuse of Drugs

The Advisory Council on the Misuse of Drugs, set up under the 1971 Act, has a duty to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to it likely to be misused, and of which the misuse is having or appears capable of having harmful effects sufficient to constitute a social problem. The Council advises ministers on measures which it thinks ought to be taken to prevent the misuse of such drugs or to deal with social problems connected with their misuse. In particular, the Council advises on measures: to restrict the availability of drugs or supervise arrangements for supply; to provide advice, treatment, rehabilitation and after-care facilities; to promote co-operation between the various professional and community services which have a part to play in dealing with the social problems connected with misuse; to educate the public (and in particular the young) about the dangers of drug misuse and to publicise the dangers; and to promote research. These terms of reference and the membership of the Council emphasise the need for a multi-disciplinary response to the problems of drug misuse, involving not only lawyers and the police but also, in particular, psychiatrists, doctors, pharmacists, social workers, educationalists and research workers.

Recent Developments

The lack of reliable information about the full size of the drug misuse problem —narcotic and non-narcotic—and the extent to which it is changing causes many difficulties. A number of points about recent trends in narcotic drug addiction can, however, be seen.

After the late 1960s the number of people known to be receiving treatment for addiction to narcotic drugs rose gradually. At the end of 1968, the year when the notification of addicts became compulsory, the number of these addicts was 1,746. By the end of 1969 the number had fallen to 1,466, but thereafter it rose, reaching 1,970 in 1974. In both 1975 and 1976 the numbers again fell, reaching 1,879 at the end of 1976 but rose to 2,023 at the end of 1977 (see p 23). There has been a steady increase in the number of new addicts notified each year: since 1970 the figure has risen gradually from 711 to 1,112 in 1977 (see p 25).

The number of people known to be receiving treatment for narcotic addiction shows signs of levelling off, but the available figures do not give the whole picture. There is reported to be, for example, a considerable number of misusers of opiates who are not notified as addicts. Research quoted in the *First Interim Report* by the Treatment and Rehabilitation Working Group of the Advisory Council on the Misuse of Drugs (see Reading List, p 38) suggests that the non-clinic population of opiate misusers is about as large as

the clinic population under treatment. There is evidence of substantial traffic in illicit heroin originating largely in South-East Asia, affecting most of the countries of Western Europe, but so far this has not been reflected in the number of people under treatment at the clinics.

From those involved with drug misusers—the clinics, hospitals' accident and emergency departments and voluntary agencies—there is much evidence that, whereas in the early 1960s drug misusers tended to take a single drug of their choice, young drug misusers nowadays are likely to experiment with a wide range of drugs. According to the *First Interim Report* mentioned above, the drug problem has changed rather than diminished, and the growth of multiple drug misuse (the misuse of two or more drugs at one time) has probably become the major drug problem of the 1970s.

There has recently been a marked resurgence in amphetamine misuse, accompanied by a growth of 'home' production, and a continuing rise in popularity as a drug of misuse of dipipanone in tablet form. Barbiturate misuse, often by intravenous injection, continues to give considerable cause for concern in many areas, and there have been numerous sporadic instances of the misuse of other drugs and chemicals not controlled by legislation. The dangerous practice of sniffing solvents has been reported among some groups of children.

Cannabis, however, remains the drug most commonly misused, circulating in a variety of forms (see p 9). In 1977 well over two-thirds of the people found guilty of offences involving controlled drugs were guilty of the unlawful possession of the drug (see p 13).

PREVENTING DRUG MISUSE

SINCE availability is an important factor in determining which particular drugs are misused, and to what extent, the Government's preventive policy starts with limitation of the supply of those drugs, narcotics and others, which lend themselves to misuse.

Many drugs—such as the opiates, cannabis, the amphetamines and LSD—are controlled under special legislation, the Misuse of Drugs Act 1971, which penalises unlawful manufacture, supply, possession, import and export. The highest penalties under the legislation relate to 'trafficking' offences. Evidence in the past few years has shown that considerable harm can be caused by other drugs too, especially barbiturates, the latter not being controlled by the 1971 Act, and voluntary measures have been taken by the medical profession with the aim of limiting access to certain drugs of this kind.

THE LAW

The principal legislation concerned with the control of drugs in the United Kingdom is the Misuse of Drugs Act 1971 and the various regulations made under it (see Reading List, p 38). Other related statutes are the Customs and Excise Act 1952, the Medicines Act 1968 and the Poisons Act 1972.

The Misuse of Drugs Act, together with the regulations made under it, came fully into force on 1 July 1973, replacing and modernising existing laws on the control of drugs that are liable to be misused. The drugs 'controlled' under the Act are classified in two groupings. In the first, under the Act, they are placed in classes for the purpose of the maximum penalties which may be applied for offences—see below; this grouping is based broadly on the drugs' potential harmfulness when misused. In the second grouping, under the regulations, drugs are placed in different lists for the purposes of the controls to be applied to their use for legitimate reasons (see p 12); this grouping is on the basis of several factors, in particular the extent of drugs' use in medicine and the need to prevent their being misused.

Classification for Penalties

The Act divides drugs likely to be misused into three categories according to their accepted dangers and harmfulness in the light of current knowledge. Changes can be made in the classification on the evidence of new scientific knowledge or to meet new forms of drug misuse. The Home Secretary can have a drug added to, or removed from, those scheduled by the Act, or he can have any particular drug moved from one category to another. This procedure requires prior consultation with the Advisory Council on the Misuse of Drugs (see p 6) and the approval of Parliament.

The three categories into which controlled drugs fall are as follows.

Class A includes opium, heroin, morphine, methadone and other opiate drugs placed under the strictest control by the United Nations Single Convention on Narcotic Drugs 1961 (see p 31). It also contains THC (tetrahydrocannabinol); certain hallucinogens, such as LSD,

regarded by the World Health Organisation as particularly dangerous; and injectable amphetamines.

Class B covers opiate drugs, including codeine, which are less strictly controlled by the Single Convention. It also includes cannabis, cannabis resin and certain stimulant drugs of the amphetamine group, such as dexamphetamine.

Class C contains other drugs which on present experience are considered to present lesser dangers.

Cannabis

Cannabis is easily the most commonly misused controlled drug in the United Kingdom, circulating in a variety of forms including the resin, tightly bound stalks and flowering tops, and purified extract from the resin.[1]

In 1968 a sub-committee of the Advisory Committee on Drug Dependence, which was later superseded by the Advisory Council on the Misuse of Drugs, published a report on the drug (see Reading List, p 38). The Committee's witnesses estimated the number of cannabis users in the country at anywhere between 30,000 and 300,000 people, and indicated that cannabis-smoking was a social rather than a solitary activity which featured, without class barriers, among young people in particular. The Committee concluded that, although no encouragement should be given to the wider use of cannabis, the dangers of its use had been overstated, and the existing criminal sanctions intended to curb its use were unjustifiably severe. A recommendation was made that maximum penalties for offences involving the drug should be reduced. Successive governments, however, did not fully accept the Committee's proposals, and severe maximum penalties for cannabis offences, in particular for trafficking, were written into the Misuse of Drugs Act 1971.

Public debate on cannabis and the law has nevertheless continued, and during 1977 it was announced that a substantial majority of members of the Advisory Council on the Misuse of Drugs believed, in principle, that imprisonment should no longer be available in relation to a person, who with no previous conviction for a drugs offence, is summarily convicted of unlawful possession of cannabis or cannabis resin. The Council considers, however, that the question of amending the penalties in relation to cannabis and cannabis resin opens up much wider questions about the classification of controlled drugs generally and the penalties applicable. It is therefore undertaking an urgent and comprehensive review of the classification of drugs under the 1971 Act and of the penalties laid down by the Act.

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[1]Cannabis is the generic name for Indian hemp, cannabis sativa. There are many local names for preparations of the drug – for example, the flowering or fruiting tops may be termed marihuana or dagga; the resin obtained from the flowering tops is usually called hashish or charras. English-speaking countries have an extensive vocabulary for cannabis, including pot, grass and weed.

The definition of cannabis in the Misuse of Drugs Act (as amended by the Criminal Law Act 1977) includes any plant of the genus cannabis or any part of any such plant, by whatever name designated, except that it does not include cannabis resin or any of the following products after separation from the rest of the plant: (a) mature stalk of any such plant, (b) fibre produced from mature stalk of any such plant, and (c) seed of any such plant. Cannabis resin means the separated resin, whether crude or purified, obtained from any plant of the genus cannabis.

Offences Involving Possession and Trafficking

The main feature of the penal side of the Misuse of Drugs Act is the sharp distinction between offences of trafficking, carrying very severe penalties, and offences of possession, which carry less severe penalties. Nevertheless, penalties for unlawful possession of controlled drugs are still substantial.

For unlawful possession of drugs listed under Class A (including heroin, morphine and LSD) the maximum penalty on indictment[1] is seven years' imprisonment (or a fine, or both). For illegal possession of drugs controlled under Class B, the maximum penalty on indictment is five years' imprisonment (or a fine, or both). This applies to the illegal possession of cannabis and the non-injectable amphetamines, for example. For the unlawful possession of the least dangerous drugs, listed in Class C by the Act, the maximum penalty is two years' imprisonment (or a fine, or both).

It is an offence to be in any way knowingly concerned in the unlawful production or supply of a controlled drug; it is illegal for occupiers or people concerned in the management of premises to permit unlawful production or supply to take place there (this includes the preparation of opium for smoking and the smoking of cannabis); and it is an offence to possess a controlled drug (lawfully or not) with the intention of supplying it to another person. All these offences, if tried on indictment, carry maximum penalties of 14 years' imprisonment (or a fine, or both) when controlled drugs from Classes A or B are involved, and of five years' imprisonment (or a fine, or both) for Class C drugs.

Policing Arrangements

The British police service consists of a number of independent forces, normally linked with local government, and each responsible for the enforcement of the law and the maintenance of public order in its own area. There is constant co-operation among the forces.

Almost all of the 43 forces in England and Wales have full-time specialist drug officers, generally employed in drug squads with operational responsibilities throughout their own areas, although a few function only within a limited area such as a major town, drug offences elsewhere being dealt with by non-specialised officers. Many forces, furthermore, have appointed special officers, who are either members of the drug squad or in close touch with it, to inspect retail chemists' premises and records as their sole duty or in conjunction with other drug work.

There is no national policing agency for drugs, but a central drugs intelligence unit at Scotland Yard, the headquarters of London's Metropolitan Police, comprises both Metropolitan Police and provincial officers. Operating

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[1]When a prosecution takes place in a magistrates' court and the offender is dealt with summarily, the penalties for unlawful possession of the various classes of controlled drugs are very much less severe than for offences tried on indictment in the Crown Court. (Magistrates' courts deal with about 98 per cent of criminal cases in England and Wales, and conduct preliminary investigations into the more serious cases. The Crown Court takes all criminal work above the level of magistrates' courts, and trials are held before a jury.) Prosecution procedures are different in Scotland; most drug offences are dealt with under summary procedure in the sheriff courts, while the more serious cases are heard under 'solemn procedure' either by sheriff and jury trial or at the High Court.

on a 24-hour basis, it has a national responsibility for receiving, collating, evaluating and disseminating information about the criminal misuse of drugs. It works in close contact with police forces in the United Kingdom and overseas, the Home Office and the Investigation Division of the Board of Customs and Excise. Officers from the unit travel overseas to attend international conferences and to further links with forces elsewhere.

In Scotland five of the eight regional forces employ full-time drug squads, and the other three have personnel operating part time on drugs misuse and have appointed drugs liaison officers to deal with problems as they arise. Specialist officers are trained through the provision of an annual drugs course, and the general instruction of officers attending the Scottish Police College is carried out by specialist lecturers. Officers from other parts of Scotland are given opportunities to gain experience of drug problems in the Glasgow and Edinburgh areas.

In Northern Ireland similar responsibilities rest with specialist officers of the Royal Ulster Constabulary, employed in drug squads.

Police Powers

The Misuse of Drugs Act sets out the details of police powers of arrest and search in relation to drugs offences.

The police have the right, in connection with the Act, to enter the premises of people carrying on business as producers or suppliers of controlled drugs, and to inspect the books of the business or its stock of drugs. If the police have reasonable grounds to suspect that any person is in possession of a controlled drug in contravention of the Act, they have power to search that person and to detain him for the purpose of searching (the same applies to a vehicle or vessel with the additional power that the police can require the person in charge of it to stop), and they can retain, for the purpose of proceedings under the Act, anything found in the course of the search which appears to be evidence of an offence.

The Act provides powers for the police to search premises on a warrant granted by a magistrate (or justice of the peace or sheriff in Scotland). Before granting a search warrant the magistrate must be satisfied, by information on oath, that there is a reasonable ground for suspecting that a person in the premises has in his possession or under his control (a) any controlled drugs, in contravention of the Act or regulations, (b) any document relating to a transaction which was (or would have been) an offence against the Act (or, if carried out outside the United Kingdom, an offence against the provisions of a corresponding law in that place).

Detailed statistics of 'stop searches' and applications for search warrants are kept for examination by Her Majesty's Inspectors of Constabulary. The Home Office has advised the police that particular types of clothes and hairstyle should never, by themselves or together, be regarded as constituting reasonable grounds to stop and search. During 1977 in England and Wales nearly 16,000 people were stopped and searched for controlled drugs; a quarter were found to be in illegal possession of such drugs.

A police officer can arrest without a warrant a person who has committed, or is reasonably suspected by the officer of having committed, an offence under the 1971 Act if (a) he has reasonable cause to believe that the person will

abscond unless arrested; or (b) he does not know and cannot to his satisfaction ascertain the person's true name and address.

Customs and Excise

Officers of the Board of Customs and Excise have powers to detain people who, with intent to evade customs controls, are concerned in the import or export of goods contrary to a restriction or prohibition. They can search any person (or vehicle) entering or about to leave the United Kingdom, or within a dock area or customs airport, if there are reasonable grounds to suspect that he or she is carrying any article the importation of which is prohibited or restricted.

Under the Customs and Excise Act 1952 goods imported contrary to any prohibition are liable to forfeiture. Where there are reasonable grounds to suspect that anything liable to forfeiture is kept in any building, an officer may, in certain circumstances and by force if necessary, enter it, conduct a search, and retain or remove any such thing. Officers have powers to stop and search vehicles or vessels reasonably suspected of carrying goods liable to forfeiture.

During the fiscal year 1976–77 the Board of Customs and Excise made 1,535 seizures arising from attempts to smuggle controlled drugs into the United Kingdom. Of these, 1,299 were seizures of cannabis. Some 4,500 kg of drugs were seized, including 4,433·5 kg of cannabis in herbal, resin or liquid form; 15·4 kg of cocaine; 2 kg of opium; and 30·9 kg of heroin and morphine. The estimated street value of all the controlled drugs seized in the year was about £13·8 million. Following customs detection over 700 people were successfully prosecuted.

The Board of Customs and Excise co-operates closely with other enforcement agencies: joint operations are mounted from time to time with British police forces, and assistance is given to, and received from, enforcement organisations in other countries.

Statistics of Drug Offences

Some 12,704 people were found guilty of offences involving controlled drugs in 1977. The corresponding figures for earlier years were 14,439 in 1973, 12,137 in 1974, 11,603 in 1975 and 12,482 in 1976. The increase between 1976 and 1977 was more than accounted for by the increase in the number of people found guilty of cannabis offences. Over two-thirds of the people found guilty of drug offences in 1977 were convicted of possessing cannabis unlawfully. In general there has recently been a continuing increase in the number of people found guilty of drug trafficking offences. Fuller details of the offences of which people were convicted during 1977 are given in Table 1.

Since 1973 the number of young drug offenders has been decreasing as the number of older offenders, particularly those aged 25 and over, has been increasing. In 1977, 42 per cent of people found guilty of all drug offences were aged 25 or over, 34 per cent were 21 to 24 years, and the remainder were under 21 years.

Types of Control

Four different types of control are applied to different groups of drugs in

TABLE 1

Numbers of People Found Guilty of Offences under the Drugs Legislation and Other Offences where Drugs were also Involved, by Type of Offence and Type of Drug, United Kingdom, 1977

Type of offence	Type of drug								
	All drugs	Cocaine	Heroin	Methadone	Dipipanone	LSD	Cannabis	Amphetamines	Others
Total found guilty of all offences ..	12,704	307	392	346	377	277	10,440	1,772	1,283
Offences under the Misuse of Drugs Act									
Unlawful production	18	—	—	—	—	—	2	14	6
Unlawful supply	740	18	45	37	28	22	465	158	76
Possession with intent to supply unlawfully	477	15	35	20	6	19	326	115	39
Unlawful possession	10,810	178	245	217	248	252	9,061	1,517	883
Cultivation of cannabis plant ..	975	—	—	—	—	—	975	—	—
Permitting premises to be used for unlawful purposes	305	—	—	—	1	2	297	12	2
Other Drug Act Offences	178	1	—	1	1	—	10	6	164
Unlawful import or export	813	46	46	1	—	7	692	32	55
Offence not under the drugs legislation where drugs were obtained or handled illegally	487	132	128	150	222	—	10	221	331

Since a person may be found guilty of several offences involving one or more drugs, or of a single offence involving several drugs, the figures in the table do not add up to the totals.

accordance with the extent of their use and their value in medical practice and their harmfulness if misused.

The hallucinogenic drugs, including LSD, and cannabis, which have virtually no therapeutic uses, are the most strictly controlled, and are available on licence only. In most cases licences are available only for research purposes (a few psychiatrists use LSD in clinical practice), and are issued only on the advice of the Medical Research Council, the Department of Health and Social Security or the Agricultural Research Council.

Drugs in the second group—the opiates (such as heroin, morphine and methadone) and the major stimulants (such as the amphetamines)—are subject to controls which are almost as stringent as those for the first group, the only major difference being that, because these drugs are widely used in medical practice, it is more convenient to give general authority to certain classes of people who have to use them professionally (for example, pharmacists, doctors and veterinary surgeons) rather than to issue individual licences. Manufacture on a commercial scale and wholesale dealing in the drugs, however, are under licence only. The purpose of the controls is to confine the drugs to genuine medical use. There are record-keeping and safe-custody requirements, and the drugs are available only on prescription.

In the third group are a small number of minor stimulants which are thought less likely to be misused and less harmful if they are misused. Commercial manufacture and wholesale dealing are controlled by registration with the Home Office, and the groups of people given authority to use them professionally are the same as for drugs in the second group. The same restrictions apply as in the second group, except that record keeping is not required.

The fourth group contains preparations of certain controlled drugs—that is, controlled drugs combined with other substances in such small amounts or in such ways that they are not liable to produce dependence or cause harm if misused. Controls relate only to manufacture and supply, and not to record keeping or safe custody.

Notification of and Supply to Addicts

The Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973 require any doctor who attends a person whom he considers, or reasonably suspects, to be addicted to certain controlled drugs[1] to notify the Chief Medical Officer of the Home Office. Various particulars, such as name, age, address and the drugs concerned, are given, in complete confidentiality. (Some information about addicts is also obtained from other sources, including police reports and the inspection of the records of wholesale and retail suppliers.)

The regulations also prohibit, except under Home Office licence, the prescribing, supply or administration to addicts of heroin or cocaine, other than to treat organic disease or injury. Licences to prescribe are granted only to doctors working in hospitals or similar institutions, with the result that the treatment of dependence on heroin and cocaine is in the hands of

[1]Cocaine, dextromoramide, diamorphine, dipipanone, hydrocodone, hydromorphone, levorphanol, methadone, morphine, opium, oxycodone, pethidine, phenazocine and piritramide.

the hospital service rather than general practitioners. Similar provisions exist in Northern Ireland.

Control of Over-prescribing

The Misuse of Drugs Act contains special provisions to enable quick measures to be taken to counter the problem of the over-prescribing of controlled drugs by doctors—the problem that caused particular concern during the 1960s. Some measures have also been taken as the result of voluntary co-operation within the medical and pharmaceutical professions themselves. The Home Secretary has powers to demand information about the supply of any dangerous substance, whether controlled or not, from any pharmacist or doctor in an area, if it appears that the area has special social problems caused by the extensive misuse of that substance. Other information about over-prescribing is obtained through the periodical inspection by authorised officials of the records of retail pharmacists, from pharmacists themselves bringing their suspicions to the notice of the authorities and directly from drug-users. All prescriptions are eventually available for scrutiny, although not normally until several weeks after dispensing.

The general legal position of a doctor in the United Kingdom is that he is entitled to prescribe controlled drugs as he thinks fit for his patients, except that to supply heroin or cocaine to addicts for the purposes of treating their addiction he must be licensed (see p 14). The Home Secretary (or, in Northern Ireland, the Department of Health and Social Services), however, has power to direct the withdrawal of a doctor's authority to possess, prescribe, administer, manufacture, compound or supply specified controlled drugs. This power also relates to dentists, veterinary surgeons, veterinary practitioners and pharmacists. It can be exercised when a practitioner (that is, a doctor, dentist or veterinarian) or a pharmacist has been convicted of a drugs offence, or when a special tribunal has found that a doctor has contravened the regulations concerning the notification of and supply of drugs to addicts, or that a practitioner has prescribed, administered, supplied or authorised the administration or supply of controlled drugs in an irresponsible manner. The 1971 Act does not define the phrase 'irresponsible manner', but provides a co-ordinated framework of investigation, tribunal and appeal procedure to assist the Home Secretary in his decision.

Where immediate action to prevent irresponsible prescribing is called for, the Home Secretary can proceed at once to refer the case to an independent panel of persons from the same profession as the practitioner concerned with a view to temporary suspension of the practitioner's authority to prescribe specified drugs before his case is referred to a tribunal for formal investigation.

The Home Secretary may restore an authority to prescribe controlled drugs if after a reasonable period he is satisfied that the practitioner has mended his ways and is unlikely to offend again.

The General Medical Council is the statutory body responsible for keeping and publishing a Register of duly qualified doctors, for ensuring that the educational standard of entry to the Register (and thus to the profession) is maintained, and for taking disciplinary action against registered doctors if it appears that because of misconduct they may be unfit to remain on the Register. Through its disciplinary committee the Council has the power to erase

from the Register the name of a doctor who after due inquiry is found to have been convicted of a criminal offence or to have been guilty of serious professional misconduct. A doctor's registration may also be suspended, successively, for periods of up to one year. A number of doctors have had their names erased from the Register, or their registration suspended, following convictions for offences involving drugs or after a finding of serious professional misconduct in respect of charges involving non-bona fide prescribing of drugs, or personal abuse of drugs.

Voluntary Measures

Some measures to control the prescribing of certain drugs subject to misuse have been taken as a result of voluntary co-operation within the medical and pharmaceutical professions themselves. In the late 1960s, for example, a purely voluntary arrangement between the Government, pharmaceutical manufacturers and the medical profession confined supplies of injectable methylamphetamine to hospital pharmacists who made them available to general practitioners on application in strictly limited quantities. When a few doctors then began to prescribe powdered amphetamine sulphate, which could be taken by intravenous injection after dissolution in water, action by the Pharmaceutical Society in advising its members to refuse to dispense these prescriptions produced a new way of dealing with the problem.

More recently, following an initiative by the Advisory Council on the Misuse of Drugs, a group of medical practitioners launched a campaign to alert their professional colleagues to the dangers inherent in the use of barbiturates as hypnotics and sedatives, that is as sleeping pills. (The Advisory Council had previously concluded that there would be difficulties in controlling the use of barbiturates by law and that voluntary methods should be tried.) This independent Campaign on the Use and Restriction of Barbiturates (CURB, as it was [illegible]n) was later extended to patients and the public and attracted government financial help. Its effects are being assessed, but a degree of success has been achieved, and the Government believes that important lessons for the future can be learned, not least in fostering co-operation with the medical and dental professions in providing information and advice for practitioners and the public.

Other voluntary measures aimed at limiting access to drugs of this kind include greater precautions by doctors and pharmacists against burglary, and reduction of stocks held on their premises.

The Medicines Act 1968 and the Poisons Act 1972

Separate legislation controls the manufacture and distribution of medicines, the marketing of new medicines and the sale or supply of non-medicinal poisons. The Medicines Act 1968 covers all aspects of the control of medicines except prices. It includes within its scope medicines for human and veterinary use.

The main provisions of the Act are:

1. The establishment of a Medicines Commission appointed by ministers to give them advice on matters relating to the execution of the Act and to medicinal products generally.

2. The establishment of expert advisory committees appointed by ministers on the advice of the Commission.
3. A licensing system applicable to the marketing, importation, manufacture and distribution of medicinal products.
4. A code of law covering the wholesale and retail sale or supply of medicinal products.
5. Powers for ministers to make regulations concerning labelling and containers for medicines and the promotion of their sales.

Fuller details are set out in COI short note *Control of Medicines in Britain*, SN5944.

The Poisons Act 1972 is concerned only with non-medicinal poisons. It provides for the listing of substances to be treated as poisons, and for this Poisons List to be divided into two parts. Part one consists of poisons which can only be sold retail by a person lawfully conducting a retail pharmacy business; part two comprises poisons which can be sold either by a person lawfully conducting a retail pharmacy business or by a 'listed seller' (that is, a person on a list kept by the local authority).

The Poisons Board prepares the list of poisons for the Home Secretary's approval, and advises the Minister on the making of rules relating to the sale and supply of poisons, their storage, transport and labelling, the containers in which they may be sold or supplied, and related matters.

The Poisons List and Poisons Rules are amended by the Home Secretary from time to time after consultation with the Poisons Board. The legislation does not regulate possession of listed poisons but, with the Poisons Rules, imposes restrictions on sale and supply. Northern Ireland has comparable poisons legislation.

HEALTH EDUCATION

Restricting the availability or supply of drugs is only one course of preventive action. Studies by the Advisory Council on the Misuse of Drugs have highlighted the importance of educating the public, particularly young people, about the potential hazards of drug misuse. Not enough is yet known about the types of health education that are most effective in this difficult area—an ill-advised approach, by feeding interest in drugs in the wrong way, may actually encourage experimentation—but the Council considers that, as in the case of alcohol abuse, education should not focus solely on the problems of drug misuse but should preferably form part of a more broadly based health education programme. 'People must be dissuaded from believing that there is a pill for every ill and must be reminded that experimenting with drugs is too dangerous to be done for "kicks" since it can lead to dependence and death.'[1]

The Health Education Council plays a continuing role in advising on ways to achieve better public awareness and understanding of health problems. Though an independent agency, the Council receives an annual government grant. It disseminates advice and publicity material through area

[1]*Prevention and Health*, a Government White Paper on preventive medicine, published in December 1977.

health authorities, local authorities (and health and social services boards in Northern Ireland), professional organisations, industry and voluntary bodies. Its counterpart in Scotland is the Scottish Health Education Unit. Both bodies have produced booklets and other educational material on the dangers involved in drug misuse.

From time to time the Press, radio and television have shown with much realism the consequences of drug misuse; television in particular is regarded as having a potentially powerful influence on the attitudes of the young.

Because of the problems drugs can cause for young people the government education departments (as well as those dealing with home affairs and health) are in close touch with the Advisory Council on the Misuse of Drugs and other organisations working in this area. In *Health Education in Schools,* published in 1977 (see Reading List, p 38), the Department of Education and Science sets out facts about the misuse of drugs, glues and solvents, and discusses attempts to control the problem and the role of teachers. The book notes, according to 1975 findings, that many boys and girls seem to have the opportunity to experiment with drugs which they ignore or soon abandon; that some join a minority who are attracted especially to cannabis or LSD; and that very few indeed step into dependence on heroin or its associates. There are wide variations from area to area in the extent of such experimentation, as well as changes from year to year and at least the possibility of changes in fashion. There is evidence indicating that the great majority of children are well aware both of the differences between the effects of different drugs and of the dangers of dependence, and have pity or contempt for those who are 'hooked', but at the same time are willing to experiment (often as part of a group activity) in practices which they believe offer little risk.

A Government White Paper on preventive medicine published in 1977[1] noted that, although a recent report on drug misuse among children of school age, prepared by the Advisory Council on the Misuse of Drugs, had suggested that 'attitudes may already be changing and leading to a decline in drug misuse among young people, the Government continues to regard the matter with grave concern'.

The need is recognised for close co-operation between teachers, local social services departments and others involved with the welfare of young people whenever problems of this kind arise. Particularly vulnerable are those moving into higher education after leaving school and those who, on leaving home for the first time, may find the process of adjustment traumatic and difficult. Their problems are often compounded by the easier availability of drugs, by contact with people of different social backgrounds, and the greater opportunities for drug experimentation. The primary health care services—including family doctors, community nurses and health visitors working with social work staff—play an important part in the education and counselling of young people to help them to overcome problems without resort to drugs. The Government believes that more sophisticated health education campaigns may be needed to help to inform such young people about the realities and risks. The attitudes of teachers and of contemporaries are seen as having particular importance. Methods of teaching about

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[1]*Prevention and Health,* Cmnd 7047, HMSO, £1·60. ISBN 0 10 170470 4.

experimentation with drugs are being discussed, but the aim is to enable young people to reach sensible decisions about drugs use in situations where drugs may be offered.

Secondary prevention, including counselling and advisory services, especially for young people, helps drug misusers by ensuring early advice and treatment before they become heavily dependent.

TREATMENT AND REHABILITATION

PEOPLE who misuse drugs have problems extending beyond those of medical treatment to everyday matters such as employment and housing, and the treatment and rehabilitation of misusers are seen in the United Kingdom as being part of a single process, involving medical, psychiatric and social care provided by the National Health Service, social services departments and voluntary organisations. In the interests of clarity this chapter deals first with treatment procedures, for narcotic drug misusers and for other misusers, and then with approaches to rehabilitation.

NARCOTIC DRUG MISUSE AND THE ROLE OF THE CLINICS

Treatment for narcotic drug addiction is not compulsory nor is there any registration of people dependent on drugs although doctors must notify the central authorities of patients they believe to be addicted to certain narcotics.

Until the sudden change in drug misuse in the early 1960s the circumstances in which doctors might properly prescribe narcotic drugs to patients were generally accepted as those defined by the report of the Rolleston Committee in 1926 (see p 3). This freedom of doctors to prescribe narcotic drugs to addicts unfortunately left open a door to abuse, and the new situation of the 1960s led to the (second) report of the Brain Committee (see p 4) and the implementation in law and administrative action of most of its proposals.

Legislation was passed enabling regulations to be made to restrict the number of doctors who could supply heroin and cocaine to addicts, and to require the statutory notification of addicts dependent on certain narcotic drugs (see p 5). Administrative action comprised the provision of facilities for the treatment of these addicts. Hospital authorities were asked to provide facilities in mental illness hospitals or in the psychiatric departments of general hospitals for the 'in-patient' treatment of addicts willing to be withdrawn from their dependence. The authorities were also asked to provide 'out-patient' services for the treatment of addicts who would not accept withdrawal. The aims of out-patient treatment were seen as balancing the needs of the addict with the need to contain heroin addiction by continuing to supply the drug in minimum quantities where this was necessary in the doctor's opinion, and, where possible, by persuading addicts to accept withdrawal treatment. A complete refusal to supply drugs, it was felt, would not cure addiction, but would encourage the development of a black market on a scale hitherto unknown in the country.

To meet the need in the London area, where addicts are largely concentrated, 14 special out-patient clinics—treatment centres—have been established. In other parts of the country, where there are far fewer patients dependent on drugs, treatment is usually given by the ordinary hospital psychiatric services, although where numbers justified them special clinics similar to those in London were set up.

While addicts are under the penal system—in prison hospitals, remand homes and borstals—they are given compulsory withdrawal treatment under medical supervision. In some circumstances addicts in custodial care may also be treated in special hospitals.

Treatment Centres

Government departments do not dictate the pattern of work in the treatment of drug dependence. Together with, for example, nursing and social work colleagues, the consultant psychiatrist in charge of each treatment centre has individual responsibility for his patients' treatment and care, the responsibility for prescribing resting with the doctor. For this reason alone, there is no one uniform programme of care. Although, as in the introduction to this pamphlet, reference is sometimes made for the sake of convenience to 'the British approach' or 'the British system' of treatment, involving the administration or prescribing of narcotic drugs to addicts, individual clinical judgment is all-important and, as in other aspects of health care, rests with a multi-disciplinary team of specialists. No single form of treatment is practised to the exclusion of others. The care of each patient's case is a matter for the team.

There is nevertheless a basic common purpose shared by all the treatment centres, and this is recognised in various ways. When the centres were first established, there was little experience of treating addiction in the hospital service, certainly not on an out-patient basis, and it was important for common problems to be identified and for experience to be shared. The staff of the London centres, for example, consult each other regularly, and meet as a group as the need arises. Despite differences of practice which reflect the individual judgment of different professionals, there are many points on which concerted action has been agreed as a matter of common interest, and individual decisions can take account of the collective experience of the treatment centres as a whole.

The primary concern of the treatment centres is the treatment and rehabilitation of their patients, but the fact that the centres have become in effect the only source from which addicts can legally obtain heroin or cocaine means that the objective of preventing the spread of addiction cannot be achieved without their participation in guarding against evasion of the statutory controls. Special safeguards govern both the acceptance of patients for treatment and the arrangements for supplying drugs.

If a new patient presents himself at a treatment centre, the centre tries to satisfy itself on two points before accepting him for any form of treatment which involves the prescribing of drugs. First it must decide whether the patient is genuinely addicted to such an extent that it is justifiable to prescribe drugs either as a prelude to gradual withdrawal or for maintenance therapy where the aim is to stabilise the patient and enable him or her to function normally in the community until motivated to accept withdrawal treatment. This is done by a clinical/social assessment on a multi-disciplinary basis. Various means are used to gauge the presence and extent of addiction, including biochemical tests to establish the actual fact of drug use. Checks are made from the Home Office's central index of known addicts to try to ensure that the patient is not already obtaining drugs from another centre. A patient is not normally accepted at his or her first appearance, but is asked to return on at least one further occasion so that it can be seen whether he or she is using the drugs in question persistently.

Special precautions are taken against the fraudulent alteration of prescriptions and the illicit sale by patients of the drugs prescribed to them.

It is usual for a single prescription to cover a week's or a fortnight's supply of drugs, but in order to prevent the addict from holding such a relatively large quantity at any one time the prescription specifies that the drug be dispensed in daily doses, and the patient goes to the pharmacy each day to collect that day's supply, with two days' supply on Saturdays since pharmacies are generally closed on Sundays. Although the prescribing of heroin and cocaine has been restricted to the drug treatment centres, doctors can prescribe other opiates (methadone for example); they are encouraged, however, to send addicts to the centres for such treatment. Addicts undergoing treatment sometimes also use illicit supplies of other drugs.

The ultimate aim of the treatment of drug addicts is the withdrawal of the drug (or drugs) of dependence and the establishment of social functioning, but treatment may take the form of withdrawal or of maintenance therapy where the aim is to stabilise addicts and enable them to function normally in the community until they are motivated to accept withdrawal treatment. (In some clinics long-term maintenance therapy is not offered but withdrawal therapy is, together with social and psychological help and support towards rehabilitation.)

Most addicts being withdrawn from heroin have methadone substituted for heroin as a preliminary stage. In addition, most clinicians consider that patients being maintained on drugs on a longer-term basis may benefit from the substitution of methadone for heroin. Among the advantages often attributed to methadone are: that it produces less euphoria than heroin; that, as its action lasts longer than that of heroin, it needs to be taken less frequently and so is less disruptive of the patient's normal life; and that it can be taken orally. Methadone prescribed by the treatment centres may be for intravenous use, but patients who are encouraged to take the step from heroin to injectable methadone may subsequently find it easier to be weaned from the practice of injection and to accept methadone in oral form (which can itself reduce the risk of over-dosage). Withdrawal after the substitution of methadone is claimed by some clinicians, though not by others, to be less difficult than straightforward withdrawal of heroin, and the withdrawal syndrome to be less severe, although longer lasting.

Little use has been made of 'blockade' doses of methadone in oral form; generally the objective of giving minimum doses seems to have been followed with methadone as much as with heroin. Longer-acting methadone preparations have not been used, nor have narcotic antagonists.

The amounts of heroin and methadone prescribed for addicts in England and Wales (*not* the United Kingdom) in the period 1970–76 are shown in Table 2. Most new patients accepted at clinics are being prescribed methadone.

Of the 2,023 addicts recorded in the United Kingdom in 1977, some 67 per cent were being prescribed methadone alone, and a further 8 per cent methadone and heroin. The proportion of addicts being prescribed heroin alone or in combination with drugs other than methadone was about 4 per cent. The prescribing of morphine has recently been falling (2 per cent of addicts in 1977), but the proportion of addicts receiving dipipanone alone has been rising, and reached 11 per cent in 1977. Fuller details of the types of drug being prescribed are given in Table 3.

The treatment given in addition to withdrawal, substitution and mainten-

TABLE 2

Amounts of Heroin and Methadone Prescribed for Narcotic Drug Addicts Attending National Health Service Hospitals in England and Wales, Annual Totals 1970–76

Year	Heroin (gms)	Methadone	
		Ampoules (gms)	Other forms (gms)
1970	17,392	11,344	3,488
1971	14,201	11,548	3,742
1972	14,322	14,227	8,227
1973	14,287	19,099	9,072
1974	15,332	21,454	8,295
1975	15,474	20,937	9,563
1976	13,178	17,297	11,682

ance therapy varies from centre to centre. Individual help with social and personal problems is given, and in addition to the medical treatment some centres use group psychotherapy. The general approach is multi-disciplinary, involving, as well as medical help, social work help for addicts and their families. (The role of social workers was examined in a 1969 report on *The Rehabilitation of Drug Addicts*—see p 27.)

TABLE 3

Number of Narcotic Drug Addicts in the United Kingdom known to the Home Office at End of Year, by Type of Drug being Prescribed in Treatment

Type of drug	1972	1973	1974	1975	1976	1977
Methadone alone ..	1,056	1,201	1,300	1,314	1,292	1,362
Methadone and heroin ..	194	219	238	207	161	147
Methadone, heroin and other drugs	7	4	5	5	5	6
Methadone and other drugs but not heroin ..	21	15	8	16	19	23
Heroin alone	102	112	109	87	78	69
Heroin and other drugs but not methadone ..	35	43	40	17	9	10
Morphine alone	72	69	72	54	41	44
Pethidine alone	52	45	52	50	49	47
Dextromoramide alone ..	29	47	56	62	61	72
Dipipanone alone ..	33	45	67	120	146	225
Cocaine alone	3	3	3	3	2	2
Other drugs alone* ..	6	7	6	3	4	6
Other drug combinations..	5	5	14	14	12	10
Total	1,615	1,815	1,970	1,952	1,879	2,023

*Involving levorphanol and phenazocine in 1972–77 and medical opium in 1973–74.

Most addicts are treated on an out-patient basis (see Table 4) although some need a period of hospital in-patient 'crisis intervention' treatment for physical and psychiatric problems.

Since the treatment centres were first established, the out-patient approach has assumed a larger role, and correspondingly less use has been made of in-patient treatment facilities, than was generally expected. Some doctors now believe that many patients are better able to undergo even complete withdrawal from drugs while being treated as out-patients. All the out-patient centres, however, can refer patients for in-patient treatment, and a number of patients are transferred to in-patient departments in this way both for withdrawal and for supportive treatment during acute episodes of their condition.

TABLE 4

Out-patients and In-patients Attending National Health Service Hospitals for Narcotic Drug Addiction in England and Wales, Annual Averages 1970–76

Year	Out-patients			In-patients		
	London	Elsewhere	Total	London	Elsewhere	Total
1970	955	200	1,155	68	30	98
1971	830	206	1,036	43	25	68
1972	953	299	1,252	48	19	67
1973	1,045	335	1,380	36	24	60
1974	1,125	371	1,496	38	38	76
1975	1,145	401	1,546	39	25	64
1976	1,062	391	1,453	41	16	57

Hospitals which treat addicts as in-patients of course deal with many of the same problems as the out-patient centres, enabling the patient to assume or resume a normal social life. The support of social work, occupational therapy and other specialised departments of the hospital is equally available where in-patient treatment is given.

Treatment of the physical complications that can be caused by intravenous injection—such as daily dressings of skin infections and drainage of abscesses—is often carried out in the accident and emergency departments of general hospitals. More serious complications arising from the sharing of infected syringes—such as septicæmia and infective hepatitis—are treated on an in-patient basis in general medical wards of hospitals.

Patients Receiving Treatment

The number of addicts in the United Kingdom known to the Home Office to be receiving narcotic drugs in the years 1972–77 are shown in Table 5. The continuing increase in the number of addicts notified for the first time is also shown. The number of people who ceased to be recorded as addicts during the year has increased each year since 1972.

TABLE 5

Numbers of Narcotic Addicts in the United Kingdom known to the Home Office, 1972–77

	1972	1973	1974	1975	1976	1977
Addicts known to be receiving drugs at 1 January	1,549	1,615	1,815	1,970	1,952	1,879
Added during the year People notified as addicts by medical practitioners:						
Not previously known . .	799	807	873	922	985	1,112
Known in earlier years . .	586	599	566	535	543	620
Total.	1,385	1,406	1,439	1,457	1,528	1,732
Taken off during the year People no longer recorded as addicts at 31 December:						
Removed by reason of death . .	65	61	77	68	63	40
Admitted to penal or other institution . . . . . . }	1,254	437	387	484	514	442
No longer seeking treatment . . }		708	820	923	1,024	1,106
	1,319	1,206	1,284	1,475	1,601	1,588
Addicts known to be receiving drugs at 31 December	1,615	1,815	1,970	1,952	1,879	2,023

The average age of notified addicts is gradually increasing. A pool of addicts on long-term maintenance who are unwilling to try to break their dependence on drugs has built up in the years since the present treatment system was introduced in 1968. About 20 per cent of addicts were under 25 years in 1977, compared with 51 per cent in 1972. Some 41 per cent were aged 25 to 29, 18 per cent 30 to 34, 10 per cent 35 to 49, and 10 per cent 50 and over (the ages of a few addicts were not known). Each year recently there have been fewer notifications of addicts in their teens and early 20s. Almost three out of every four addicts known at the end of 1977 were male. Figures for the years 1972–77 are given in Table 6.

TABLE 6

Numbers of Narcotic Addicts in the United Kingdom known to the Home Office, 1972–77, by Sex and Age

	1972	1973	1974	1975	1976	1977
Number notified as taking drugs on 31 December	1,615	1,815	1,970	1,952	1,879	2,023
Males	1,194	1,369	1,459	1,438	1,388	1,468
Females.	421	446	511	514	491	555
Age distribution:						
Under 20 years	96	84	64	39	18	20
20–24	727	750	692	562	411	387
25–29	376	530	684	754	809	826
30–34	117	134	163	219	247	355
35–49	118	136	163	169	189	208
50 and over	165	180	197	193	188	201
Age not stated	16	1	7	16	17	26

TREATING OTHER FORMS OF DRUG MISUSE

The problem of multiple drug misuse which does not necessarily involve narcotic drugs gives rise to considerable concern, and existing services are being examined to see whether better treatment provision for misusers can be made. Consideration is being given to the question of whether the model of treatment established for narcotic drug misusers is appropriate for other misusers, or whether professional skills gained in the narcotic treatment centres should be used in other ways—for instance, through support and counselling agencies dealing with young people generally. Special attention is being paid to the need for earlier intervention in individuals' drug misuse problems.

Most of the misusers who find their way to the treatment services are treated through the general psychiatric services, either as out-patients or as in-patients, alongside patients who have other problems. Withdrawal treatment of addicts dependent on barbiturates, for example, can be an in-patient procedure because of the serious physical and mental complications which may occur during and after withdrawal. A few of the special treatment centres hold clinic sessions for the out-patient treatment of non-narcotic drug misusers, but often encounter the problem that many patients fail to keep appointments or to persist with treatment. An alternative approach being considered would involve a multi-disciplinary team working in the community rather than in a hospital, offering help to drug misusers as part of the local youth and social work services for young people generally; such a service would be provided with consultation and referral facilities by the team treating addicts at one of the established treatment centres.

A particular problem is the drug misuser who is prone to take overdoses—this can happen frequently during periodic crises. Accident and emergency departments of some hospitals are familiar with the type of patient who usually discharges himself as soon as he is resuscitated. It is recognised that there is a need to find a way of helping these often disturbed and self-destructive people, many of whom are young. This will involve closer liaison between the accident/emergency departments and psychiatric departments. However, in addition, an experimental short-term residential unit, funded by the Department of Health and Social Security and statutory authorities and operated by a voluntary agency, was opened in London in May 1978 where patients' needs can be assessed, and attempts made to persuade them to accept help. The working of the unit is being carefully assessed.

REHABILITATION

The treatment and rehabilitation of drug misusers, though dealt with separately for the sake of clarity in this pamphlet, are seen as parts of a single process, with rehabilitation starting as soon as a misuser seeks professional advice or attends an out-patient clinic. The aim of rehabilitation is to motivate a misuser—whether he uses narcotic drugs or others—to leave the drug sub-culture or group and to develop new social contacts, for, it is believed, without this, treatment of physical and psychological dependence is not in itself likely to succeed. There is seen to be a need for continuing support so that a drug misuser can mature and learn to live in society without the physical, social and emotional aid of drugs.

A report published in 1969, *The Rehabilitation of Drug Addicts* (see Reading List, p 38), advanced the view that: 'Rehabilitation begins with the first contact with the addict. Use must be made of the opportunity which prescribing in the hospital out-patient clinics gives to build a constructive relationship with the addict so that he can be influenced towards withdrawal. The clinics are strategically placed to form the focal point for the whole process of rehabilitation.'

The report placed particular emphasis on the appointment of adequate numbers of doctors and of social workers, to be employed full time in the centres as members of the therapeutic team. It also made proposals designed to ensure that the work of the centres was effectively co-ordinated with other services available for addicts, mentioning in particular general practitioners, voluntary bodies and local authorities. The recommendations were commended by the Government to hospital authorities, and the subsequent staffing of the centres has generally been based on them, although the report itself recognised that because of general shortages of certain categories of staff—particularly social workers—it would not be possible in the short term for the proposals to be implemented in full.

A great deal of social and family casework is done with addicts, and social workers provide a link between addicts and the community, especially family, friends, employers and voluntary agencies. Many narcotic addicts who attend the treatment centres—especially those on long-term maintenance—lead reasonably stable lives, often living with their families and remaining in work. Each centre also sees, however, a number of disorganised addicts who need social work help with their emotional and family relationships, accommodation and education or employment. This group can be extremely difficult to help, and social workers need special knowledge of young people and the needs of misusers to develop skills in working with them and interpreting their needs to others.

The problems of the drug misusers who are not in touch with the treatment centres—particularly those of multi-drug misusers—are often encountered by community-based social workers from both official and voluntary agencies (this includes youth and community workers), who can draw upon the support and special experience of their colleagues in the centres. The Government feels that this may be the right pattern of help, in that it should be considered with the broader spectrum of social services for young people which may best be able to assist provided always that they can call in those with specialised knowledge when required.

A number of voluntary organisations take a special interest in the patterns of drug misuse and dependence, sometimes with financial support from local authorities. The help they give takes such forms as detached or 'street level' contact for advice and support, hostels or emergency accommodation, day centres or locally-based counselling services and parents' groups.

One of the matters referred to in the report, *The Rehabilitation of Drug Addicts*, was the provision of special hostels for addicts who had completed hospital treatment and had been withdrawn from drugs. A number of such hostels have been established; most are run by voluntary organisations, some receiving financial aid from local authority sources.

The voluntary status of these rehabilitation houses is reflected in the wide

variety of their approaches. The Concept Houses, for example, are based on the pattern of the Synanon and Phoenix Houses in the United States. As an ex-addict works through the intensive programme, usually over a six–to eighteen-month period, he or she progresses up a rigidly structured hierarchy, the highest positions being those of the staff (which some residents eventually become). Many of the admissions to these houses are the result of a court order requiring residence in a rehabilitation centre. There are also several hostels run by religious orders, using various rehabilitation approaches. The requirements for acceptance in a hostel of a particular denomination may differ from one hostel to another. There are also a few less easily classified houses run on community, or 'surrogate family', lines. Unlike the official treatment centres, most of these residential projects are situated outside London.

Accommodation for homeless addicts still using drugs is a major problem since non-specialist hostels are reluctant to accept such potentially disruptive inmates, and the lack of a fixed address frustrates the development both of contacts with support services and of a motivation to be withdrawn. One voluntary agency, the ROMA (Rehabilitation of Metropolitan Addicts) Housing Association, provides accommodation in London for addicts attending out-patient clinics.

INFORMATION AND RESEARCH

Information

Drug misuse is a difficult area for gathering definite information, and facts and figures have to be drawn together from many sources—the local hospitals, the experience of family doctors and chemists, schools, the police and voluntary bodies. The fact that doctors must by law notify the central authorities of people suspected to be addicted to certain narcotic drugs (see p 14) provides information in a limited field, but it does not permit the identification of misusers of other drugs,whether or not they may be considered addicted. Some drug misusers, though not recorded on the index of cases of addiction, may come to the notice of the police or customs, for example through offences against the drugs legislation.

The Department of Health and Social Security provides health authorities with centrally-held information on narcotic addiction, but is encouraging them to build up information on drug misuse in their own areas and to plan services accordingly. Planning and the co-ordination of activities involves area health authorities, social services authorities (which are linked for this purpose by joint consultative committees) as well as voluntary organisations. Since trends in misuse change, it is seen as important that there should be a flexible and local approach to the problem so that a response can be made to needs as they arise.

The Standing Conference on Drug Abuse (SCODA) fosters co-operation between voluntary organisations working in the field of drug dependency and misuse. It publishes a summary sheet listing services provided by the organisations, including both residential and information services, and (jointly with several other national voluntary groups) a Directory of Projects which takes the form of a guide to projects in England and Wales for drug takers, homeless single people, alcoholics, people with a history of mental illness, adult offenders and their families.

The Institute for the Study of Drug Dependence, an independent charity, collects, collates and disseminates information on all aspects of drug dependence. With a reference library and an information retrieval system, it provides a centre for the study of dependence. It promotes and undertakes research, arranges lectures, discussions and seminars, and co-operates with British and international organisations in furthering study and exchanging information.

Research

Research into drug misuse is regarded as of paramount importance, and research programmes are commissioned or carried out by the Home Office (this is a statutory power under the Misuse of Drugs Act 1971), the Department of Health and Social Security and the Medical Research Council (see below). Many small research projects are financed by hospitals or university departments, and individual studies are sponsored by independent organisations. Broadly speaking, research covers three main areas: biochemical and pharmacological studies; clinical and treatment studies; and epidemiological, social and psychological descriptive studies.

The Advisory Council on the Misuse of Drugs has a duty to review the situation with respect to drugs which are being, or appear likely to be, misused and of which the misuse is having, or appears capable of having, harmful effects sufficient to constitute a social problem.

The Medical Research Council, the main government agency for the support of medical and related biological research in the United Kingdom, undertakes research into the problems of drug dependence. It receives its main financial support through a parliamentary grant, but has executive control of its funds. It has the freedom to pursue an independent scientific policy, but also carries out research commissioned by the Department of Health and Social Security and other government departments. Such commissions account for approximately a fifth of the Council's expenditure.

A substantial amount of work on drug dependence is in progress under the Council's auspices, both in its own research establishments and (with research grant support) in universities and other institutes. Two examples of research are: work at the University of Oxford on the chronic effects of centrally active drugs on brain chemistry and structure; and, at the Addiction Research Unit at the Institute of Psychiatry in London, a long-term research programme, financed jointly by the Council and the Department of Health and Social Security, on drug dependence from the social, epidemiological, psychological and treatment standpoints.

The Social Science Research Council, which encourages, supports and carries out research in the social services, has been supporting a study of the evolution of policies and attitudes towards narcotics in Britain.

Specialised journals dealing with research into the misuse of drugs (among other subjects) include the *British Journal of Addiction,* published by the Society for the Study of Addiction. Reports on research projects into drug misuse are published from time to time in medical journals such as the *British Journal of Psychiatry,* the *British Medical Journal, The Lancet,* and *Nature.*

APPENDIX 1

INTERNATIONAL CONTROLS

Since the first step towards the creation of international controls of dangerous drugs was taken in 1909, an effective system has been built up, beginning in 1920 under the auspices of the League of Nations and continuing since 1946 under those of the United Nations (UN). Well over 100 countries now participate in the system.

The basic aims of international drug control are to prevent the misuse of dangerous drugs and the resulting damage to public health and society in general; to stop the diversion of drugs from lawful to illegal channels; and to ensure that the effective control of dangerous drugs in one country is not impeded by lack of control in another. The international control system which has been set up to achieve these aims requires that governments exercise control over the production and distribution of dangerous drugs, take measures to combat the illicit traffic, maintain the necessary administrative machinery, and report their actions to special international bodies.[1]

The United Kingdom has played a full part in the development of international co-operation in this field, and is a party to all the international agreements so far in force except the 1936 Convention for the Suppression of Illicit Traffic in Dangerous Drugs, the 1953 Opium Protocol and the 1971 Convention on Psychotropic Substances. Measures adopted over the past 60 years to control the international misuse of dangerous drugs are listed below.

1912 International Opium Convention, signed at The Hague.

1925 Agreement Concerning the Manufacture of, Internal Trade in, and Use of, Prepared Opium, signed at Geneva.

1925 International Opium Convention, signed at Geneva.

1931 Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, signed at Geneva.

1931 Agreement for the Control of Opium Smoking in the Far East, signed at Bangkok.

1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs, signed at Geneva.

1946 Protocol Amending the Existing International Measures, signed at New York.

1948 Protocol, signed at Paris, bringing under international control drugs outside the scope of the 1931 Convention for limiting the manufacture and regulating the distribution of narcotic drugs.

1953 Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium, signed at New York.

1961 Single Convention on Narcotic Drugs, signed at New York.

1971 Convention on Psychotropic Substances, signed at Vienna.

1972 Protocol to Amend the 1961 Single Convention on Narcotic Drugs, signed at Geneva.

UN Fund for Drug Abuse Control

In 1971 the establishment of a United Nations Fund for Drug Abuse Control was

[1]The UN Commission on Narcotic Drugs and the International Narcotics Control Board.

announced by the UN Secretary-General. The aims of the Fund are the promotion of measures to control the misuse of drugs in many parts of the world through projects covering, for example, crop replacement, the treatment and rehabilitation of addicts, research, law enforcement, education and information. The Fund comprises voluntary contributions from both governmental and non-governmental sources.

To date the United Kingdom has contributed some £160,000.

European Co-operation

At a European level several organisations are concerned with problems of drug misuse and dependence, and there are frequent informal contacts, for example to exchange information in order to tighten customs controls over the smuggling of controlled drugs.

A framework for governments to discuss common political and economic problems, including the problems of drug misuse and dependence, is provided by the Council of Europe, an intergovernmental body founded in 1949. The Council's main purposes are to uphold the principles of parliamentary democracy and to provide a framework for member governments to discuss common political and economic problems. The United Kingdom is one of the Council's 20 member states. Before 1975 the Council's interest in drug misuse was centred on the association between misuse and crime. In 1975, however, an *ad hoc* committee of the Council, which had been studying the matter for two years, recommended that the Council should have a wider role in the field of drug misuse in general. The committee's recommendations for action, which were accepted by the Council, were for exchanges of information and certain broad studies to be carried out under the auspices of the Council's divisions and directorates. The first such study was on the problems of young drug misusers and travellers trafficking in Europe and elsewhere. A second study now being carried out is concerned with the treatment and rehabilitation of people dependent on drugs.

Since 1971 United Kingdom Government ministers and officials have been working out with their counterparts in European Community member countries, and Sweden, ways of co-operating in the fight against drug misuse and trafficking. (The United Kingdom became a member of the Community at the beginning of 1973.) Collaboration is continuing on a programme covering such matters as the reduction of the demand for controlled drugs and the enforcement of controls. Within the Community, the European Assembly is also concerned with the problem of drug trafficking and dependence.

APPENDIX 2

DRUGS CONTROLLED UNDER THE MISUSE OF DRUGS ACT 1971[1]

PART 1: CLASS A DRUGS

1. The following substances and products:

(*a*) Acetorphine.
Allylprodine.
Alphacetylmethadol.
Alphameprodine.
Alphamethadol.
Alphaprodine.
Anileridine.
Benzethidine.
Benzylmorphine (3-benzylmorphine).
Betacetylmethadol.
Betameprodine.
Betamethadol.
Betaprodine.
Bezitramide.
Bufotenine.
Cannabinol, except where contained in cannabis or cannabis resin.
Cannabinol derivatives.
Clonitazene.
Coca leaf.
Cocaine.
Desomorphine.
Dextromoramide.
Diamorphine.
Diampromide.
Diethylthiambutene.
Difenoxin.
Dihydrocodeinone *O*-carboxymethyloxime.
Dihydromorphine.
Dimenoxadole.
Dimepheptanol.
Dimethylthiambutene.
Dioxaphetyl butyrate.
Diphenoxylate.
Dipipanone.
Drotebanol (3,4-dimethoxy-17-methylmorphinan-6ß, 14-diol).
Ecgonine, and any derivative of ecgonine which is convertible to ecgonine or to cocaine.
Ethylmethylthiambutene.
Etonitazene.
Etorphine.
Etoxeridine.
Fentanyl.
Furethidine.
Hydrocodone.
Hydromorphinol.
Hydromorphone.
Hydroxypethidine.
Isomethadone.
Ketobemidone.
Levomethorphan.
Levomoramide.
Levophenacylmorphan.
Levorphanol.
Lysergamide.
Lysergide and other *N*-alkyl derivatives of lysergamide.
Mescaline.
Metazocine.
Methadone.
Methadyl acetate.
Methyldesorphine.
Methyldihydromorphine (6-methyldihydromorphine).
Metopon.
Morpheridine.
Morphine.
Morphine methobromide, morphine *N*-oxide and other pentavalent nitrogen morphine derivatives.
Myrophine.
Nicomorphine (3,6-dinicotinoylmorphine).
Noracymethadol.
Norlevorphanol.
Normethadone.
Normorphine.
Norpipanone.
Opium, whether raw, prepared or medicinal.
Oxycodone.
Oxymorphone.
Pethidine.
Phenadoxone.
Phenampromide.

[1]As amended by the Misuse of Drugs Act 1971 (Modification) Orders of 1973, 1975 and 1977.

Phenazocine.
Phenomorphan.
Phenoperidine.
Piminodine.
Piritramide.
Poppy straw and concentrate of poppy-straw.
Proheptazine.
Properidine (1-methyl-4-phenylpiperidine-4-carboxylic acid isopropyl ester).
Psilocin.
Racemethorphan.
Racemoramide.
Racemorphan.
Thebacon.
Thebaine.
Trimeperidine.
4-Bromo-2,5-dimethoxy-α-methylphenethylamine.
4-Cyano-2-dimethylamino-4, 4-diphenylbutane.
4-Cyano-1-methyl-4-phenylpiperidine.
N,*N*-Diethyltryptamine.
N,*N*-Dimethyltryptamine.
2,5-Dimethoxy-α,4-dimethylphenethylamine.
1-Methyl-4-phenylpiperidine-4-carboxylic acid.
2-Methyl-3-morpholino-1, 1-diphenylpropanecarboxylic acid.
4-Phenylpiperidine-4-carboxylic acid ethyl ester.

(*b*) any compound (not being a compound for the time being specified in sub-paragraph (*a*) above) structurally derived from tryptamine or from a ring-hydroxy tryptamine by substitution at the nitrogen atom of the sidechain with one or more alkyl substituents but no other substituent;

(*c*) any compound (not being methoxyphenamine or a compound for the time being specified in sub-paragraph (*a*) above) structurally derived from phenethylamine, an *N*-alkylphenethylamine, α-methylphenethylamine, an *N*-alkyl-α-methylphenethylamine, α-ethylphenethylamine, or an *N*-alkyl-α-ethylphenethylamine by substitution in the ring to any extent with alkyl, alkoxy, alkylenedioxy or halide substituents, whether or not further substituted in the ring by one or more other univalent substituents.

2. Any stereoisomeric form of a substance for the time being specified in paragraph 1 above not being dextromethorphan or dextrorphan.

3. Any ester or ether of a substance for the time being specified in paragraph 1 or 2 above not being a substance for the time being specified in Part II (below).

4. Any salt of a substance for the time being specified in any of paragraphs 1 to 3 above.

5. Any preparation or other product containing a substance or product for the time being specified in any of paragraphs 1 to 4 above.

6. Any preparation designed for administration by injection which includes a substance or product for the time being specified in any of paragraphs 1 to 3 of Part II (below).

PART II: CLASS B DRUGS

1. The following substances and products:

Acetyldihydrocodeine.
Amphetamine.
Cannabis and cannabis resin.
Codeine.
Dexamphetamine.
Dihydrocodeine.
Ethylmorphine (3-ethylmorphine).
Methylamphetamine.
Methylphenidate.
Nicocodine.
Nicodicodine (6-nicotinoyldihydrocodeine).
Norcodeine.
Phenmetrazine.
Pholcodine.
Propiram.

2. Any stereoisomeric form of a substance for the time being specified in paragraph 1 of this part.

3. Any salt of a substance for the time being specified in paragraph 1 or 2 of this part.

4. Any preparation or other product containing a substance or product for the time being specified in any of paragraphs 1 to 3 of this part, not being a preparation falling within paragraph 6 of Part I.

PART III: Class C Drugs

1. The following substances:

Benzphetamine.
Chlorphentermine.
Mephentermine.
Methaqualone.
Phendimetrazine.
Pipradrol.

2. Any stereoisomeric form of a substance for the time being specified in paragraph 1 of this part.

3. Any salt of a substance for the time being specified in paragraph 1 or 2 of this part.

4. Any preparation or other product containing a substance for the time being specified in any of paragraphs 1 to 3 of this part.

PART IV: Meaning of Certain Expressions

'Cannabinol derivatives' means the following substances, except where contained in cannabis or cannabis resin, namely tetrahydro derivatives of cannabinol and 3-alkyl homologues of cannabinol or of its tetrahydro derivatives;

'Coca leaf' means the leaf of any plant of the genus *Erythroxylon* from whose leaves cocaine can be extracted either directly or by chemical transformation;

'Concentrate of poppy straw' means the material produced when poppy-straw has entered into a process for the concentration of its alkaloids;

'Medicinal opium' means raw opium which has undergone the process necessary to adapt it for medicinal use in accordance with the requirements of the British Pharmacopoeia, whether it is in the form of powder or is granulated or is in any other form, and whether it is or is not mixed with neutral substances;

'Opium poppy' means the plant of the species *Papaver somniferum L*;

'Poppy straw' means all parts, except the seeds, of the opium poppy, after mowing;

'Raw opium' includes powdered or granulated opium but does not include medicinal opium.

APPENDIX 3

NOTES FOR PARTICIPANTS IN METHADONE MAINTENANCE PROGRAMMES WHO INTEND TO VISIT THE UNITED KINGDOM

Methadone is one of the drugs subject to international control under the United Nations Single Convention on Narcotic Drugs 1961. Importation of the drug into the United Kingdom is controlled by licence, and import licences are normally granted only for commercial transactions and not to enable individuals to import their personal supplies even if they have obtained them legitimately in their own country. Offences arising from any unauthorised attempt to import the drug carry severe penalties.

Methadone is available in the United Kingdom in all its main forms, but may be supplied or prescribed only by a doctor registered (on the British Medical Register) to practise medicine in the United Kingdom and who is also resident in the country. Pharmacists are not allowed to supply the drug against a prescription given by a doctor whose name does not appear on the Register.

The British National Health Service provides medical treatment free of charge and dispenses medicines at fixed low charges, but this service is intended only for people ordinarily resident in the United Kingdom. While visitors are not denied emergency treatment for conditions arising in the United Kingdom, this concession does not generally extend to the treatment of pre-existing conditions, particularly where it seems clear that the patient was aware before coming that he or she would be needing treatment while in the country.

Visitors to the United Kingdom who suffer from any pre-existing condition, including drug dependence, must therefore make their own private arrangements for treatment, and this normally involves paying for medical consultations and for any drugs prescribed for their treatment. While there are specialist drug dependency clinics, almost all operate within the National Health Service and, as such, are precluded from accepting patients from overseas who are not ordinarily resident in the United Kingdom. Participants in methadone maintenance programmes who ish to visit the United Kingdom are therefore advised to ask their doctors to make appropriate arrangements for treatment before leaving their own country.

The method of treatment in individual cases is decided by the doctor concerned. It may include a period when the patient is supplied on a maintenance basis with a drug to which he or she is addicted or a substitute, but this is entirely a matter of individual medical judgment. There has been a recent trend in the drug treatment clinics towards prescribing methadone on a maintenance basis to addicts dependent on heroin or other narcotic drugs. This trend was initiated by the doctors working in the clinics and not by the central government health departments.

Further information on the availability of private medical services may be obtained from the Institute for the Study of Drug Dependence (address on p 37).

Entry into the United Kingdom

The rules relating to entry into the country are outlined in COI reference publications *Immigration into Britain*, R5976, and *Residence in Britain: Notes for People from Overseas*, R6026. Visitors may be admitted for private medical treatment at their own expense. Immigration officers will wish to see evidence that arrangements have been made for consultation or treatment, and be satisfied that a visitor's means are sufficient to pay for such treatment. For this purpose the Port Medical Inspector may be asked to give an assessment of the likely cost. A visitor detected attempting to import methadone or other drugs without authority may be refused admission.

LIST OF ORGANISATIONS

Advisory Council on the Misuse of Drugs, c/o Home Office, Queen Anne's Gate, London SW1H 9AT.

Department of Education and Science, Elizabeth House, York Road, London SE1 7PH.

Department of Health and Social Security, Alexander Fleming House, London SE1 6BY.

Health Education Council, 78 New Oxford Street, London WC1A 1AH.

Institute for the Study of Drug Dependence, 3 Blackburn Road, London NW6 1XA.

Home Office Drugs Branch, Queen Anne's Gate, London SW1H 9AT.

Medical Research Council, 20 Park Crescent, London W1N 4AL.

Northern Ireland Department of Health and Social Services, Dundonald House, Upper Newtownards Road, Belfast BT4 3SF.

Scottish Health Education Unit, 21 Lansdowne Crescent, Edinburgh EH12 5EH.

Scottish Home and Health Department, St Andrew's House, Edinburgh EH1 3DE.

Standing Conference on Drug Abuse, 3 Blackburn Road, London NW6 1XA.

Welsh Office, Cathays Park, Cardiff CF1 3NQ.

READING LIST

(Published by Her Majesty's Stationery Office unless otherwise indicated)

Principal Legislation		£
Misuse of Drugs Act 1971. C.38. ISBN 0 10 543871 5.	1971	0·30
The Misuse of Drugs Regulations 1973. ISBN 0 11 030797 6.	1973	0·16
The Misuse of Drugs (Safe Custody) Regulations 1973. ISBN 0 11 030798 4.	1973	0·08
The Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973. ISBN 0 11 030799 2.	1973	0·05
Medicines Act 1968. C.67. ISBN 0 10 546768 5.	1968	2·60
Poisons Act 1972. C.66. ISBN 0 10 546672 7.	1972	0·13
Northern Ireland		
The Misuse of Drugs (Northern Ireland) Regulations 1974. ISBN 0 337 84272 8.	1974	0·22
The Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973. ISBN 0 337 83179 3.	1973	0·10½
The Misuse of Drugs (Notification of and Supply to Addicts) (Northern Ireland) Regulations 1973. ISBN 0 337 83180 7.	1973	0·05
The Poisons (Northern Ireland) Order 1976. ISBN 0 11 061214 0.	1976	0·28
General		
Advisory Council on the Misuse of Drugs, Treatment and Rehabilitation Working Group: First Interim Report.	1977	
Amphetamines and Lysergic Acid Diethylamide (LSD). Report of the Advisory Committee on Drug Dependence. ISBN 0 11 340338 0.	1970	0·30
Amphetamines, Barbiturates, LSD and Cannabis: their Use and Abuse. Department of Health and Social Security report. ISBN 0 11 320181 8.	1970	0·52½
Brain Committee: First Report of the Inter-departmental Committee on Morphine and Heroin Addiction.	1961	0·06
———Second report. ISBN 0 11 320476 0.	1965	0·13
Cannabis. Report of the Advisory Committee on Drug Dependence.	1968	
Delinquency Among Opiate Users. Home Office Research Unit Report No. 23. ISBN 0 11 340663 0.	1974	0·41
Drug Misuse and the Law, by S. Bradshaw. ISBN 0 333 13560 1. *Macmillan*	1972	0·95
Drug Misuse and the Law: the Regulations, by J. S. Hotchen. ISBN 0 333 18294 4. *Macmillan*	1975	2·95
Health Education in Schools. Department of Education and Science. ISBN 0 11 270456 5.	1977	2·50
The Law Relating to the Misuse of Drugs, by Paul Lydiate. ISBN 0 406 27802 4. *Butterworths*	1977	4·50
Misuse of Drugs in Scotland. ISBN 0 11 491319 6.	1975	0·31
Rehabilitation of Drug Addicts. Report of the Advisory Committee on Drug Dependence.	1969	
Report of the Departmental Committee on Morphine and Heroin Addiction (the Rolleston Committee report).	1926	

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