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COMMISSION ON NARCOTIC DRUGS

Tenth Session

SUMMARY RECORD OF THE TWO HUNDRED AND SEVENTY-FIRST MEETING

Held at Headquarters, New York,
on Monday, 25 April 1955, at 11.15 a.m.

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55-11555

PRESENT:

Chairman:	Mr. VAILLE	France
Rapporteur:	Mr. SALDANHA	India
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	Mr. LABIB	Egypt
	Mr. PANOPOULOS	Greece
	Mr. ARDALAN	Iran
	Mr. RABASA	Mexico
	Mr. CALLE Y CALLE	Peru
	Mr. FORYS	Poland
	Mr. OZKOL	Turkey
	Miss VASILYEVA	Union of Soviet Socialist Republics
	Mr. WALKER	United Kingdom of Great Britain and Northern Ireland
	Mr. ANSLINGER	United States of America
	Mr. NIKOLIC	Yugoslavia
Observers:	Mr. DANNER	Federal Republic of Germany
	Miss YAMANE	Japan
	Mr. GRANDJEAN	Switzerland
Also present:	Mr. MAY	Permanent Central Opium Board

Representatives of specialized agencies:

	Dr. HALBACH	World Health Organization

Representatives of non-governmental organizations:

	Mr. NEPOTE	International Criminal Police Commission
	Mrs. WALSER	Women's International League for Peace and Freedom
Secretariat:	Mr. YATES	Director, Division of Narcotic Drugs
	Mr. PASTUHOV	Secretary of the Commission

DRUG ADDICTION (E/CN.7/289, chapter XII; E/CN.7/296; E/CN.7/L.87; E/NL.1953/Summary, paragraphs 7.574 to 7.596; E/NR.1953/Summary, chapters II B, VI C and VIII)

Mr. YATES (Secretariat) said that the new revised form of annual reports (E/NR.1954/Form) had only begun to be used in 1955. Despite their efforts, relatively few Governments had as yet sent in the information called for in the form. Accordingly there was not enough material in the possession of the Narcotics Division to warrant the submission of another general report to the Commission.

The Division was building up a body of information concerning drug addiction, from data in the reports of Governments and material published in technical reviews and periodicals, so as to enable it in due course to prepare such studies as the Commission might ask for on selected topics in this field. It was especially grateful to the Governments of the United States and France for their assistance. In the United States, the Federal Hospital at Lexington (Kentucky), which consisted both of a technical centre for addicts and a research centre of the United States National Institutes of Public Health, had supplied much oral and written information. Experts working at the Hospital had agreed to contribute to the Narcotics Bulletin on certain subjects of special interest to the Commission. In the case of France, with the co-operation of Mr. Vaille's service, a member of the Division had made a very full study of the methods used in France to combat drug addiction. The work of the Presidential Commission in the United States and the Senate Enquiry in Canada would also be of great value to the Commission; the Governments concerned would make available the conclusions of the bodies in question to the Secretariat.

Drug addiction took very different forms in different countries, and statistics were not readily comparable. Nevertheless, some comparative studies of countries with similar social structures and levels of development might be very useful. France, the Federal Republic of Germany, Canada, Mexico and Chile, for example, had communicated valuable data concerning addicts classified according to age group, sex and occupation. When other countries had done likewise, the collected material might be the subject of some interesting research.

(Mr. Yates, Secretariat)

Drug addiction had some of the same causes and some of the same characteristics as many other social phenomena. When, for example, a country was passing through a critical phase of rapid social change or particularly dynamic development, the strains of living manifested themselves among some of the weaker personalities in the form of alcoholism, mental illnesses or drug addiction. For that reason, the statistics for addiction might for some purposes be more significant if considered in conjunction with statistics on these and other factors as well as in isolation.

The information at hand showed that many countries were concerned about drug addiction of therapeutic origin. Those countries would probably like to investigate the problem, by samplings for instance. Denmark and France had carried out some very interesting studies of that kind. Cases of drug addiction in the medical or related professions were likewise a matter of concern in some areas.

He commented on the provisions relating to the treatment of drug addiction adopted by the Commission at its ninth session. As Mr. May had pointed out in his article on the single convention, few countries would have the need or the resources to set up institutions as elaborate as Lexington Hospital. They would therefore normally have to use existing institutions (and if necessary expand them) to give effect to the relevant provisions of the convention. In most cases, compulsory treatment was given in closed institutions, in asylums or prisons where it was easier to cut off patients from narcotic drugs. As regards mental illness, it was interesting to note that some countries were working out methods of treatment based on general hospitals. Clearly, in this partially analogous field, those methods were in some way superior, particularly from the point of view of avoiding social stigma and for the morale of the patient, and might prove worth consideration in appropriate cases, for instance in some adolescent cases. It was very difficult to arrange effectively closed accommodation in a general hospital. This was an organizational problem in which the experience of countries with experience of in-patient treatment of drug addicts would certainly be very useful.

(Mr. Yates, Secretariat)

Under the revised form, the information to be provided by Governments dealt mainly with the first two stages of treatment: disintoxication and psychotherapy and rehabilitation.

For the purposes of disintoxication or "withdrawal", the known therapeutic methods were satisfactory. Psychotherapy presented a more difficult problem because there was a pretty general shortage of psychiatrists which was likely to remain, they were expensive, and the treatment of the general run of addicts would not normally have the highest priority. A complete psychotherapeutic service should however include the possibility of reference for deep therapy where worthwhile results could be expected, for example, among addicts from the medical and related professions. A good deal had still to be done in that field, and the Commission and Governments might look to the WHO and its mental health service for assistance. For the general run of addicts, however, emphasis might be placed on measures of social rehabilitation, which themsevles provided a measure of psychic rehabilitation. In the course of the process of rehabilitation, for example, the former addict might be taught a trade which would enable him to earn his living and provide for his family. Such methods had the further advantage that they could be applied to groups and hence were not too expensive, especially if so organized that the work of the patients and their instuctors could somehow be set off against the expense or part thereof. In that connexion countries with very different conditions could well profit by ideas developed at Lexington Hospital.

There was a third, and perhaps the most difficult, stage in the treatment of addicts, a stage which the form of annual reports only touched upon: reintegration in the community. Possibly it was because ex-addicts were not followed up sufficiently that recidivism was so frequent among them. At that stage, though the central agency could help, guide and co-ordinate, the principal operational responsibility must be with the various social groups - the family, neighbourhood, employer, etc.

In conclusion he thought that the pessimism of some of the authorities whom the Division had been studying was not justified; and cited the dramatic fall in the number of opium smokers in the East, the mastery gained over the chewing of the coca leaf in Colombia and Ecuador, and the suppression of the former legal abuse of opiates in Europe and North America.

Mr. HOSSICK (Canada) recalled that at the ninth session his delegation had stated that Canada regarded drug addiction as a serious problem. At that time, the Canadian Government had already set on foot an inquiry in the Province of British Columbia. The inquiry which had been proceeding for a year under the direction of Dr. Stevenson, an eminent psychiatrist, had been undertaken under the auspices of the University of British Columbia with the help of a grant by the Government of Canada. The report on the inquiry made two recommendations, one relating to the establishment of treatment and rehabilitation facilities for addicts, and the other to the amendment of the Opium and Narcotic Drugs Act to permit the establishment of clinics where registered addicts could legally receive narcotic drugs in limited quantities. After a thorough study of the recommendations, Dr. Stevenson had concluded that the establishment of the suggested clinics was not desirable, an opinion which was shared by the competent Canadian authorities. He had proposed instead that addicts should be sent to hospitals to undergo withdrawal treatment, and then to open rehabilitation centres. Copies of Dr. Stevenson's report had been supplied to the Secretariat.

The Ontario Department of Reform was shortly to open a pilot treatment centre with twenty-five beds. It would be a closed institution admitting patients from Ontario reform institutions who were thought capable of readjustment to normal life. They would be given all possible medical and psychiatric treatment and facilities for occupational retraining.

The establishment of a Senate committee to study the traffic in narcotic drugs was further evidence of the importance which the Canadian Government attached to the suppression of drug addiction. The Committee had already begun its work, but would not have the necessary data on which to base its report until some months had elapsed. It was hoped that the report would enable the Government to form a very accurate idea of drug addiction in Canada as a whole.

Meanwhile, the competent authorities had continued their investigations. The number of addicts in the whole of Canada was estimated at 3,212, of whom 2,364 were delinquents (including 26 under 20 years of age), 515 persons whose addiction originated in medical treatment and 333 members of the medical or allied professions. The figure did not of course include persons for whom narcotic

(Mr. Hossick, Canada)

drugs were prescribed for medical purposes. Although the numbers had declined by comparison with previous years, the existence of addicts was clearly still a disturbing fact. It should however, be noted that, apart from the twenty-six cases referred to above - and those twenty-six had not been attending school when they contracted the vice, and had previously attracted the notice of the police in connexion with other offences - there were no adolescents among the addicts. The schools were not contaminated and there was no danger that they would be.

Thus, two proposals for the treatment of drug addicts were under study in Canada. The Canadian enforcement authorities were sparing no effort to stamp out traffic in narcotic drugs and they had already obtained excellent results.

Mr. ANSLINGER (United States of America) referred to the studies undertaken in his country - an inquiry into drug addiction among adolescents carried out in Chicago, and an inquiry to be followed by a report, by an inter-departmental committee. The Chicago study was interesting, for it would give figures which could be regarded as accurate. The two studies showed that drug addicts, including adolescents, invariably in one way or another attracted the attention of the authorities.

Durg addiction was a community problem, as was shown by the results obtained in the State of New Jersey, whose narcotic drugs legislation was among the best in the United States.

Narcotic clinics comparable to those mentioned by the Canadian representative had been tried out in the United States, but had been dropped on the recommendation of the American Medical Associations, since so far from producing satisfactory results they had in fact spread addiction.

An excellent report had been communicated to him by the representative of Canada. Chief Constable Mulligan of Vancouver, the author of the report, dealt with the problem of drug addiction, not theoretically, but in a practical and realistic way. Mr. Anslinger asked the Canadian representative to convey his congratulations to Chief Constable Mulligan.

Mr. SALDANHA (India) wished to describe the situation in his country in detail, to dispel any misconceptions entertained by some members of the Commission by reason of India's reservations on the subject of opium in the case of the 1953 Protocol and, more recently, on the subject of cannabis in the case of the single convention.

So far as the consumption of alcohol and narcotic drugs was concerned, the following directive principle was embodied in the new Indian Constitution: "The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of all intoxicating drinks and all drugs which are injurious to health." Most of the States had already begun to carry the principle into effect, notwithstanding the loss of revenue and the heavy expenditure on enforcement. A committee had been set up, India's Manning Commission, to examine the possibility of accelerating the pace of prohibition. It should also be pointed out that only a very small fraction of India's population, perhaps not more than 2 or 3 per cent, used alcohol or narcotic drugs.

There was no addiction to morphine drugs in India. The manufacture of opium alkaloids was restricted to the single State factory, and no case of illicit manufacture or import had come to the knowledge of the authorities.

Addiction to cocaine and its salts was negligible. A Government laboratory was the only institution authorized to manufacture cocaine, the raw material it used was seized and confiscated crude cocaine. In 1954 illicit imports of cocaine had amounted to only 0.8 kilogrammes. In the past three years, the total licit imports of cocaine had not exceeded 45 kilogrammes for a population of some 350 millions.

No case of addiction to synthetic drugs had come to light. There was no manufacture of synthetic drugs, and licit imports were made under the import-export certificate system as required by the 1948 Protocol.

(Mr. Saldanha, India)

The consumption of opium for quasi-medical purposes had been consistently reduced since 1949 and would cease altogether by the end of 1959. Annual consumption had amounted to 500 tons, or about one sixteenth of a gramme per capita in 1910 and had fallen to 80 tons, or less than one fortieth of a gramme per capita, in 1954.

The State of Assam had adopted an elaborate procedure for the medical treatment of addicts. The procedure had been first introduced in 1948 and other State Governments were adopting or going to adopt a similar system, where necessary.

Cannabis was consumed only in the form of ganja and bhang. The collection of the resin from cannabis (charas), its manufacture, import and consumption were prohibited. Expert studies on the Indian varieties of the cannabis plant, however, had shown that they were poor in the yield of narcotic resin. The smoking of ganja was confined to the lower strata of the population. Bhang was consumed in the form of beverage and sweetmeats; they were used on festive and religious occasions by all classes of the population. Being a stimulant rather than a narcotic drug its use, unlike that of opium, was not frowned upon by public opinion. Both ganja and bhang were subject to heavy excise duties and therefore expensive. A high-level conference held in India in 1949 had recommended that State Governments should make every effort to discontinue the use of ganja for non-medical purposes within ten years. However, in view of the relentless policy of restriction followed by the States with respect to quasi-medical uses of opium, the progress achieved in reducing the use of less dangerous drugs such as ganja had been less rapid than planned. Nevertheless, twenty States had either prohibited the cultivation of the cannabis plant or had refused to issue the licences required for its cultivation.

He hoped that the information he had provided would enable the members of the Commission to form an idea of the precise nature of the consumption of opium and cannabis in India.

Miss VASILYEVA (Union of Soviet Socialist Republics) said that, owing to the absence of unemployment and in view of the well-being and cultural level of the population, drug addiction was not a problem in the USSR. There were only a

(Miss Vasilyeva, USSR)

few isolated cases of addiction of therapeutic origin. The addicts were treated in hospitals with satisfactory results, particularly if the treatment was extensive.

The drugs used by the addicts in question were opium and opium preparations, obtained, from lawful sources, upon production of a medical prescription. Pharmacies and prescriptions were subject to such strict supervision that the addicts could not obtain narcotic drugs illicitly. The fact that there was no private trade in narcotic drugs and that authority to sell narcotics was confined to a few government bodies facilitated supervision. The production and import of narcotic drugs were reserved to the State, with the consequence that their use for medical and scientific purposes exclusively was guaranteed.

The annual reports of Governments and the documents published by the United Nations showed that a number of countries had enacted special legislation intensifying the campaign against drug addiction, and that addiction no longer constituted a grave danger in those countries. But at the same time she felt obliged to express her concern at the position obtaining regarding addiction and the illegal use of narcotic drugs in a great many other countries. Moreover, it was evident that poor social conditions played a large part in the spreading of addiction. That point had been emphasized by the representative of Hong Kong at the seminar organized by the United Nations at Rangoon. It could thus be said that economic difficulties represented one of the main causes of addiction. Special attention should therefore be paid to that factor when the question of measures to combat addiction was being considered.

Mr. WALKER (United Kingdom), explaining the figures concerning drug addiction provided by his Government, said that in the United Kingdom, as in many other countries, addicts were not required to register. But while the exact number of addicts could not be given, the authorities had reasonable ground for believing that the figures provided were substantially accurate.

There was still some opium-smokers in the United Kingdom, mostly persons of Asian extraction, usually Chinese, though the number seemed to be declining. On the other hand, the use of cannabis, practised by persons from overseas, appeared

(Mr. Walker, United Kingdom)

to be spreading among the British population. Britons were conservative in their habits and would hesitate to acquire the habit of using a syringe. They were much less likely to object to smoking a cigarette which looked like an ordinary cigarette, particularly if offered in places where young persons usually gathered. For this reason the cannabis problem was a matter of some concern to the Government. No substantial change had occurred in the number of addicts who used manufactured narcotic drugs.

The authorities were convinced that the number of clandestine addicts was negligible. To begin with, as the United States representative had pointed out, addicts sooner or later attracted the attention of the authorities. Moreover, a series of samplings had produced negative results. The attempts made to prepare statistical data concerning drug addicts in prisons had been abandoned because the resulting figures were too small to be of interest. A few months previously the Chief Constable of a large port had carried out a careful investigation but had been unable to find evidence of large-scale drug addiction.

He thanked the Canadian representative for having distributed Dr. G.H. Stevenson's interesting study "Arguments for and against the legal sale of Narcotics". The passages which referred to the United Kingdom were, on the whole, correct, but some statements needed qualification. On page 8, for instance, it was said that "each physician treating an addict must report the addict by name to the Home Office" and that "if he learns that the addict patient is getting additional narcotics from another physician as well, he is expected to discontinue treatment and report the circumstances to the Home Office". That was not quite the case. It was true that an index of addicts existed, but it was not based on compulsory reporting. Some members of the medical profession would probably consider such disclosure a breach of professional secrecy.

The memorandum cited by Dr. Stevenson on page 8, which specified the circumstances in which morphine or heroin could be administered, was more than thirty years old. That explained why it mentioned only those two narcotic drugs. The instructions in the memorandum reflected the limited knowledge of that period. Since it had been written, great experience had been acquired in Canada

(Mr. Walker, United Kingdom)

and the United States concerning the treatment of addicts; this was not so in the United Kingdom, where the small number of addicts made specialization unprofitable and difficult.

Subject to those qualifications, Dr. Stevenson's study accurately described the system applied in the United Kingdom. In particular, it was correct to say that the administration of narcotics to addicts by reason merely of their addiction was not encouraged, and that there had to be serious reasons for a physician to administer narcotics to a patient or to issue a prescription for them.

Mr. NIKOLIC (Yugoslavia) said that not a single case of drug addiction had been reported in Yugoslavia, even in Macedonia where the opium poppy was cultivated. The fact was worth noting since the producing countries were often held responsible for the spread of drug addiction, a myth which should be disproved. The Governments of Canada, India and the United States should be commended for the measures they had taken to combat the scourge of drug addiction. The failure of the representatives of those countries and other States to place sufficient emphasis on drug addiction induced by synthetic narcotic drugs was nevertheless unfortunate. It would be most desirable to determine the extent of the addiction attributable to the use of the new narcotic drugs, in order that more effective action might be taken to combat that form of addiction.

Mr. OZKOL (Turkey) said that the Governments of Canada, India and the United States should be congratulated on their contribution to the campaign against addiction. The action of the United States was of value not only for its direct results in the prevention and suppression of addiction but for the information it furnished on the development of that social scourge. In particular, the researches carried out by Rasor and Crecraft into pethidine hydrochloride addiction at the Lexington (Kentucky) Hospital summarized by Mr. Eddy for the Expert Committee on Drugs Liable to Produce Addiction were most enlightening. The statistical data given in their paper showed that the total number of pethidine addicts admitted to the hospital from 1 July 1950 to 30 September 1953 had risen

(Mr. Ozkol, Turkey)

to 457, or approximately 141 annually from only 6 in the year 1946/1947. The stud of case histories and characteristic symptoms left no room for doubting the existence of pethidine addiction; the conclusion of the authors was that persons who had never been addicted to opiates became pethidine addicts and showed characteristic withdrawal symptoms. He had noted with some concern the high proportion of doctors, nurses and members of allied professions among pethidine addicts. He felt that the Commission should draw attention to the danger.

Mr. RABASA (Mexico) said that it was not possible to give the precise number of addicts in his country because the use of narcotic drugs was not treated as an offence in Mexico. Although the Government authorities were empowered to intern addicts, many of them eluded supervision. In 1953, 313 persons had been officially designated as addicts; it was not possible to determine how many of them were recurrent cases. As trafficking in drugs was not permitted, addicts obtained their supplies from illicit sources, except for those, numbering 42 in 1953, who were under treatment. Of the 313 persons officially designated as addicts, it was estimated that 94, or 30 per cent, had become addicted as a result of medical treatment. Of the 219 remaining addicts, most were believed to have become addicted through the example of others or at the instigation of traffickers. The incidence of addiction was particularly marked among men between the ages of 30 and 40. Addiction was relatively rare among the young and less frequent among women than men. The addicts were often persons who were unemployed or had no particular trade or occupation, and most of them were virtually social outcasts. Thirty per cent of them used morphine, heroin or their derivatives, and 70 per cent marihuana and to a lesser degree cocaine. The Ministry of Public Health and Social Welfare was now examining what could be done to ensure the medical treatment and re-education of addicts. It was planning to reorganize the Federal hospital for drug addicts, which had been closed for administrative reasons, and administered a special wing of the insane asylum of Mexico as well as a building belonging to the Mexican Institute of Social Security. In those establishments addicts were given a progressive disintoxication cure which varied in length according to the patient's health. Some of the inmates were voluntary patients.

(Mr. Rabasa, Mexico)

The Government hoped that its economic, health, agricultural and cultural policy would help to reduce the seriousness of drug addiction. Opium addiction was not very widespread and there was nothing to show that it was on the rise. It was illegal and not a single case had been detected in 1953. The coca plant was not cultivated in Mexico. It was strictly forbidden in Mexico to cultivate, deal in and use cannabis in any form and to deal in or use derivatives or preparations with a cannabis base.

Mr. ARDALAN (Iran) observed that drug addiction in Iran was no longer so serious a social scourge as it had been a few years before. Young persons did not fall into the habit of some of their elders. The coca leaf was practically unknown in his country; cannabis was not cultivated and its use was not permitted; the only form of drug addiction was opium addiction. There were 13 persons officially designated as drug addicts. Most of them were suffering from incurable diseases and under treatment in hospital. Other addicts obtained their supplies from the illicit traffic but most of them were elderly persons. Thus, the evil was tending to disappear. Official action was aimed at broadening supervision in order to prevent persons who might have a tendency to drug addiction from obtaining supplies in the illicit market. Legislation making illicit trafficking in narcotic drugs severely punishable was under study in Parliament.

Mr. ANSLINGER (United States of America) drew attention to the situation in Denmark as shown by a special study which had been forwarded by the Danish Government with its Annual Report for 1953. Based on an extensive analysis of prescriptions, this report showed that there had been a serious amount of forged or falsified prescriptions and that the per capita consumption of morphine was very high. It was not difficult to draw the necessary conclusions from these phenomena.

He formally requested the representative of the World Health Organization to ask WHO whether it would not be possible to draw up, for the use of doctors, a set of rules to be observed in making out prescriptions for narcotic drugs. He hoped that the Commission would support that request.

Mr. PANOPOULOS (Greece) congratulated the Secretariat on its remarkable work in the matter of drug addiction and, among delegations, particularly the delegation of Canada on Dr. Stevenson's report. The Commission should draw the attention of Governments to the growing danger of drug addiction through the use of synthetic drugs, as reflected in the report of the Federal Republic of Germany. In particular, the statistics relating to the consumption of polamidon, dolantine and chloradon indicated that those narcotic drugs were becoming increasingly popular among addicts. It was quite disturbing to note that 70 per cent of the addicts treated at the Lexington Hospital, in an experiment dealing with 1,000 patients, had had to be re-hospitalized in spite of the advance methods of treatment. In Greece, heroin addiction was declining as supervision became more effective. On the other hand a slight increase in the number of hashish addicts had been noted; it was difficult to control the cultivation of cannabis, especially in mountainous areas.

He was concerned at the differences in the methods used by States to combat drug addiction. There should be an international study of the treatment of addiction and a five-year plan, based on its conclusions, should be drawn up to make such treatment more effective.

The meeting rose at 5 p.m.