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ABSTRACT

Concerned with clarifying some of the more complex issues in drug abuse, the National Clearinghouse for Drug Abuse Information has prepared this special report on the British narcotics system. Underlying the British approach is the belief that narcotic dependence is a medical problem to be treated by medical professionals rather than a criminal problem to be handled by law enforcement agents. The history of British narcotics treatment policies may be divided into three periods: The Rolleston Committee (1924), Convening of the First Brain Committee (1958), and Convening of the Second Brain Committee (1964). Operation of a new "system" following the 1964 conference is described and evaluated, one which utilizes only specially designated doctors in clinics to treat addicts by employing heroin, methadone or encouraging withdrawal. Legal aspects of the situation, together with opinions of authorities in the field, are also expressed. Bibliographic references are listed. (BL)

report series

NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION

SERIES 13, NO. 1

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The National Clearinghouse for Drug Abuse Information recognized the need for clarifying some of the more complex issues in drug abuse by gathering the significant research on each subject and summarizing the major findings on various aspects of the problem. Report Series 11 through 18 deal with the pharmacology, chemistry, clinical effects, treatment and the patterns of use of each drug and provide a background in the area by outlining the history, legal status and the opinions of authorities in the field. These fact sheets were written and researched by the Student Association for the Study of Hallucinogens (STASH), Beloit, Wisconsin, under Contract No. HSM-42-71-26.

THE BRITISH NARCOTICS SYSTEM

Serious consideration of the British approach to the treatment of heroin addiction has often been clouded by misinformation about the system, which ranges from the assertion that narcotics are legal in England to the belief that the British approach is identical to the American treatment policy. Neither statement is completely true. An addict in Great Britain can, through the proper channels, legally obtain heroin or morphine. On the other hand, as in America, there has been increasing emphasis on switching the addict to methadone and/or eventually encouraging him to undergo withdrawal. Underlying the British approach is the belief that narcotic dependence is a medical problem to be treated by medical professionals rather than a criminal problem to be handled by law enforcement agents.

Although this basic premise has remained fairly constant over time, the actual regulations pertaining to treatment policy have been modified to deal both with problems of administration and the changing character of narcotics addicts. In 1924, an appointed committee concluded that under certain circumstances a physician could administer heroin or morphine to confirmed addicts. In later years this was changed so that now only specially designated doctors in clinics may treat addicts by employing heroin, methadone or encouraging withdrawal. Although three periods (each with its typical addict population and regulations)

divide the history of British narcotics treatment policy, there has been a tendency toward enacting stricter rules concerning the prescription and administration of opiates to addicts.

The First Period: The Rolleston Committee (1924)

In 1924, the British Minister of Health appointed a group of distinguished physicians to consider the possibility that the practice of administering heroin to addicts violated the International Opium Convention of 1912. This committee headed by Sir H. D. Rolleston reviewed the Dangerous Drugs Act (1920) and published a report in 1926 which concluded:

> . . . morphine or heroin may properly be administered to addicts in the following circumstances, namely a) where patients are under treatment by the gradual withdrawal method with a view to cure, b) where it has been demonstrated that after a prolonged attempt at cure that the use of the drug cannot be safely discontinued entirely, on account of the severity of the withdrawal symptoms produced, and, c) where it has been similarly demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is regularly administered, becomes incapable of this when the drug is entirely discontinued.

However, the report warned the practitioner not to hastily assume that either the minimum dosage has been reached or that withdrawal was "unsafe." This early decision has determined to a large extent the tone of subsequent British narcotics legislation.

Until the early 1960's, the number of known narcotics addicts in England remained insignificant; the total number of all known drug addicts averaged under 500 in any one year. A number of authors have suggested that the original cornerstones of British policy were laid down because of the small number of narcotics addicts and that the success of the British system depends on the fairly low prevalence rates of addiction.

The count of known opiate addicts was based for a long time on an informal report issued by the Home Office. The Home Office compiled lists of addicts from records required of all pharmacists filling narcotic prescriptions. Individual doctors might have independently reported a case of addiction to the Home Office, although they were not required to do so by statute. One member of the Home Office staff summed up the role of the Home Office report: "The Home Office keeps an index of known addicts--that is to say addicts who come to our notice one way or another, but the inclusion of an addict's name has no significance other than showing he is known to us; it confers on him neither privileges nor disabilities" (Clark, 1962). Because of this method of compiling the register, the list would not include addicts who had obtained their drugs from the black market or addicts whose names had been temporarily removed from the register because they were in prison or abroad.

Reports from the Home Office reveal that in pre-World War II years, the addicts were generally professional people, such as doctors and nurses; they were more often female than male and were usually middle-aged. Exemplifying the concept

of the "stabilized addict," these individuals were able to live useful and relatively normal lives with small regular daily doses of narcotic drugs obtainable on prescription.

The 1950's, however, marked a change in this pattern of narcotic use. The addicts during these later years tended to be younger and predominantly male. They congregated in groups in the music clubs of London. Dr. Richard Phillipson dates the change back to a 1951 theft of a large quantity of morphine, heroin and cocaine from a hospital dispensary in Kent. Although the culprit was arrested three months later, he had successfully disposed of most of the heroin and cocaine at London Jazz clubs. His fifteen regular customers had subsequently approached doctors for prescriptions, requested larger supplies than needed to maintain their habits, and spread the surplus out among their friends.

The medical profession throughout the 1950's, jealously guarded its prerogative to prescribe heroin to addicts. For example, in February, 1955, the Secretary of State for the Home Department announced that the government intended to refuse to grant further licenses for the manufacture of heroin. The reaction from physicians and the medical community was strong opposition and indignation. In May, an article in the British Medical Journal urged that alternative means be found to arrest the abuse of heroin. At approximately the same time, the British Medical Association passed a resolution protesting the threatened ban. Even the Economist and the Times saw fit to join the battle with critical editorials that argued against the ban on the grounds that important uses for heroin still remained and that the government had issued the statement without consulting the medical profession. In response to extensive protest, the government rescinded its statement and agreed to continue granting licenses indefinitely.

Second Period: Convening of the First Brain Committee (1958)

In 1958, a committee to review the advice of the Rolleston Committee was appointed under the chairmanship of the late Lord Brain. The committee met to consider whether new methods of treating heroin addiction rendered the Rolleston recommendations obsolete; and to decide if the increasingly popular synthetic analgesics, such as pethidine and methadone, should come under stricter control or review. Their final report, published in 1960, recommended no major changes in British drug policy and reaffirmed the doctor's prerogative to prescribe narcotic drugs, including heroin. This decision was based on the belief that there had been no major increase in the number of new addicts per year.

Two American doctors, Granville S. Larimore and Henry Brill, made a month-long study of the British system at about the time of the first Brain Committee meetings. Larimore and Brill concluded that the relatively low level of addiction in Britain at that time could be attributed, not to the British narcotic system, but rather to the cultural attitude of the British people. Using a host-agent-environment epidemiological theory of addiction, they hypothesized:

> In England what appears to be the major gap in the epidemiological picture, probably for cultural reasons is the susceptible individual. Certainly drugs are available (even though limited) through medical channels and by our standards an environment conducive to spread exists in certain areas although admittedly there is not environment which appears to be as heavily seeded with narcotics as are certain areas in this country.

Other authors argue that the system itself reduced the criminal activity associated with narcotic use, preventing the intrusion of organized crime, consequently keeping narcotic use above ground and, therefore, contained. Although the reasons why the British have not developed a massive narcotics dependence problem are still subject to debate, there is no question that, beginning in 1960, the British began to see an increase in the number of new known addicts, although this number has still remained small; in 1959, there were 454 known addicts; in 1960, 437; in 1961, 470; in 1962, 532; in 1963, 635; and by 1969, 2881. As the numbers increased, the character of the addicts again changed.

In the 1960's, addiction spread from jazz musicians to a larger, more heterogeneous population. Individuals dependent on narcotics came from upper socioeconomic classes as well as from working classes; men outnumbered women 4 to 1; and during this period most of the new known cases of non-therapeutic addiction were individuals between the ages of 18 and 25. These new addicts tended to be multiple drug users, experimenting with cocaine and other substances, such as methamphetamine.

Third Period: Convening of the Second Brain Committee (1964)

Finally, in 1964, the Interdepartmental Committee reconvened to "consider whether in the light of recent experience the advice they gave in 1961 in relation to the prescribing of addictive drugs by doctors needs revising and if so to make recommendations." Reports from the Home Office, the Ministry of Health and the Scottish Home Office were considered by the Committee for some time. The police and the Home Office submitted evidence which indicated that organized trafficking in dangerous drugs, as well as illicit importation of drugs remained at insignificant levels. Consequently, the Committee focused on the heroin obtained from over-prescriptions that constituted the "gray" market.

The Committee found that a small group of doctors in the 1960's had over-prescribed narcotics to addicts. For example, in 1962, one million tablets (one-sixth grain each) of heroin were prescribed; 600,000 of these came from one doctor in London. The same doctor on one occasion prescribed 900 tablets of heroin to one addict and three days later prescribed for the same patient another 600 tablets to "replace pills lost in accident." However, the Second Brain Committee concluded that such questionable practices were limited to a group of about six or seven irresponsible physicians. While unwilling to ban completely the use of heroin in Great Britain, the Committee felt that insufficient controls may have led to the increase in addiction that had occurred at that time.

In their report of July 1965, the Committee recommended a complete revision of the British drug program. The proposed controls more closely approximated the concept of a "system" than anything that had existed previously. Their conclusions were five-fold: (1) centers should be organized to treat addiction problems; (2) only doctors at centers should be authorized to prescribe heroin and cocaine to addicts; (3) a system of the notification of addicts, more stringent than that which existed should be established; (4) doctors at centers should be given advice in cases where addiction was in question; and, finally (5) doctors at centers should be given the power to detain addicts in inpatient facilities without the addict's consent. All but the last recommendation were passed into law by the spring of 1968.

Operation of the New British "System"

By the spring of 1968, seventeen clinics had been set up to provide both inpatient and outpatient facilities for the treatment of narcotics addicts. A patient who did not wish to undergo withdrawal treatment could be maintained on minimum dosage of heroin on the understanding that the staff of the clinic would work to win his confidence and trust so that he eventually might be convinced to undergo withdrawal.

The Advisory Committee on Drug Dependence, established approximately at the same time that the clinics were being set up, published a report which emphasized that outpatient clinics should not be "regarded as mere prescribing units without any positive objective. Outpatient clinics are also rehabilitation clinics. Their object should be to encourage the addict to accept hospital admission for withdrawal and to make use of the opportunity which prescribing gives to build a constructive relationship with the patient."

A few preliminary reports have analyzed the programs of specific clinics operating under this new mandate. T.H. Bewley, after working for a year at one clinic, made the following observations: At first, a large number of patients were transferred to the clinics, keeping the staff busy. Consequently, there was a tendency for the over-taxed staff to prescribe relatively high doses to patients. However, in later months, when the number of new patients dropped off to about 60 per month, smaller doses of heroin were prescribed; and there was an increase in the amount of methadone prescribed in place of heroin. In 1969, about 1,300 patients were attending all the clinics in any given month. These patients attended the clinics every week and picked up daily prescriptions at local pharmacies. Efforts were made to spread prescriptions around town in order to avoid problems that had existed earlier when groups of addicts "hung around" specific pharmacies. Urine tests indicated that most patients used the drugs prescribed to them as well as other substances, primarily amphetamines and barbiturates.

Philip Boyd described another clinic that was established to deal primarily with heroin addicts under the age of 18. At this clinic, there were outpatient facilities for some sixty youngsters and inpatient facilities for ten. The aim of this program, compatible with the recommendations of the Second Brain Committee report, was a gradual reduction in the prescribed dose of narcotics. As in most of the clinics, difficulties were encountered in trying to assess the size of a patient's drug habit: "One quickly learns in the clinic interchange (which begins to resemble the bargaining in a Moroccan market place) to judge how little will be tolerable to the patient, and in the course of subsequent interviews, one gets to know the patient well enough to assess this need fairly well."

The clinics' physicians found that traditional tests to determine the nature and extent of addiction in any particular individual were falsified by some youngsters anxious to obtain heroin or cocaine. Of the 131 patients who applied for help the first year, for example, only 87 were registered as heroin addicts. One year later, 39 of these were no longer attending the clinic, while 48 remained in the program. Of those still enrolled in the program, 17% were totally abstinent, 73% were taking a substantially reduced amount of opiate (methadone only), and 10% were using either the same or a slightly greater dose of opiates.

In addition to the establishment of clinics, the 1968 British legislation made the registration of addicts mandatory. Glasser and Ball, a team of American writers, did a comprehensive review of the registration process, but as is typical of most of the discussion across the Atlantic regarding the "British system," their review elicited some harsh criticisms from English authorities.

In general, Glasser and Ball argued that the "British system" is a "myth": the loose, informal structure of the register disproves the notion that the British drug policy is a system. They also contended that the recent changes in drug policy have brought the English narcotics policy closer to that prevailing in the United States.

The British Medical Journal took issue with Glasser and Ball in an editorial entitled "Trans-Atlantic Debate on Addiction": "A system which leaves much to the individual doctor, which leaves many matters undefined, is as much a system as one which is based on tightly defined legislative controls." In addition, the editorial rejected the notion that the British (with the 1968 law) had moved in a direction similar to the United States as "an incomplete interpretation of recent developments, and one which incidentally invites us to overlook what are still profound differences in emphasis." The editorial continued, "To suppose that the British prescribing system was discredited by the alarming growth in heroin addiction in the 1960's, and thereafter abandoned, would be considerable misreading of history. The same essential policy is being maintained as heretofore, with the difference that prescribing is limited to specially approved doctors operating from specified clinics and notification now compulsory....The British response still permits the prescribing of heroin and still gives central responsibility to the individual physician. And without undue complacency, it may be claimed that this policy seems to have had some real success in containing what threatened to be an explosive epidemic."

British law specifies that an addict must be registered with the Home Office, but it does not specify what information should be recorded, what defines an addict, nor how the information should be released. No legal consequence is attached to an individual's name appearing on the register; it neither officially declares him to be an addict, nor does it obligate him to report for treatment. Medical opinion determines if a given individual is an addict, although this is Home Office policy, rather than legal procedure. Any information obtained on an individual addict is confidential, available only to physicians treating specific patients and to the police; private citizens, employers and attorneys have no access to the register. The register does not so much provide complete data about individual addicts as it fills the need for a good source of incidence and prevalence data.

Evaluation

Because of the fairly recent changes in the British narcotic law, it is difficult to thoroughly evaluate the program as it exists today. The 1970 Home Office statistics, however, indicate a slight lowering of the peak number of addicts on their narcotics register for the year; 1969 had a peak of 2,881; 1970 had a peak of 2,661. At the end of 1969, only 1,466 addicts were receiving treatment for heroin addiction; at the end of 1970, only 1,430 were receiving treatment. Despite any problems that may have been encountered with the implementation of the British system as it was originally planned, the number of addicts in Great Britain is surprisingly low, both in totals and on a per capita basis.

Dr. Griffith Edwards, an English physician, delineated five basic concepts that were part of the operational plan projected in the modified narcotics laws of 1968. The first concept was that prescribing doctors in clinics would not start new patients on heroin unless they were absolutely sure that the patient was addicted and truly needed the drug. However, because of limited staff and facilities, it is often difficult to determine the nature and extent of dependence in a particular individual. The usual tests are only fine enough to classify a patient as not an addict. The absence of needle marks, for example, might be an indication that the individual does not inject heroin. Their presence, however, will not insure that the patient is a regular confirmed user instead of a casual user. Urine tests provide evidence that can be conclusively negative, but not conclusively positive. The only completely satisfactory method is to admit the patient to a hospital briefly to determine the extent of withdrawal symptoms, but because of limited facilities, this is not a realistic alternative. Consequently, a few non-addicts have been addicted through the clinic system.

Another premise was that the doctors at the clinics would prescribe conservatively, thereby lessening the risk of patients having a surplus of heroin to sell on the black market. However, lack of personnel has made an accurate assessment of the size of a patient's habit difficult, as described above. Blood tests are more indicative of the time the patient took the last dose than they are of the amount of the daily dose. To assess carefully the patient's daily dose, the doctor would have to insist on hospital admission for titration of drugs against withdrawal symtoms. The doctor and the patient are at odds in that the patient seeks a large dose and the doctor prefers to prescribe smaller amounts. However, while doctors do not want their patients selling excess drugs, they also do not want the patient out on the black market soliciting drugs to maintain himself. But conservative prescription practices have reduced the amount of heroin available on the black market. This is confirmed by the recent black market price increases, which have risen from one pound to three pounds for 60 mg. of the drug.

A third point, which would result from the legal availability of the drug for addicts, was that the British system would undercut the black market and prevent organized crime from being involved in the sale of heroin. In this way, the British program has been successful because there has been no evidence of a large supply of black market drugs other than those diverted from legal channels.

In 1968, Chinese heroin was found illegally on some individuals. This pale pinkish-brown gritty powder, sold in folded paper triangles, did not dissolve rapidly and solutions had to be heated and filtered through a plug of cotton wool before being drawn up into the syringe. There were some speculations that the appearance of Hong Kong heroin indicated involvement of organized crime in the London black market. However, these reports showed a high correlation between the sudden appearance of the heroin and a simultaneous large increase in the number of Chinese restaurants in London. Many of the kitchen staff had come from Hong Kong to work in London and those who had been addicted in Hong Kong probably brought some of the heroin with them. The fact that no major new supply route from the Far East has been opened was confirmed when the availability of Chinese heroin declined markedly in 1969. In general it is felt that the low price of heroin on the black market has not made it lucrative enough for organized crime to get involved in the illegal importation and sale of narcotics.

Although the 1968 law accepted the use of heroin and methadone for addict maintenance, it placed emphasis on the long term goal of withdrawal for most addicts. In theory, a patient may not be initially motivated to request withdrawal, but through contact with the clinic staff, motivation will gradually build up in him. The dosage will be decreased over time and the offer of hospital admission for the purpose of undergoing withdrawal will finally be accepted. However, by being so supportive, the staff may prevent the patient from developing a compelling interest in going "straight." Consequently, the process of building trust with the patient may reduce motivation. The British have had difficulty in maintaining a low rate of recidivism among withdrawn addicts.

Finally, the founders of the British System believed that there are some patients who cannot function without drugs, but on a regular maintenance dose can live normal and useful lives as stabilized addicts. The impression of clinic doctors has been that the current younger addicts do not settle down to a job or manage their lives responsibly. Consequently, the Rolleston Committee's notion of the stabilized addict is losing favor, and there is a marked tendency to encourage addicts to undergo withdrawal or to at least substitute methadone maintenance for heroin maintenance.

Patterns of drug abuse in Great Britain are changing. After 1968, there was a rapid increase in amphetamine and barbiturate misuse. When the prescription of heroin and cocaine was restricted, a few doctors irresponsibly switched their addicts to methamphetamine. Finally, a voluntary agreement was made between the pharmaceutical manufacturers and the Ministry of Health, whereby supplies of methamphetamine were restricted to hospital pharmacies. Also, a number of methadone addicts who have not previously had experience with heroin have been coming to the clinics as new patients. This suggests that a limited amount of methadone prescribed in the clinics has been diverted to the black market.

Issues and Opinions

The history of the British narcotic system is wrought with controversy. For years debate has raged over whether or not the British drug program actually constitutes a system. Some say that system can be just as much a loosely gathered set of regulations and customs as it can be a tightly structured organization of laws. Others insist that it has only been in recent years, when policies have been coordinated, that we can justifiably speak of a "British system." On the part of the Americans, there has been much misunderstanding about what the British program intends to do and how it strives to reach its objectives:

> The system of controls formerly applied to these drugs, often erroneously called the "British System" and reputedly designed to prevent dependence on them, has been adequate in the absence of a widespread demand for drugs of dependence. However, when--as in other countries--the younger age groups began to seek drugs the system of controls was shown to be inadequate.
>
> --World Health Organization

> The growing rate of drug addiction in Britain has forced revisions of the laws but the underlying philosophy which guides the British approach remains unaltered: the thesis was and is that the interests of treatment and prevention are best served

by regarding the addict as a patient, by giving him heroin if he so demands, by wooing him rather than coercing him into treatment and by keeping addiction above ground rather than by driving it into the criminal underworld. The next few years will show whether this philosophy can be the basis of a viable policy.

--Griffith Edwards (UK)

The British System was devised to deal with a small number of people who were addicted to narcotics in the pre-war days. They were largely professional people, predominantly female, tending to middle age and a very different problem to (sic) our present addiction population. But the essential difference between then and now is that we are trying to deal with a communicable disease....In my opinion an error is being perpetuated in the upholding of the British System.

--P.A.L. Chapple (UK)

....It might be noted in passing that the concept of providing an addicted individual with a plentiful supply of the noxious agent with which to seal his doom is, in certain aspects at least, ethically and morally repugnant, whether that agent be alcohol, a narcotic or some other substance.

--Granville W. Larimore (US)
Henry Brill (US)

Most English workers in the field do not believe that even the most skilled and intense psychological cajoling, or for that matter, harassment, will move the patient away from drugs until he has made the decision himself. Both the American and British drug scenes are littered with the failures which support this view. It is the recognition that many addicts don't want to be cured--no matter how much society wishes it was otherwise--that is a key rationale for giving free narcotics at clinics.

--Edgar May (US)

Although the epidemic of heroin addiction in Britain in the 1960's and the emergence of a "junkie subculture" where none existed before must be cause for concern, the problem should be viewed in perspective. Heroin addiction is by no means our most prevalent addiction problem. In 1968 there were under 2,500 heroin addicts compared with 250,000 alcoholics. As a nation we swallow 3,000,000 sleeping capsules every night and it has been estimated that some 500,000 individuals take hypnotics habitually (of whom at least 50,000 are physically addicted to barbiturates).

--Pierce James (UK)

The program that is being advocated here is not British. It is rather a proposed expansion of an unofficial medical program that is presently being applied in the United States to privileged addicts of the upper social strata. What is advocated is that the same consideration that is extended to an addicted society lady from Washington, to an addicted member of Congress, or to addicted members of the medical profession also be extended to drug users of humble social status who have no important connections. It is a plan for giving

all addicts genuine equality before the law. It is consistent with basic ideals of justice, of individual rights, of the proper treatment of the sick, and of the right to be judged as an individual rather than as a member of a category. It is a program toward which the United States is moving and for which there is no substitute.

--Alfred Lindesmith (US)

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