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Adolescent Drug Taking

Drug taking among teenagers has been a topic of considerable interest and concern to medical practitioners, welfare officers, juvenile courts and the police, for the past few years. Recently, legislation has been introduced to try to control the supply of certain drugs, and the Brain Committee has been reconvened 'to consider whether in the light of recent experience the advice the Committee gave in 1961 in relation to the prescribing of addictive drugs by doctors needs revising and, if so, to make recommendations'.

My particular recent interest has been in the consumption of amphetamine and amphetamine-barbiturate mixtures by the younger age group – mainly as Drinamyl or 'purple hearts' – this interest naturally following on earlier work on amphetamine addiction and amphetamine psychosis arising in 1954.

The dangers of misuse of amphetamine drugs have been reported by many writers since 1954, including Connell (1958), Kennedy & Fish (1959), Beamish & Kiloh (1960), Bell & Trethowan (1961), Kiloh & Brandon (1962), Connell (1962, 1964*a*,*b*) and Wilson & Beacon (1964).

In general, it seems that the amphetamines are prescribed most commonly by family doctors for various complaints such as depression, tiredness, listlessness and obesity; less widely by general physicians; and very little indeed by psychiatrists.

The Brain Committee (Ministry of Health & Department of Health for Scotland 1961) drew attention to the fact that of 214,000,000 National Health Service prescriptions in 1959, some 5,600,000 or approximately 2·5% were for preparations of the amphetamines and phenmetrazine. The conclusion that 'such prescribing is excessive though hardly to an extent that could give rise to concern' and 'we have formed the impression that, while serious cases of addiction arise from time to time, such abuse is not widespread' is not borne out by recent papers (Kiloh & Brandon 1962, Brandon & Smith 1962). For instance Kiloh & Brandon calculated that the average monthly quantity of amphetamine prescribed in Newcastle City and County was 200,000 tablets, 53% of which were dispensed as Drinamyl. Various sources of illegal supply included obtaining them from friends, hairdressers, claiming that the original prescription was lost, obtaining multiple prescriptions for various members of the family, registering with several doctors, using false names (one patient was traced on the lists of 15 doctors), forging prescriptions by altering amounts or stealing blank E.C.10 forms.

Brandon & Smith (1962), in a study of prescribing in general practice, found evidence which suggested that 20% of those taking the amphetamine drugs were habituated or addicted, and that approximately 520 patients were habituated to amphetamines in Newcastle upon Tyne.

Wilson has dealt with his experiences in his valuable Liverpool studies (Wilson & Beacon, 1964). There is, however, very little scientific material on drug taking amongst the adolescent group in this country and until very recently reports concerning this problem have mainly been confined to the daily or weekly papers.

Linken (1963) carried out an enquiry into the problem of adolescent drug taking, believing – before commencing his enquiry – that 'drug taking among young people was only a fringe problem'. He mixed with coffee-bar groups, Chelsea sets, and university groups, and found that there was drug taking in most levels of adolescent communities, including schools. Of the group of students in schools, universities, and colleges for higher education that he studied, 4% had drug experience of one type or another, and of a group

of 'say 150 young people in an all-night coffee bar' Linken suggests that at least 30 individuals would have smoked hemp or taken stimulant drugs that evening. Even schoolboys in grammar school gave him an account of marihuana smoking and it was certainly not considered a vice or a potential criminal activity. Linken noted amphetamine taking, sniffing asthma cures, amyl nitrite taking, gum sniffing and some barbiturate taking in this age group.

Sharpley (1964) investigated the coffee bars, all-night clubs, &c., in Soho and entitled one report 'My Pep Pill Soho Trip – Super Teenagers are the Prey for Pushers'. She describes graphically the activities of these teenagers, 'tireless, sleep free, talkative super-teenagers drifting from club to café with a strange, sterile energy'. They came from all over England. She describes the addicts ('junkies' or 'kicksters') who take excessive quantities – up to 50 purple hearts (Drinamyl) at a time – and notes that most of these are on 'skippers' – that is, living off what they can find. She draws attention to the ease of obtaining these drugs and to the prostitutes, 'main liners' (morphine addicts), transvestites, &c., who also hang around these clubs.

It was largely due to the reports by Linken and Sharpley and to police anxieties, that the then Home Secretary, Mr Henry Brooke, visited these haunts, and this led to the new legislative proposals. At the present time the *Evening News* is using the Paul Temple strip cartoon to draw attention to the purple heart situation.

Psychiatrists, however, rarely see these individuals. They are dealt with by social agencies, the courts, and one of the difficulties may well be that few psychiatrists have enough experience of misuse of these drugs to feel happy about the assessment of the problem; nor have they interest or special experience in the problems of adolescents in maturing emotionally. Furthermore, the toxic effects of the amphetamine drugs soon disappear and the individual who is examined may either show no obvious abnormalities or may not be considered psychiatrically abnormal because he does not show overt symptoms of psychosis or neurosis.

During the past year I have been running an evening clinic to which adolescents can be referred, and have lately been making it known that I should be interested in these cases. Only 5 cases of adolescents involved in this kind of drug activity have come my way, though each of these has known many other adolescents who are also taking the drugs in large quantities. I am satisfied that the information given to me by these 5 individuals, none of whom knew any other member of the small group, is accurate in that they each confirm the picture in all essential details. Their evidence also tallies with the observations of Linken and Sharpley.

The following brief case histories may serve to high-light the problems posed by drug activity among adolescents.

Case 1 Boy aged 15¼ when he first started taking drugs soon after leaving school. He obtained them at Soho cafés and clubs. He had taken Benzedrine, Dexedrine, the 'roaring twenties'; had smoked reefers and had sniffed amyl nitrite. The best, however, was Drinamyl (purple hearts) which he had taken in quantities of up to 50 a short session.

He had experienced several episodes of paranoid psychosis and had taken drugs only at weekends until three weeks before his breakdown. His intelligence was average and his EEG normal.

He had twice been before the juvenile court on account of offences unrelated to his drug taking.

He had had palpitations and panic attacks when taking large doses of Drinamyl and feared that he would die.

He was the youngest of 3 siblings.

Case 2 Boy aged 15 when he began taking drugs shortly after leaving school. He obtained them at clubs and cafés in the West End of London and at Brighton. He had taken 'black bombers', preludin and Dexedrine and had smoked reefers. He found Drinamyl best, taking up to 120 at a session.

He experienced several episodes of paranoid psychosis and on very high doses became confused and suffered from formication. He had been offered injections of morphia and heroin and knew someone who regularly took cocaine.

He was an only child and at the age of 14 began to truant from school, to drink and smoke, and became aggressive at home. He had three appearances in juvenile courts for larceny unrelated to his drug taking and had been admitted previously to mental hospital for six weeks to withdraw him from drugs.

Case 3 Boy who first took drugs at 15¼ years soon after leaving school. He began on Nostroline inhalers (amphetamine inhaler since withdrawn) and also smoked reefers. He found that Drinamyl was most effective and took up to 100 at a session; he obtained them from clubs and cafés in Soho.

He experienced several episodes of paranoid psychosis. He used to sweep and clean clubs to earn money to obtain the drugs. Whilst under the influence of drugs he entered into active and passive homosexual practices. He knew where to get heroin.

He was an only child and began to truant from school at the age of 14 and to steal money from his parents. His IQ was 94 and his EEG was normal.

Case 4 Boy aged 16 when he first began to take drugs. He had taken Dexedrine, Benzedrine and phenobarbitone but found Drinamyl best. He obtained them at Soho clubs and cafés and knew someone who was taking heroin regularly, noting the deterioration in this person.

He had experienced several episodes of paranoid psychosis and was admitted to hospital after taking a

number of barbiturate tablets as well as Drinamyl which led to grand mal attacks. His EEG was normal.

He had begun taking drugs during the week as well as at the weekend six months before I saw him. He was happy when at school and wished he were back there. He had a good work record until recently. He was the elder of two sons.

Case 5 Boy aged 17 who did not take drugs but 'pushed' them for financial gain. He knew 11 boys and 2 girls in the local school area who were taking drugs. He was before the juvenile courts on three occasions for larceny and had a very poor work record.

The present situation with regard to adolescent drug taking is serious and it would be most unwise for the medical profession to continue with an attitude of complacency. The very recent work of Scott & Willcox (*see Lancet* 1964), which demonstrates that the urine of 18% of those admitted to boys' and girls' remand homes gave positive reactions to amphetamines, is clear evidence of a large problem in this selected population.

Various questions which require answer can be posed, such as:

(1) What proportion of teenagers who take these drugs become addicted to them?
(2) How easy or how difficult is it to break the purple heart addict from his addiction?
(3) What effect, if any, does drug taking have on personality development when the onset of the drug taking is during the impressionable and emotional period of adolescence when the individual is trying to come to terms with the challenges of social mixing, heterosexual contacts and with a wider authority than that of the home and school?
(4) What proportion of teenagers who take amphetamines or amphetamine barbiturate mixtures become addicted later to other drugs – particularly morphia, heroin and barbiturates?
(5) Can teenage drug taking be regarded primarily as being culturally determined behaviour associated with the concept of obtaining 'kicks' and 'giggles'? If so, when is the next culture shift to be expected and what direction will it take?
(6) What steps should be taken to deal with the problem at present?

I am not satisfied that the taking of drugs by this age group is necessary and beneficial. Far greater harm is being done to those who take them than is indicated by the literature.

I regard the drug taking as being culturally determined behaviour, usually occurring at weekends, and my experience suggests that there may well be a shift on the way. However, a patient I saw recently suggested that the apparent decrease in this behaviour in the West End of London is due to the fact that the drugs are now much more freely available in suburban areas of London and in the other large cities so that individuals are less inclined to come down to London for supplies.

I am disturbed at the sophistication these adolescents show concerning the availability of narcotic drugs. They have all known where to go to obtain morphine or have known someone taking this drug whom they could contact if they ever wished to take it. Could the next culture shift be towards morphia and heroin, as has happened in the United States of America? May the shift turn them to barbiturates or perhaps alcohol?

The prime need is to consider the protection of adolescents who have not taken the drugs so that it becomes far more difficult for the casual person to be involved in this kind of behaviour. If methods could be adopted to make it much less likely that the casual person would find himself in a situation where the drugs were freely available this would be very valuable prophylaxis.

Other measures which may help are:

(1) Special clinics for the assessment and long-term follow-up of drug takers, sited in the main population areas – such as the evening clinic I run at the Maudsley Hospital. A clinic should have access to special investigation units and particularly to a department which can undertake urine tests for amphetamine. Such a clinic would be in an adult psychiatric department and would make possible the channelling of drug takers in sufficient numbers for research and follow-up studies. Addicts to morphine-like drugs should not attend at the same time as amphetamine addicts, because of the risk of transfer to the hard drugs. Close links should be established between a clinic and possible sources of referral – family doctors, probation officers, juvenile courts and social workers, who are already concerned about this problem.
(2) Extensive education of general practitioners and consultants so that the dangers of these drugs can be brought more effectively to notice. It may well be that the rather rigid definition of addiction adopted by the Interdepartmental Committee on Drug Addiction has encouraged a casual attitude towards these drugs, which are consequently placed under the label of drugs of habituation rather than drugs of addiction.

There are many 'unknowns' in this field, and I do not consider that there is sufficient evidence to warrant removal from the pharmacopœia of these amphetamine drugs, which are found to be of value, particularly by general practitioners.

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Opiate Addiction

Legal Position

In 1926 the Rolleston Committee made certain recommendations which have influenced our attitude towards drug addiction both in the medical profession and in governmental circles up to the present time (Ministry of Health 1926). In their report they outlined circumstances in which morphine or heroin might be legitimately administered to addicts. Since that time the legal position of a practitioner with regard to dangerous drugs has been governed by the Dangerous Drugs Act of 1951, and the Dangerous Drugs Regulations of 1953. The Home Office (1956) has issued a memorandum in which the duties of the doctor and the dentist under these regulations are defined, and here it is stated that the authority granted to a doctor to possess and supply dangerous drugs is limited by the words 'so far as may be necessary for the practice or exercise of his profession'. In 1961 a further committee, under the chairmanship of Lord Brain, reported on the national situation with regard to addiction and suggested certain modifications in the methods of control (Ministry of Health & Department of Health for Scotland 1961). At that time, with the figures available, the situation with regard to drug addiction appeared to be relatively stable and did not call for any major alterations in the *status quo*. Since the time of the publication of that report, however, there have been a few disturbing factcrs emerging in our national figures for addiction, a point which I will amplify later in this paper. The Interdepartmental Committee of 1961 has been reconvened within the past few months, and I have no doubt that it will have under its consideration these recent alterations in the national situation.

Current Methods of Control

It is difficult to discuss addiction without comparison with the situation in other countries, and in particular the USA. In the United Kingdom with a population of approximately 50,000,000 our most recent stated figure of known addicts was 635. In the USA with a population approximately three times as great a figure is given of around 50,000 addicts. One has to accept these bare facts although there is little doubt that in both countries estimates of the number of addicts leave much to be desired. Such a numerical disparity between two countries in which the mode of life is essentially similar is intriguing. Do we in this country have a hidden reservoir of addicts who do not appear in our official statistics? Are our numbers of addicts in fact very much higher than we realize? Although many of our addicts are known to the Home Office Dangerous Drugs Department, we have no policy of registration of addicts. Should we have one? I wonder if the time has not come for us to consider seriously whether a form of notification of drug addiction is necessary. Some of the Commonwealth countries have adopted a form of registration. There are numerous reasons for and against such a decision. I do not personally think that the notification of drug addiction to administrative medical authorities would lead to any greater difficulties for the addict, and I see no reason why any interference in the doctor–patient relationship should occur. Accurate notification could lead to earlier treatment, and it would also lay this perennial ghost of the hidden reservoir of addicts, so frequently referred to by our overseas colleagues. The most pertinent reason in favour of notification, however, is that within the past few years there has been a steady increase in the incidence of opiate addiction, as revealed even in the figures at present available to us (Table 1).

Table 1
Known drug addicts 1959–63 (Home Office data)

	Known addicts	*Addicted to heroin*	*Addicts of non-therapeutic origin*
1959	454	68	22%
1960	437	94	28%
1961	470	132	33%
1962	532	175	40%
1963	635	237	45%