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EFFECTS ON INDIVIDUALS, SOCIETY AND INTERNATIONAL DRUG CONTROL OF THE PRESCRIPTION OF NARCOTIC DRUGS TO DRUG ADDICTS

Report of the Secretariat

Summary

The Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, recognizes that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering, and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes, while also recognizing that addiction to narcotic drugs constitutes a serious danger for the individual and is fraught with adverse social and economic consequences for society. Parties to the 1961 Convention are required to take such legislative and administrative measures as may be necessary, inter alia, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of narcotic drugs. The international drug control conventions do not contain any definition of the expression "medical and scientific purposes". Since each Party to the conventions must introduce its own implementing legislation, it is possible for States to reach different conclusions as to what legitimate scientific and medical purposes are. An overview of current practices in the prescription of narcotic drugs in different countries shows that such drugs are being prescribed to address the long-term problem of chronic drug addiction and to respond to a sharp increase in injecting drug use. Methadone is the most commonly prescribed drug. Some States find methadone prescription to be effective in changing the behaviour of drug addicts. Others doubt its effectiveness or instead concentrate on policies designed to influence the behaviour of people so that they do not take part in any drug abuse. In only a few States is heroin prescribed to drug addicts.

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INTRODUCTION

1. The Commission on Narcotic Drugs, at its thirty-eighth session, adopted resolution 1 (XXXVIII) of 23 March 1995 on prohibition of the use of heroin. In that resolution, the Commission recalled its resolutions 5 (S-V) of 23 February 1978 and 2 (XXXII) of 11 February 1987, in which it had strongly urged Governments to prohibit the use of heroin on human beings. Aware of the growing advocacy of the non-medical use of heroin and its controlled supply to addicts, the Commission requested the Executive Director of the United Nations International Drug Control Programme (UNDCP) to ask the International Narcotics Control Board and the World Health Organization (WHO) for an opinion on this question for consideration by the Commission at its thirty-ninth session.

2. At its thirty-ninth session, the President of the Board made a statement on the subject. WHO informed the Commission that its opinion on the matter, after consideration by its Expert Committee on Drug Dependence, would be presented to the Commission at a future session. The Commission then decided to include an item on the agenda of its fortieth session on the effects on individuals, society and international drug control of the prescription of narcotic drugs to drug addicts, and requested a report by the Secretariat on the issue. The present report responds to that request.

I. EVOLUTION OF THE PRESCRIPTION OF NARCOTIC DRUGS AND INTERNATIONAL DRUG-CONTROL EFFORTS

A. Historical background

3. In the late nineteenth and early twentieth centuries there was an increasing awareness of the dangers associated with the narcotic drugs that had previously been widely used for pain relief, especially opium-based preparations. At that time, many countries began to restrict the distribution of such drugs, while permitting their use for medical and scientific purposes. In 1909, 13 countries formed an Opium Commission, leading to the conclusion of the International Opium Convention, signed at The Hague on 23 January 1912. Later, the League of Nations created an Advisory Committee on Traffic in Opium and Other Dangerous Drugs to provide advice on drug-trafficking issues and to develop related international legislation. The International Opium Convention, signed at Geneva on 19 February 1925, strengthened the supervision of the narcotics trade. The Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, signed at Geneva on 13 July 1931, supplemented the provisions of the prior conventions. Parties to the 1931 Convention agreed that only a restricted quantity of drugs would be manufactured in and imported to their respective countries.

4. The United Nations was established after the Second World War, and authorized to carry out the functions previously belonging to the League of Nations under the narcotics treaties. At the first session of the United Nations, the Economic and Social Council created the Commission on Narcotic Drugs to replace the League of Nations Advisory Committee on Traffic in Opium and Other Dangerous Drugs.

5. The Single Convention on Narcotic Drugs of 1961,[1] as amended by the 1972 Protocol,[2] aimed at unifying the pre-existing multilateral treaties involving narcotics control and simplifying the international control machinery. The 1961 Convention merged the Permanent Central Opium Board and the Drug Supervisory Body into one body, the International Narcotics Control Board. In addition to the 1961 Convention, the other drug control conventions currently in force are the Convention on Psychotropic Substances of 1971[3] and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.[4]

B. Controls required under the international drug control conventions

6. The policy of permitting the use of narcotic drugs for medical and scientific needs, while preventing their harmful uses, is articulated in the preamble to the 1961 Convention, which reads as follows:

> "Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes,
>
> "Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind,
>
> "Conscious of their duty to prevent and combat this evil,
>
> "...
>
> "Desiring to conclude a generally acceptable international convention replacing existing treaties on narcotic drugs, limiting such drugs to medical and scientific use ..."

7. Heroin (diacetylmorphine) is listed in Schedules I and IV of the 1961 Convention and is subject to all measures of control applicable to drugs under that Convention. The principal features of the regime include:

the limitation to medical and scientific purposes of all facets of the narcotics trade (including drug manufacture and domestic and international trade) and of drug possession and use; the requirement that Governments authorize the legitimate narcotics trade in their countries and that a specific authorization is needed for certain individual international transactions; detailed record-keeping; requirement of medical prescriptions for the supply or dispensation of controlled drugs to individuals; and a system for limiting the quantities of those drugs available by manufacture or importation in each country to those needed for medical and scientific purposes.

8. Furthermore, parties to the 1961 Convention are required to adopt any special measures of control for drugs in Schedule IV which in its opinion are necessary, having regard to the particularly dangerous properties of those drugs (article 2, paragraph 5 (a). Article 2, paragraph 5 (b), also provides that:

> "A Party shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party."

9. Such special measures to protect the public health and welfare might include, for example, a requirement that manufacturers draw the attention of physicians to the dangerous properties of the drugs, restrictions on their therapeutic use or a measure of prohibition. A party is obliged to apply such special measures only if it believes them to be necessary. Its opinion on the matter could generally not be challenged by another party, but this provision must be carried out in good faith, like other treaty provisions.[5] One domestic situation in which measures of prohibition would be appropriate might be, for example, if members of the medical profession were administering or prescribing drugs in Schedule IV in an unduly extensive way, and other less radical measures such as warnings by public authorities had proven to be ineffective. Article 2, paragraph 5, leaves the prohibition to the judgement, though theoretically not to the discretion, of each party.

10. Whether the prohibition of the dangerous drugs in Schedule IV, including heroin, should be mandatory or only recommended was a controversial question at the United Nations Conference for the Adoption of a Single Convention on Narcotic Drugs, which met in New York from 24 January to 25 March 1961, as it had been in respect of earlier drug control treaties. A proposal to abolish the use of heroin had been made as early as 1923 in the League of Nations Advisory Committee on Traffic in Opium and Other Dangerous Drugs. Such proposals were also made, but not endorsed, at the conferences held at Geneva in 1924/25 and 1931 that respectively adopted the 1925 and 1931 conventions referred to in paragraph 3 above. The 1931 conference, by way of compromise, included article 10 in the 1931 Convention, imposing a particularly restrictive regime on the international trade in heroin. Under that provision, export of diacetylmorphine and of its preparations were prohibited, except for shipments to a country that did not manufacture the drug, and only in such quantities as were necessary for the medical and scientific needs of the importing country. The Conference also adopted a recommendation (VI) to the effect that each Government should examine in conjunction with the medical profession the possibility of abolishing or restricting the use of heroin.[6]

11. Other controls imposed by the 1961 Convention include article 4, which requires Parties to take such legislative and administrative measures as may be necessary, inter alia, to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.

12. Furthermore, pursuant to the 1961 Convention, the Board, among its other duties, administers an estimates system whereby the cultivation, production, manufacture, trade and distribution of drugs is limited to an adequate amount required for medical and scientific purposes, and ensures their availability for such purposes.

13. The provisions of the 1988 Convention must be considered in relation to the 1961 Convention and the 1971 Convention. Each Party to the 1988 Convention is required to adopt such measures as may be necessary to establish as criminal offences certain acts under its domestic law. Such offences relate, inter alia, to actions that are prohibited under the 1961 Convention and the 1971 Convention, for example the illicit manufacture, distribution or sale of any narcotic drug or psychotropic substance. Since the 1961 Convention clearly permits the authorized provision and use of drugs, including heroin, for medical or scientific purposes, the 1988 Convention also permits it for such purposes.

14. The international drug control conventions do not contain any definition of the expression "medical and scientific purposes". Since each Party to the conventions must introduce its own implementing legislation, it is possible for States to reach different conclusions as to what legitimate scientific and medical purposes are. For example, the prescription of heroin and morphine to addicts by medical doctors is permitted in a small number of countries as part of treatment or maintenance programmes, as well as for research purposes, while such prescription is forbidden elsewhere. Furthermore, morphine is used for pain relief of the terminally ill in many countries; heroin is used in very few countries.

II. OPINION OF THE WORLD HEALTH ORGANIZATION ON THE MEDICAL USE OF HEROIN AND ITS CONTROLLED SUPPLY TO ADDICTS

15. In May 1953, the Sixth World Health Assembly adopted a resolution (WHA6.14) on diacetylmorphine (heroin). Being convinced that heroin was not irreplaceable for medical practice, the Assembly recommended that Member States that had not already done so should abolish the importation and production of the drug. The Assembly further recommended that campaigns be undertaken to convince doctors and Governments that heroin was not irreplaceable for medical practice.

16. The Commission, in its resolution 1 (XXXVIII), requested the Executive Director to ask WHO for an opinion on the growing advocacy of the non-medical use of heroin and its controlled supply to drug addicts. The formal UNDCP request for the opinion of WHO clarified that WHO should also give an opinion on whether the controlled supply of heroin to addicts could be construed as medical use of the substance. The Director-General of WHO submitted those questions to the Expert Committee on Drug Dependence at its thirtieth meeting, held from 14 to 18 October 1996, for its views. The opinion of the Expert Committee was reported to the Executive Board of WHO in January 1997, but the opinion of WHO was not yet officially available when the present report was prepared. Any official communication on the matter received from WHO will be brought to the attention of the Commission by an addendum to the present report.

III. POSITION OF THE INTERNATIONAL NARCOTICS CONTROL BOARD ON THE CONTROLLED DISTRIBUTION OF HEROIN TO DRUG ADDICTS

17. Pursuant to Commission resolution 1 (XXXVIII), the President of the Board delivered a statement to the Commission at its thirty-ninth session. The President of the Board said that the international drug-control system had evolved with the common understanding that free and unrestricted availability of narcotic drugs to people for non-medical purposes led to widespread abuse with serious public health consequences. The will to restrict to only medical and scientific uses appeared to be weakening in some countries, and the proliferation of radically liberal attitudes and legitimization of non-medical use of drugs under the umbrella of harm minimization was not justifiable. He argued that while a reduction of harm to the individual might be demonstrated in certain circumstances, the harm caused by such a policy to society as a whole could be highly significant.

18. The President of the Board pointed out that the expansion of clinical trials or treatment schemes involving heroin presented a danger to the international drug-control system, in the sense that supporters of

legalization took advantage of the trials to achieve their own objectives. He added that no Government should support the proliferation of such trials.

IV. PRACTICES OF PRESCRIPTION OF NARCOTIC DRUGS

A. Overview of practices of prescription of narcotic drugs to drug addicts

19. To assist in preparing the present chapter of the report, a questionnaire was sent out by UNDCP to Member States to collect information on ongoing, discontinued and planned programmes for the supply or dispensation of narcotic drugs to drug addicts for maintenance purposes. Questions were also asked about the reasons behind decisions to begin or to discontinue such programmes, as well as the reasons behind decisions not to supply narcotic drugs to drug addicts. A total of 61 States answered the questionnaire.

20. Twenty-six States and two territories reported that they had no programmes providing narcotic drugs to drug addicts: Argentina, Azerbaijan, Belgium, Cape Verde, Chad, Colombia, Cuba, Dominica, Dominican Republic, Falkland Islands (Malvinas), Ghana, Indonesia, Iran (Islamic Republic of), Jamaica, Japan, Lebanon, Maldives, Micronesia (Federated States of), Niue, Pakistan, Philippines, Qatar, Russian Federation, Saint Lucia, Slovakia, Thailand, Tunisia and Turkey.

21. Thirty-one States and one territory reported the existence of programmes providing narcotic drugs to drug addicts: Australia, Austria, Bahrain, Canada, Croatia, Cyprus, Denmark, Finland, Germany, Guatemala, Hong Kong, Iceland, Ireland, Italy, Kyrgyzstan, Latvia, Lithuania, Malta, Mexico, Monaco, Morocco, Netherlands, Norway, Oman, Panama, Portugal, Slovenia, Spain, Sri Lanka, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland. In addition, another 12 States that did not respond to the questionnaire sent by the Secretariat reported substitution or maintenance programmes in the 1995 annual reports questionnaire: Czech Republic, France, Greece, Honduras, India, Israel, Jordan, Luxembourg, Mauritius, Paraguay, Republic of Moldova and Singapore. Methadone was the predominant drug for maintenance. Only two States (Switzerland and the United Kingdom) were known to provide heroin to drug addicts.

22. With regard to States responding that they had no maintenance programmes providing narcotic drugs to drug addicts, the majority (17) reported that the issue was never raised within their borders because the problem of addiction to opiates did not exist, was very limited or did not require special attention. Yet another reason was that it was not considered a priority, since there were other more pressing concerns. In general, the prevention and treatment means already existing were considered sufficient.

23. Other States (11) did not authorize the prescription of narcotic drugs to drug addicts on the basis of policy decisions. The reasons given were, inter alia: the "zero-tolerance option" chosen by the Government (Argentina); the fact that "it is important to change the behaviour of people so that they do not take part in any drug abuse" (Japan); consideration of the non-effectiveness of the administration of methadone and other opiates in comparison with treatment (Lebanon); the fact that "prescribing narcotic drugs to drug addicts results in an increase in drug abuse" (Russian Federation); uncertainty about the long-term implications of drug prescription for maintenance; and the problem of diversion (Sri Lanka).

24. Thirteen States reported that programmes for the distribution of narcotic drugs to drug addicts were not under consideration, either because the problem did not exist, or because treatment needs and services were at an early stage and injecting drug use was not a relevant problem (Cape Verde, Jamaica, Philippines and Tunisia). Lebanon challenged the impact of the programmes, and was concerned about the possibility of abuse and diversion of the prescribed narcotic drugs.

25. Germany, though reporting an ongoing methadone programme, pointed out that the preconditions of the law for prescription and distribution of heroin to a selected group of addicts had not been fulfilled, because such projects did not meet a "public interest". On the other hand, in 1996 the Netherlands made a decision in principle to start small-scale experiments involving the supply of heroin "on strict medical grounds to seriously ill addicts whose physical state and social situation are beyond hope".

26. A small number of countries reported that they were considering the introduction of methadone programmes (Slovakia and Turkey). In addition, Pakistan reported that the sale of narcotic drugs and psychotropic substances on prescription by registered medical practitioners was under consideration. Indonesia and the Federated States of Micronesia could consider authorizing maintenance programmes in order to reduce drug-related crime, if there were an obvious increase in the abuse of opiates (Indonesia) or if circumstances changed in the future (Federated States of Micronesia).

27. Only five States (Iran (Islamic Republic of), Italy, Netherlands, Oman and Sweden) were known to have discontinued maintenance programmes. The Islamic Republic of Iran had abolished methadone maintenance, since "according to the law addiction is known as a crime". In Italy, experimental use of injectable morphine for treatment of opiate addicts was authorized during the period from 1980 to 1985. The majority of the addicts who entered morphine treatment requested to be moved to methadone treatment. While having authorized methadone syrup for treatment of opiate addicts, Italy had discontinued some maintenance programmes because it was felt that the availability of maintenance programmes could lead both to an underestimation of the need for the gradual cessation of drug abuse as a final goal of treatment, and to neglect of other support services, such as psychological, social and educational counselling. In 1983, a two-year small-scale (37 patients) morphine-dispensing programme was initiated at Amsterdam, whereby "extremely problematic addicts" who failed to respond to methadone treatment received oral methadone and injectable morphine on a daily basis. The aim of the experiment was to lessen the harm that the addicts inflicted on themselves and to change their lifestyles. Targets were formulated individually with respect to somatic and psychiatric problems, housing, income management, daily time allocation etc. On the whole, the morphine-dispensing experiment resulted in more progress than deterioration. However, in a number of cases the progress was rather limited. With regard to the effects on poly-drug use, urine analysis showed that while heroin use seemed to decrease among the clients, the use of amphetamine seemed to increase with time. There was no noticeable negative effect of the programme on other drug-intervention programmes at Amsterdam.

28. Oman reported that its methadone programme had been discontinued because it was considered to be counterproductive, since "it only substituted an illegal narcotic with a legally supplied narcotic". From 1965 to 1967, stimulants of the central nervous system and opiates (morphine) were legally prescribed to a group of 156 drug addicts at Stockholm. The idea behind the experiment was to limit the harmful effects of abuse, both on society and on the individual drug addict. Through the offer of legally prescribed drugs, the drug addicts would also receive offers of care and their medical and social status would improve. The physicians taking part in the project practiced what was termed "liberal prescription", that is, the patients chose their own drugs and doses. An interview survey and an analysis of registry data showed that while drug offences ceased almost entirely during the experiment, other crimes increased. The number of crimes per individual actually showed a slight increase. The experiment was discontinued, partly because of extensive leakage of legally prescribed drugs into the illegal market.

29. A total of 44 States and territories have reported that they have maintenance programmes for drug addicts. More detailed information was provided by those which completed the special questionnaire requesting information for the preparation of the present report (32 States and territories).

30. The reasons given for starting the programmes were several, but they may be divided into three main categories:

(a) The chronic heavy drug abuse that developed among a specific portion of the population of drug addicts. This seems to be, with few exceptions, a characteristic of countries with a long history of drug abuse and injecting drug use (Canada, Denmark, Ireland, Portugal, Switzerland and United Kingdom);

(b) The need to address an unexpected increase in injecting drug use, in drug-related deaths or in the prevalence of infection by the human immunodeficiency virus (HIV), for which the health services were partly or completely unprepared (Bahrain, Croatia, Kyrgyzstan, Lithuania, Mexico and Norway);

(c) The fact that maintenance programmes were considered to be part of the strategy to address drug abuse, also as a result of the experience of other countries (Cyprus, Guatemala, Hong Kong, Latvia and Slovenia).

31. Another reason mentioned was the concern for public health, particularly related to the rapid spread of HIV among injecting drug users. Also, an increase in crime and violence were indicated as factors that influenced the decision on the programmes. The failure of drug-free treatment services and the number of relapse cases convinced some States of the need to provide narcotic drugs for the chronic drug addicts who had failed in other programmes. In other cases the lack of drug-free treatment services in clinical facilities motivated Governments to authorize the prescription of narcotic drugs to deal with the increasing number of drug addicts. The experience of other countries also influenced the decision on the implementation of the programmes.

32. Almost all programmes prescribed methadone. Other drugs prescribed were buprenorphine (Switzerland and the United Kingdom), codeine (Germany and Switzerland), dihydrocodeine (Germany), heroin (Switzerland and the United Kingdom), L-alpha acetyl methadol (Portugal), morphine (Guatemala, Mexico and Switzerland) and pethidine (Guatemala).

33. The methadone maintenance programmes had been in place for a relatively long time in Sweden and the United Kingdom (1966) and in Switzerland (1975), although regulations to prevent excessive or inappropriate prescribing or diversion may be of later date. Methadone maintenance programmes started later in Bahrain (1985) and Austria (1987). More recently, such programmes were initiated in Finland (1990), Croatia (1991), Mexico (1993), Norway (1994), Lithuania (1995) and Latvia (1996).

34. About half (15) of the States and territories that reported details on their maintenance programmes said that the programmes were supposed to continue for a long time or indefinitely. Some stated that the programmes were an integral part of a series of treatment services available to drug addicts (Denmark and Slovenia), or that research had demonstrated the efficacy of methadone treatment as a general approach (Australia and Canada). Others said that the programme would continue "until necessary". Some countries reported that the programmes would continue while funds were available (Latvia), pending legislative and political decisions (Monaco, Kyrgyzstan and Switzerland), or pending a scientific decision made by experts (Finland).

35. The table summarizes responses by countries that provided statistics on the number of people undergoing maintenance treatment. Most countries provided statistics on the number of people participating currently, or during one year, in the maintenance programmes.

Table. Number of drug-dependent people served by programmes prescribing narcotic drugs

Country or territory	Number of people served
Australia	17 356
Bahrain[a]	1 700
Canada	3 278
Croatia[a]	1 500
Finland[a]	20
Germany	30 000
Guatemala[a]	4
Hong Kong	10 000
Ireland	1 650
Kyrgyzstan[a]	2 136
Latvia	32
Lithuania	213
Malta	64
Mexico	280
Netherlands	12 500
Norway	100
Oman	50
Panama[a]	100
Portugal	1 500
Sweden	475
Switzerland	16 000
United Kingdom	20 000

[a]Cumulative number of people served by the maintenance programme since its inception.

36. The criteria for admission to the programmes were usually a mix of the following:

(a) Drug dependency. Serious opiate dependency, particularly heroin (in Australia, persons diagnosed as opioid-dependent should be assessed by an approved methadone prescriber to be appropriate for treatment). People admitted must have a relatively long history of dependency (at least four years of intravenous abuse of opiates for admission to methadone treatment in Sweden; two years of dependency for admission to heroin maintenance in Switzerland) and injecting drug use;

(b) Health risk. HIV-positive and pregnant drug-dependent persons;

(c) Failure in other treatment options. For example, two proven unsuccessful efforts to follow treatment or another substitution programme are necessary for admission to heroin maintenance in Switzerland. Other examples are: documented failure in short-term detoxification and drug-free treatment options; and failure to comply with abstinence requirements;

(d) Administrative and control criteria. Age (over 18 in Croatia for methadone, and over 21 in Switzerland for heroin); admission as patients of State clinics (Latvia); voluntary request and informed

consent; body fluids checked for other substance and to control abstinence (Austria, Denmark and Mexico); deposition of driving licence and access to criminal records (Switzerland).

37. Procedures for administration vary. In some States, the narcotic drugs are administered only by a certified psychiatrist in clinical settings and in a controlled situation (Bahrain, Croatia, Guatemala, Norway, Oman, Panama and Sweden). In other States and territories, authorized general practitioners or medical doctors prescribe narcotic drugs to drug addicts who meet the criteria set by the competent authorities (Austria, Canada, Hong Kong, Iceland, Ireland, Latvia, Lithuania, Mexico, Monaco, Netherlands, Portugal and Switzerland). Some addicts can also obtain the drug on a take-home basis on prescription by a general practitioner (methadone in the United Kingdom) exercising his or her clinical judgement.

38. Prescription of heroin to opiate addicts has been allowed in the United Kingdom since the 1920s. Traditionally, heroin maintenance was defined as bona fide medical treatment if addicts who had failed to respond to treatment were able to live relatively normal lives when provided with a regular supply of the drug. In most cases, they received their regular prescription from their family doctor. Since 1968, prescription of heroin and of cocaine has been legally restricted to physicians specially licensed by the Home Secretary for that purpose. Whereas currently about 150 people receive either heroin or cocaine prescriptions, more than 20,000 are under methadone treatment.

39. A three-year trial of prescription of narcotic drugs to drug addicts was approved by the Council of Ministers of Switzerland in 1992. The first projects were set up in January 1994 to provide 250 drug addicts with injectable heroin, 250 with injectable morphine, and 200 with injectable methadone. The design has been modified since then, and the number of persons provided with injectable heroin has been increased to 800. As of October 1996, approximately 800 addicts were receiving heroin, 200 methadone (intravenously), approximately 40 buprenorphine (orally), and 39 morphine (intravenously or orally). No figures were given on the number of addicts receiving codeine. In addition to the above-mentioned figures, approximately 13,800 people were enrolled in methadone programmes, mainly for oral administration.

40. The prescription of heroin is expected to continue until 1998 for those who were enrolled in the programme before June 1996. Further continuation of the programme and admission of new patients depend on the results of the final evaluation and on government decisions.

41. At the request of the Government of Switzerland and the International Narcotics Control Board, WHO coordinated an evaluation of the Swiss studies on prescription of narcotic drugs to drug addicts. The results of the evaluation were not available when the present report was drafted.

B. Reported effects of prescription of narcotic drugs to drug addicts

42. Most of the States with maintenance programmes reported ongoing or completed evaluations, but few have provided evaluation reports to the secretariat. Methadone maintenance programmes vary according to admission criteria, length of treatment, dosage, combination with other types of treatment etc. Many factors influence the results, not least the broader health and social welfare context in which the maintenance programmes are carried out. The results of the evaluations provided by Member States are therefore not directly comparable.

43. Randomization poses ethical problems. To the knowledge of the Secretariat, there are only a few experimental substitution studies involving a control group not receiving treatment.[7,8,9] No study has been found in which drug addicts were offered substitution or drug-free treatment by random allocation.

44. The three experimental studies show similar results: methadone substitution is more efficient than placebo treatment or no treatment at all, particularly with regard to reduction of heroin consumption and involvement in criminal activity, as long as the patients are in long-term treatment.

45. With regard to heroin maintenance, an evaluation was conducted[10] in a controlled trial carried out in London during the late 1970s. Ninety-six confirmed heroin addicts were either randomly allocated to heroin maintenance or were refused it and offered oral methadone instead. All patients were interviewed before randomization, and followed up for a period of 12 months.

46. Almost all heroin patients continued to inject regularly. The majority persisted in obtaining illicit drugs in addition to their prescription, though usually in small or moderate amounts. The use of other drugs, such as barbiturates and stimulants, showed little overall change. For many patients, there was little qualitative change in lifestyle. The majority remained in contact with other drug users and involved in drug-related activities, though often less intensively than before. Most persisted in some criminal activity, though less than half were dependent on crime as a source of income. Although the extent of criminal activity decreased during the year, the proportion arrested during the trial year was the same as during the year prior to intake, when they were not receiving a prescription.

47. The patients who were refused heroin tended to polarize toward the extremes on a number of measures. They were more likely, on the one hand, to be totally abstinent, or almost so, while, on the other hand, those who did continue using and injecting regularly were obtaining larger quantities of illicit heroin than those given a heroin prescription. In terms of social functioning, either they had stopped associating with other addicts and ceased drug-related activities, or they were heavily involved in the drug scene. Those no longer involved in the drug scene were more likely to be employed, and much less likely to depend on crime as a major source of income. At the other extreme, patients who were injecting regularly and heavily were almost all unemployed and largely dependent on crime as a means of support. Their health was no different from that of those receiving heroin.

48. The findings suggest that legal prescription of heroin is unlikely, by itself, to produce any dramatic change in lifestyle or social functioning. In particular, it is unlikely to eliminate, though it may reduce somewhat, the criminal activity of addicts, especially those whose delinquence started at an early age and prior to heroin abuse.

Notes

[1]United Nations, Treaty Series, vol. 520, No. 7515.

[2]Ibid., vol. 976, No. 14152.

[3]Ibid., vol. 1019, No. 14956.

[4]Official Records of the United Nations Conference for the Adoption of a Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Vienna, 25 November-20 December 1988, vol. I (United Nations publication, Sales No. E.94.XI.5).

[5]Commentary on the Single Convention on Narcotic Drugs, 1961 (United Nations publication, Sales No. E.1973.XI.1), p. 65.

[6]Ibid., p. 66.

[7]V. P. Dole and others, "Methadone treatment of randomly selected criminal addicts", New England Journal of Medicine, vol. 280, 1969, pp. 1372-1375.

[8]R. G. Newman and W. B. Whitehall, "Double-blind comparison of methadone and placebo maintenance treatments of narcotic addicts in Hong Kong", Lancet, 9 September 1979, pp. 485-488.

[9]L. Gunne and L. Grönbladh, "The Swedish methadone maintenance program: a controlled study", Drug and Alcohol Dependence, vol. 7, 1981, pp. 249-256.

[10]Hartnoll and others, "Evaluation of heroin maintenance in controlled trial", Archives of General Psychiatry, vol. 37, August 1980, pp. 877-884.