MINISTRY OF HEALTH
SCOTTISH HOME AND HEALTH DEPARTMENT

DRUG ADDICTION

THE SECOND REPORT
OF THE
INTERDEPARTMENTAL COMMITTEE
ON DRUG ADDICTION

LONDON
HER MAJESTY'S STATIONERY OFFICE
1965

INTERDEPARTMENTAL COMMITTEE
ON DRUG ADDICTION

REPORT

To The Rt. Hon. Kenneth Robinson, M.P., Minister of Health.
The Rt. Hon. W. Ross, M.P., Secretary of State for Scotland.

Introduction

1. We were originally convened in 1958 with the following terms of reference:

" to review, in the light of more recent developments, the advice given by the Departmental Committee on Morphine and Heroine addiction in 1926; to consider whether any revised advice should also cover other drugs liable to produce addiction or to be habit-forming; to consider whether there is a medical need to provide special, including institutional, treatment outside the resources already available, for persons addicted to drugs; and to make recommendations, including proposals for any administrative measures that may seem

expedient, to the Minister of Health and the Secretary of State for Scotland".

2. In our report, published in 1961, we concluded that addiction should be regarded as an expression of mental disorder rather than a form of criminal behaviour (paragraph 27); that the satisfactory management of cases of addiction was not possible except in suitable institutions, but that the compulsory committal of an addict to such an institution was not desirable (paragraph 28); and that, as the problem was small, the establishment of specialised institutions, for the treatment of drug addiction was not practicable (paragraph 30). We felt that initial treatment of an established addict could best be undertaken in the psychiatric ward of a general hospital (paragraph 31).

3. We further concluded that a system of registration of addicts would not be desirable or helpful (paragraph 35), as on the evidence before us the incidence of addiction to dangerous drugs was very small and there seemed no reason to think that any real increase was occurring, We thought, too, that special tribunals should not be set up, to investigate particular cases and advise whether a doctor's authority to possess and supply dangerous drugs should be withdrawn, as irregularities in prescribing these drugs were infrequent and would not justify further statutory controls (paragraphs 40-45).

Appointment

4. We were re-convened in July, 1964, with the following terms of reference:
" to consider whether, in the light of recent experience', the advice they (1) gave in 1961 in relation to the prescribing of addictive drugs by doctors needs revising and, if so, to make recommendations ".

5. The only changes in membership of the re-convened committee were the appointments of Dr. Henry Matthew and Dr. A. J. Pitkeathly in place of Sir Derrick Dunlop and Dr. A. H. Macklin, who were unable to serve again.

Procedure

6. In so far as " the advice they gave in relation to the prescribing of addictive drugs " was specified for revision, we interpreted our terms of reference as meaning that we were not being invited to survey the subject of drug addiction as a whole, but rather to pay particular attention to the part played by medical practitioners in the supply of these drugs.

7. We have held eight meetings. We first studied submissions from the Home Office, the Ministry of Health and the Scottish Home and Health Department setting out the developments in drug addiction since 1961.1 Then we invited written and oral evidence from a number of persons with a special experience in this field. Throughout our proceedings, too, we had the assistance of officers from the three Government departments mentioned.

The new situation

8. We learned that:
(i)Over the years 1959-1964 the total number of addicts to dangerous drugs (2) known to the Home Ottice had risen from 454 to 753.(3) During this period, the number of heroin addicts had risen from 68 to 342, while the incidence of addiction to other dangerous drugs remained more or less the same (Appendix I). Most of the new addicts were taking heroin.
(ii) The number of cocaine addicts had increased from 30 in 1959 to 211 in 1964. Virtually all of these were using the drug in conjunction with heroin (Appendix I).
(iii) The number of those who had become addicted to dangerous drugs other than as a result of medical treatment had risen from 98 in 1959 to 372 in 1964. For heroin the corresponding figures were 47 and 328 respectively (Appendix I). Thus, out of 342 heroin addicts, 328 were

of non-therapeutic(4) origin.
(iv) There had been a significant change in the age distribution of addicts. In 1959 only 50 out of 454 (i.e. 11 per cent) were less than 35 years old ; by 1964 this group numbered 297 out of 753 (i.e. nearly 40 per cent), 40 of them being under 20 years of age (1 being as young as 15). All 40 under 20 and the majority under 35 were taking heroin (Appendix II).
(v) In 1962 the United Kingdom produced 36 kilogrammes of heroin and consumed 40 kilogrammes In 1964 production had risen to 55 kilogrammes and consumption to 50 kilogrammes (Appendix III).These quantities far exceed those of any other country for which returns are published. This is to some extent due to the fact that the United Kingdom is one of the relatively few countries where heroin can legally be used for medical treatment, but the figures are nevertheless very disturbing.
(vi) The increase in addiction to heroin and cocaine appeared to be centred very largely on London, but indications of a similar trend, on a much smaller scale, had been observed in one or two of the other large cities.

Supplies

9. How have the new addicts obtained their supplies? In our first report we recorded the view of the Home Office and the police that the trafficking in illicit supplies was negligible. We have looked again at the possibility that an organised traffic has produced a wave of addiction, but we are satisfied from our enquiries of the Home Office, the Metropolitan Police and our witnesses that there is at present no evidence of any significant traffic, organised or otherwise, in dangerous drugs that have been stolen or smuggled into this country.
10. Supplies of dangerous drugs have sometimes been obtained by forging or altering prescriptions, or by obtaining second prescriptions on the false plea that the first has been lost, or by approaching various doctors under assumed names. But we doubt whether, in view of the vigilance of the medical and pharmaceutical professions and the careful work of the police and the Home Office Inspectorate, such methods have contributed substantially to the quantities of dangerous drugs available to new addicts.
11. From the evidence before us we have been led to the conclusion that the major source of supply has been the activity of a very few doctors who have prescribed excessively for addicts. Thus we were informed that in 1962 one doctor alone prescribed almost 600,000 tablets of heroin (i.e. 6 kilogrammes) for addicts. The same doctor, on one occasion, prescribed 900 tablets of heroin (9 grammes) to one addict and, three days later, prescribed for the same patient another 600 tablets (i.e. (6 grammes) " to replace pills lost in an accident ". Further prescriplions of 720 (i.e. 7-2 grammes) and 840 (8.4 grammes) tablets followed later to the same patient. Two doctors each issued a single prescription for 1,000 tablets (i.e. 10 grammes). These are only the more startling examples. We heard of other instances of prescriptions for considerable, if less spectacular, quantities of dangerous drugs over a long period of time. Supplies on such a scale can easily provide a surplus that will attract new /recruits to the ranks of the addicts.
12. The evidence further shows 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 judgment.
13. Some of the doctors concerned told us that they had embarked on the treatment of addicts out of a sense of duty because they felt that the treatment facilities elsewhere were inadequate.

Measures to curtail supplies

14. In considering measures for the better control of prescribing and supplying we have borne in mind the fact that doctors in this country have always had the right to use dangerous drugs. We said in our last report that this system had worked well. We remain convinced that the

doctor's right to prescribe dangerous drugs without restriction for the ordinary patient's needs should be maintained.

15. We have also borne in mind the dilemma which faces the authorities responsible for the control of dangerous drugs in this country. If there is insufficient control it may lead to the spread of addiction — as is happening at present. If, on the other hand, the restrictions are so severe as to prevent or seriously discourage the addict from obtaining any supplies from legitimate sources it may lead to the development of an organized illicit traffic. The absence hitherto of such an organised illicit traffic has been attributed largely to the fact that an addict has been able to obtain supplies of drugs legally. But this facility has now been abused with the result that addiction has increased. To prevent this abuse without sacrificing the basic advantages of the present arrangements we suggest : —

(a) a system of notification of addicts;

(b) the provision of advice where addiction is in doubt;

(c) the provision of treatment centres;

(d) the restriction of supplies to addicts.

16. Our special concern has been heroin and cocaine to which most of the new addicts have become addicted. We therefore consider that special restrictions should apply to these two drugs alone, which, in the remaining paragraphs of this report, we refer to as "restricted drugs". But this is not to imply that their medical use should be banned. If, in future, circumstances should change, and other drugs of addiction should take the place now occupied by heroin and cocaine, it would be necessary promptly to amend the "restricted" list accordingly.

Definition of an addict

17. For the purposes of our proposals an accepted definition of an addict is required. We suggest that it should be on the following lines: "A person who, as the result of repeated administration, has become dependent upon a drug controlled under the Dangerous Drugs Act and has an overpowering desire for its continuance, but who does not require it for the relief of organic disease". This definition embraces addiction to all dangerous drugs and not just that to heroin and cocaine, with which we are specially concerned at the moment.

Notification of addicts

18. We recommend that all addicts, as defined above, should be formally "notified" to a central authority and this authority should keep an up-to-date list of such addicts with relevant particulars. The term " notification " is used in the Public Health Act, which lays upon doctors the duty to notify patients who are suffering from certain infectious diseases. We think the analogy to addiction is as apt for addiction is after all a socially infectious condition and its notification may offer a means for epidemiological assessment and control. We use the term deliberately to reflect certain principles which we regard as important, viz. that the addict is a sick person and that addiction is a disease which (if allowed to spread unchecked), will become a menace to the community. We would object to any attempt to equate the term with "registration", which we rejected in our previous report. Apart from any other consideration "registration" might seem to imply that the addict is officially recognised as having the right to an approved quantity of dangerous drugs.

19. It should become the statutory duty of any registered medical practtitioner who comes into professional relationship with an unnotified addict, as defined in paragraph 17, to make notification to a central authority. Provision should be made so that any registered medical practitioner can refer to the list promptly and at any hour of the day or night if there is need to check whether or not a particular addict has been notified, or to obtain further particulars about an addict's history.

20. A doctor may sometimes be in doubt as to whether a patient is an addict according to the definition. He should then be able readily to obtain a further professional opinion from a member of an officially recognised panel of doctors covering the country. Membership of this panel should reflect a wide variety of medical and surgical interests, so that all relevant factors may be taken into account before addiction is diagnosed and notification made. This panel should not be confined to doctors who are on the staff of treatment centres which we describe below (paragraph 22 and following).
21. Continuing routine scrutiny of pharmacists' records (see footnote 3 on page 5) for repeated prescriptions of dangerous drugs to particular patients will provide a means of ascertaining addicts who have not been notified.

Treatment centres
22. Since, as we have said, the addict should be regarded as a sick person, he should be treated as such and not as a criminal, provided that he does not resort to criminal acts. In our previous report we stated that satisfactory treatment of addiction was possible only in suitable institutions. To this principle we still strongly subscribe. But while at that time we could say that the problem was so small that the establishment of specialised institutions for the treatment of addiction was not justifiable, the position has now changed to such an extent that we consider that such centres should be set up as soon as possible, at least in the London area. Each centre should have facilities for medical treatment including laboratory investigation and provision for research. A centre might form part of a psychiatric hospital or of the psychiatric wing of a general hospital.
23. In the rest of the country addiction to dangerous drugs does not seem to be a. serious problem at present. But while we do not think that the establishment of special units, such as we have outlined in paragraph 22, is as yet necessary beyond the London area, we feel nonetheless that some arrangements for treatment must be made on a national basis. We think that the Health Departments should ensure that all Regional Hospital Boards make suitable provision for the treatment of addicts in selected hospitals in their regions. Some Boards, we understand, have already initiated measures of this kind.
24. In formulating these proposals we are mindful of the obstinacy of some addicts and the likelihood that some of them will not attend a treatment centre. Since compulsory treatment seems to meet with little success, there is little that can be done for these people beyond restricting the possibility of illicit supplies. Others may wish to break off treatment after they have embarked upon it. This may be a short-lived feature caused by the discomfort of the withdrawal symptoms. We think that the staff of the treatment centres should have powers to enable them compulsorily to detain such a patient during such a crisis. This, we appreciate, would require legislation.

Rehabilitation
25. The withdrawal of a drug is only the first step in the treatment of an addict. Those who are discharged after satisfactory withdrawal of the drug of addiction may soon relapse on returning, to their old haunts. Indeed, it is generally recognised that the prognosis for the severely addicted is not very hopeful, so that some patients may have to remain indefinitely under the care of treatment centres. The situation would, in our view, be greatly improved if there were proper facilities for long-term rehabilitation, both psychological and physical, in the treatment centres and elsewhere. To go into more detail about this would be outside our terms of reference, but we wish to emphasize that the organisation and provision of these facilities is essential if relapse is to be avoided.

Limitations on supplies to addicts

26. We said in paragraph 16 that our special concern at this time has been the extent of the addiction to heroin and cocaine. We are satisfied that the dangers described in paragraph 11 justify the introduction of statutory controls to confine to doctors on the staff of the treatment centres we have described, the prescribing, supply and administration of these "restricted" dangerous drugs to drug addicts. It would then be the duty of the doctors at the treatment centre to determine a course of treatment and, if thought necessary, to provide the addict with drugs. Treatment should be available on both an in-patient and out-patient basis. We repeat that our proposals are dependent on such treatment facilities being readily available at short notice.

27. We see no need at present to confine the prescription, supply and administration of other dangerous drugs for addicts to doctors on the staff of recognised treatment centres. These drugs are far more widely used than heroin and cocaine in the management of organic disease and other conditions. Addicts who use these other drugs form a limited group whose addiction has usually arisen from their administration during the course of medical treatment and has not given rise to the same problems as have arisen with addiction to heroin and cocaine. We think therefore that the inconvenience that would be caused by the limitation of supply of these other drugs to treatment centres would not be justified.

28. Under the statutory powers that would be required to implement these proposals a doctor, other than the members of the medical staff at a treatment centre, would be prohibited from supplying, administering and prescribing "restricted" dangerous drugs to addicts. In an emergency - when, for example, an addict is prevented for the time being from getting to a treatment centre, or meets with a serious accident, or becomes organically ill — we think that the doctor in charge of the case should get in touch with the apropriate treatment centre and seek authorisation before he orders or administers such drugs.

29. We think it right to emphasise that the restrictions we have suggested apply at present only to heroin and cocaine and only in respect of prescription, supply or administration to addicts. Doctors should retain the right to prescribe, supply or administer any dangerous drug required for other patients in the treatment of organic disease.

Private hospitals and private practice

30. We intend our recommendations to apply to all doctors whether in private practice or working in the National Health Service. Both are already subject to the same controls under the present law as far as dangerous drugs are concerned. In the case of hospitals and nursing homes that are outside the National Health Service, we recommend that a managing body wishing to offer facilities for the treatment of addicts should be required to obtain the approval of the central authority to be regarded as a treatment centre and that the central authority should be empowered to lay down such conditions as might be necessary for the establishment and its staff to play the full part in co-ordinated treatment, research and notification that we have described in paragraphs 19 and 22.

Disciplinary procedures

31. If the proposals we have put forward above are accepted, it will become an offence for a doctor

(a) to fail to notify , the central authority of an addict (as defined in paragraph 17) with whom he has come into professional relationship and who is not already notified ; and

(b) not being a recognised member of the medical staff of a treatment centre, to prescribe for, administer to or suplly to an addict "restricted" dangerous drugs except in accordance with the procedure laid down for emergencies (see paragraph 28).

32. Let us consider, first, how such cases will, under the arrangements we have proposed, come to notice. As we have mentioned in paragraph 21, the routine inspection of pharmacists'

registers under the present machinery for the enforcement of the Dangerous Drugs Act and Regulations, should bring to light any case in which a doctor is repeatedly prescribing dangerous drugs for a particular patient. Where a doctor was found to be prescribing " restricted " dangerous drugs, he would—as at present—be interviewed by a Regional Medical Officer of the Health Departments and, if necessary, by a member of the Dangerous Drugs Inspectorate. In most cases the doctor would be able to give good reasons for the supplies. If , for instance he could show that the patient required the drug for adequate medical reasons (e.g. someone in the painful stage of a malignant disease , or if he could show that he had obtained the opinion of one of the officially recognised panel of doctors referred to in paragraph 20 that the patient was not an addict as defined in paragraph 17, that would be a sufficient explanation and no further action would need to be taken.

33. If however, the doctor was unable to satisfy the Regional Medical Officer or, if necessary, a member of the Dangerous Drugs Inspectorate and had failed to consult a member of the official panel, or declined to give any information, it seems to us that the case could justifiably be regarded as a prima facie one of a doctor prescribing "restricted" dangerous drugs for an addict. But we do not consider that it would be appropriate for a case of this kind to be dealt with by a court of law, as the issues involved are primarily those of professional judgment and conduct.

34. We therefore recommend that any doctor against whom a prima facie case of this kind can be made out (and we would expect such cases to be very rare) should come before a tribunal of his professional colleagues to justify his action. As the case would reach this stage only if the doctor had refused to obtain a second opinion from a member of the official panel, or if he had refused to give information about the case, the onus should be on the doctor to show that his patient was not an addict and that the prescribing of " restricted " dangerous drugs was justified by a need for their use in medical treatment.

35. We further suggest that the appropriate tribunal for this purpose would be the Disciplinary Committee of the General Medical Council. Already this body deals with questions of professional conduct, and the over-prescribing of restricted dangerous drugs, we think, comes into this category.

36. The procedure we then envisage would be for the central authority, having established a prima facie case against a particular doctor, to bring the facts to the attention of the Disciplinary Committee. If that body, on examination of the facts, finds the case proved, there should be provision for the doctor's authority, to prescribe, supply and administer restricted dangerous drugs to be withdrawn. Legislation would be necessary to enable the General Medical Council to assume this responsibiity.

Prescriptions

37. In our last report we said that there was no need to introduce a distinctive prescriction form for dangerous drugs. if the recommendations we have made above are adopted, we think there is still no need for such forms. We think, however, that in view of the greater danger of forgery to circumvent the new restrictions we have proposed, there should be a statory duty on all doctors under the Dangerous Drugs Regulations, when writing prescriptions for dangerous drugs, to use words as well as figures to specify the quantities. This has already been recommended to doctors as good medical practice by the British Medical Association and the Health Departments.

Consequences

38. We believe that the proposals which we have made will make it more difficult for addicts to obtain supplies of heroin and cocaine. The immediate effect may be to bring into the open a number of addicts now .dependent for their supply on addicts who are receiving their drugs

from doctors. As pointed out (footnote 1 on page 2) the number of these ad iets cannot be precisely estimated. We should not feel disturbed if a number came to notice provided facilities were organised to treat them. At the same time the risk that illicit traffic in drugs will in any event increase has to be accepted. It will be for the appropriate authorities to ensure that the criminal law is rigorously enforced.

Other habit-forming drugs

39. In our previous report we drew attention to the extensive use of drugs affecting the central nervous system, other than those controlled under the Dangerous Drugs Act. We said then that the position required careful watching, although we could see no grounds at that time for suggesting further statutory control. Although this problem is not within our present terms of reference and we have not specifically taken evidence about the present position, we feel obliged to say that we are disturbed at the large quantity of habit-forming drugs currently in circulation. We have noted with approval the operation of the Drugs (Prevention of Misuse) Act 1964 and the action taken by the Health Departments to draw the attention of doctors to the methods that persons dependent on these drugs use to obtain excessive supplies.

40. We are particularly concerned at the danger to the young. Witnesses have told us that there are numerous clubs, many in the West End of London, enjoying a vogue among young people who can find in them such diversions as modern music or all-night dancing. In such places it is known that some young people have indulged in stimulant drugs of the amphetamine type. Some of our witnesses have further maintained that in an atmosphere where drug takin is sociall acceptable, there is a risk that young people may be persuaded to turn to cannabis, probably in the form of "reefer" cigarettes.

There is a further risk that if they reach this stage they may move on to heroin and cocaine

41. The phenomena of habituation, dependence and addiction involve a complex variety of social, medical and psychological factors. The present trends, particularly in wider consumption of "pep" pills, may foreshadow a significant change in public attitudes to the taking of dangerous drugs. We feel that this feature of contemporary life deserves thorough study so that remedial action on all relevant fronts may be planned with full knowledge and understanding.

Advisory committee

42. Dependence on drugs is not a static but a changing problem. We think that it should be under constant observation. We therefore recommend the establishment of a standin advisor committee to survey the whole field and to call attention to any evelopment that may be a cause for concern or worthy of closer study. The constitution of the committee we leave to discussion between the relevant government departments, the medical and other professions. We consider that it should have a broadly-based representation, that it should concern itself with misuse of all dangerous drugs and other drugs which are likely to produce dependence, and the causes and effects of such misuse, and that it should have authority to advise on corrective health and social measures.

Summary

43. We give below a summary of our main conclusions and recommendations. We realise that, for many of them to be put into effect, new legislation will be needed.

(i) There has been a disturbing rise in the incidence of addiction to heroin and cocaine, especially among young people (paragraph 8) ;

(ii) the main source of supply is the over-prescribing of these drugs by a small number of doctors (paragraph 11) ;

(iii) there is now a need for further measures to restrict the prescribing of heroin and cocaine (paragraph 16) ;
(iv) for the purposes of our report we have suggested a definition of an "addict" (paragraph 17) ;
(v) all addicts to dangerous drugs should be notified to a central authority (paragraph 18) ;
(vi) to treat addicts a number of special treatment centres should be established, especially in the London area (paragraph 22) ;
(vii) there should be powers for compulsory detention of addicts in these centres (paragraph 24) ;
(viii) the prescribing of heroin and cocaine to addicts should be limited to doctors on the staff of these treatment centres (paragraph 26) ;
(ix) it should be a statutory offence for other doctors to prescribe heroin and cocaine to an addict (paragraph 31) ;
(x) disciplinary procedures against doctors alleged to have prescribed heroin and cocaine irregularly to addicts should be the responsibility of the General Medical Council (paragraph 35) ;
(xi) when prescribing dangerous drugs, a doctor should indicate the quantities by words as well as figures (paragraph 37) ;
(xii) an advisory committee should be set up to keep under review the whole problem of drug addiction (paragraph 42).

44. We are greatly indebted to our Secretaries, Dr. Roy Goulding and Mr. A. H. H. Jones, for all that they have done to facilitate and expedite our work, and to the following for their valuable assistance: Dr. J. M. Johnston of the Scottish Home and Health Department ; Mr. P. Beedle, Mr. T. C. Green, Mr. C. G. Jeffery and Mr. H. B. Spear of the Home Office ; and Mr. R. F. Tyas of the Ministry of Health.

(Signed)
BRAIN
A. LAWRENCE ABEL
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ROY GOULDING - A. H. H. JONES Joint Secretaries
31st July, 1965.

(1) i.e. the Interdepartmental Committee
(2) In this report the term " dangerous drugs " refers exclusively to those substances controlled under the Dangerous Drugs Act, 1965 (which consolidated the Dangerous Drugs Acts, 1951 and 1964).
(3) The Home Office obtains information about prescriptions of dangerous drugs from the routine police examination of records kept by pharmacists. It also receives information from other sources and, with the assistance of the Health Departments, makes enquiries to establish cases of addiction. At any one time there are probably some addicts who are getting supplies from illicit sources and have not come to notice. Their number cannot be precisely estimated.

(4)By " non-therapeutic " we mean persons whose addiction originated other than from the administration of dangerous drugs for medical treatment.

APPENDIX I

Addicts to Dangerous Drugs

	1959	*1960*	*1961*	*1962*	*1963*	*1964*
Total number of addicts to dangerous drugs	454	437	470	532	635	753
Number of addicts to heroin ...	68	94	132	175	237	342
Number of addicts to cocaine ...	30	52	84	112	171	211
Total number of addicts of non-therapeutic origin	98	122	159	212	270	372
Number of heroin addicts of non-therapeutic origin	47	72	112	157	222	328

APPENDIX II

Ages of Addicts to Dangerous Drugs

	1959	*1960*	*1961*	*1962*	*1963*	*1964*
Age under 20	—	1	2	3	17	40
Taking heroin	—	1	2	3	17	40
Age 20–34	50	62	94	132	184	257
Taking heroin	35	52	87	126	162	219
Age 35–49	92	91	95	107	128	138
Taking heroin	7	14	19	24	38	61
Age 50 and over	278	267	272	274	298	311
Taking heroin	26	27	24	22	20	22
Age unknown	34	16	7	16	8	7
Total	454	437	470	532	635	753

APPENDIX III

Manufacture and Consumption of Heroin (in kilogrammes)

	1959	*1960*	*1961*	*1962*	*1963*	*1964*
Manufacture						
United Kingdom ...	68	66	69	36	49	55
Belgium	9	10	5	9	7	not yet available
France	2	—	5	3	6	
Netherlands	—	2	—	—	—	
Consumption						
United Kingdom ...	45	41	40	40	44	50
Belgium	9	9	7	7	7	not yet available
France	2	4	3	2	3	
Portugal	1	1	1	1	—	
Paraguay	—	—	1	—	—	
Czechoslovakia	1	1	—	—	—	

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