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DRUG ADDICTION

Note by the Secretary-General

Introduction

1. The Commission on Narcotic Drugs at its eighth session[1/] decided to give a higher priority to the subject of Drug Addiction and placed it third on its list of priorities. This summary of the background and current status of the international aspects of the problem of drug addiction has been prepared for the use of the Commission when it discusses this item at its ninth session.

2. In the wide sense the purpose of the nine existing international treaties[2/]

1/ E/2423, para. 28, p. 3.

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1. International Opium Convention signed at The Hague, 23 January 1912.
2. Agreement concerning the Manufacture of Internal Trade in and Use of Prepared Opium, signed at Geneva, 11 February 1925 (referred to in this paper as "1925 Agreement").
3. International Opium Convention, signed at Geneva, 19 February 1925 (referred to in this paper as "1925 Convention").
4. International Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, signed at Geneva, 13 July 1931 (referred to in this paper as "1931 Convention").
5. Agreement for the Control of Opium-Smoking in the Far East, signed at Bangkok, 27 November 1931 (referred to in this paper as "1931 Agreement").
6. The Convention of 1936 for the Suppression of the Illicit Traffic in Dangerous Drugs.
7. Protocol of 1946 amending the Agreements, Conventions and Protocols on Narcotic Drugs, concluded at The Hague on 23.I.1912; at Geneva on 11.II.1925 and 19.II.1925 and 13.VII.1931; at Bangkok on 27.XI.1931, and at Geneva on 26.VI.1936.
8. Protocol, signed at Paris on 19 November 1948, bringing under international control drugs outside the scope of the Convention of 13 July 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success on 11 December 1946.
9. Protocol, signed at New York, 23 June 1953, for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of Opium.

concerning the control of narcotic drugs is the reduction and progressive elimination of drug addiction. The treaties[3/] are, however, essentially concerned with control (or preventive) measures, measures to prevent narcotics getting into the hands of persons illegally. Limitation of narcotic drugs to the world's need for medical and scientific purposes is thus the basic principle of the present international control system. With this in view, the treaties include, on the one hand, measures for limiting and controlling the production of raw materials and the manufacture of and trade in narcotic drugs; on the other, for a constant surveillance of the illicit traffic and of the national measures to combat it. The questions envisaged in the Commission's decision at its eighth session are not these measures but the subjective aspects of the problem of drug addiction - measures with regard to the identification, treatment, rehabilitation of drug addicts, the underlying causes of drug addiction, and the role of scientific research as well as of education and propaganda.

International Provisions

3. The suppression of opium smoking in the Far East was the major goal of the two opium conferences which met in Geneva in 1924/25 and in Bangkok in 1931. Several provisions in the treaties, and recommendations adopted by the conferences are specifically directed at the treatment and control of opium smokers, and deal with aspects of the problem including instruction in schools and propaganda to discourage opium smoking; information as to the number of smokers; registration of smokers; prohibition of minors from smoking; proselytism; extension of health services; encouragement of treatment and after-care of smokers; research on the effects of opium smoking on smokers and methods of cure; the preparation of annual reports giving information pertaining to the problem.[4/]

4. Apart from the provisions regarding opium smoking referred to above, the 1931 Convention is the only treaty containing a provision relating to drug addiction which seems to suggest another approach to the problem than that of control.

3/ See paragraph 3 below as regards opium smoking.

4/ 1925 Agreement. Articles II, VII, X.
1931 Agreement. Article II. Final Act of the Conference of Bangkok. Recommendations IV, VIII, IX, X, XI.

Article 15 of the 1931 Convention reads:

"The High Contracting Parties shall take all necessary legislative or other measures in order to give effect within their territories to the provisions of this Convention.

"The High Contracting Parties shall, if they have not already done so, create a special administration for the purpose of:

.....

"(c) Organizing the campaign against drug addiction, by taking all useful steps to prevent its development and to suppress the illicit traffic." 5/

In this Convention Governments thus undertook an express obligation regarding drug addiction; the "control" (or preventive) approach was however predominant.

The scope of international activities undertaken by directive of the international organs however was wider than the references in the Conventions.

Work of the International Organizations

League of Nations

5. In undertaking its studies and in planning its programme to combat drug addiction, the Assembly and Council of the League of Nations were aided and advised by both the Opium Advisory Committee and the Health Committee. The work of these bodies in so far as it related to drug addiction was summarized for the Commission on Narcotic Drugs at its first session, 6/ but may be briefly recalled.

In 1930 the Opium Advisory Committee was requested by the General Assembly of the League: 7/

"To study and report to the Council upon the question whether Governments should be asked to indicate, as far as it is possible for them to do so, either in their annual reports or by means of an answer to a special questionnaire, the approximate number of persons in their

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5/ See also Recommendation X of the Final Act of the 1931 Convention.

6/ E/C.S.7/26.

7/ League of Nations Official Journal. Special Supplement No. 83, p.45.

country addicted to each type of drug, the approximate amounts of such drugs consumed, and the method of treatment employed."

The Opium Advisory Committee, at its fourteenth session in 1931,[8] decided to consult both the Health Committee and Governments which were asked to provide as far as possible all the information which they had on the subject.[9]

At its nineteenth session in 1934, the Opium Advisory Committee approved the form of Annual Reports from Governments required under article 21 of the 1931 Convention. Section II, 2 of this form requested "Any available information as to new developments regarding addiction in the country".[10]

6. At its twentieth session in 1935, the Opium Advisory Committee requested the Secretariat to prepare a study giving all the statistical information on drug addiction in the different countries which was at its disposal. As a result of this study, the Committee, at its twenty-first session, decided to send a questionnaire to governments[11] with a request to supply for a few years, as from January 1937, annual information on the extent of drug addiction, treatment and categories of drug addicts in their countries.

7. At its twenty-fourth session (1939),[12] the Opium Advisory Committee instructed the Secretariat, inter alia, "To carry out a comparative study of the legal and practical standpoint taken at present in the various countries regarding drug addiction and the addict, such study to include both addiction to manufactured drugs and addiction to prepared opium."

A draft questionnaire on the attitude of Governments de jure and de facto with regard to drug addiction and addicts was considered by the Opium Advisory Committee at its twenty-fifth session (1940) but was not circulated to Governments at that time.[13]

8/ C.168(a).M.62(a).1931.XI.

9/ (a) Circular letter CL.294.131.XI of 23 November 1931.
(b) Replies from Governments CC 1408 (1) (Oct.1953).

10/ C.530.M.241.1943.XI.Annex 3. (C.C.1600).

11/ See Annex 1.

12/ C.262.M.13.1939.

13/ Annex II.

8. The Health Committee at its seventeenth session (1931)[14] decided to study methods of treatment of drug addicts and considered appointing a committee on the subject. However, at its twentieth session (1932),[15] after considering the documentation and advice of experts, the Committee concluded that the documentation gave an adequate account of the direct treatment of addicts, except for opium smokers, which problem was of special importance to the Far East, but that methods of treatment recommended for western countries were not always appropriate to the Far East; the Committee, therefore, proposed further study of the problem and the treatment of opium smokers and decided to establish a scheme of work in collaboration with the Opium Advisory Committee before appointing the committee suggested at its seventeenth session.

9. The International Labour Organisation also made enquiries and conducted a series of studies concerning conditions affecting the opium smoker as a worker.[16]

10. The Opium Advisory Committee during this period frequently considered the advantages and disadvantages of education and propaganda concerning the abuse of narcotic drugs.

As early as its second session[17] the Opium Advisory Committee recommended that in order to facilitate the general control of the traffic in dangerous drugs ... Governments should consider the advisability of undertaking educational work as to the dangers of indulgence in drugs...

The Assembly of the League in 1925 [18] also debated the advisability of propaganda campaigns to ... "acquaint the masses with the terrible consequences resulting from the use of dangerous drugs and thereby to restrict the consumption of such drugs"...

14/ C.398.M.160.1931, p.38.

15/ C.652.M.312.1932, p.7.

16/ Opium and the Worker, Studies and Reports, Series B, Social and Economic Conditions, No.22.

17/ O.C.47/1.

18/ League of Nations. Official Journal. Special Supplement 38, Fifth Committee p.167.

The Health Committee and the Opium Advisory Committee, at that time believed ... that such propaganda could only usefully be directed to the medical profession, pharmacists, nurses, etc., and might do more harm than good if used generally ...

Ten years later in 1935, the question of education and propaganda was fully debated by the Fifth Committee of the Assembly[19] at its sixteenth session, and several Governments furnished information on the steps taken and progress made by using these measures in their countries or territories. The Fifth Committee, in its report to the Assembly, was convinced of the urgency of measures of this kind being taken ... and requested the Advisory Committee to try and outline a constructive plan for organizing on an international basis ... the campaign of education and propaganda against the abuse of narcotic drugs ... Governments were asked to furnish information as to measures already taken and experience gained as to their effectiveness ...

After studying the information supplied by Governments[20] the Opium Advisory Committee at its twenty-first session in 1936, again decided that propaganda should only be practiced in certain countries where addiction was a substantial problem. In other countries, it was felt that it would be dangerous, but the Opium Advisory Committee continued to believe in the usefulness of propaganda among the medical and allied professions.

United Nations

11. The Commission on Narcotic Drugs of the United Nations, when it held its first session in 1946, considered the various aspects of drug addiction, including the new problem arising from the development of synthetic narcotic drugs liable to produce addiction, and decided to send out the questionnaire mentioned in paragraph 7 above, which had been prepared by the League[21]. At its third session in May 1948 the Commission considered an analysis of the replies received from governments to this questionnaire,[22] and in connexion

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19/ League of Nations. Official Journal. Special Supplement 142, pp. 37-45.

20/ O.C.1642.

21/ Annex II.

22/ E/CN.7/111 and Adds. 1,2,3,4.

with it the Secretariat was requested to "analyse and classify the replies according to the various subjects treated in the questionnaire[23]. At its fourth session[24] the Commission considered the analysis prepared by the Secretariat[25] and requested it to "begin work on an analytical study of the laws and regulations relating to drug addiction". At this session, the Commission also requested the Expert Committee on Drugs Liable to Produce Addiction of the World Health Organization to furnish it with certain definitions of terms connected with drug addiction. In addition it adopted a revised form for drug addiction for Chapter II of the Annual Reports.[26]

12. At its fifth session, the Commission discussed the definitions submitted by the Expert Committee and took note of them (See paragraph 21 below).

13. At its sixth session, the Commission discussed the question of education and propaganda in connexion with drug addiction and approved a draft resolution[27] by which the Economic and Social Council would reaffirm the principle adopted by the Advisory Committee of the League[28] on the value of education and propaganda. The Economic and Social Council at its thirteenth session decided to take no action on this resolution.

14. Section 41 of the Draft Single Convention, entitled "Cure of the Drug Habit",[29] reads as follows:

> "Parties undertake to use their best endeavours to limit the use of drugs for the cure of the drug habit to treatment in closed (licensed) (State) institutions."

23/ E/799, para. 14, p.16.

24/ E/1361 (9), p. 19.

25/ E/CN.7/166.

26/ E/CN.7/173.

27/ E/1998, Annex A, p. 23, E/CN.7/SR.146-147.

28/ Paragraph 10 above.

29/ The Expert Committee on Drugs Liable to Produce Addiction of the World Health Organization has proposed that the term "Drug Addiction" and not "Drug Habit" be used to describe this phenomenon.

19. At its fourth session, the Committee took note "of the lack everywhere of any adequate means of ascertaining the incidence of addiction, including that arising from the legitimate medical use of potentially addicting drugs. The Committee again recommended that governments be urged to consider the desirability of setting up, or adding to, facilities for investigating the various aspects of drug addiction, particularly because of the rapidly accumulating number of synthetic substances with morphine-like effect."[39/]

20. In recommending the establishment of an Expert Committee on Mental Health, the World Health Assembly[40/] recommended that this subject should include alcoholism and drug addiction as well as mental health proper.

At its first session in 1949[41/] the Mental Health Committee considered the part it should play in the problems of the prevention and treatment of drug addiction, including alcoholism. The Committee believed that economic social and cultural factors played an important role in the epidemiology of drug addiction and that there was room for a specialist group to make recommendations for a programme which would be integrated into the general mental health programme of the World Health Organization. It recommended the establishment of two expert sub-committees: one on drug addiction and one on alcoholism to work closely together. This proposal was adopted by the Executive Board at its fifth session in 1950. The Committee also felt that control measures (i.e. as referred to in paragraph 2) might not, in the future, suffice to check drug addiction and that the problem should also be regarded from the view point of "preventive medical" measures. The sub-committee on alcoholism has held two meetings[42/] the sub-committee on drug addiction, however, has not yet been convened.

39/ WHO/ADD/44.

40/ Off. records of WHO 13 309.

41/ WHO Technical Report Series No. 9.

42/ WHO Technical Report Series Nos. 42 and 48.

At its eighth session the Executive Board of the World Health Organization[43] after considering the report of the first session of the sub-committee on alcoholism of the Expert Committee on Mental Health, authorized the holding of a meeting of the Expert Committee on Drugs Liable to Produce Addiction to be devoted to the problems of alcohol. This meeting was held in October 1953 as an Expert Committee on Alcohol, concerned with the physiological pharmacological and biochemical properties of alcohol.[44]

Definition of drug addiction

21. No definition of drug addiction is contained in the nine international treaties concerning narcotic drugs, although it is referred to in different terms in various articles and provisions of the treaties.[45] Definitions of drug addiction or drug addict are, however, given in some national laws.[46]

The clinical description of drug addiction, that is evidence of tolerance, dependence and habituation[47] is often used in medical literature but will not serve the purposes of a definition in the international control of drugs. Some drugs which governments have considered it desirable and feasible to place under control and which are accordingly controlled under the present conventions do not give rise to all the conditions mentioned above. Cocaine,[48] for instance, is not generally held to produce a true abstinence syndrome and

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43/ EBS/R/45.

44/ WHO/APD/ALC/8 and Corr. I.

45/ Article 14 d of the 1912 Convention; Articles 8 and 10 of the 1925 Convention; Articles 11, 15 of the 1931 Convention; Article I of the 1948 Protocol.

46/ i.e. Germany, Turkey, USA (California State Law).

47/ Tolerance : the need to increase the dose to obtain the same effect.
Dependence : abstinence symptoms, i.e. physiological changes which ensue if the drug is withheld.
Habituation: the necessity of taking the drug in order to experience euphoria, i.e. an emotional and psychologic dependence.
Vogel, Isbell and Chapman, Journal of American Medical Association 138, No. 14, 1948.

48/ G.H. Josie, Report of drug addiction in Canada, 1948.
Goodman and Gilman, Pharmacological basis of Therapeutics, 1941, New York, p. 295.

marihuana[49] does not generally lead to pharmacological dependence or tolerance, whereas other drugs and substances which at present are not considered suitable by Governments for international control may fulfil all three conditions of tolerance, dependence and habituation.[50]

22. The Commission on Narcotic Drugs at its fourth session,[51] in discussing the definition of "drug addiction" in connexion with the proposed single Convention decided to request the Expert Committee on Drugs Liable to Produce Addiction of the World Health Organization to furnish it with such a definition.

The Expert Committee, in the report of its second session, submitted the following definitions:[52]

1. "Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic).

   "Its characteristics include:

   (1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;

   (2) a tendency to increase the dose;

   (3) a psychic (psychological) and sometimes a physical dependence on the effects of the drug.

   "An addiction-producing drug is one which produces addiction as defined."

49/ Goodman and Gilman, Pharmacological basis of Therapeutics, 1941, New York, pp. 184 and 295.
P.O. Wolff, Marihuana in Latin America, 1949. The threat it constitutes, p.46.

50/ Harris Isbell, Medical Clinics of America, March 1950.
Harris Isbell and Walter White, American Journal of Medicine, Vol. XIV, No. 5, 1953.
P.O. Wolff, British Journal of Addiction, 1953, Vol. 50, No. 1
Journal Suisse de Médecine, No. 39, 1953.
Maurer and Vogel, Narcotics and Narcotic Addiction, 1954, Springfield, Ill. Chapter III.

51/ E/1361, Annex B (8).

52/ WHO Technical Report Series No. 21 (6).

2. "A habit-forming drug is one which is or may be taken repeatedly without the production of all of the characteristics outlined in the definition of addiction and which is not generally considered to be detrimental to the individual and to society."[53/]

At its sixth session, the Commission heard a further explanation from the representative of the World Health Organization as to why the Expert Committee had proposed separate definitions for addiction-producing drugs - i.e. for those to be placed under international control and for habit-forming drugs.[54/]

23. The Commission has not, as yet, taken a decision as to how the question of definition should be dealt with for the purposes of the proposed single Convention.

Scope of International Work

24. While national authorities and organizations at or below the national level are concerned with a wide range of activities on drug addiction, counterpart international activities have been relatively limited in scope.

25. The Commission will no doubt wish to review what topics or problems in the field are of international concern; whether it is feasible and desirable to tackle them by international action; and if so, what kind of action would be appropriate, and by what organs it should be carried out. It is understood that topics so selected that were appropriate to the work of the World Health Organization or another specialized agency would be referred to that agency. Between such topics as might be selected for attention at the international level and those which it may be regarded as unsuitable or unprofitable at the present time to project from the national on to the international level, there

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53/ Report of the Fifth Session (E/1889/Rev.1) paragraph 189 which reads: "The Commission refrained from taking a final decision on the subject, considering it desirable that the problem should be further studied. It, however, decided to take note, with appreciation, of the work done on drug addiction at its request by the Expert Committee of the World Health Organization on Drugs Liable to Produce Addiction."

54/ E/CN.7/SR.123.

may be some intermediate cases where, while international work is not undertaken, it may be considered useful to invite or encourage Governments to make available or organize their knowledge for the benefit of others.[55/] Finally, there is the question of the relative priority of such topics as might be selected for international attention, since the available resources are limited.

26. A primary difficulty in considering the questions in the previous paragraph is the lack of adequate, up-to-date and comparable information regarding the extent of addiction. Under the provisions of the 1931 Convention, some statistical information is provided in Chapter II of the Annual Reports of Governments, but the figures are rarely exhaustive and are often not comparable. The reporting of addicts to national authorities, if done at all, is done by different ways in different countries. There is also the question of undiscovered addicts whose number can only be partially estimated on the basis of such factors as the volume of seizures and the number of convictions for narcotics offenses.

27. Again, the character of drug addiction, although it may arise from basically the same reasons, differs in different regions of the world. The problems may be either those of countries where under-developed economic and social conditions do not provide adequate living standards, or of countries where a highly developed civilization subjects its people to emotional stresses.[56/]

The particular effects of the drugs available in different regions are associated with elements in the pattern that may be variously assessed. The suppression of certain forms of addiction such as opium-smoking or the abuse of cannabis may open the way to a greater abuse of "white drugs". In certain countries custom permits certain practices, for instance coca leaf chewing, whereas in other countries they would be socially unacceptable.

55/ Addiction to euphoric drugs in Denmark, by Palle Wiingaard, Skanderborg (Communication from the State Board of Health).
Communication to the Secretary-General by the Danish Government in connexion with the Annual Reports for 1952.

56/ See also third report, Mental Health Committee, WHO Technical Report Series No. 73.

28. Again, there is wide lack of agreement regarding the basic causes of addiction, and the ways in which they operate. Much research remains to be done both on the therapeutic side - medical, biological, pharmacological, psychological - and also on the place and meaning of drug addiction in the context of wider social problems such as juvenile delinquency, criminality, and various forms of unsatisfactory living conditions. Until there is more complete knowledge of the basic causes, it is likely to be difficult to reach a generally accepted viewpoint regarding prevention and treatment.

29. While lack of agreement on basic causes does not and should not preclude improvements being made in the situation, it makes the necessary steps more difficult to plan, and imposes an approach on empirical lines. The Commission may accordingly find it helpful to consider the following list of topics, which have emerged from current review of annual reports and national legislation as well as other material on the subject, to which the questions set out in paragraph 25 above may be applied.

I. Statistical Information

A. Classification of addicts such as: types of classification: sex, age; social and economic status; health status; occupation, urban or rural residence status; geographical situation (altitude and climate, etc.); race or nationality; background of criminal or social behaviour; addicts using also alcohol, barbiturates, etc.

B. Reporting of addicts: Methods of reporting: (a) by officials; (b) by doctors, nurses, pharmacists, clergy, social workers; obligatory or voluntary reporting; collection and examination of narcotics prescriptions by appropriate authorities; registration of addicts (central or other registers).

II. Treatment of Addicts

A. Compulsory or voluntary

Compulsory treatment: Scope: addicts, recidivists, criminal offenders (selected groups), addicts endangering welfare of family or capacity to fulfil civil obligations (national service), juveniles (age limit); Initiation of treatment by: family, guardians, public health authority, school authority, social agencies, police authority, public prosecutor, other law enforcement officers, others.

B. Institutional or Non-Institutional Treatment

Institutional: closed or otherwise, public or licensed private, general or special ward (mental or specifically for addicts), prisons;

Non-Institutional: out-patient departments, private and public health doctors.

C. Degree and character of control of public authorities over use of narcotic drugs in treatment and dosage.

D. Committing authority: court, other public authority, parent, guardian, others.

E. Methods to be used to enforce compulsory treatment.

F. Methods of medical treatment.

III. After Care and Rehabilitation

Compulsory or voluntary - psychiatric, vocational guidance and training for juvenile addicts, occupational therapy, group therapy after leaving institutional care, follow up and supervision of rehabilitated addicts (by parole officers, social workers, religious groups, teachers).

IV. Question of the cost of treatment after care, and rehabilitation

V. Treatment of Addicts in Penal Law

A. Penalties for the unauthorized use of narcotic drugs as such under certain circumstances.

B. Penal provisions intended to enforce compulsory treatment and after care.

C. Application of system of parole and suspended sentences to drug addicts.

D. Treatment of addicted prisoners, isolation, cure, and after care.

E. Proselytism.

F. Crimes or offenses committed by persons intoxicated by narcotic drugs.

VI. Education and Propaganda

A. Question of conditions under which education and propaganda can be useful in combatting drug addiction.

B. Education and propaganda directed to members of the medical and allied professions in order (i) to inform them of the problems involved, (ii) the part they are expected to play.

Methods of obtaining Information

30. In order to obtain the material and data to undertake the study of any of the topics outlined above which might be selected, the following methods could be considered:

(a) Questionnaire to all countries, or to a selected group of countries most likely to be able to supply such information. This might be done as part of the revision of the form of Annual Reports.

(b) Requests to individual countries to supplement already available information.

(c) System of national correspondents. This method of gathering information has been used successfully by the United Nations Secretariat in the fields of Prevention of Crime and Treatment of Offenders and in Social Welfare. An appropriate person is appointed by the government to act as national correspondent, and as such, acts as a focus for gathering all information in the field, transmitting it to the Secretariat. Regional meetings have been arranged to discuss common problems.

(d) Arrangements with government administrations and research centres to evaluate conditions and methods employed.

Possible Methods of Action on the International Level

31. These may include measures such as: discussion, on the international level, of certain national or regional problems; exchange of available information on the subject; organization and co-ordination of research; recommendations, such as model laws and regulations; minimum standards under appropriate provisions in international treaties.

O.C.1657

ANNEX I

Text of questionnaire circulated by the League of Nations

"From January 1937,[1] Governments are requested to supply the Secretary-General of the League of Nations annually with information on the following points;

I. Extent of Addiction

1. Approximate number of addicts in the country.[2]

2. Number of addicts who obtain their supply:

(a) from legitimate sources,

(b) from illicit sources.

3. Methods employed to ascertain the approximate number of addicts in the country.

II. Establishments for the Treatment of Addicts.

Number and nature of public establishments for the treatment of addicts.

III. Addiction and the Professions.

1. Total number of:

(a) doctors

(b) dentists

(c) pharmacists

(d) veterinary surgeons

2. The number of known addicts in each of the above classes.

3. The number of each of the above classes convicted of violation of the narcotic laws."

1/ Any Government in possession of information in respect of the period 1930-1936, or any part of it, is requested to include such information in its reply.

2/ Including opium-smokers, whether smoking Monopoly opium or obtaining supplies of prepared opium illicitly.

ANNEX II

Text of questionnaire circulated by the United Nations

QUESTIONNAIRE REGARDING LEGAL AND PRACTICAL STANDPOINT TAKEN UP REGARDING DRUG ADDICTION AND DRUG ADDICTS
E/CN.7/166, 30 April 1949

(Manufactured-Drug Addiction[1/])

(The answers to the following Questionnaire should be followed, where appropriate, by references to the relevant laws).

1. (a) Is non-medical consumption of manufactured drugs punishable by law as such, or is it punishable only in certain circumstances, and if so, in which?

   (b) Is the fact of habitual recourse to manufactured drugs, or the fact of addiction, punishable by law?

   (c) How are drug addiction and the drug addict defined in the laws or in the various administrative regulations? Are addicts classed as sick or vicious persons or as delinquents, etc.? (The penalties, if any, which are applicable under (a) and (b) above should be mentioned).

2. Is non-medical and public consumption of manufactured drugs or the inducing of others to consume such drugs a punishable offence? (State the penalties, if any).

3. Are the various acts covered by the generic term "illicit traffic in narcotic drugs" held to be aggravated if committed under the influence of a pathological condition induced by the consumption of narcotics?

4. Does the drug addict come within the scope of preventive, administrative, or judicial measures of various kinds such as:

   (a) Registration by the public health or administrative authorities? (Describe the organization and purpose of the registration system).

1/ The term "Manufactured drugs" should be understood to mean drugs, preparations, and specialties falling within the scope of the international Conventions on narcotic drugs.

(b) Compulsory institutional internment?
(Is this merely a measure of security - i.e. internment designed to effect the segregation of drug addicts, or is it internment for purposes of cure and rehabilitation? Where the latter type of system exists, a description should be given.)

(c) Compulsory or voluntary treatment?
(Describe the organization of the administrative system for compulsory, voluntary, home, institutional, or out-patient (ambulatory) treatment.)

(d) Supervision by the police authorities, local banishment, or other similar subsidiary penalties.

5. Are doctors entitled to treat drug addicts with narcotic drugs?

6. What limits are set to the treatment of a drug addict by a doctor?

(a) Are doctors compelled to make addicts take a course of disintoxication treatment, and is the patient allowed to be treated at home or must he enter a closed institution?

(b) Has the doctor discretionary powers in prescribing drugs for his addict patient, or is he obliged to prescribe doses decreasing to the point of complete withdrawal?

(c) Is the doctor obliged to notify any public health or administrative authority of each case of addiction he is called upon to treat?

(d) Give particulars of any other measures which are compulsory for doctors treating addicts.

7. What are the rights and responsibilities of doctors as regards the treatment of sick persons with narcotic drugs?[2/]
Is the administration of sedatives (manufactured drugs) to patients suffering from painful diseases of various kinds or subjected to operative procedures left to the discretion of the attending physician, or does the law on the

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2/ Excluded from the category of drug addicts are persons suffering from any medical condition (not including withdrawal symptoms) which is medically recognized as calling for treatment by the administration of narcotic drugs. This question has therefore not been put for the purpose of studying cases of narcotic-treated severe chronic diseases as such, but merely in order to gain an idea of the amount of latitude which is left to the medical practitioner in administering narcotic drugs, since many cases of chronic addiction may develop as a result of some acute disease in which narcotic drugs had to be administered.

practice of medicine set limits and enforce supervision, in such a way that certain maximum doses cannot be exceeded, that prescriptions must be renewed, that the administration of high doses is subject to administrative approval; or are any other methods of supervision applied which limit the discretionary powers of medical practitioners?

It should, in particular, be stated whether the doctor is entitled to keep a supply of narcotic drugs in his own consulting rooms, and what measures of supervision are applied to him.
