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LAWS AND REGULATIONS

PROMULGATED TO GIVE EFFECT TO THE PROVISIONS OF THE CONVENTION OF 13 JULY 1931 FOR LIMITING THE MANUFACTURE AND REGULATING THE DISTRIBUTION OF NARCOTIC DRUGS, AS AMENDED BY THE PROTOCOL OF 11 DECEMBER 1946

NORWAY

Communicated by the Government of Norway

NOTE BY THE SECRETARY-GENERAL -- In accordance with Article 21 of the Convention of 13 July 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol of 11 December 1946, the Secretary-General has the honour to communicate the following legislative texts.

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E/NL.1960/130

Circular letter No. 8771/59, I.2. Ministry of Social Affairs

AMENDMENTS TO THE ACT OF 26 FEBRUARY 1932 RESPECTING TEMPERANCE COMMITTEES AND THE TREATMENT OF INEBRIATES AND DRUG ADDICTS[1]

Committal of drug addicts to hospitals, etc.

In its circular letter of 26 May 1959, the Ministry provided information on the amendments to the Act which are applicable to inebriates.

As was explained in that circular letter, the Act, as amended, also relates to persons who make excessive use of intoxicating or narcotic substances other than alcohol, viz., drug addicts.

Under the Act the provisions applicable to inebriates also apply to drug addicts, but drug addicts may, in addition, be compulsorily committed to a hospital for a period of not more than two years.

Under the Act, therefore, the following measures may be taken in the case of drug addicts:

1. The temperance committee may seek to induce a drug addict to apply for admission to a hospital or sanatorium voluntarily. Cf. article 5 of the Act.

2. In accordance with the provisions of article 8, the committee may order a drug addict to go to a hospital designated by it for a period not to exceed thirty days, and the committee may also order continued hospitalization. Cf. article 6a.

1/ Note by the Secretariat: This law as amended in 1957 has been published under the symbol E/NL.1960/96

3. The committee may decide to commit a drug addict to a sanatorium or hospital for a maximum period of two years. Cf. article 7.

The Act thus provides that a drug addict may also be committed to a sanatorium, on either a voluntary or a compulsory basis. Drug addiction, however, raises such special problems that, as a rule, it cannot be treated in the existing sanatoria, which are intended for inebriates. The following remarks made by the Director of Public Health are relevant:

> "The best solution will undoubtedly be the establishment of a special institution for the treatment of drug addicts. At the very least, this institution should have a closed and an open section for men and similar but smaller sections for women. The whole institution (hospital or clinic) should be properly isolated from its surroundings.
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> "The Director of Public Health considers that the Act cannot be fully effective until such an institution has been established."

The Ministry of Social Affairs is attempting to find a place suitable for the treatment of drug addicts. It is expected that such an institution can be established before long. The Director of Public Health considers that the compulsory committal of drug addicts for a period not to exceed two years, as provided in article 7, should be to such an institution only, and thus not to an ordinary sanatorium for inebriates or to a hospital. At present, therefore, drug addicts may only be compulsorily committed to a hospital under article 6a or voluntarily committed to a hospital. Only in exceptional cases may drug addicts be committed to a sanatorium for inebriates.

Voluntary committal to a hospital

All ordinary hospitals are permitted to accept drug addicts as voluntary patients.

In addition, the following psychiatric clinics may accept drug addicts applying for admission as voluntary patients, cf. Act No. 3 of 25 June 1935 concerning the admission of voluntary patients to sanatoria:

Gaustad Hospital, Vinderen, Oslo,
Eg Hospital, Kristiansand S.,
Rotvoll Hospital, Charlottenland St., Strinda,
Rønvik Hospital, Bodø,
Dikemark Hospital, Asker,
Blakstad Hospital, Asker,
Sanderud Hospital, Hjellum st. near Hamar,
Presteseter Hospital, Reinvoll st.,
Lier Institution, Lier,
Valen Hospital, Valen, Sunnhordland,
Neevengården Hospital, Bergen,
Opdøl Hospital, Hjelset near Molde,
Østmark Hospital, Trondheim,
Oslo Hospital, Ekebergveien 1, Oslo,
Dr. Dedichen's Private Clinic, Alnabru, Oslo.

Compulsory committal to a hospital under article 6a, cf. article 8

The Ministry has provisionally provided that drug addicts may be compulsorily committed to the following hospitals by virtue of the decision (order) of a temperance committee:

1. Psychiatric Clinic, Vinderen,
2. Diakonissehus Hospital, Lovisenberggaten, Oslo,
3. Central Hospital for Østfold, Fredrikstad,
4. Aust-Agder Central Hospital, Arendal,
5. Central Hospital, Kristiansand,
6. Kristiansand Medical Association Clinic for Nervous Disorders, Kristiansand (Kongsgård Sanatorium),

7. Stavanger Hospital, Stavanger,
8. Haugesund Hospital, Haugesund,
9. Ålesund County Hospital, Ålesund,
10. Central Hospital, Trondheim,
11. Troms and Tromsø Hospital, Tromsø,
12. Drammen Hospital, Drammen,
13. Haukeland Hospital (section A), Bergen,
14. Solli Sanatorium for Nervous Disorders, Nesttun near Bergen,
15. Lillehammer County Hospital, Lillehammer.

As regards both drug addicts and inebriates, a decision for compulsory committal to a hospital can be carried out only if the authority in charge of the hospital is prepared to admit the patient in the particular case concerned. Before the committee takes a decision, it must therefore make sure that the hospital will accept the patient. The hospital is also entitled to discharge a patient before the expiry of the thirty-day period or before the expiry of the period of continued hospitalization ordered by the committee (for not more than thirty days at a time).

Furthermore, a hospital cannot be required to keep a patient who refuses to continue his treatment at the hospital or who attempts to escape.

Hospitals should, of course, give advance notice to the temperance committees of all discharges in the case both of patients who have been admitted on a voluntary basis at the instance of a committee and of those who have been compulsorily committed under article 6a.

Cases of compulsory committal to a hospital under the new article 6a are dealt with in accordance with the provisions of article 8, and the decision on them must be in the form of an order. It is essential that a physician regard the committal as necessary. The committee decides on the hospital to which the patient is to be admitted. Under article 9, an appeal from the committee's order lies to the Supreme Court.

On the advice of the responsible hospital physician, the committee may order continued hospitalization for up to thirty days at a time. The total period of hospitalization ordered by the committee may not, however, exceed ninety days in any one year. Committee decisions imposing continued hospitalization are not subject to the provisions of article 8. Hence, in cases involving continued hospitalization, the committee's proceedings are not to be presided over by the competent district or town court judge as chairman. Likewise, no appeal from a decision on continued hospitalization lies to the Supreme Court, but the decision may be submitted to the Ministry for review. This must be done not later than three days after the person concerned has received notice of the decision. An appeal to the Ministry does not have suspensory effect.

With regard to expenses incurred in connexion with the hospitalization of a drug addict and family allowances during such hospitalization, the provisions of the circular letter of 26 May 1959 concerning the hospitalization of inebriates are applicable. Attention is drawn to the special circumstances that have been taken into account in the case of expenses connected with voluntary hospitalization in psychiatric clinics (institutions).

Instructions regarding drug addiction and the treatment of drug addicts

As a means of aiding the temperance committees, the chief medical officer for the care of inebriates has issued the following instructions:

1. Drug addiction is a generic term for a number of conditions which are characterized by the fact that a patient takes one or several toxic substances in order to achieve a change in his mental condition and that he becomes dependent on such substances. The change in mental condition that is sought is of different kinds. Some patients use the substance to achieve a state of exhilaration (euphoria), others to obtain a measure of relief from nervous tension or anxiety, and still others to achieve relatively brief periods of complete or partial loss of consciousness. It will be readily understood that there is no sharp dividing line between

alcoholism and drug addiction, and it may well be argued that alcoholism is a form of drug addiction in which the patient uses alcohol only.

Drug addicts will also come to depend on the toxic substance physically, so that an interruption of supply will lead to a number of unpleasant and in some cases dangerous withdrawl symptoms.

2. The expression "narcotic drugs" is a generic term for the toxic substances used by drug addicts. Most of these substances are used by physicians in the treatment of illness, and most people come into contact with narcotic drugs sooner or later as a result of illness. A single course of treatment with doses prescribed by a physician will as a rule not entail any danger of addiction, unless there is a strong predisposition to it. The most common narcotic drugs are the following:

A. The opium group. This is a generic term for the toxic substances found in ordinary opium tincture (opium drops) and for substances closely related to these. Some drug addicts use opium in the form of drops, but most of them use pure preparations which are designated by their ordinary medical names. Cover names for the various substances do not appear to be used on a wide scale. The substances most frequently used by addicts in the opium group are: morphine, thebaicin, ketogan, pethidine[2] and methadone. These substances are employed by physicians as analgesics. Drug addicts use them primarily to achieve a carefree mood of exhilaration for a brief spell, but to such an extent as to lose consciousness or considerably reduce consciousness for a period of varying length. These substances are mainly taken as drops or by injection, but the use of pills is also fairly common.

Codeine is primarily a cough remedy, but it is also often used by drug addicts as it produces a feeling of relaxation, or in larger doses strongly reduced consciousness. The most common preparation is nyodid [hydrocodone bitartrate][3] but dicodid [hydrocodone] is also used. Codeine is generally taken in the form of pills.

Heroin [diacetylmorphine] is a substance that is somewhat related to the morphine group as regards its effects, viz., mainly exhilaration and relaxation. It is widely used by addicts in North America but has so far not been used to any great extent in Norway.

B. Soporifics group. Virtually all soporifics can be and are abused, but those of the barbituric acid type are the most popular. Various substances are used against insomnia, some acting more rapidly, others more slowly.

In the case of alcoholics and others whose brain is habitually in a completely or partially toxic state, sleeping drugs frequently no longer produce sleep when taken in normal doses, but have a slightly stimulating and relaxing effect. Most persons abusing these drugs believe that in combination with some alcohol they obtain a pleasant intoxicating sensation with relatively few after-effects. In addition, it is cheaper to become intoxicated in this way than through the use of alcohol alone.

The most commonly used (or abused) sleeping drugs are amycol and allypropinal, and to a much lesser extent sovinal, veronal, seconal and phenemal. Sleeping drugs are often advertised as being harmless and this is true when they are taken in small doses and for the purpose for which they are intended. If however, they are used otherwise than as prescribed - as, for example, with alcohol or as a restorative after intoxication - they can very easily lead to abuse and addiction. Persons suddenly deprived of barbituric acid preparations often develop withdrawal symptoms and are liable to convulsive fits.

C. Amphetamine. This substance was long regarded as relatively harmless, but the experience of recent years has shown that it is often abused and that it leads to serious addiction in a brief space of time. Amphetamine, taken in small doses, has an immediate stimulating effect, and after ten to fifteen minutes it produces a certain feeling of

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2/ Note by the Secretariat: Proposed or recommended international non-proprietary names of drugs are underlined.

3/ Note by the Secretariat: The words in square brackets have been inserted by the Secretariat.

exhilaration accompanied by a heightened self-esteem and self-confidence. It is also accompanied by an impairment of the critical faculties to the extent of affecting the user's actions. Furthermore, most people are made somewhat nervous and restless by amphetamine, and this is particularly noticeable where larger doses are taken. As this restlessness causes discomfort, many users attempt to reduce it by simultaneously taking sleeping drugs, such as for example, amycal. For a time, a mixed preparation designated "Amycal comp." was produced, but this has now disappeared from the market.

Amphetamine has been sold under such trade names as mecodrine, benzedrine and benzafinyl, and has also been given such cover names as holiday tablets, examination pills and pep pills. Amphetamine is now occasionally prescribed as such by physicians in the case of lethargy and similar conditions. It is found in small amounts in the weight-reducing agent known as afatin, which has been abused by some patients who have taken large quantitites of as much as 100 doses a day. This preparation is therefore now issued on prescription only, in common with sleeping drugs and other amphetamine preparations.

D. Cocaine is a toxic substance of which there has been relatively little abuse in Norway, but considerable abuse elsewhere. It produces a feeling of excitement and gives great energy and thus acts as a stimulant to strong physical exertion for a short period. The effect is brief and addiction rapid, so that consumption quickly increases. Cocaine is generally used in the form of a powder which is taken like snuff through the nose, but solutions are also administered by injection. Cocaine is employed by physicians as a local anaesthetic, particularly in the throat and nose, but also in the eyes. There should be no need to prescribe cocaine for a patient's own use.

E. Other substances. Ether (naphtha) is sometimes used as an intoxicant and can be either drunk or inhaled. It is similar in effect to alcohol but acts much more rapidly. Physicians employ ether as an anaesthetic in operations.

Trichloroethylene ("tri") is a cleaning agent occasionally misused as an intoxicant. Addicts inhale the liquid substance from a rag or piece of waste which has been dipped into it. Its effect is similar to that of alcohol, but more rapid.

Meproban is a new drug which has been widely used as a tranquillizer. Experience, however, has shown that some patients begin to increase the dose on their own account and become addicted to the substance. A sudden deprivation of meproban leads to fairly violent withdrawal symptoms, often accompanied by epileptic fits.

Bromine was at one time widely employed as a tranquillizer by physicians but is now being increasingly abandoned. Cases of abuse rarely occur.

Paraldehyde has also been abused to some extent, particularly by alcoholics. This substance produces effects somewhat similar to alcohol. The same is true of chloral.

3. The process of drug addiction

The process of drug addiction is, as regards most types of drugs, relatively fast. Morphine and related substances lead to serious addiction in the course of a few weeks, and the increased tolerance for the substance very soon induces the addict to take large doses. In the case of sleeping drugs, addiction usually takes longer and greatly resembles alcoholism. Addiction to amphetamine and cocaine is rapid, and the patient begins to use large doses within a short time.

Narcotic substances have a stronger paralysing effect on the activity of the brain than does alcohol, and hence permanent damage to the brain will develop quicker in drug addicts than in alcoholics. The damage goes deeper, and the patient's ability to pull himself together disappears very rapidly. Also, in view of the very marked physical dependence on narcotic drugs, the drug addict feels the compulsion of acquiring fresh supplies more strongly than does the alcoholic.

In the beginning, the addict will as a rule attempt to acquire narcotic drugs by lawful means, most often by consulting a physician and pretending to be suffering from some ailment

which requires the administration of an analgesic or tranquillizing agent. He will go from physician to physician, using different names and having prescriptions made up in different pharmacies, or he will persuade other people to obtain the prescription from the physician and then have it made up in a pharmacy. It is probable that the overwhelming majority of misued drugs reach the patients in this way. Smuggling and other illicit forms of traffic do, of course, occur, but for the present on a smaller scale. Experience in other countries, and particularly in the large towns, shows that such forms of traffic will tend to increase with the size of the town and its resultant anonymity.

If the legal method of procuring drugs is unsuccessful, many, and perhaps most, drug addicts will not shrink from the use of unlawful means such as forging prescriptions, breaking into pharmacies and so on.

4. Purpose and possibilities of treatment

Drug addicts generally have no clear awareness of their own condition and thus little motivation to seek treatment. Deterioration is so far-reaching and rapid that help must be given promptly if it is to be of any use. As in the case of alcoholics, the aim of the treatment is total abstinence from the drug; there is no middle way. Any attempt to use drugs in normal doses will lead to a relapse, perhaps to an even worse degree than in the case of alcoholics. The fact must be accepted that a good many addicts are too far gone to be saved as individuals and that they will be damaged for the rest of their lives. At the same time, they must be given treatment, both because in some instances surprising results may be achieved and because action by the authorities may prevent further contagion. Drug addicts have a strong tendency to try and drag others with them, and they should therefore be isolated from surroundings in which they can meet persons, such as alcoholics, who may be inclined to follow their example.

In the treatment of drug addicts, it is thus the social factors which often play the predominant role with regard to committal and to the attempts to achieve a cure.

5. Methods of treatment

As in the case of alcoholism, there are two stages in the treatment of drug addiction. The first stage consists in sobering the patient, i.e. in getting him through the phase of physical and psychic withdrawal symptoms. The time needed for this varies in accordance with the type of toxic substance and the addict's degree of tolerance to it. In most cases, however, this stage takes three to four weeks. Withdrawal may take the form of complete deprivation of the toxic substance, or of a somewhat gradual reduction of doses. As regards some substances, including morphine, an abrupt withdrawal may lead to such alarming symptoms that small quantities of the drug must be given in order to ward them off. In such cases, a more gradual withdrawal is apt to be more successful. At any event, whether a rapid or a slow method is used, it is essential that the patient should be under constant supervision, preferably in a closed section, during the withdrawal stage. No reliance can ever be placed on an addict's assurances that he will take no more drugs or on his promises that he will not procure any. During the withdrawal stage, a patient is virtually always in such a stage of physical and mental tension that he can scarcely be regarded as responsible for his actions. It is therefore doubly necessary for a watch to be kept, and supervision must be very strict. The completion of acute withdrawal is followed by the second stage, which is at least equally important and is indispensable if detoxication is to serve any useful purpose. In this phase the patient must be taught to live a normal life again, i.e. without having recourse to drugs whenever he is beset by difficulties or misfortunes. An attempt must be made to wean him from that refusal to face reality to which he has become accustomed, and the rehabilitation phase may be said to be a re-education to face life.

Clearly this will take a long time, and years must be expected to elapse before anything can be said about the final outcome. Treatment for less than one year can generally be regarded as wasted. Hence, neither the patient nor his relatives should ever be given the impression that the period of treatment will be short. While acute withdrawal requires admission to a hospital-type institution, the remaining rehabilitation phase may take place in an institution similar to a sanatorium for inebriates. Communication with the outside

world must, however, be under stricter control in the case of drug addicts, largely because persons from outside, e.g. other drug addicts, will often attempt to induce the patient to take drugs again.

In the withdrawal stage, pharmacotherapy must often be resorted to in order to deal with the purely physical symptoms, while in the rehabilitation stage, psychiatric and psychological treatment is of prime importance. Such treatment, however, also plays a part during the first stage, since, for example, a consciousness of the need for treatment must be cultivated in the patient. The physical and mental aspects of treatment must be accompanied by social measures so that the patient's path may be somewhat smoother when he must once again depend on himself.

6. The practical task of the temperance committees in the treatment of drug addiction

A. The detection of cases will often require an active effort by the committee. Drug addicts tend to conceal their condition to a much greater degree than alcoholics and are capable of doing so both from their family and others. As a result, the committee wil be informed of the patient's condition by either the patient himself or his family only when the addiction has reached an advanced stage and often when the possibility of a cure is considerably reduced. If its work is to be effective, the committee must therefore seek close co-operation with the local physicians and pharmacists, who as a rule will be able to observe the persons who are entering the danger zone. If a committee suspects addiction, it must always take energetic steps to have the case examined, and if its suspicion is borne out, for example, by application to a physician or pharmacist, it must act without delay.

The committee must keep a particularly close watch on alcoholics who begin to pay frequent visits to physicians or pharmacists. In many instances, this will mean that the alcoholic is beginning to supplement his drinking with sleeping drugs or other substances. As soon as this is suspected, the committee should therefore drawn the physician's attention to the situation. The committees must expect to encounter considerable difficulties in this part of their work, for the patient will try every possible means to protect himself.

B. Warnings. Although a warning from the committee will hardly make any impression on a patient who is a confirmed addict, it may have some effect on persons who have only just begun to abuse drugs.

It is also very important for the committees to combine their warnings to alcoholics with a warning against drugs, by explaining, for example, that the abuse of narcotic drugs is just as serious in its effects as the abuse of alcohol. This may protect a number of alcoholics from following the pattern of forsaking alcoholism only to embrace drug addiction, which alcoholics wrongly believe to be less dangerous. "After all, I got my pills from the doctor", it is often argued.

C. Ambulant treatment of drug addicts is difficult to carry out and is to be regarded as nothing more than a makeshift until the patient can be transferred to a hospital or sanatorium for detoxication and subsequent treatment. Ambulant treatment must be administered by a physician who tries to reduce the dose of narcotic drugs as far as possible. The physician must make it clear to the patient that he prescribes the substance merely on condition that the patient will undergo a course of withdrawal in a hospital as soon as room can be found for him. In this way it is possible in most cases to exercise some supervision so that, at least, the consumption of the drug does not in the meantime increase.

D. Committal to a hospital or sanatorium for drug addicts

The fact must be accepted that, at least to begin with, it will be extremely difficult to persuade drug addicts to consent to their committal to a hospital or sanatorium for treatment. This is due mainly to the patient's failure to realize his condition, but also to his fear of the considerable discomfort inherent in the withdrawal process. The committees will therefore have to exert considerable pressure to effect a committal, and they must not shrink from compulsory committal. This will be an unpleasant duty for many committees, particularly in small communities where concealment is difficult, but if anything is to be done for drug addicts,

sharp reactions have to be accepted. In view of the fact that drug addicts have great powers of simulation, the order for compulsory committal must be very carefully drafted, lest the addict receive the impression that he can evade it. As many drug addicts will, to begin with, certainly use their right of appeal, the committees must leave no loopholes in the committal order.

As soon as drug addicts discover that compulsory committal can in fact be carried out, it will probably be easier to persuade them to undergo treatment on a voluntary basis, but it must be anticipated that a few years will be required to bring about such a change of attitude.

When a patient is hospitalized, it must be realized that a stay of three to four weeks cannot lead to any worthwhile results, and that the withdrawal stage is merely a preparation and condition for further treatment. Steps should therefore immediately be taken to obtain authority for longer hospitalization, preferably for a period of two years.

E. After-care for drug addicts is basically the same as after-care for alcoholics. Supervision, however, must be stricter, and at the first sign of a relapse, an attempt must be made to put the patient back into hospital. It is essential that the nature of the drug addiction be explained to the addict's family and contact with the family must be regarded as even more necessary for drug addicts than for alcoholics.

The Ministry, in drawing attention to these instructions, would like to point out that for the time being provision can only be made for the committal of drug addicts to a hospital on a voluntary basis under article 5 and for their compulsory committal to a hospital under article 6a; only in very exceptional cases can there be any question of committing drug addicts to sanatoria for inebriates.

The question of committing drug addicts to a special institution will be dealt with again as soon as possible. Cf. article 7.

Ministry of Social Affairs
Oslo, 28 December 1959
By authority
K.J. ØKSNES

ROLF KNUDSEN

E/NL.1960/131

Circular letter No. 1925/60 I.2. Ministry of Social Affairs

COMMITTAL OF DRUG ADDICTS TO A SPECIAL SANATORIUM

Reference is made to the Ministry's circular letter of 28 December 1959[4/] concerning the committal of drug addicts to hospitals, etc., and notice is hereby given that the Ørje sanatorium for inebriates has now been converted into a temporary institution for the treatment of drug addicts, with accommodation for seventeen patients.

As Ørje is an open institution, it will be difficult to admit drug addicts who are at the acute withdrawal stage. Hence, before such patients can be committed to Ørje, they will have to undergo detoxication for a period of three to four weeks in the closed section of some hospital. The hospitals whose names and addresses are given in the circular letter of 28 December 1959 - and now also Faret hospital, Solum near Skien (a psychiatric hospital for patients committed on a voluntary basis under Act No. 3 of 25 June 1935) - may be used for detoxication treatment, i.e. for the acute withdrawal stage. In this connexion, it should be pointed out that hospitals authorized to receive patients who are committed on a compulsory basis also admit patients who consent to be committed.

4/ Note by the Secretariat: E/NL.1960/130.

Particulars of the drug addicts committed to the Ørje sanatorium may and should as a rule be entered on the form used for the committal of inebriates.

Where drug addicts are committed to Ørje on a voluntary basis, the declaration by the patient should also as a rule be made on the same form as that used for the committal of inebriates to a sanatorium. The declaration must be made for a period of at least one year, but preferably two years. No false hopes should be aroused in the patient that he might be discharged within less than one year. Experience has shown that shorter periods of treatment for drug addicts are in by far the most cases useless. Only those drug addicts will, at least for the time being, be admitted to Ørje who consent to be committed there.

Applications for admission to the Ørje sanatorium for drug addicts must be sent to the chief physician for the treatment of inebriates, Bjørnebekk Sanatorium, Ås. The chief physician decides whether and when the patient may be admitted. Wherever possible, the patient ought to have been committed to a hospital for the purpose of detoxication three to four weeks before the date set by the chief physician for his admission to the Ørje sanatorium, so that he may be transferred to Ørje direct from the hospital when the withdrawal phase has been completed. Hospitalization which is not followed by prolonged treatment in an institution for drug addicts must be regarded as virtually useless.

Applications for admission to Ørje must be accompanied by information regarding the hospital to which the patient is to be sent beforehand for the detoxication treatment or, as the case may be, the hospital where such treatment is being or has been given. In addition, the hospital must be informed that the patient after treatment there is to be transferred to the Ørje sanatorium for drug addicts. As regards the committal of drug addicts to hospitals, reference is made to the circular letter of 28 December 1959, which should be read in conjunction with the circular letter of 26 May 1959 concerning the committal of inebriates to hospitals.

Patients who are being committed for the treatment of drug addiction to a hospital or sanatorium must be accompanied there. No reliance can ever be placed on a drug addict's assurances that he will not smuggle narcotics into the place of treatment. His intentions may be excellent, but the craving for some form of narcotic drug is often so strong that he is virtually a helpless prey to it.

As far as expenses connected with an addict's stay at the Ørje sanatorium and assistance to his family during that period are concerned, the Act respecting temperance committees,[1] etc. provides that the relevant provisions relating to treatment in a sanatorium for inebriates shall apply; cf. article 15, paragraphs (2) and (3), article 16, fourth paragraph, and article 12 of the Act.

Payments out of the insurance fund in respect of a drug addict's stay at the Ørje sanatorium shall be governed by the same provisions as apply to sanatoria for inebriates. Sickness benefit, if any, is also paid in accordance with those provisions; cf. the circular letters of 10 July 1957 and 20 May 1958. The provisions of those circular letters regarding the expenses connected with an inebriate's stay at a sanatorium and regarding cash benefits (pocket money and sickness benefits) during such period also apply to a drug addict's stay at the Ørje sanatorium.

Expenses connected with a drug addict's stay in a hospital, and the sickness benefit and family allowances paid during such period, are governed by the same provisions as apply to an inebriate's stay in a hospital. Reference is made in this regard to the circular letters of 26 May and 28 December 1959.

The Ministry would point out that before a patient is committed either to a hospital or to the Ørje sanatorium, an undertaking must be obtained from the insurance fund in respect of his stay there.

Ministry of Social Affairs

Oslo, 8 March 1960

By authority

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