

Fall 1975

## The British Experience, 9 J. Marshall J. Prac. & Proc. 67 (1975)

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### Recommended Citation

H. B. Spear, The British Experience, 9 J. Marshall J. Prac. & Proc. 67 (1975)

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## THE BRITISH EXPERIENCE

by H. B. SPEAR\*

To a British observer, the most puzzling and disappointing feature of the North American drug scene is the persistent misunderstanding of what has come to be known as the "British system." This misunderstanding persists despite numerous British accounts<sup>1</sup> of our drug addiction problems, laws and administrative procedures, and scores of "on-site" enquiries by North Americans,<sup>2</sup> who seek in the comparative freedom from

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\* Mr. Spear joined the Drugs Branch Inspectorate of the Home Office in 1952 and became Deputy Chief Inspector of the Drugs Branch in 1965. The Drugs Branch of the Home Office is responsible for legislation relating to drug abuse and is concerned with daily drug control in England, including general intelligence on drug abuse and the supervision of the legitimate production and distribution of controlled drugs.

Mr. Spear has contributed two articles to the BRITISH JOURNAL OF ADDICTION: *The Growth of Heroin Addiction in the United Kingdom* and *The Influence of Canadian Addicts on Heroin Addiction in the United Kingdom*.

The views and interpretations of the British Drug Program as expressed in this article are the personal views of Mr. Spear and should not be considered the official position of the Home Office.

1. P. BEAN, *THE SOCIAL CONTROL OF DRUGS* (1974); M. GLATT, *THE DRUG SCENE IN GREAT BRITAIN* (1967); J. ZACUNE & C. HENSMAN, *DRUGS, ALCOHOL AND TOBACCO IN BRITAIN* (1971); Bewley, *Recent Changes in the Pattern of Drug Abuse in the United Kingdom*, XVIII BULL. ON NARCOTICS 4 (1966); *The Prevention and Treatment of Drug Dependence in Britain*, BR. INFO. SERV. (1973); Proceedings of the Anglo-American Conference on Drug Abuse, *The Evaluation of the Anglo-American Conference on Drug Abuse*, 1973 ROY. SOC. MED.; Proceedings of the Anglo-American Conference on Drug Abuse, *The British Approach*, 1973 ROY. SOC. MED. 99; Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada, Ottawa at 297-311 (1955) [J.H. Walker reporting]; Cahal, *Drug Addiction and the Law*, 1970 J. ROY. COLL. GEN. PRACT. 20, 32; Edwards, *The British Approach to the Treatment of Heroin Addiction*, LANCET April 12, 1969; Glancy, *The Treatment of Narcotic Dependence in the United Kingdom*, XXIV BULL. ON NARCOTICS 4 (1972); Hawks, *The Epidemiology of Drug Dependence in the United Kingdom*, XXIII BULL. ON NARCOTICS 3 (1970); James, *The Changing Pattern of Narcotic Addiction in Britain 1959-1969*, 6(1) INT. J. ADDICT. 119-134 (1971); Jeffery, *Drug Control in the United Kingdom*, MODERN TRENDS IN DRUG DEPENDENCE (1970); Spear, *The Growth of Heroin Addiction in the United Kingdom*, 64 BR. J. ADDICT. 245 (1969).

2. E. BRECHER, *THE CONSUMERS UNION REPORT, LICIT AND ILLICIT DRUGS* (1972); CUSHNY, KLEIN & KRASNER, *DRUG-TRIP ABROAD* (1972); H. JUDSON, *HEROIN ADDICTION IN BRITAIN* (1974); A. LINDESMITH, *THE ADDICT AND THE LAW* (1966); E. SCHUR, *NARCOTIC ADDICTION IN BRITAIN AND AMERICA* (1963); ZINBERG & ROBERTSON, *DRUGS, AND THE PUBLIC* (1972); *The British Narcotics System*, NAT. CL. HOUSE FOR DRUG ABUSE INFO., Series 13.1 (1973); Glaser, *The British "System" and the American System*, PHIL. MED., May 5, 1972 at 68-69; Glaser & Ball, *The British Narcotic "Register" in 1970*, J.A.M.A., May 17, 1971 at 216-17; Josephson, *The British Response to Drug Abuse*, in IV DRUG USE IN AMERICA, THE PROBLEM IN PERSPECTIVE: TECHNICAL PAPERS OF THE SECOND REPORT OF THE NATIONAL COMMISSION ON MARIJUANA AND DRUG ABUSE (App. 1973); King, *Drug Addiction—Crime or Disease*, REPORT OF A.B.A.-A.M.A. JOINT COMMITTEE ON NARCOTIC DRUGS (1961); Larimore & Brill, *The British Nar-*

drug addiction in the United Kingdom some solution to the drug abuse problem in their own countries. The debate in North America centres on whether or not there is a "British system," and if so, what it is and how it works, whether it has been a success or a failure, and more especially, if it can be applied to North America.

Although there are well-known references in nineteenth century literature to the use of opiates in the United Kingdom, the British Government first became concerned with drug addiction as a colonial rather than a domestic problem. Opium preparations, such as laudanum, were widely used, particularly in East Anglia and Lincolnshire for the self-treatment of minor ailments, and since these preparations could be purchased without restriction, cases of addiction undoubtedly occurred. Despite the widespread use and availability of opium preparations, there was no evidence that abuse was so excessive as to give cause for public concern sufficient to justify the introduction of special measures. On the other hand, the prevalence of opium smoking in British Far Eastern territories attracted much more attention in the press and Parliament and led to full British participation in the various international conferences starting with the Shanghai Conference of 1909.

The need for special measures to deal with domestic drug abuse arose in connection with another drug, cocaine, which came into prominence during the First World War. During this period, cocaine was being peddled to and by prostitutes in London, and a number of cases of cocaine being given to the troops were reported. Although cocaine was controlled by poisons legislation, the supply and possession of the drug by civilians was not supervised. Accordingly, in 1916 the Commissioner of Police of the Metropolis asked the Home Secretary to introduce appropriate legislation if the traffic in cocaine was to be effectively checked. The Commissioner's letter provides an interesting illustration of the concern with which official circles viewed this new threat. It is reasonable to suggest that this same concern might well have been similarly expressed had the abuse of opium preparations reached similar proportions.

To stamp out the evil, now rapidly assuming huge dimensions, special legislation is imperatively needed. I beg therefore to ask that the necessary powers may be obtained with the least

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*cotic System*, 60 N.Y. STATE J. MED. 107-115 (1960); Larimore & Brill, *Second On-Site Study of the British Narcotic System*, 1(2) N.Y. STATE NARCOTIC ADDICT. CONTROL COMM. 1-14 (1968); Lewis, *A Heroin Maintenance Program in the U.S.*, 223 J.A.M.A. 5 (1973); Lieberman & Blaine, *The British System of Drug Control*, 3 DRUG DEPENDENCE (1970); Mahon, *The British System, Past and Present*, 6(4) INT. J. ADDICT. 627-34 (1971); May, *Narcotics Addiction and Control in Great Britain*, REPORT TO THE FORD FOUNDATION (1972).

possible delay, and I am desired to associate with me in this request the General Officer Commanding the London District, with whom I have from time to time had grave conferences on the subject, and who sees in such a step alone the necessary protection for his troops in London. Great as is the need, however, in my judgment protective measures are no less needed in the interests of the civilian population, at present gravely menaced.

. . . .

I wish to urge to the utmost of my ability, that it will be of no value in any restrictive measures, merely to deal with illicit sales; it is essential if the problem is to be seriously grappled with, that the unauthorised possession of this drug shall be an offence punishable, at least in certain circumstances, with imprisonment without the option of a fine.

The Commissioner made a number of specific proposals to be embodied in legislation and regulations made under the Defence of the Realm Act. These proposals had been introduced to deal with the special war-time circumstances and were subsequently amended to restrict possession of cocaine to authorised persons, such as doctors, persons holding certificates issued by the Home Secretary or persons who had received the drug on a doctor's prescription. Defence of the Realm Regulation 40B also required that those persons lawfully dealing in cocaine keep records which would be available for inspection. A later amendment which is of importance in the history of drug control in the United Kingdom, provided that a person such as a doctor, who was convicted of an offence against the regulations, would no longer be authorised to prescribe drugs. There was some discussion of extending these controls to morphine, but it was agreed that abuse of morphine was not nearly so urgent or serious a matter and that no action need be taken. Opium was, however, included with cocaine, not because of any domestic problem, but because of attempts which had been made to smuggle opium to China from Great Britain.

The importance of these early measures is that they were introduced to meet what was the first evidence of substantial drug abuse in the United Kingdom. The early regulations established the principles that possession of controlled drugs should be restricted to those persons with a legitimate need to handle them, and that records of transactions in the drugs should be maintained and should be made available for inspection. These still form the basis of British drug control. The special war-time measures certainly met the spirit, and in many respects exceeded the letter, of the Hague Convention of 1912, which had not yet come into force.

A year after the new regulation, the Commissioner of Police was able to report that the traffic in cocaine was "almost extin-

guished," which suggested that Regulation 40B had been effective. This success was interpreted as being due almost entirely to the restrictions introduced in 1916, and the police urged that the controls should be embodied in permanent legislation at the end of the war. This was done in the Dangerous Drugs Act of 1920, which gave effect to requirements of the Hague Convention. Until 1964, British drugs legislation continued to follow essentially this procedure of honoring the obligations imposed by the various international conventions.

An essential aspect of British drug regulation is the governmental agencies which implement the legislative and administrative controls. The Home Secretary is responsible for the administration of the Misuse of Drugs Act of 1971. The functions of the Home Department, or Home Office as it is more commonly known, include the administration of justice and criminal law, the treatment of offenders, the probation and prison services, public morals and safety, the police, fire and civil defence services, immigration and nationality, community relations, and community and urban programmes. The organisation within the Home Office primarily responsible for the administration of the Misuse of Drugs Act is the Drugs Branch, which consists of an administrative section dealing with policy, Parliamentary and international matters and a licensing section, which issues licenses to importers and exporters of drugs and to firms which manufacture and distribute controlled substances. There is also an Inspectorate which is responsible for the inspection of licensed firms, liaison with the police and other enforcement agencies such as H. M. Customs and Excise, and with treatment agencies such as hospitals and clinics. The Inspectorate also has certain enforcement functions, but the activities of the Drugs Branch Inspectors are concerned primarily with the investigation of abuse by the professional classes, including doctors and pharmacists and, in particular, with the irresponsible prescribing or supply of controlled drugs by such persons.

The two main enforcement agencies in the United Kingdom are the police and H. M. Customs and Excise. The latter operates on a national basis but there is no national police agency in this field equivalent to the D.E.A. or the F.B.I. In England and Wales there are presently 47 autonomous police forces of which the largest is the Metropolitan Police, with headquarters at the internationally well-known Scotland Yard. The Chief Officer of each force, known as the Chief Constable except in London, is entirely responsible for the enforcement of the law in his area. The 20 forces in Scotland, for which the Secretary of State for Scotland and not the Home Secretary is responsible, will be reduced to

8 in 1975 with the amalgamation of some of the smaller forces into larger units. Although there is excellent liaison and co-operation among all enforcement agencies and between these and the Home Office Drugs Branch, there is no direction of enforcement activity by central government. With respect to drug control, the police in the United Kingdom have a two-fold responsibility of taking action against the illicit traffic and the unlawful use of drugs and a more routine responsibility of carrying out regular inspections of pharmacies throughout the country, the authority for which was first given to them in 1917 under the Defence of the Realm Regulations. To achieve the former, most forces have now established special Drug Squads and they have for the last two years been supported by a Central Drugs Intelligence Unit, which, although based at Scotland Yard, is staffed by officers from the Metropolitan Police, the provincial police, and H. M. Customs and Excise. Many forces have also appointed specialist officers to carry out the pharmacy inspections, but even in those areas where specialists have not been appointed, the officers required to conduct inspections receive special training and advice both from Home Office Inspectors and other specialist officers.

A number of other agencies assist in maintaining the controls, the most important of which is the Department of Health and Social Security (formerly the Ministry of Health), which is responsible for administering the National Health Service and for providing the Home Office with advice and assistance on the medical aspects of drug abuse. Regional Medical Officers of that Department visit doctors routinely, in the course of which they offer advice on the requirements of drugs law and, at the request of the Home Office, enquire into the circumstances under which a doctor may be prescribing drugs to a patient or obtaining drugs on his own authority. In relation to medical treatment, it is not always appreciated in North America that although the United Kingdom has had a comprehensive National Health Service since 1948, private medicine still exists, and within the context of drug addiction, as with any other condition, a patient is as free to consult a private physician as he is to consult one practising entirely within the National Health Service.

Whereas the detail of the control machinery may vary, the basic principles of drug control in the United Kingdom are founded on the same international framework as that of the United States and Canada. Moreover, breaches of our control are regarded as serious offences and are subject to heavy penalties. For nearly 50 years, the maximum penalty which could be imposed by the courts, following conviction on indictment, was 10 years imprisonment and/or a fine of 1,000 £. The Misuse of

Drugs Act of 1971 increased the maximum penalties for certain offences, so that participation in the production or supply of controlled drugs carries a punishment of up to 14 years and an unlimited fine. However, in fairness, it should be noted that the maximum penalties are rarely imposed. There are no mandatory sentences for drug offences.

In the years which followed the enactment of the Dangerous Drugs Act of 1920, the decline in the use of cocaine, as reflected in the prosecution statistics, continued. In 1921, the first year of operation of the Act, there were 58 prosecutions for cocaine offences out of a total of 67 for manufactured drugs. Yet, by 1927 the number of cocaine prosecutions had fallen to 2. Apart from a brief period in the 1960's, when cocaine was made more popular by a particular London physician who prescribed it in conjunction with heroin, it would be nearly 50 years before the drug again gave rise to any concern in the United Kingdom. Similarly, opium offences, which had numbered 184 in 1921, declined in the ensuing years until 1938, when only 6 prosecutions were recorded. Since abuse of opium in the United Kingdom has always been largely confined to persons of Chinese origin, the dramatic rise in opium prosecutions during the Second World War was due to special war-time conditions. The Chinese population was increased by seamen, there was an increase in police activity in Liverpool, a city which has always had an appreciable Chinese population, and trade routes changed, which involved the United Kingdom in the opium traffic from India and other Far Eastern countries to North America. At the end of the war opium offences again declined to a negligible number.

Students of the British "system" or "experience" are, however, primarily concerned with the extent of addiction to opiates. Following the decline in the popularity of cocaine as a drug of abuse, the Annual Reports to the League of Nations usually stated that drug addiction is not prevalent in the United Kingdom. This claim has been viewed with skepticism, if not total disbelief, by some observers whose assessment of the British "experience" appears to have been based on the fundamental but highly erroneous assumption that the scale of opiate abuse in Britain at the beginning of this century was similar to that in the United States.<sup>3</sup> Such an assumption ignores the generally

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3. *Proceedings of the Special Committee on the Traffic in Narcotic Drugs in Canada*, Ottawa at 15-16 (1955). Hon. Paul Martin, Minister of National Health and Welfare, stated in the opening session:

You will find that the number of drug addicts reported to be in existence in the United Kingdom is approximately 300 and in France is about 700. It would not be proper for me as a member of the Government to make detailed comment on those figures but I simply find it difficult to accept them. . . .

*Id.* at 390. H. Isbell stated:

accepted view of the important role played by the American Civil War in spreading the morphine habit,<sup>4</sup> an event which had no counterpart in the United Kingdom. Furthermore, many observers ignored certain evidence of a negative nature, which supported the British view that addiction was not widespread. In the period between the two World Wars, there was very little press or Parliamentary interest in drugs. The Commissioner of Police of the Metropolis, who had first brought the cocaine problem to official notice in 1916, did not even refer to the subject in his annual report about the state of crime in London until 1963. The number of deaths attributable to drug addiction, as recorded in the Registrar General's statistics of deaths, was insignificant and, as the evidence presented to the Rolleston Committee (see p. 75 *infra*) demonstrated, very few doctors, either in general or hospital practice, ever saw cases of addiction. Furthermore, for many years there had been an arrangement whereby prison medical officers reported to the Home Office all cases of addiction coming to their notice, regardless of the offence with which the prisoner had been charged. Nevertheless, very few new cases were reported under this procedure, indicating that there was no significant criminal addict population (i.e., addicts who were confirmed criminals apart from their addiction), another aspect of the British "experience" sometimes not fully appreciated in North America. The few cases of addiction which did occur were usually noticed as a result of routine enquiries into regular or unusually large prescriptions of opiates to individuals.

A few cases did come to light as a result of other police enquiries, but until the 1960's the number of these was neg-

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I must say I am somewhat confused: Great Britain has a drug law; it has signed all the international treaties and conventions which the United States and Canada have signed; it has an enforcement system. Yet, with all these, it is said they have no drug problem. It is a little hard for me to understand why they have all this and no problem.

*Council on Mental Health*, 165 J.A.M.A. (1957):

Accuracy of the figures on addiction in Great Britain has been questioned. The system of checking retail outlets for narcotic drugs is not as thorough in England as in the United States and Canada so that considerable diversion from legal stocks could conceivably occur.

"The Federal Bureau of Narcotics insists that the English have an illicit traffic of the same magnitude and viciousness as our own and that the enforcement policies of the two countries are identical." King, *Drug Addiction—Crime or Disease*, REPORT OF THE A.B.A.-A.M.A. JOINT COMMITTEE ON NARCOTIC DRUGS at 127 (1961). This was in reference to ANSLINGER & TOMKINS, *THE TRAFFIC IN NARCOTICS* 296 (1953) and *Hearings of the Senate Judiciary Committee*, pt. 5, at 1437 (1955).

4. C. TERRY & M. PELLEN, *THE OPIUM PROBLEM* (1928); *DRUGS AND YOUTH: PROCEEDINGS* (J.R. Wittenborn ed. 1969); Proceedings of the Anglo-American Conference on Drug Abuse, *The British Approach*, 1973 *ROY. SOC. MED.* 100.



ligible. As far as can be ascertained, no attempt was made by the Home Office, in the period immediately following the introduction of the Dangerous Drugs Act of 1920, to compile detailed statistics about the number of addicts coming to notice. Largely as a response to the growing interest in addiction shown by the League of Nations, the first official estimate that there were 300 addicts in the country was made in 1934. In the following year this estimate was revised to 700, but thereafter the figures quoted in the Annual Reports to the League of Nations, and later to the United Nations, were of the actual number of addicts known to the Home Office in the year in question. Since the estimates were prepared from an Addict Index in which records were retained until nothing had been heard of a case for ten years, the estimated figures were inflated. In 1945, the record retention period was reduced to five years, and the number of addicts, as reported to the League of Nations, correspondingly dropped from 559 in 1940 to 367 in 1945. The recording procedure was again revised in 1957 and only those addicts known to have been using drugs in the year in question were included in the statistics. The principal source of information was still the routine inspections of pharmacy records, but increasingly doctors voluntarily notified the Home Office of cases of addiction, and a growing number of addicts were coming to notice through other police enquiries.

Since 1968, when statutory notification of addiction was introduced, the statistics have included only those cases which have been the subject of an official notification. Addicts become subjects of notification when they come into a professional relationship with a doctor, or when they are found in possession of drugs by the police and there is clear evidence that the offender is addicted. Such an offender would not be included unless his case had been referred at some stage to a doctor, such as a police surgeon, who was satisfied that the criteria of the Notification Regulations were met. In view of the intense interest in British drug statistics,<sup>5</sup> it should be emphasised that no claim has ever been made that the figures quoted in the Annual Reports represent every drug addict in the United Kingdom. Clearly such a target would be impossible to achieve since many addicts remain "hidden" for long periods before coming to official notice. What the figures represent is an accurate account of the number of addicted persons who do come to the notice of the Home Office.

Despite the absence of any deliberate collection of informa-

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5. Johnson, *Understanding British Addiction Statistics*, XXVII BULL. ON NARCOTICS 1(1975).

tion about addicts, it soon became apparent after 1920 that there were a number of instances where exceptionally large drug supplies had been made available to certain doctors or to individual patients on a doctor's prescription. Further enquiries into the circumstances of these cases revealed that the drugs had been supplied, not as part of the medical treatment of some organic disease, but simply to enable persons who had become addicted to satisfy their craving. In some instances doctors had issued large quantities over long periods to patients they saw at infrequent intervals, occasionally arranging for the prescriptions to be sent by post. Doctors had also supplied drugs to persons previously unknown to them, without making any attempt to check on their history or to communicate with the patients' previous doctors. Moreover, a number of doctors were found to be purchasing drugs to gratify their own addiction. Under the regulations, a registered medical practitioner was authorised to possess and supply drugs so far as was necessary for the practice of his profession, but no attempt had been made to define what constituted professional practice. Therefore, cases of the type described above placed the Home Office, which was responsible for administering the law, in a position of considerable difficulty. It was clearly the intention of Parliament that the availability of drugs should be limited to the requirements of genuine medical practice; it was therefore necessary, whenever such a case came to notice, for the Home Office to determine how far Parliament's intentions had been frustrated and if so, how this situation should be handled. Since it was impossible for the Home Office to recognize cases of bona fide medical treatment, an attempt was made in 1924 to resolve this dilemma. The Minister of Health appointed a Departmental Committee on Morphine and Heroin Addiction, commonly known as the Rolleston Committee after its Chairman, Sir Humphrey Rolleston, a distinguished physician of the day. The purpose of the committee was

to consider and advise as to the circumstances, if any, in which the supply of morphine and heroin (including preparations containing morphine and heroin) to persons suffering from addiction to those drugs may be regarded as medically advisable, and as to the precautions which it is desirable that medical practitioners administering or prescribing morphine or heroin should adopt for the avoidance of abuse, and to suggest any administrative measures that seem expedient for securing observance of such precautions.

Of all the British reports about drug addiction, the Rolleston Committee's<sup>6</sup> is probably the most important since it established principles which, with minor and very recent modifications, have

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6. REPORT OF THE DEPT. COMM. ON MORPHINE AND HEROIN ADDICT. (HMSO 1926).

for 50 years guided the attitude of British doctors towards the treatment of drug addiction. Undoubtedly these principles created the concept of a British "system" in the minds of many observers. Nevertheless it is likely that there would have been fewer misunderstandings of the Rolleston proposals if the full text of the Report had received as much attention as the major recommendations of the Committee.

The Committee's recommendations must be viewed against the background of the drug problem as it was seen in 1924. Since the Committee was essentially composed of physicians, the Report took a narrow, medically oriented approach to drug addiction. The Report is an interesting balance of common sense and sound practical advice, and to a modern observer, astonishing naivety. Thus, in paragraph 24, the Committee suggests that

. . . although sources of illegitimate supply exist, it appears that those who might, in other circumstances, have obtained the drugs from non-medical sources are usually lacking in the determination and ingenuity necessary for overcoming the obstacles which the law now places in their way.

Whether or not there was an appreciable number of non-therapeutic addicts in 1924, and the evidence from other sources suggests that there was not, the Committee clearly saw no reason to regard non-therapeutic addiction as a serious threat. Therefore, they confidently predicted that the "further operation of the present restrictions on supply, coupled with greater care by practitioners in the use of drugs in treatment, may go a long way to extinguish the evil."

It is hardly surprising, in view of the Committee's medical orientation, that the Report should regard addiction "as a manifestation of a morbid state and not a mere form of vicious indulgence," but it is the Committee's acceptance that there were certain groups suffering from addiction to which administration of morphine and heroin could be regarded as legitimate medical treatment which has attracted the most comment and which has probably given rise to much of the misunderstanding about the so-called "British system." The groups were:

- (a) those who are undergoing treatment for cure of addiction by the gradual withdrawal method;
- (b) persons for whom, after every effort has been made for the cure of the addiction, the drug cannot be completely withdrawn, either because:
  - (i) complete withdrawal produces serious symptoms which cannot be satisfactorily treated under the ordinary conditions of a private practice; or
  - (ii) the patient, while capable of leading a useful and fairly normal life so long as he takes a certain non-progressive quan-

tity, usually small, of the drug of addiction, ceases to be able to do so when the regular allowance is withdrawn.

Less frequently quoted are the qualifications which the Committee placed on these recommendations. These make it abundantly clear that the Committee did not intend the concept of maintenance doses to be adopted except in extreme circumstances. Thus, paragraph 49 states:

It should not, however, be too lightly assumed in any case, however unpromising it may appear to be at first sight, that an irreducible minimum of the drug has been reached which cannot be withdrawn and which, therefore, must be continued indefinitely . . . .

Paragraph 53 states:

When the practitioner finds that he has lost control of the patient, or when the course of the case forces him to doubt whether the administration of the drug can, in the best interests of the patient, be completely discontinued, it will become necessary to consider whether he ought to remain in the charge of the case, and accept the responsibility of supplying or ordering indefinitely the drug of addiction in the minimum doses which seem necessary. The responsibility of making such a decision is obviously onerous, and both on this ground and for his own protection, in view of the possible inquiries by the Home Office which such continuous administration may occasion, the practitioner will be well advised to obtain a second opinion on the case.

The Committee's views, although accepted by the Government, did not have the force of law and merely served as guidelines for those doctors who found themselves with addicted patients. These guidelines were brought to the attention of the medical profession in a memorandum<sup>7</sup> issued jointly by the Home Office and the Ministry of Health (D.D. 101), which has frequently been interpreted by North American observers<sup>8</sup> as giving legal effect to the Committee's recommendations. It did not do so, and from 1920 until the present day the only limitation imposed by the law on a doctor's right to possess and supply controlled drugs has been that he should be acting "so far as may be necessary for the exercise of his profession, function or em-

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7. *Memorandum on the Duties of Doctors and Dentists* (Home Office, D.D. 101).

8. *Council on Mental Health*, 165 J.A.M.A. (1957):

The 300 addicts to manufactured drugs are managed under a regulation which states that drugs may be given to an addict by a physician when it has been demonstrated that the patient, whilst capable of leading a useful and normal life when a certain dose is regularly administered, becomes incapable of this when the drug is entirely discontinued. This particular regulation is the major difference between the British and the U.S. regimes.

Larimore & Brill, *The British Narcotic System*, 60 N.Y. STATE J. MED. (1960). In a reference to D.D. 101, Brill and Larimore incorrectly state that "[i]t provides the administrative authority for what is perhaps the most publicized facet of the British Narcotics system."

ployment and in his capacity as a member of his said class. . . ." It was of course expected that a doctor would act in accordance with these guidelines but failure to do so was not an offence against the drugs legislation. Since the right of doctors in the United Kingdom to prescribe what they think best for their patients, in accordance with their conscience and professional judgment, has always been regarded as virtually sacred, it may seem strange that such important guidelines were not effectively backed by legislation. However, the very fact that the Government saw fit to issue D.D. 101 demonstrates the importance attached to the Rolleston recommendations and refutes the view which has been held in North America that the United Kingdom permitted and even encouraged the unrestricted administration of narcotics to addicts.

The Rolleston Committee also recommended that Tribunal machinery should be established to deal with doctors who contravened the guidelines proposed in its new report. Nevertheless, the Committee specifically rejected making it a statutory requirement that doctors should seek a second opinion before continuing to supply drugs to a patient over whom the doctor had lost control. The Committee also rejected a proposal that compulsory notification of addiction should be introduced, a measure which was implemented 40 years later. Although the Tribunal would have been appropriate machinery for enquiring into instances of irresponsible prescription of drugs by doctors, no Tribunal was ever convened. The reasons for this failure are not now clear, but it seems likely that there was a lack of suitable cases for reference, which was primarily the result of the negligible demand for drugs. Furthermore, it was occasionally possible to deal informally with doctors who contravened the law in the case of such technical offenses as failure to keep records. The Tribunal recommendations were dropped from the regulations in 1953, as part of a general overhaul of the procedural rules. This revision, however, was not regarded as an urgent matter, and before the rules could be revised the First Interdepartmental Committee on Drug Addiction (Brain I)<sup>9</sup> had been set up to review the advice given by the Rolleston Committee. The Brain Committee came to the conclusion, for reasons which will be seen later, that there was no need to recommend Tribunal machinery. The failure to provide the safeguards which Rolleston had felt were necessary can only be described in the light of subsequent events as extremely unfortunate, since the Brain Committee's rejection of Tribunals, or some alternative machinery, meant that

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9. FIRST REPORT OF THE INTERDEPT. COMM. ON DRUG ADDICT. (The Brain Comm.) (HMSO 1961).

there was no supervision over the prescription of drugs by doctors until 1973, when Tribunals were revived under the Misuse of Drugs Act of 1971. During those twenty years, medical practitioners, acting in the course of their professional duties, had absolute freedom to prescribe opiates for any patient, without restrictions as to quantity and regardless of whether or not the Rolleston guidelines, which had been reaffirmed by the Brain Committee, were followed. As will be seen, this loop-hole in drug control was fully exploited by the new group of heroin addicts emerging in the 1950's and 1960's.

During the period from 1926 until the end of the Second World War, drug addiction in the United Kingdom remained remarkably stable and on a very small scale. The vast majority of the addicts coming to notice were persons who had become addicted as a result of some organic condition (i.e., therapeutic addicts) and, as might be expected, were usually of middle age, from all social classes, and scattered throughout the country in isolation from each other. At any time during this period, between ten and twenty per cent of the addict population were members of the medical or paramedical professions who had become addicted through access to drugs in the course of their work. Occasionally non-therapeutic addicts who had acquired their addiction overseas emerged. The best example of this situation was a small group of heroin addicts which came to notice in London just before the Second World War.

In the immediate post-war years, interest in heroin declined and the 1949 Annual Report to the United Nations recorded that addiction to this drug was now "comparatively rare." In 1951, however, there emerged the first signs of a revival of interest in heroin.<sup>10</sup> The incident which brought this revival to official notice was the theft from a hospital in Kent of a large quantity of morphine, heroin and cocaine. When the thief was arrested some three months later, he had successfully disposed of almost all of the heroin and cocaine in jazz clubs in the West End of London. When the stolen source of supply was removed, customers of the thief appeared as patients of a number of London doctors. Almost all of the new patients were previously unknown as addicts. They were younger and from different social groups than those of pre-war heroin addicts. Moreover, these new addicts were more active proselytisers than their older counterparts and more adept at locating doctors from whom they were able to obtain more than enough heroin to support their own habits and to provide a surplus which could be shared, sold

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10. Spear, *The Growth of Heroin Addiction in the United Kingdom*, 64 BR. J. ADDICT. 36-38 (1969).

or loaned to friends and acquaintances. Since many of the new addicts were receiving drugs from doctors, the number of heroin addicts coming to notice during inspections of pharmacy records, and also being found in unlawful possession of heroin by the police, began to increase. Although the increase in the number of addicts was slow initially, the numbers were growing more rapidly by 1960.

In the meantime, the First Interdepartmental Committee on Drug Addiction had been established in 1958 to review the recommendations of the Rolleston Committee. The reason for this new enquiry was not the increasing heroin addiction. Instead, it was felt that the time was right to review the Rolleston principles, which had been laid down about forty years earlier, inasmuch as a large range of synthetic analgesics had been developed and the new Single Convention on Narcotic Drugs was about to commence.

In 1960, the Brain Committee produced what can best be described as a "no change" report. The Committee reaffirmed the major findings of the Rolleston Committee, and concluded that the incidence of addiction was still very small, that departmental arrangements ensured that nearly all the addicts were known to the authorities, and that there was no need to reestablish the Tribunal machinery. The last conclusion was based on the Committee's view that

the right of doctors in Great Britain to continue at their professional discretion the provision of dangerous drugs to known addicts has not contributed to any increase in the total number of patients receiving drugs in this way.

Some British observers disagreed with this conclusion.<sup>11</sup> Nevertheless it would probably be unfair to criticize the Brain Committee for its failure to appreciate the significance of the change in the pattern of opiate addiction which had first appeared in 1951, since it was not until 1961 that the total number of heroin addicts known to the Home Office exceeded one hundred. The 1960 statistics, which revealed an increase from 68 heroin addicts in 1959 to 94 in 1960, were not available before the Report was completed.

The change in the nature of heroin addiction in the United Kingdom had first been detected in 1951, some eight years before the first of a group of Canadian heroin addicts, anxious to test the reported liberality of the "British system," arrived in London.<sup>12</sup> Although a number of international experts have at-

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11. H. JUDSON, *HEROIN ADDICTION IN BRITAIN* (1974).

12. CUSHNY, KLEIN & KRASNER, *DRUG-TRIP ABROAD* (1972); Frankeau, *Treatment in England of Canadian Patients Addicted to Narcotic Drugs*, 90 *CAN. MED. ASS'N. J.* 421 (1964); Spear & Glatt, *The Influence of Ca-*

tributed the changes in the British heroin scene to the influence of these new arrivals,<sup>13</sup> their influence was minimal, even though they would cause obvious increases in the addict total.

The gradual increase in the number of young heroin addicts, and the methods by which they were able to secure their supplies, continued to attract the interest and concern of the Home Office Drugs Branch. Eventually the Minister of Health asked Lord Brain to undertake a further enquiry

to consider whether, in the light of recent experience the advice the InterDepartmental Committee gave in 1961 in relation to the prescribing of addictive drugs by doctors needs revising and, if so, to make recommendations.

The conclusions of this Second Interdepartmental Committee,<sup>14</sup> like the findings of the Rolleston Committee, have received much publicity and critical comment. It is necessary only to summarize the major conclusions of the Committee:

- (a) there had been a disturbing rise in the incidence of addiction to heroin and cocaine, especially among young people;
- (b) the major source of supply had been excessive prescribing for addicts by a small group of doctors, acting within the law and in accordance with their professional judgment;
- (c) the doctor's right to prescribe for the ordinary patient's needs should be maintained; but,
- (d) a system of notification of addicts should be introduced;
- (e) special treatment centres should be established, having facilities for medical treatment, including laboratory investigation and a provision for research;
- (f) the supply of heroin and cocaine to addicts should be confined to doctors at these treatment centres;
- (g) a Standing Advisory Committee should be established to survey the whole field and to call attention to any development that may be a cause for concern or worthy of closer study.

These recommendations were accepted by the Government and eventually implemented. Two additional recommendations, however, were not implemented. One of the rejected proposals was that breaches of these new arrangements should be dealt with by the General Medical Council, the profession's disciplinary body. The other recommendation, which was also rejected, provided that powers should be granted for brief detention of

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*nadian Addicts on Heroin Addiction in the United Kingdom*, 66 BR. J. ADDICT. 141-49 (1971); Zacune, *A Comparison of Canadian Narcotic Addicts in Great Britain and in Canada*, XXIII BULL. ON NARCOTICS 4 (1971).

13. N. BEJEROT, ADDICTION; AN ARTIFICIALLY INDUCED DRIVE 46 (1972); E. BRECHER, THE CONSUMERS UNION REPORT, LICIT AND ILLICIT DRUGS 123 (1972).

14. SECOND REPORT OF THE INTERDEPT. COMM. ON DRUG ADDICT. (The Second Brain Comm.) (HMSO 1965); Glatt, *A Review of the Second Report of the Interdepartmental Committee on Drug Addiction*, XVIII BULL. ON NARCOTICS 2 (1966); Ollendorff, *Drug Addiction and the Brain Report*, 4 J. LIVERPOOL PSYCH. SOC. 2 (1966); Afon, ANARCHY 60, 33 (1966).



those addicts who were undergoing treatment if a crisis had arisen which might induce the patient to abandon treatment. This last proposal has frequently been misinterpreted as being a recommendation for compulsory treatment powers, but Lord Brain and his colleagues saw it as simply a first-aid measure to be used in an emergency to assist a doctor in controlling a patient being treated on a voluntary basis.

Much of the publicity given to this Committee's Report was focused on the conclusion that there had been no more than six doctors prescribing heroin in excessive amounts. Despite the conclusions of the Committee, it would be a very considerable misreading of the history of the spread of heroin in post-war Britain to suggest that these practitioners were the cause of the recent outbreak. In the first place such an assessment ignores the fact that addicts had been free to approach and receive opiates from doctors of their choice before the first drug controls in 1916. Since 1916 there had been a considerable increase in the demand for drugs, heroin in particular, which had not existed at the time of the Rolleston enquiry in 1924-1925, and had not been appreciated by Lord Brain and his colleagues in 1958-1960. Moreover, in fairness to those six doctors, it has to be pointed out that their involvement usually arose from a compassion and sympathy for the problems of the young addicts. The vast majority of general practitioners and their hospital colleagues had refused to accept addicts as patients because any doctor who was prepared to do so was quickly inundated with such patients.<sup>15</sup> As Glatt has commented:

. . . Simply put there are only a few doctors who are prepared to treat addicts, and even fewer who, although within their legal rights, do, in view of the Brain Commission (sic), nothing to help the situation. . . . It is highly unlikely that British doctors will suddenly unite in a conscientious effort to help the addicts. In general, addicts have a very poor prognosis, and basic to the ideology of most doctors is that they should attempt to cure their patients. This of course means that the doctor must first accept the idea that drug addiction is a disease and treatable in general practice. It would seem that this idea is not yet accepted by many British doctors. The fact that only thirteen doctors make a practice of treating addicts supports this opinion . . . .

The second Brain Report was published in 1965 and expressed the difficulty in which the Committee found itself in the following terms:

We remain convinced that the doctor's right to prescribe dangerous drugs without restriction for the ordinary patient's needs

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15. M. GLATT, *THE DRUG SCENE IN GREAT BRITAIN* (1967); A. HAWES, *GOODBYE JUNKIES* (1970); Hewetson & Ollendorff, *Preliminary Survey of 100 London Heroin and Cocaine Addicts*, 60 *BR. J. ADDICT.* 109-14 (1964).

should be maintained. 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 supplies from legitimate sources it may lead to the development of an organized illicit traffic. The absence hitherto of such an organized illicit traffic has been attributed largely to the fact that an addict has been able to obtain supplies of drugs legally . . . .

It was not until 1968, following the passage through Parliament of the Dangerous Drug Act of 1967, which provided the necessary statutory authority, that the major recommendations of the Second Brain Report were implemented. The delay was strongly criticised by some of those working amongst addicts in the West End of London,<sup>16</sup> who saw the situation deteriorating as the number of addicts increased and as several of those doctors, who had been prepared to help in anticipation of the implementation of the recommendations, withdrew from the scene. Although Lord Brain had introduced the concept of treatment centres, no detailed blueprint had been offered beyond the suggestion that there should be laboratory facilities and opportunities for research. It must be remembered that at that time there were very few specialist units for the treatment of addiction upon which such a network of treatment centres might be developed. Moreover, the distribution of the heroin addicts whose treatment was to be transferred from general practitioners to the new treatment centres was not uniform. While by far the largest group was in London, it was also important to ensure that adequate treatment facilities existed in the provinces. In Birmingham, for instance, some fifty young heroin addicts had emerged within a few months of the opening in 1965 of a unit for the treatment of alcoholism.<sup>17</sup> After detailed discussions with the medical profession, treatment centres were established in London, mainly in association with the main teaching hospitals. Regional Hospital Boards in the provinces were also asked to provide such treatment facilities as they thought might be needed.

The Dangerous Drugs Act of 1967, which restricted the prescription of heroin and cocaine for addicts to doctors on the staff of the treatment centres, and regulations giving effect to this restriction, came into force in April 1968. Although only those doctors who have been given special licences by the Home Office

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16. AMPHETAMINES AND LYSERGIS ACID DIETHYLAMIDE (LSD) (Report of the Advisory Committee on Drug Dependence) (HMSO 1970).

17. H. JUDSON, HEROIN ADDICTION IN BRITAIN (1973); O'CALLAGHAN, DRUG ADDICTION IN BRITAIN 128-32 (1970); Nyman, *Addiction Unit-All Saints Hospital*, BR. HOSP. J. & SOC. SERV. REV. (August, 1969).

may now prescribe heroin and cocaine for addicts, any doctor is perfectly entitled to prescribe these drugs for patients suffering from organic disease. The only drugs to which the restriction presently applies are heroin and cocaine, but powers have been retained to extend this list if it becomes necessary. Morphine, methadone and other similar drugs may therefore be used by unlicensed doctors in the treatment of addiction and, despite reports to the contrary,<sup>18</sup> there is no compulsion on an addict to attend a treatment centre. However, a heroin addict will be unable to obtain heroin unless he attends a centre where the licensed doctor is willing to supply him.

The proposal that all addicts should be notified to the Home Office was brought into operation on 22nd February 1968. An unofficial notification system had already been in operation, primarily with respect to the new heroin addicts for several years, and it is only fair to record that without exception all those doctors to whom the Brain Committee had drawn attention cooperated fully in supplying information about their patients. Notification is sometimes confused with "registration," under which an addict is regarded as someone entitled to a regular supply of drugs. An addict whose name has been notified to the Home Office acquires no official status or privilege, and the course of his treatment remains entirely a matter for the doctor in charge of the case. Information about addicts who have been notified is only disclosed under carefully controlled circumstances, usually to doctors who are anxious to check the history of a new patient or to determine whether the addict is currently under the care of another practitioner. For the purposes of notification, an addict is defined as someone who has "as a result of repeated administration become so dependent upon the drug that he has an overpowering desire for the administration of it to be continued." Both failure to notify and the prescription of heroin to an addict by an unlicensed doctor would be dealt with by a Tribunal, and the ultimate sanction would be the withdrawal of the doctor's right to prescribe drugs.

The operation of the treatment centres has been described by several observers,<sup>19</sup> and it should be emphasized that the

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18. GIRDANO & GIRANO, DRUGS, A FACTUAL ACCOUNT 159 (1973); *A Federal Source Book: Answers to the Most Frequently Asked Questions About Drug Abuse*, NAT. CL. HOUSE FOR DRUG ABUSE 25 (1970); REPORT OF THE COMMISSION OF INQUIRY INTO THE NONMEDICAL USE OF DRUGS, at 18 (Canada 1972).

19. H. JUDSON, HEROIN ADDICTION IN BRITAIN (1973); *Consumers Guide to Drug Treatment Facilities*, 3 DRUGS AND SOCIETY 3 (1973); T.H. Bewley, *The Evaluation of the Effectiveness of Prescribing Clinics for Narcotic Addicts in the United Kingdom*, DRUG ABUSE: PROCEEDINGS OF THE INTERNATIONAL CONFERENCE (1972); Gardner & Connell, *One Year's Experience in a Drug Dependence Clinic*, 11 LANCET 455 (1970); May,

policy adopted by a particular centre is entirely a matter within the professional judgment and discretion of the consultant in charge of the centre. There is no central direction of treatment policy, although opportunities are provided for both the medical and nursing staff of the centres to meet each other, officials of the Department of Health and Social Security, and the Home Office in order to discuss ideas and mutual problems. Thus it is possible to find within the general treatment framework some centres which will prescribe heroin or cocaine, others which will not, some which provide injectable methadone and yet others which will only supply methadone for oral use. In at least one unit, the addicts must attend to have the drugs personally administered to them by the unit staff.

It has been suggested that the present arrangements for treating addicts in the United Kingdom provide unique opportunities for studying the phenomenon of drug dependence, and in recent years British workers have made significant contributions to the international literature on this subject.<sup>20</sup> Certainly these arrangements have made it possible to monitor closely the changes which have taken place in the extent and nature of intravenous drug use since 1968. While it may be tempting to ascribe these changes to the restrictions imposed following Brain II, the general upsurge in the demand for drugs, which has occurred in the 1960's, cannot be ignored. This upsurge, which is a phenomenon not confined to the United Kingdom, was first

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*Narcotics Addiction and Control in Great Britain, REPORT TO THE FORD FOUNDATION (1972).*

20. R. COCKETT, DRUG ABUSE AND PERSONALITY IN YOUNG OFFENDERS (1971); J. MOTT & M. TAYLOR, DELINQUENCY AMONG OPIATE USERS (1974); Beckett & Lodge, *Aspects of Social Relationships in Heroin Addicts Admitted for Treatment*, 29 BULL. ON NARCOTICS (1971); Bewley & Ben-Arie, *Study of 100 Consecutive Patients*, 1 BR. MED. J. 727 (1968); Blumberg, *British Opiate Users*, 9 INT. J. ADDICT. (1974); Boyd, *Treatment and Follow-up of Adolescents Addicted to Heroin*, 4 BR. MED. J. 604 (1971); Bransby, *A Study of Patients First Notified by Hospitals as Addicted to Drugs*, 3 HEALTH TRENDS 75-78; Chapple, Somekh, & Taylor, *Follow-up of Cases of Opiate Addiction from Time of Notification to the Home Office*, 1 BR. MED. J. 680-83 (1972); Chapple, Somekh, & Taylor, *A Five Year Follow-up of 108 Cases of Opiate Addiction*, 67 BR. J. ADDICT. 33-38 (1972); d'Orban, *Heroin Dependence and Delinquency in Women: A Study of Heroin Addicts in Holloway Prison*, 65 BR. J. ADDICT. 67-68 (1970); Gordon, *Patterns of Delinquency in Drug Addiction*, 122 BR. J. PSYCH. 205-10 (1973); James, *Delinquency and Heroin Addiction in Britain*, 9 BR. J. CRIM. (1969); Kosviner, *Heroin Use in a Provincial Town*, 1 LANCET 1189 (1968); McSweeney & Parr, *Drug Pushers in the United Kingdom*, 228 NATURE 422-24 (1970); Stimson & Ogbourne, *A Survey of a Representative Sample of Addicts Being Prescribed Heroin at London Clinics*, XXII BULL. ON NARCOTICS 13 (1970); Willis, *Delinquency and Drug Dependence in the United Kingdom and the United States*, 66 BR. J. ADDICT. 235-48; Willis, *Drug Dependence: Demographic and Psychiatric Aspects in United Kingdom and United States Subjects*, 64 BR. J. ADDICT. 135-46 (1969); Wright & Turner, *An Analysis of the Effects of Drug Abuse as Seen and Treated in a Casualty Department*, 66 BR. J. ADDICT. 77-78 (1971).

seen in connection with the use of cannabis, a drug which first began to appear in the United Kingdom in appreciable quantities in the immediate post-war years, when its use was almost entirely confined to the newly established immigrant communities of certain large cities. The Annual Reports to the United Nations described this new development in the following terms:

1947—There has been a considerable increase in the number of seizures of Indian Hemp. . . . It seems unlikely that there is any organised traffic in this drug; usually small bundles of the green tops are found hidden in various parts of ships coming from Indian and North African ports to the United Kingdom, and, these, if successfully run ashore, would be sold to the petty traffickers who are in touch with both the coloured seamen of the East End and the clubs frequented by negro theatrical performers in the West End of London.

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1950—. . . [I]t is now clear that the traffic in hemp is of much greater importance in the United Kingdom than the traffic in opium. . . . To a large extent the increase in the numbers of prosecutions in 1950 is the reflection of an increased realisation by the Police of the problem involved, it now being clear that whereas the traffic in opium is still almost entirely confined to the seaports, the traffic in hemp has spread to all parts of the country where there is a large coloured population.

. . . .

1956—Opium and cannabis, which are not produced in the United Kingdom, continued to be imported on a very limited scale and were used almost exclusively by persons of Asiatic, African or West Indian origin.

However, by 1954 it was clear that there was a well marked tendency for the indigenous population to figure more prominently in the prosecution statistics,<sup>21</sup> and 1952 saw the first conviction of an English teenager for an offence involving cannabis. Since 1952 the number of prosecutions and seizures has increased, in keeping with the experience of many other Western countries, and there is undoubtedly a very widespread use of the drug. The United Kingdom has not escaped the intense public debate about cannabis and the Report on Cannabis by the Advisory Committee on Drug Dependence (the Wootton Report)<sup>22</sup> was the first of the recent series of international studies of this controversial drug. Under current British law cannabis offences can attract maximum penalties of fourteen years imprisonment and/or an unlimited fine, for participation in the production or

21. ADVISORY COMMITTEE ON DRUG DEPENDENCE, CANNABIS 8 (1968). Paragraph 35 consists of the following information on cannabis offenders:

	1963	1964	1965	1966	1967
White	296	284	400	767	1737
Coloured	367	260	226	352	656

22. *Id.*

supply of the drug, or up to five years and/or an unlimited fine for unlawful possession. Although previously doctors had a general authority to prescribe the few medicinal preparations containing cannabis, the Misuse of Drugs Regulations in 1973 established controls by requiring that anyone who wished to possess the drug for some legitimate purpose should be licensed by the Home Office. There are no proposals at this time for changing these controls over cannabis. In practice, licenses are issued solely for the purposes of bona fide research.

In the early 1960's, evidence appeared of the abuse of amphetamines by young persons patronising certain clubs in the West End of London, and to a lesser extent in other large cities.<sup>23</sup> This was at first a "weekend abuse" with abusers taking comparatively large quantities of "purple hearts" (a combination of dexamphetamine and amylobarbitone) to enable them to stay awake and active throughout the weekend. Gradually, however, more serious casualties began to appear and the abuse of these preparations attracted considerable press and Parliamentary concern. Finally, the Drugs (Prevention of Misuse) Act of 1964 was passed in an attempt to deal with the outbreak. The main effect of the Act was to create an offence of unlawful possession, since up to that time amphetamines were controlled only by poisons legislation, which did not provide for such an offence. Dealers in bulk, such as manufacturing chemists and wholesalers, were required to register with the Home Office, and the importation of amphetamines was prohibited, except under licence. However, it soon became clear that the Act was deficient in two respects. First, there was no requirement that those who would be handling drugs lawfully keep their stocks under secure conditions. Since drugs were not securely stored, pilfering and theft continued to provide one of the major sources of supply. Second, no provision had been made to deal with the number of liberal prescribers of amphetamines who had come to notice. Since the second Brain Committee had not by then reconvened to reconsider the irresponsible prescribing of heroin, the absence from the 1964 Act of any provision to deal effectively with the amphetamine over-prescriber was understandable.

The creation of the offence of unlawful possession of amphetamines was followed by a development which has frequently occurred during the history of the British drug abuse scene. This development was that, as legal controls restrict the availability

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23. Cockett & Marks, *Amphetamine Taking Among Young Offenders*, 115 BR. J. PSYCH. 1203-04 (1969); Connell, *Amphetamine Misuse*, 60 BR. J. ADDICT. 9-27 (1964); Kiloh & Brandon, *Habituation and Addiction to Amphetamines*, 2 BR. MED. J. 40-43 (1962); Scott & Wilcox, *Delinquency and the Amphetamines*, 111 BR. J. PSYCH. 865-75 (1965); Sharpley, *EVENING STANDARD*, Feb. 3, 6, May 1, 1964.

of one substance, the interest of the drug abusers turns to other less rigidly controlled preparations. Thus, as prosecutions of amphetamine users increased, and as doctors in Ipswich voluntarily stopped prescribing amphetamines, it was found that methaqualone, initially in conjunction with alcohol, was becoming more popular. The first reports of this new trend were received by the Home Office in 1967, but it was not until 1971 that steps were taken to bring the problem under control.

At the same time that the above phenomenon was occurring, LSD was also becoming popular. In 1966, this drug was brought within the scope of the Drugs Act of 1964, but it was not until 1971, following the appearance of LSD in tablet form, that convictions for the possession of this drug reached their peak. Like cannabis, LSD had been the subject of an enquiry by the Advisory Committee on Drug Dependence<sup>24</sup> and, although previously used quite frequently in some psychiatric hospitals, LSD can now only be handled lawfully by persons specially licensed by the Home Office. The place of LSD in the formative years of the British psychedelic scene has been described by Leech in his excellent personal account of the changes in the drug scene in the West End of London.<sup>25</sup>

The transfer of treatment for heroin addicts from general practitioners to the care of treatment centres was largely completed by April 1968, and as the notification and addict statistics for that year show, there was an even larger increase in the number of new cases coming to notice than in any of the previous years. As many of these "new" cases did not reappear in subsequent years, it seems likely that a portion of these may have represented fraudulent attempts to persuade the then inexperienced staff at the treatment centres to prescribe drugs for them. Other addicts preferred the less disciplined atmosphere of the black market because prescriptions of heroin and cocaine were reduced by the majority of treatment centre doctors who discontinued the use of cocaine and in many instances prescribed methadone to replace heroin which addicts had previously been receiving.

The first noticeable effect of the reduction in prescriptions of heroin was an increase in the illicit price of the drug. For many years, the price of heroin had remained stable at 1£ (\$2.35) for six hypodermic tablets, each containing 10 mgms. of the drug, but shortly after the treatment centres began operations, the price of tablets rose to 1£ each. The substitution of methadone, often in injectable form, for heroin was soon accompanied by the

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24. REPORT OF THE ADVISORY COMMITTEE ON DRUG DEPENDENCE, AMPHETAMINES AND LYSERGIS ACID DIETHYLAMIDE (LSD) (1970).

25. K. LEECH, KEEP THE FAITH BABY (1973).

emergence of a black market in methadone ampoules, which had not previously existed, and as a result of the growing use of methadone, cases of primary methadone addiction began to appear at the treatment centres. Many of the new methadone addicts were supplied by heroin addicts who sold the methadone they had received for treatment in order to purchase more heroin on the black market.

The heroin which these addicts bought, and which was first seen in the West End of London in significant (by United Kingdom standards) quantities in 1968, was the so-called "Chinese" heroin, the off-white gritty powder, corresponding to the Number 3 variety of illicit heroin, familiar to enforcement officers in Hong Kong and the Far East. What must be appreciated is that British addicts had been unaccustomed to using heroin in powder form because their supplies had invariably consisted of pharmaceutically prepared hypodermic tablets of guaranteed strength and purity. The addicts were initially rather suspicious of this new product, but once these suspicions had been overcome, the number of addicts found unlawfully possessing this form of "Chinese" heroin began to rise. "Chinese" heroin is now an established feature of the British illicit market in opiates, although it is impossible to estimate its extent.

The most serious complication which arose from the introduction of the new treatment arrangements was the development of an appreciable misuse of injectable methylamphetamine.<sup>26</sup> As has already been seen, amphetamines had been abused for some years, but there was little or no evidence of any significant abuse of these drugs by injection. But in 1968, following the removal of his authority to prescribe opiates, a particular general practitioner, who had been a liberal prescriber of heroin, although he was not one of those referred to in the Brain Report, began to prescribe methylamphetamine ampoules for his patients. In one month alone, this particular doctor prescribed a total of approximately 24,000 ampoules for about 150 different persons. In addition to these prescriptions, smaller amounts were prescribed by two other doctors practising in the London area. Methylamphetamine was then controlled under the Drugs (Prevention of Misuse) Act, which, as has been seen, contained no provision for dealing with such prescriptions. For legal reasons it was not possible to place the drug under the more stringent regime of the Dangerous Drugs Acts. The problem was solved with the

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26. de Alarcon, *An epidemiological Evaluation of a Public Health Measure Aimed at Reducing the Availability of Methylamphetamine*, 2 *PSYCH. MED.* 293 (1972); Glatt, *Abuse of Methylamphetamine*, II *LANCET* 215-16 (1968); Hawks, *Abuse of Methylamphetamine*, 21 *BR. MED. J.* 715-21 (1969); James, *Amethylamphetamine Epidemic*, I *LANCET* 96 (1968).



willing cooperation of the manufacturers of the preparation, who agreed with the Government to restrict their sales of methylamphetamine injections to hospitals, from which small quantities could be obtained by those general practitioners who might require the drug for the few conditions in which it was indicated. This arrangement, together with the removal from the scene of two of these prescribers, one of whose name was erased from the Medical Register by the General Medical Council and the other who was convicted of a serious criminal charge arising out of his drug activities, effectively disposed of the methylamphetamine problem.

The solution of this particular problem, however, did not end the search for substances to supplement the lower doses of heroin being purchased by the treatment centres, and it was not long before reports of the intravenous use of barbiturates were received. Formerly, only middle aged and older persons had abused these substances,<sup>27</sup> but the new abusers were primarily heroin addicts, who were supplementing their prescribed quantities of heroin or methadone with barbiturates. The barbiturates were obtained from doctors on either a casual or regular basis, from thefts at pharmacies or other legitimate storage points, or by means of forged prescriptions. Since control of barbiturates has remained under poisons legislation, it is not possible to provide any reliable estimate of the extent of this abuse, but the intravenous use of these substances still exists and is now accompanied by what appears to be a much more extensive oral abuse by the young "pill taking" fraternity. The question of the measures to be taken to deal with this new difficulty has been studied by a Working Group of the Advisory Council on the Misuse of Drugs (the successor to the Advisory Committee on Drug Dependence proposed by Brain II), but on present indications it is unlikely that barbiturates will soon be brought within the scope of the Misuse of Drugs Act of 1971.

How far the British "experience," "approach" or "attitude" should be dignified with the term "British system" is largely a matter of semantics. The British Medical Journal considers "a system which leaves much to the individual doctor, which leaves many matters undefined, is as much a system which is based on tightly defined legislative controls," whereas Freedman feels that the British approach is more casual than a system should be.<sup>28</sup> But of far more relevance is the effect which the British

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27. Glatt, *The Abuse of Barbiturates in the United Kingdom*, XIV BULL. ON NARCOTICS 19-38 (1962); Mitcheson, *Sedative Abuse by Heroin Addicts*, LANCET 606-07 (Mar. 21, 1970).

28. *Proceedings of the Anglo-American Conference on Drug Abuse*, 1973 ROY. SOC. MED. 6.

approach or system has, or has not, had on the extent and nature of opiate abuse in the United Kingdom. The debate over the British system in North America is characterised by two extremes. Glaser and Ball regard the British system as a "myth" and contend that the controls which existed until 1968 were successful because there was a negligible level of addiction in the country. Brecher, however, describes the Rolleston recommendations as "magnificent." Specific results of the "system," according to Brecher, were the reduction of the United Kingdom addict population to 700 by 1935 and subsequently to 301 in 1951. Brecher also calls attention to the effects of the system on law enforcement, whose real task he saw was "to keep narcotics out of the hands of non-addicts" and who "unlike their opposite numbers in the United States were not saddled with the hopeless responsibility of trying to keep narcotics out of the hands of the addicts."

As the facts presented in this article show, the Brecher version of the British "experience" is inaccurate in a number of respects, and any conclusions drawn from these inaccuracies must be challenged. In 1926 the Rolleston Committee reported that addiction was "rare," and the first serious estimate of the number of addicts in the country, which was made in 1935, put the total at 700. Yet Brecher misquotes the Annual Report to the League of Nations, in which this estimate was given, when he stated that "by 1935 . . . there were only seven hundred addicts left in the entire country." The subsequent reduction of addicts to 301 in 1951, was, as has been shown, very largely due to the changes adopted in the method of compiling the figures. The "modest change" in the British heroin problem did not occur in 1960 with the migration to London of a group of 15 Canadians plus a smaller group of Americans. Rather, the new heroin sub-culture began to emerge in 1951, some eight years before the first Canadian heroin addict settled in the United Kingdom. Nevertheless, the myth of the 1960 migration persists. Brecher also states that the adoption of American anti-heroin propaganda methods contributed to the development of the British heroin sub-culture, but there is little support for this theory. In his review of the origins of the heroin outbreak in Crawley, de Alarcon clearly showed the importance of the case to case spread of addiction.<sup>29</sup>

On the other hand, the view of Glaser and Ball, that the British were able to adopt a medically oriented approach because the extent of addiction was negligible, accords with the views

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29. de Alarcon, *The Milroy Lectures*, ROY. COLL. PHYSICIANS (1971); de Alarcon, *The Spread of Heroin Abuse in a Community*, XXI BULL. ON NARCOTICS 17-22 (1969).

of most British observers, especially those who have been most closely involved with the problem. The claim of Glaser and Ball that there is no evidence to implicate large scale organized or syndicated crime in the narcotic black market in Great Britain, was as true in 1920 as it was in 1970 when their study was undertaken. Since there never has been large scale syndicated crime in the United Kingdom, Brecher's view that one of the positive benefits of the "British system" has been the elimination of the criminal black market in heroin is properly discredited. Glaser and Ball have been criticised for their statement that the British "have moved in a direction similar to that of the United States" because of their recent changes in drug control. The British Medical Journal took issue with Glaser and Ball and pointed out that the British had not in fact abandoned their traditionally medically oriented approach. Nevertheless, it is understandable that the limitations imposed for the first time on the British doctor's "sacred" freedom to prescribe whatever he felt his patient's condition required, should appear to transatlantic observers as a move towards greater enforcement. In reality the 1968 measures and the machinery subsequently introduced in the Misuse of Drugs Act of 1971 to deal with irresponsible prescribing, merely provided the safeguards to the British approach, which the Rolleston Committee, some forty years earlier, had felt were necessary if their recommendations were to be followed.

As long as such widely divergent interpretations, as those held by Glaser and Ball on the one hand, and Brecher on the other, can result from the same set of facts, the debate on whether or not the British "experience" provides any lessons for North America is unlikely to be resolved. It is certainly not the purpose of this paper to suggest that any of the arrangements which exist in Britain would have any relevance in another country. All that can be said of the recent British "experience" is that it has provided lessons for the British. Some British workers, like de Alarcon,<sup>30</sup> would argue that the British were slow to learn from their recent experience. Others, however, contend that the benefits and costs of inaction seem to be frequently forgotten. In Britain, for example, (and perhaps even

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30. de Alarcon, *The Milroy Lectures*, ROY. COLL. PHYSICIANS 19 (1971):

With the wisdom of hindsight and the epidemiological evidence at our disposal it seems obvious that the dramatic changes in morbidity and in clinical presentation should have led to such action (to stop the uncontrolled availability of the drugs). However, the warnings were ignored. By the time the controlling measures were enforced in 1968 a young population who had learned to enjoy injecting opiates, alone or combined with other drugs, was already in existence; a population likely to move to the injecting and use of other drugs and to resort to the black market for heroin once legal supplies were curtailed.

in the United States), the benefits of leaving those who use opiates to do so clearly and categorically, instead of pretending to treat them, may be very great. There is no doubt that the current legislative and administrative controls permit a swift response to any new development in this complex field. In the meantime the British approach remains essentially the same as it has been since the cocaine outbreak of 1916, but it would be naive, as Hawks suggests,<sup>31</sup> to imagine that the total drug situation can be controlled through the policy of prescribing adopted by the clinics any more than the present abuse of drugs can be controlled by the rigid prescription of only certain substances. The clinics are only one element, though an important one, in the equation. Without the successful curtailment of illicit sources of drugs, and the provision of legitimate and accessible alternatives to addicts, the clinics are unlikely to be successful in the long range. Only time will tell whether the equation will ever be completely solved.

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31. *Proceedings of the Anglo-American Conference on Drug Abuse, 1973* Roy. Soc. Med. 33.

**APPENDIX A**  
**UNITED KINGDOM STATISTICS OF DRUG ADDICTION AND CRIMINAL OFFENCES INVOLVING DRUGS**

DRUG ADDICTS	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	
												Year Total	As at 31.12.69
<b>TOTAL NUMBER</b>	442	454	437	470	532	635	753	927	1349	1729	2782	2881	1466
<b>DRUGS†</b>													
No. taking heroin	62	68	94	132	175	237	342	521	899	1299	2240	1417	499
No. taking methadone	12	60	68	59	54	55	61	72	156	243	486	1687	1011
No. taking cocaine	25	30	52	84	112	171	211	311	443	462	564	311	81
No. taking morphine	205	204	177	168	157	172	162	160	178	158	198	345	111
No. taking pethidine	117	116	98	105	112	107	128	102	131	112	120	128	63
<b>ORIGIN</b>													
No. of therapeutic origin	349	344	309	293	312	355	368	344	351	313	306	289	247
No. of non-therapeutic origin	68	98	122	159	212	270	372	580	982	1385	2420	2533	1196
No. of unknown origin	25	12	6	18	8	10	13	3	16	31	56	59	23
<b>AGES</b>													
Under 20	—	—	1	2	3	17	40	145	329	395	764	637	224
Under 20 taking heroin*	—	—	1	2	3	17	40	134	317	381	709	598	221
20-34	—	50	62	94	132	184	257	347	558	906	1530	1789	897
20-34 taking heroin*	—	35	52	87	126	162	219	319	479	827	1390	1709	872
35-49	—	92	91	95	107	128	138	134	162	142	146	174	116
35-49 taking heroin*	—	7	14	19	24	38	61	52	83	66	78	101	69
50 and over	—	278	267	272	274	298	311	291	286	279	260	241	204
50 and over taking heroin*	—	26	27	24	22	20	22	16	20	24	20	46	40
Age unknown taking heroin*	—	34	16	7	16	8	7	10	14	7	82	40	25
Age unknown taking heroin*	—	—	—	—	—	—	—	—	—	1	43	26	13
<b>SEX</b>													
No. of male addicts	197	196	195	223	262	339	409	558	886	1262	2161	2295	1067
No. of female addicts	245	258	242	247	270	296	344	369	463	467	621	586	399
<b>PROFESSIONAL CLASSES</b> (Medical or Allied)													
<b>TOTAL NUMBER</b>	74	68	63	61	57	56	58	45	54	56	43	43	26

NB 1. It will be seen that the statistical data from 1969 is presented differently from the preceding years. Previously these statistics had been based on the total number of addicts coming to the notice of the Home Office during the course of the year. New recording procedures have made it possible to give details of those addicts known to have been receiving supplies of drugs at the end of the year as well as the total number of cases coming to notice during the year.

2. † These figures refer to drugs used alone or in combination with other drugs. Thus an addict using both heroin and cocaine will be included under both drugs, and it must be pointed out that the majority of the cocaine addicts shown are also using heroin.
3. • From 1969 this figure is for addicts to *heroin and/or methadone*. The reason for this is that as a result of a deliberate policy adopted by hospital clinics in the treatment of heroin addiction by weaning patients from heroin on to methadone, methadone has supplanted heroin as the drug most commonly used by addicts.

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APPENDIX B

DRUG ADDICTS	1970		1971		1972		1973	
	Year Total	As at 31.12.70	Year Total	As at 31.12.71	Year Total	As at 31.12.72	Year Total	As at 31.12.73
TOTAL NUMBER	2661	1430	2769	1555	2944	1619	3025	1818
DRUGS†								
No. taking heroin	914	437	959	385	868	339	866	380
No. taking methadone	1820	992	1927	1160	2171	1280	2247	1440
No. taking cocaine	198	57	178	58	178	46	194	51
No. taking morphine	346	105	346	103	292	90	268	84
No. taking pethidine	122	80	135	73	98	59	81	50
ORIGIN								
No. of therapeutic origin	295	231	265	218	244	180	207	174
No. of non-therapeutic origin	2321	1177	2457	1313	2659	1413	2631	1505
No. of unknown origin	45	22	47	24	41	26	187	139
AGES								
Under 20	405	142	338	118	279	96	253	84
Under 20 taking heroin*	365	136	304	111	260	95	226	83
20-34	1813	959	2010	1123	2262	1221	2368	1415
20-34 taking heroin*	1705	921	1912	1088	2178	1195	2262	1375
35-49	158	112	156	112	178	120	185	137
35-49 taking heroin*	95	69	94	73	126	87	129	95
50 and over	253	195	226	179	204	165	214	181
50 and over taking heroin*	50	39	47	35	42	36	49	42
Age unknown	32	22	39	23	21	17	5	1
Age unknown taking heroin*	18	10	19	9	7	5	3	1
SEX								
No. of male addicts	2071	1053	2134	1135	2272	1197	2345	1371
No. of female addicts	590	377	635	420	672	422	680	447
PROFESSIONAL CLASSES (Medical or Allied)								
Total Number	38	26	44	22	33	23	29	15

**APPENDIX C****AGES OF "UNDER 20" ADDICTS KNOWN  
TO HOME OFFICE**

	14	15	16	17	18	19	Total
1960	—	—	—	—	—	1	1
1961	—	—	—	—	1	1	2
1962	—	—	1	—	—	2	3
1963	—	—	2	2	2	11	17
1964	1	—	1	8	11	19	40
1965	—	8	5	19	42	71	145
1966	1	17	26	68	111	106	329
1967	—	3	38	82	100	172	395
1968	—	10	40	141	274	299	764
1969 Total	—	—	24	83	218	312	637
31.12.69	—	—	6	33	73	112	224
1970 Total	—	1	9	49	117	229	405
31.12.70	—	1	1	18	30	92	142
1971 Total	—	—	10	45	114	169	338
31.12.71	—	—	2	13	34	69	118
1972 Total	1	1	7	27	85	158	279
31.12.72	—	—	3	13	24	56	96
1973 Total	—	—	7	39	78	129	253
31.12.73	—	—	2	9	24	49	84



**APPENDIX D**  
**OFFENCES INVOLVING DRUGS CONTROLLED**  
**UNDER:— DDA—1965**

	Cannabis	Opium	Manufactured Drugs	Drugs (Prevention of Misuse) Act 1964
1945	4	206	20	
1946	11	65	27	
1947	46	76	65	
1948	51	78	48	
1949	61	52	56	
1950	86	41	42	
1951	132	64	47	
1952	98	62	48	
1953	88	47	44	
1954	144	28	47	
1955	115	17	37	
1956	103	12	37	
1957	51	9	30	
1958	99	8	41	
1959	185	18	26	
1960	235	15	28	
1961	288	15	61	
1962	588	16	71	
1963	663	20	63	
1964	544	14	101	
1965	626	13	128	958*
1966	1119	36	242	1216
1967	2393	58	573	2486
1968	3071	73	1099	2957
1969	4683	53	1359	3762
1970	7520	66	1214	3885
1971	9219	55	1570	5516
1972	12611	98	2068	5284
1973	14119	244†	8497**	

From 1945 to 1953 inclusive the figures relate to prosecutions.

From 1954 onwards the figures relate to convictions.

\* This figure is in respect of the period 31 October 1964 to 31 December 1965.

† Includes Medicinal Opium.

\*\* Includes offences under the Dangerous Drugs Act 1965, the Drugs (Prevention of Misuse) Act 1964 and the Misuse of Drugs Act 1971 which came into force on 1 July 1973 and which repealed the 1965 and 1964 Acts.