MEDICAL PRACTICE

Today's Treatment

The Illicit Drug Scene

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Drug taking is probably not in itself a social or medical problem or a cause of such problems, and most drug takers never come to the notice of "official" agencies. The minority who constitute a problem may be involved with drug taking for complex or psychological reasons; they may be relying on drugs until alternative support becomes available.

The commonest illicit drug is cannabis. Others include lysergide (LSD), which like cannabis is obtained wholly from unlawful sources. Amphetamines (and other central nervous stimulants) and barbiturates (and other central nervous depressants) are also taken illicitly though their source originally may have been legitimate—for example, they may have been stolen from pharmacies or overprescribed by doctors. Finally, opiates may find their way on to the black market from diversion of prescribed drugs on the one hand to smuggling of "Chinese heroin" on the other.

Cannabis

In Britain cannabis is generally smoked. It is widely used and most people who use it never come to the attention of either the police or the medical profession. It is used for social reasons since it makes people feel relaxed and sometimes slightly euphoric; the feeling may be described as a pleasant "high." Perception of space and time may be affected. Like the value of capital punishment as a deterrent the dangers of cannabis is one of those topics which are argued with a fervour that is sometimes inversely proportional to the amount of knowledge of the subject. No drug is perfectly safe, and it would be surprising, knowing what we now know of the long-term ill effects of tobacco and alcohol, if there were not some long-term ill effects from a substance which is smoked and acts as both a depressant and a mild hallucinogen. There is insufficient evidence about the long-term effects of chronic use. Widespread use of cannabis would cause further problems in such areas as driving and the control of machinery since cannabis affects driving skills and there is no simple equivalent to the breathalyser to monitor levels of use.

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REPORTS ON CANNABIS

Since 1968 there have been three reports about cannabis—from England, Canada, and the United States. Many of the members of the commissions (or committees) were pillars of their respective establishments. The evidence was sifted, the need for further research reiterated, and tentative conclusions drawn. Some policy decisions had to be taken as there was little likelihood of any fresh evidence leading to a radical change of view about either the personal effects of cannabis or its effects on society. There was agreement in the conclusions of these reports. The report *Cannabis*[1] drawn up by a subcommittee (under the chairmanship of Lady Wootton) stated:

"An increasing number of people, mainly young, in all classes of society are experimenting with this drug, and substantial numbers use it regularly for social pleasure.

"There is no evidence that this activity is causing violent crime or aggressive anti-social behaviour, or is producing in otherwise normal people conditions of dependence or psychosis, requiring medical treatment. The experience of many other countries is that once it is established cannabis-smoking tends to spread. In some parts of Western society, where interest in mood-altering drugs is growing, there are indications that it may become a functional equivalent of alcohol.

"In spite of the threat of severe penalties and considerable effort at enforcement the use of cannabis in the United Kingdom does not appear to be diminishing. There is a body of opinion that criticizes the present legislative treatment of cannabis on the grounds that it exaggerates the dangers of the drug, and needlessly interferes with civil liberty."

The report made various recommendations:

"(1) We recommend that in the interest of public health it is necessary for the time being to maintain restrictions on the availability of cannabis.

"(4) The association in legislation of cannabis with heroin and the other opiates is inappropriate and new legislation to deal specially and separately with cannabis and its synthetic derivatives should be introduced as soon as possible.

"(6) Possession of a small amount of cannabis should not normally be regarded as a serious crime to be punished by imprisonment."

Briefly, the Committee thought that cannabis was not as dangerous as people had once thought and that the current penalties for use were too severe.

The Canadian Commission,[2] like their British counterparts, were not in favour of more widespread use of cannabis but did not think it had sufficiently harmful effects to justify severely repressive legislation. They thought that cannabis use should be discouraged but thought that current penalties for simple possession should be drastically reduced.

The U.S.A. National Commission on Marihuana and Drug Abuse[3] came to similar conclusions. In a final comment to their report they stated:

"We have carefully analyzed the inter-relationship between marihuana the drug, marihuana use as a behaviour, and marihuana as a social problem. Recognizing the extensive degree of misinformation about marihuana as a drug, we have tried to demythologize it. Viewing the use of marihuana in its wider social context, we have tried to desymbolize it. . . . Considering the range of social concerns in contemporary America, marihuana does not, in our considered judgement, rank very high. We would de-emphasize marihuana as a problem."

It would be desirable to discourage cannabis use if we knew how, but it has not proved easy to discourage cigarette smoking. Since the publication of *Cannabis*[1] the number of penalties for cannabis use has increased but their severity has decreased. None of the reports proved immediately acceptable, and the law may fall into disrespect and disuse in this area. Cannabis will not be legalised but attempts to stop it being used may fail. Perhaps a further review is due, not on whether penalties should be reduced or increased but on how to cope with cannabis if present sanctions are ineffective.

LSD and Other Hallucinogens

LSD is one of many substances that may produce an altered state of consciousness. Psilocybin and mescaline have been known for a long time, but LSD has only been used for the past 30 years. Unlike other psychoactive drugs—such as amphetamines or opiates—which produce a largely predictable subjective experience, hallucinogens produce widely varying sensations and experiences. Their effects are often more dependent on the individual's state of mind and general condition than on the drug. There is a large mythology among hallucinogenic drug users—for example, that such and such a drug, even a particular batch of "acid" currently on sale, gives a particular kind of trip.

In using illicit drugs the user does not have the quality or quantity control that he has when buying drugs from a chemist or having them prescribed by a doctor. This is particularly true of what is sold as "acid," which is supposedly LSD but often consists of other drugs varying from nothing to amphetamines to LSD-like substances. LSD is active in very small doses; 200 μg is a standard dose for an illicit trip. The main effects last for two to three hours and then slowly wane with periods of relatively normal feeling and perception interspersed with periods of hallucination of decreasing intensity and duration for sometimes as long as 24 hours.

Side effects may include nausea, sweating, dizziness, and a change in the pulse rate. The sensory responses are characteristically disturbed in the way sights, sounds, and smells are perceived. Emotional experience is diverse; feelings of delight, ecstasy, terror, disgust, sexuality, or ascetism have been described and may wax or wane intensely. Their quality is difficult to communicate clearly at the time or report accurately later. The commonest ill effect of LSD is the so-called "bad trip," which may involve hours of acute anxiety and fright and be remarkably unpleasant. It may, indeed, lead to the end of experimentation with LSD. Usually symptoms disappear after two or three days, but in some cases changes may occur later. The commonest is the so-called "return trip," when some of the feelings experienced during the LSD sessions may seem to come back unbidden in to the mind and for a few minutes or a few hours may leave the person alarmed, disorientated, or depersonalized.

Another though less common ill effect is a state of intense chronic anxiety, which seems to be self perpetuating. A more serious form of "bad trip" may occur when a psychotic state is produced, insight is lost, and a person may feel acutely persecuted and in mortal peril (a state of affairs which can lead to dangerous behaviour). This is rare, however, and more likely to occur if LSD is taken by someone with, for example, an incipient schizophrenic illness.

Amphetamines

The amphetamines elevate mood and induce a state of well-being which is probably the basis for their value and widespread use as stimulants. The ingestion of large amounts of these drugs may lead to aggression and dangerous antisocial behaviour, though the abuse of this class of drugs originates in and is perpetuated by the psychic drive to attain maximum euphoria. The amphetamines' capacity to induce tolerance is possessed by a few other central nervous system stimulants. Though tolerance develops slowly a progressive increase in dose permits the eventual ingestion of amounts that are several hundredfold greater than the original therapeutic dose. All parts of the central nervous system do not seem to become tolerant at the same rate so that the user will continue to experience increased nervousness and insomnia as the dose is increased. Though an individual may survive the oral administration of very large quantities profound behavioural changes that are often of a psychotic nature, including hallucinations, may occur, but these latter effects are much more likely to occur after intravenous injection. The sudden withdrawal of a stimulant drug which has masked chronic fatigue and the need for sleep permits these conditions to appear in an exaggerated fashion. Thus the withdrawal period is characterized by a state of depression, both psychic and physical, which possibly reinforces the drive to resume the drug.

Amphetamines cause arousal, wakefulness, a sense of well being, lessening of fatigue, and a feeling of increased energy and self confidence. Appetite is also inhibited. With excessive doses there may be restlessness, rapid speech, inability to sleep, euphoria, irritability, tension and anxiety, aggression, slurred speech, staggering gait, rapid heartbeats, irregular heartbeats, dry mouth, and tremors in limbs. Paranoid thinking and, eventually, delusions and hallucinations of a persecutory kind may also develop. The social consequences of severe dependence on amphetamines include involvement in illegal acts to obtain drug supplies, deterioration of work record, disruption of family life, amphetamine psychosis, a tendency to aggressive behaviour, suicidal attempts in the withdrawal phase, and rare physical consequences such as cerebral haemorrhage.

Since doctors have voluntarily curtailed their prescribing of amphetamines there has been a tendency among those endeavouring to obtain central nervous stimulants from doctors to request other stimulants such as methyl phenidate hydrochloride (Ritalin), which has similar effects to amphetamine.

Barbiturates

Barbiturates are general depressants of the central nervous system, brain, and spinal cord. In small doses they affect the

cerebral cortex and impair higher nervous function; in moderate doses they generally depress cortical function, which results in sleep or clouding of consciousness; and in high doses they paralyse the centres in the lower brain which control heart and breathing, thereby causing death. The signs and symptoms of barbiturate and alcohol intoxication are similar, as are the signs and symptoms of abstinence from these drugs. Barbiturates will suppress alcohol abstinence phenomena and alcohol will suppress at least partially the symptoms of barbiturate withdrawal. The two drugs are essentially additive and interchangeable in chronic intoxication.

Tolerance to barbiturates does develop, and with a relatively low dose it will become evident within seven days. After withdrawal tolerance is rapidly lost and some patients may become more sensitive to barbiturates than they were before chronic intoxication. Duing the chronic intoxication of continuing administration some sedative action, ataxia, etc. persists through the incomplete development of tolerance and makes the individual accident prone. There is also impairment of mental ability, confusion, increased emotional instability, and a risk of sudden overdose through delayed onset of action and perceptional distortion of time. All agents which produce barbiturate-like sedation should produce some psychic dependence because of the relief of anxiety, mental stress, etc., and physical dependence when a sufficient concentration in the organism has been attained. This possibility has been confirmed for many different sedative agents including barbiturates, the so-called non-barbiturate sedatives such as glutethamide, methyprylon, meprobamate, chlordiazepoxide, bromvaletone (bromisoval), chloral hydrate, and paraldehyde.

Diversion from Licit to Illicit Channels

The following account describes one way in which drugs may be obtained. The drug taker visits a general practitioner who has prescribed psychotropic drugs for a friend. He goes to the surgery at a busy time, preferably when the waiting room is full of young children; for this reason the practice is often on a housing estate. He registers as a temporary patient and gives his correct name but a false address. This assures him legal safety if he is arrested as well as protection against being traced (any drugs prescribed will be in a container with his name on it). He claims that he has been prescribed stimulants for "depression" or barbiturates for insomnia by a general practitioner in a distant city from which he has recently moved. He may provide a story of personal tragedy if it is asked for—for example, his parents were recently killed in a motor accident or his wife died in labour. Should the doctor show reluctance to prescribe the drugs the patient may indicate that he will not leave without creating a disturbance. With little time and a full waiting room compliance seems to be an effective solution to a difficult problem. In a study of how addicts obtained drugs from general practitioners I found that 78% initially registered as a temporary patient with the general practitioner, and 88% usually returned to the same doctor more than once. It is generally wiser not to prescribe psychoactive drugs to young people, particularly those who register as temporary patients.

The Law and Drugs

There have been several acts to control potentially dangerous psychoactive drugs.

Pharmacy and Poisons Act 1933 regulated the sale and supply of listed poisons but not their possession by individuals. The Act established a poisons board as a statutory body. The board prepares for the Home Secretary's approval lists of substances which are classed according to the degree of control deemed necessary. This comprehensive list with 16 schedules known as the Poisons List is matched with appropriate controls in the Poisons Rules. The rules lay down various requirements for manufacture, sales, storage, transport, and labelling of poisons in the list. For instance, the drugs named in Schedule 4 of the Poisons List may be made available by pharmacists only to persons with a prescription from a qualified medical practitioner.

The Medicines Act 1968 incorporated the general control of therapeutic substances. Comprehensive provision was made with respect to safety, quality, and efficacy of human and veterinary medicines.

Dangerous Drugs Act 1965 codified earlier dangerous drugs legislation and implemented the United Kingdom's obligation under the single convention on narcotic drugs, dealt with export and import of scheduled substances, and empowered the Home Secretary to make regulations for the manufacture, sale, possession, and distribution of substances scheduled in the Act and also defined other offences under the Act and provided for the granting of search warrants for premises where it was reasonably expected the contravention of the Act might be found. Maximum penalties on summary convictions or indictment were specified.

Dangerous Drugs Act 1967 made the first basic changes in the British legal approach to the problem of heroin addiction since the first Dangerous Drugs Act in 1920. It empowered the Secretary of State to require medical practitioners to notify a central authority of any addicts using drugs covered by the Act and to prohibit any doctor from administering, supplying or prescribing specified drugs except under licence. Subsequent regulations made these restrictions explicit.

Drugs, Prevention, and Misuse Act 1964 made it an offence to import or to possess without authority, substances listed in the Schedule of the Act including amphetamines, amphetamine compounds, LSD, mescaline, psilocybin, and related compounds.

Misuse of Drugs Act 1971 and Subsequent Regulations. This Act was designed to replace the Dangerous Drugs Acts of 1965 and 1967 and the Drugs (Prevention of Misuse) Act 1964. Previous drugs legislation had been constructed on a piecemeal basis to meet new drug abuses, and no drugs other than opiates, cocaine, and cannabis were controlled under the dangerous drugs laws and the extent of control differed from that in the Drugs (Prevention of Misuse) Act. For drugs other than narcotics control could be achieved only by voluntary means or by the Pharmacy and Poisons Act if there was danger from inadvertent misuse (though possession was not regulated). The Misuse of Drugs Act was designed to deal with new patterns of drug abuse as they arise and to provide penalties for drug offences according to relative harmfulness of different drugs. The Act distinguishes between unlawful possession and trafficking, with several new trafficking offences created and the penalties for trafficking increased.

The general consequence of the new legislation is to provide more flexible powers for the Home Secretary to control the availability of prescribing of a wider range of drugs without the need for new legislation. The Act considers the problem of irresponsible prescribing of drugs by a small number of doctors and provides more flexible powers to withold the authority of a doctor to prescribe psychoactive drugs if it is established that irresponsible prescribing has taken place. There is provision for three bodies to deal with this problem in the Act—a tribunal, an advisory body, and a professional panel. All these bodies consist mainly of the respondents' professional colleagues.

References

[1] *Cannabis. Report of the Advisory Committee on Drug Dependence.* London, H.M.S.O., 1968.
[2] *Canada. Commission of Inquiry into the Non-medical Use of Drugs: Cannabis.* Ottowa, Information Canada, 1972.
[3] United States Department of Health, Education and Welfare, *Marihuana and Health,* Washington, U.S. Government Printing Office, 1971.