Guidelines for the Control of Narcotic and Psychotropic Substances

In the context of the international treaties

by

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The use and abuse of drugs of natural origin has been known since antiquity. For centuries man has tried to escape from the unpleasant features of life, whether real or imaginary, by using fermented liquors or plant products such as opium, coca leaves, cannabis and, more recently, khat.

It was, in fact, the large-scale use of some of these natural products which drew attention to the need for control of such dependence-producing substances and for achieving at the same time a reduction in the demand for them. There is still great concern in the mind of the public about the abuse of narcotic drugs derived from plant material.

Additional problems have, however, arisen from the use of modern synthetic drugs created in large numbers by scientists in medicine and industry. Such drugs of great therapeutic benefit are now available as narcotic drugs of opiate-like action and also in the wider area of psychotropic activity as central nervous stimulants, sedatives, hypnotics, tranquillizers, etc. The modern synthetic drugs do indeed produce relief in a large number of people who need them, even though their indiscriminate use and overuse is causing concern. However, they have also been found to produce dependence, and sometimes abuse, creating large-scale public health and social problems through diversion into illicit traffic.

Efforts to provide an international legal framework for the control of psychoactive drugs, begun by the International Opium Commission in Shanghai in 1909, have resulted in a number of international treaties. The formulation of the 1961 Single Convention on Narcotic Drugs, with its 1972 amending Protocol, and the 1971 Convention on Psychotropic Substances are the major achievements in the development of coordinated international control of dependence-producing drugs.

The international drug control treaties are instruments which provide a framework for the regulation of a number of defined narcotic drugs and psychotropic substances, the most dangerous of which are eliminated from use. The potentially beneficial ones are subjected to controls in production, manufacture, trade and distribution so that their use can be limited exclusively to scientific and medical purposes. Furthermore, the conventions embody a policy and indicate the type of controls needed in legislation and drug regulatory work, thus helping to promote the rational utilization of the controlled substances and the prevention of their abuse and to counteract illicit international traffic.

The World Health Organization gives high priority to the responsibility assigned to it by the international drug treaties. One important aspect deals with
the scope of control of the treaties where the assessment of WHO is, in the terms of the 1971 Convention on Psychotropic Substances "determinative as to medical and scientific matters".

A rational drug policy concerning psychoactive drugs is essential for the accomplishment of WHO's programme for health for all by the year 2000. WHO stimulates and supports the continuing education of members of the health professions in the therapeutic use of these drugs in order to prevent their overuse and misuse and to caution the public about the harm they can do. The ongoing WHO programme for selecting a list of essential drugs offers another opportunity to nations to screen psychoactive drugs available in their country and to evaluate their benefit/risk ratio in the spirit of the drug control treaties.

The present guidelines constitute yet another example of this cooperation with Member States in an effort to support nations in promoting the rational use of psychoactive drugs and in directing their administrations to areas where action may be required. The guidelines aim at explaining the obligations of parties to the conventions on the control of narcotic drugs and psychotropic substances, and at clarifying how parties should formulate their national drug policies and legislation to conform with the aims and purposes of the international drug conventions. Alternatives are discussed to provide the flexibility necessary to adapt the provisions of the conventions to the national scene. Finally, the guidelines indicate areas, ways and means whereby the parties can seek technical collaboration with WHO and the relevant United Nations bodies when implementing the provisions of the conventions, and constant reference is made to the relevant WHO technical documents and publications.

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CHAPTER 1

WHO STUDY ON THE IMPLEMENTATION OF THE INTERNATIONAL DRUG CONTROL TREATIES

World Health Assembly Mandate

In 1980, the Thirty-third World Health Assembly, after having reviewed WHO work in progress, adopted resolution WHA33.27 entitled “Action in respect of international conventions on narcotic and psychotropic substances: Abuse of narcotic and psychotropic substances”\(^a\). This resolution acknowledged the role and responsibilities of WHO in relation to the abuse of narcotic and psychotropic substances, and noted the request of the United Nations General Assembly in resolution 32/124 (1977) that, in the effort to reduce drug abuse, WHO and other appropriate agencies and bodies of the United Nations should design models for prevention, treatment and rehabilitation. It then affirmed that drug abuse constitutes a serious health hazard of steadily growing proportions in developing nations as well as industrialized countries, and encouraged Member States, as they developed their national strategies for health for all by the year 2000, to give serious consideration to the inclusion of components that can deal effectively with the growing incidence of drug abuse. It also urged them to devote more attention to the incidence of drug abuse in their own societies, their regions and the world community, and particularly to the disruptive effect that drug abuse has on the lives and future careers of young people, and drew attention to the negative impact of drug abuse on socioeconomic well-being, to the increasing difficulties in enforcing the law, and to the need for measures aimed at reducing the demand for and illicit supply of drugs of abuse in their societies.

In paragraph 7(3) the World Health Assembly resolution requested the Director-General “to promote the initiation and strengthening of national and international programmes for the assessment, scheduling, control and appropriate use of narcotic and psychotropic substances, including those of plant origin, and to support such programmes by the development of appropriate guidelines in consultation with the United Nations Division of Narcotic Drugs, International Narcotics Control Board and other United Nations bodies concerned”\(^a\).

GUIDELINES FOR THE CONTROL OF NARCOTICS

The WHO Project

Directives

In the light of resolution WHA33.27, the World Health Organization formulated a proposal for a study on guidelines for the implementation of the international treaties for control of narcotic and psychotropic substances in developing countries. The proposal envisaged a number of stages, including preparatory working groups, country visits to examine the operation of various national drug control systems, and the review and finalization of the guidelines before making them available to national health authorities. The proposal also mentioned the possibility of producing a manual as a complement to the guidelines; this would deal with the more concrete and specific needs of the technical personnel who would have to implement the guidelines at the national and community levels.

The report of the first WHO Consultation on the Development of Guidelines in the Context of the International Treaties for the Control of Narcotic and Psychotropic Substances provided the following guidance on the purpose and scope of the country visits:

"It should be recognized that abuse or misuse of narcotic and psychotropic substances is—to a certain degree, which may vary from country to country, and indeed within a country from locality to locality—a corollary of the medical use of such substances. Consequently, any measures adopted at the national level with a view to the therapeutic efficacy, the safety and the quality of medicines, and measures designed to ensure the adequate functioning of pharmaceutical supply systems and the appropriate use of medicines in health practice, do in fact contribute to achieving the aims of these Conventions. Experience gained by the adoption of such measures is therefore of relevance to the international community, and of particular importance in the implementation of the present project.

The proposed country visits will afford a unique opportunity both to WHO and host countries, to obtain and interpret information relevant to the elaboration of the guidelines, and to analyse existing policies and their implementation in that context, as it were from the top down."

In order to obtain a format which would allow intercountry comparisons, a number of fields of inquiry were indicated, such as drug use policy; legislation concerning the production, importation, distribution and use of drugs; the assessment of drugs from the point of view of their therapeutic efficacy, safety—including dependence liability—and quality; national controls on drug scheduling and registration; measures to ensure the appropriate use of drugs; liaison between the health professions, the pharmaceutical industry, and the government; and cooperation at the international level.

Methods of country studies

Under the project, country visits were undertaken to six countries, namely Kuwait, Malaysia, Morocco, Nigeria, Panama and Thailand.

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* WHO unpublished document MNH/80.9.
* WHO unpublished document MNH/81.7.
* WHO unpublished documents MNH/82.9, MNH/81.27, MNH/82.42, MNH/82.36 and MNH/82.8.
Moreover, some experiences gained in earlier studies with identical or very similar objectives were available, including reports from Argentina, Finland, Jordan, Madagascar and Pakistan.\(^a\)

Valuable material was also available through reports from three WHO Travelling Seminars in the USSR in the years 1979–81 on the safe use of psychotropic and narcotic substances. The participants, mostly from developing countries, brought to these seminars country profile reports from 42 countries.\(^b\)

Finally, a country visit to the People’s Republic of China presented the possibility to report on the drug control situation of that country.\(^c\)

Comprehensive reviews of laws and regulations concerning drug use and abuse have been published by Jayasuriya\(^d\) and Chatterjee.\(^e\)

A country study group was usually made up of two international consultants and one or two national experts. The study groups, invited by the government in question, were very well received. Basic study materials, such as collections of laws, regulations, descriptions of the structure and function of health and law enforcement authorities, organizations and institutions, were prepared beforehand, as were reports on pertinent investigations and drug control, and on the use and abuse of psychoactive substances. Additional material requested was also provided. A study programme was prepared before the visits and provided the framework for interviews and discussions with leading personalities in government, health, research, law enforcement and commerce. Visits to offices, institutions and establishments in related areas were also made.

A draft report was, in almost all cases, produced during the visit. Immediately thereafter it was finalized by one of the international consultants and checked by the national experts, efforts being made to ensure the acceptance by the government concerned of the conclusions and recommendations included. It was then edited by the WHO responsible officer and issued by WHO. The reports were then made available to the respective governments and included in the information on work in progress submitted to the Commission on Narcotic Drugs and to the WHO Executive Board and the World Health Assembly. The reports were also sent for information to the International Narcotics Control Board and other United Nations bodies as appropriate.

The clarity of the country reports resulting from the visits of the study groups bears witness to the sincerity and frankness with which the groups were met by governments. They centre on the organization and functioning of national drug policy, drug laws and drug control systems, and on the assessment of actual drug use and abuse. They also explore, as far as possible, the limitations and problems in implementing the international conventions on drug control, and try to define the areas of control where international organizations might be of

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\(^b\) WHO unpublished documents MNH/78.2, MNH/79.35 and MNH/81.34.

\(^c\) WHO unpublished document MNH/82.45.


assistance in developing and supporting essential activities. Relevant information from these studies has been used in the appropriate sections of the present document.

The Final Document

A second WHO Consultation on Development of Guidelines in the Context of International Drug Treaties (November 1982) discussed a first draft of a final document, based on relevant published reports and investigations by WHO and the Division of Narcotic Drugs and other United Nations organizations. Additionally, the above-mentioned country reports were available from 13 countries, concerning their national drug policies. After the consultation, further discussions at WHO Headquarters a revised version was sent to the Regional Offices, the United Nations agencies and bodies concerned, WHO collaborating centres for research and training on alcohol and drug dependence problems, and a large number of experts. The body of comments received have been incorporated as appropriate in this book.

As this study has progressed and been discussed with persons working in the drug control field in various countries, in addition to those that were the subject of special visits, it has become clear that difficulties in the application of the conventions occur at all levels of development, including some highly industrialized countries. This view is reflected in the present book.

The present guidelines describe a variety of efforts on the part of the international community, the national authorities, and the professional groups concerned to limit the use of dependence-producing drugs with therapeutic or scientific usefulness and to come to grips with the problems of their illicit supply and demand. Because of the different institutional structures and different types of drug problem in each country, individual governments will have to make use of those elements that suit their particular circumstances, bearing in mind that various alternatives may be adopted towards similar ends.

This volume has been planned in such a way as to facilitate use. Where practicable, a simple exposition of principles is followed by more detailed discussion. Where it will be of special value, a chapter includes an outline of how action might be taken, though, for obvious reasons, such proposals are not complete. However, references are given as far as possible to WHO and other documents and publications that will provide additional information and proposals.
CHAPTER 2

THE RESPONSIBILITIES OF INTERNATIONAL ORGANIZATIONS UNDER THE INTERNATIONAL DRUG CONTROL TREATIES

International Drug Control Treaties

The early conventions

The worldwide control of psychoactive substances rests on the multilateral treaties concluded between 1912 and 1972. The operation of the international system is based on national control by individual States within the limits of their jurisdiction. In compliance with the provisions of the treaties, parties are bound to adopt appropriate legislation, introduce necessary administrative and enforcement measures and cooperate with the international drug control organs, as well as with other countries.

The first international body concerned with narcotic drugs, known as the International Opium Commission and consisting of representatives of 13 countries, met in Shanghai in 1909. Its deliberations led to the signing at The Hague of the first drug control treaty, the International Opium Convention of 1912, which established international cooperation in the control of narcotic drugs as a matter of international law.

The First Assembly of the League of Nations set up an Advisory Committee on Traffic in Opium and other Dangerous Drugs to assist and advise the League's Council on the subject. Under the auspices of the League, three main conventions were signed at Geneva. Under the 1925 International Opium Convention, a Permanent Central Opium Board was established to supervise the statistical control system introduced by that Convention, which established a system of import certificates and export authorizations for international trade in narcotic drugs. The 1931 Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs aimed at limiting world manufacture of drugs to what was required to meet medical and scientific needs by introducing a compulsory estimates system. It established a Drug Supervisory Body to monitor the operations of the system. The 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs called for the severe punishment of illicit traffickers.

The evolution of the drug control system continued after the Second World
War with the 1946 Protocol, which transferred to the United Nations the functions previously exercised by the League of Nations. While, in pre-war years, the products under control were all related to three plants—the opium poppy, the coca bush and the cannabis plant—the 1948 Protocol brought under control a number of synthetic substances that were also dependence producing. New and stricter control of the opium poppy was introduced with the 1953 Opium Protocol, which limited the use of, and international trade in, opium to established health needs, and eliminated legal over-production through the indirect method of limiting the stock of opium maintained by individual States. Furthermore, the legal production of opium for export was restricted to a small number of countries.


The whole system, which had grown somewhat complicated, was revised and modernized by the Single Convention on Narcotic Drugs (subsequently referred to as the Single Convention), adopted in 1961. The first objective was to collect and codify existing multilateral treaties, while retaining certain early provisions, such as the requirement for import and export authorizations and the estimates and statistical returns system. The international control machinery was simplified by amalgamating the Permanent Central Opium Board and the Drug Supervisory Body to form the International Narcotics Control Board. The control system of cultivation of the opium poppy was extended to the coca bush and the cannabis plant, with the additional establishment of national monopolies and special administrations for the purpose of applying the provisions of the Convention.

As a result of the Single Convention, such practices as opium smoking, opium eating, coca leaf chewing and cannabis (hashish) smoking were prohibited, after a transitional period to permit the parties to overcome the difficulties arising from the abolition of these often ancient customs. A new element was introduced into narcotic drug abuse control with provisions dealing specifically with the medical treatment and rehabilitation of abusers.

The Single Convention was to a certain extent widened and strengthened by the 1972 Protocol Amending the Single Convention on Narcotic Drugs, 1961. The Single Convention as amended underscores the necessity of intensifying efforts to prevent the illicit production, traffic in, and use of narcotic drugs. It emphasizes prevention of drug abuse as well as drug information and education, and the need for measures to ensure the treatment, rehabilitation and social reintegration of abusers. The role of the International Narcotics Control Board is strengthened, and emphasis is placed on its responsibility to endeavour to ensure a balance between demand for, and supply of, narcotic drugs and to prevent illicit drug cultivation, production, manufacture, traffic and use.

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The Convention on Psychotropic Substances, 1971

The Convention on Psychotropic Substances (subsequently referred to as the Psychotropic Convention) extends the international drug control system so as to cover new types of psychoactive substances, such as central nervous system stimulants (e.g., amphetamines), sedative-hypnotics (e.g., barbiturates) and hallucinogens (e.g., LSD and mescaline). The controlled substances are subjected to various degrees of control in trade, manufacture, distribution and use, depending on the balance between therapeutic usefulness and the risk of dependence production and degree of public health and social problems of abuse.

While the general use of some of the controlled substances is prohibited, the rest are available on medical prescription only, and the Convention provides for measures to ensure that the prescriptions are issued in accordance with sound medical practice, that the labelling of retail packages of the substances includes directions for their use and warnings as necessary, and also that advertising to the general public should as a rule be prohibited. The Convention contains special provisions for measures for the prevention of abuse and for the treatment, rehabilitation and social reintegration of abusers. The penal provisions state that abusers may, as an alternative or in addition to punishment, be made to undergo treatment, education, after-care, rehabilitation and social reintegration measures. This provision was also included in the 1972 Protocol.

International Drug Abuse Control Strategy

The United Nations General Assembly, after discussing the global control of the growing drug abuse problem in several sessions, adopted a plan for a relevant international strategy and a basic five-year programme of action, dealt with in resolution 1(XXIX) of the Commission on Narcotic Drugs transmitted by the Economic and Social Council in its decision 1981/113 of 6 May 1981. United Nations General Assembly resolution 36/168 of 16 December 1981, entitled “International drug abuse control strategy”, urges that this strategy and programme of action be given priority by all governments and be implemented as quickly as possible by the relevant United Nations bodies and other international organizations. The resolution requests the Commission to establish a task force, in consultation with the Directors-General of the appropriate specialized agencies and the other United Nations bodies concerned, to review, monitor and coordinate the implementation of the strategy and programme of action and to provide any recommendations it deems necessary regarding their future revision. The Commission on Narcotic Drugs, in its 30th Regular Session in February 1983, decided to perform the duties of the task force as a part of its regular work.

Annex II to resolution 1(XXIX) of the Commission, accepted by the General Assembly, contains a review of the strategy and policies for drug control that
gives a broad overview of the international and national actions necessary to cope with the global drug problems. This document is the first major effort to set down a concrete list of actions involving all sectors of society in the fight against drug abuse. It discusses, in detail, an international strategy for drug control aimed at attaining the following objectives:

(a) improvement of drug control systems;
(b) achievement of a balance between demand for, and supply of narcotic drugs and psychotropic substances for legitimate purposes;
(c) eradication of the supply of drugs from illicit sources;
(d) reduction of illicit drug traffic;
(e) reduction of demand for illicit drugs and prevention of inappropriate or illicit use of licit drugs;
(f) treatment, rehabilitation and social reintegration of drug abusers.

The document then continues to outline the responsibilities of Member governments and the United Nations system as follows:

"In discharging its responsibilities in this area, the United Nations must depend on the political will, commitment and support of its Members. The immediate question is how to develop a concerted plan of action in accordance with indicators stemming from a careful evaluation of present information and from a rational assessment of future projections in order to cope more effectively with this pressing humanitarian and social issue.

Member countries should be encouraged to develop drug control strategies for use by Governments and the international community in carrying out the principles of an international strategy. Such strategies should also be developed by international organizations with mandates in this field. Preparation of the strategies will allow for the setting of goals and objectives which are tailored to the individual problems and concerns of each nation and agency. This action will assist the international community in organizing a co-operative effort to combat drug abuse and in establishing goals and monitoring the efforts undertaken.

The international drug control system has from the outset been based on the recognition that the responsibility for the protection of the health and welfare of the citizens of each country lies with their Governments. In a world characterized by increasing interdependence, it is essential that enlightened national interest should stimulate co-operative international action on all aspects of the drug problem, so as to improve the quality of life of people everywhere."

United Nations Drug Control Organs

The Economic and Social Council and the Commission on Narcotic Drugs

The Economic and Social Council is responsible for formulating United Nations policies, coordinating drug control activities, supervising the implementation of international conventions, and making relevant recommendations to governments. In this work, the Council is assisted and advised by the Commission on Narcotic Drugs, which considers the changes that may be required in the existing machinery for the international control of narcotic drugs and psychotropic substances, and prepares such draft international conventions as may be necessary.
The Commission is one of the Council's six functional commissions. It is the central policy-making body of the United Nations system for dealing in depth with all questions related to the global effort of drug abuse control. The conventions assign important functions to the Commission (Single Convention, Articles 5 and 8, and Psychotropic Convention, Article 17). Its decisions or recommendations are submitted to the Council for approval or modification, and may, through this channel, give rise to decisions and resolutions in the General Assembly (Single Convention, Article 7).

The Commission was established in 1946 and consists of 40 members elected by the Council representing Member States of the United Nations and non-member States parties to the Single Convention. The membership should ensure equitable geographical representation and also include States with special experience of problems of illegal drug production and consumption. Usually, observers from some 30–50 other governments attend the Commission's sessions which, over the last decade, have been annual, with alternating regular and special sessions. There are also observers from United Nations organs, specialized agencies and intergovernmental, governmental and nongovernmental consultative organizations.

The Commission is authorized to consider all matters pertaining to the aims and provisions of the conventions, and may make related recommendations. It may also draw the attention of non-parties to its own decisions and recommendations under the conventions (Single Convention, Article 8, and Psychotropic Convention, Article 17).

A central function of the Commission under both conventions relates to decisions on changes in the scope of control of substances. In the case of the Single Convention, the Commission can accept or reject WHO's recommendations after having reviewed them. In the case of the Psychotropic Convention, the Commission may also change WHO's recommendations in the light of such economic, social, legal, administrative and other factors that it may consider relevant, or it may postpone the decision and seek further information (Single Convention, Article 3; and Psychotropic Convention, Articles 2 and 3). Such decisions by the Commission can be subject to review by the Council, at the request of a party, and the Council may confirm, alter or reverse the Commission's decisions with final effect (Single Convention, Article 3, paragraph 8, and Psychotropic Convention, Article 2, paragraph 8). The decisions of the Commission on the termination of exemptions of preparations from any measures of control are not subject to review by the Council under the Psychotropic Convention (Article 3, paragraph 4).

The International Narcotics Control Board has the right to draw the attention of both the Commission and the Council to any proposals to governments for consultations or studies, and also to cases where the aims of the conventions are seriously endangered and it has not been possible to resolve the matter in any other way (Single Convention, Article 14, and Psychotropic Convention, Article 19).

Finally, the Board's annual report on its work, in accordance with the provisions of the conventions, is submitted to the Council through the...
Commission, which may make such comments thereon as it deems fit (Single Convention, Article 15, and Psychotropic Convention, Article 18).

**The Secretary-General of the United Nations and the Division of Narcotic Drugs**

The Secretary-General is assisted by the Division of Narcotic Drugs, located in Vienna, Austria, in fulfilling the treaty functions entrusted to him. The Division is part of the United Nations Secretariat under the direct authority of the Secretary-General and acts as a secretariat to the Commission. The Department might be called "the clearing-house in the field of drug abuse control", its central activity being in the areas of drug control laws and administration, and law enforcement, which are areas in the fight against drug abuse not covered by any other organ of the United Nations system. It prepares reports to the Secretary-General, the Commission and the Council, putting together all the special documentation needed (Single Convention, Article 16).

The conventions provide for reports from the parties, formally to the Secretary-General but for analysis by the Commission, on the working of the conventions and the illicit drug activity within their borders, and in particular on specific cases of illicit traffic illustrative of particular problems or trends (Single Convention, Articles 18 and 35(f) and (g), and Psychotropic Convention, Article 16). The Division produces summaries and reports for the Commission, on the basis of this material, on the global situation and trends in illicit traffic and drug abuse.

The Division is the central repository of the United Nations system for professional and technical expertise in drug control. The text of all laws and regulations promulgated by parties in order to give effect to the provisions of the conventions are reported to it. These texts are edited and published, and provide, *inter alia*, a basis for the Division's advisory role to governments on the formulation of legislation for the control of the illicit production, traffic in, and use of drugs. The Division also advises on the administrative machinery necessary to coordinate and give effect to national drug abuse efforts. Law enforcement training is organized, including training in laboratory analytical techniques, in its narcotics laboratory. The Division is active in the dissemination and exchange of information on drug-related matters, including audiovisual and film documentation, and publishes the *Information letter* and the *Bulletin on narcotics*.

The conventions provide for a number of notifications to be sent to the Secretary-General for information and distribution to the parties and to the United Nations organs which have been assigned functions in the conventions (Single Convention, Article 5, and Psychotropic Convention, Article 33). These notifications concern changes in scope of control (Single Convention, Article 3, paragraphs 1 and 7, and Psychotropic Convention, Articles 2 and 3), special prohibitions of international trade (Psychotropic Convention, Article 13),
territorial applications (Single Convention, Articles 42 and 43, and Psychotropic Convention, Article 27), amendments to the conventions (Single Convention, Article 47, and Psychotropic Convention, Article 30), ratification of, and accession to the conventions (Single Convention, Article 40, and Psychotropic Convention, Article 25), denunciation of the conventions (Single Convention, Article 40, and Psychotropic Convention, Article 29), and reservations in respect of provisions of the conventions (Single Convention, Articles 49 and 50, and Psychotropic Convention, Article 32). In all these cases the Division acts as the secretarial unit for the Secretary-General.

The International Narcotics Control Board

The International Narcotics Control Board, located in Vienna, Austria, was created by the Single Convention of 1961 (Article 5) to carry out within the United Nations the functions in the international control of drugs assigned to it by that Convention. It continues to assume this responsibility under the Single Convention as amended by the 1972 Protocol (Article 5) and under the Psychotropic Convention (Articles 16, 18 and 19). The Board continued and superseded the respective roles of the Permanent Central Opium Board and the Drug Supervisory Body under the older conventions (Single Convention, Articles 44 and 45).

The Board has an unusual position as an independent body, reporting to the Economic and Social Council through the Commission on Narcotic Drugs, among the organizations of the United Nations system. Its function and work are governed exclusively by the conventions. Its 13 members, though proposed by Member States of the United Nations and elected by the Council, serve on the Board in their personal capacity and “shall be persons who by their competence, impartiality and disinterestedness will command general confidence”. During their term of office they cannot “hold any position or engage in any activity which would be liable to impair their impartiality” (Single Convention, Article 9, paragraph 2).

Board members serve for a period of five years, and may be re-elected. Three of the members, nominated by WHO, must have medical, pharmacological or pharmaceutical experience. The Board elects its own President and adopts its own rules of procedure. It holds at least two sessions in each calendar year. The Board has a secretariat, distinct from that of the Division of Narcotic Drugs; it is, though, an integral part of the United Nations Secretariat and, under the administrative control of the Secretary-General, carries out the Board’s decisions. The Secretary of the Board is appointed by the Secretary-General in consultation with the Board (Single Convention, resolution I, Article 6; Article 9, paragraphs 1–3; Articles 10, 11 and 16).

A major responsibility of the Board is to endeavour, in cooperation with governments, to limit the cultivation, production, manufacture and utilization of drugs controlled by the conventions to amounts necessary for medical and scientific purposes. To this end, it administers a system of forecasts and
statistical returns for substances controlled by the Single Convention, assisting
governments to achieve a balance between supply and demand, and ensuring
that the quantities of these substances necessary for legitimate purposes are
available (Single Convention, Articles 12 and 13). If any State fails to furnish
estimates, the Board is required to establish them, if practicable in cooperation
with the government concerned. The statistical returns of a party, or any other
State, must be examined by the Board with a view to determining whether the
party or State concerned has complied with the provisions of the Convention
(Single Convention, Articles 12, 13 and 21 bis).

The parties to the Psychotropic Convention also have to supply the Board
with certain statistical information on the manufacture of, and trade in its
controlled substances. There is no formal estimates system for the Psychotropic
Convention (Psychotropic Convention, Article 16, paragraphs 4–6), but there is
voluntary reporting in this connection from many governments as well as the
beginning of voluntary collection of assessments of requirements for psychotro­
pic substances listed in Schedule II of the Psychotropic Convention (see p. 41).

The Board also has the task of endeavouring to prevent the illicit cultivation,
production, manufacture of, trafficking in, and use of the controlled substances,
with a view to safeguarding the aims of the conventions and ensuring that their
provisions are fulfilled (Single Convention, Article 9, paragraphs 4–6). The
parties must provide the Board, through the Secretary-General, with
information on the working of the conventions and, additionally, with
information relating to illicit drug activity within their borders. The Board may
offer its advice to the parties on how to provide this information and how to
endeavour to reduce illicit drug activity (Single Convention, Articles 18 and
35(f) and (g), and Psychotropic Convention, Article 19). Where the Board
considers this appropriate, and in agreement with the government concerned, it
may recommend that the competent United Nations organs or specialized
agencies, or both, provide a government with technical and financial assistance
in support of its efforts to carry out its obligations under the conventions (Single
Convention, Article 14 bis).

If the Board finds that the information submitted to it provides objective
reasons for believing that the aims of the conventions are being seriously
endangered by the failure of a party or country to carry out their provisions, or if
a country has become, or if there is serious risk that it may become, an important
centre of illicit cultivation, production or manufacture of, or traffic in or
consumption of drugs, the Board may propose the opening of consultations and
the initiation of studies with—among other things—a view to indicating the
necessary remedial measures (Single Convention, Article 14, paragraph 1(a)–
(c)). The Psychotropic Convention outlines a similar procedure in somewhat
less detail (Psychotropic Convention, Article 19, paragraph 1(a) and (b)). In
especially serious cases further action may be taken by the Board, including the
submission of reports to the Commission on Narcotic Drugs and the Economic
and Social Council (Single Convention, Article 14, paragraphs 1(b), 2 and 3,
and Psychotropic Convention, Article 19, paragraphs 1(b), 1(c), 2 and 3).

The Board is instructed to prepare an annual report on its work, and such
additional reports as it considers necessary. These reports must be submitted to
the Council through the Commission and communicated to the parties, which
must permit their unrestricted distribution (Single Convention, Article 15, and
Psychotropic Convention, Article 18). The annual report has over the years
developed into a review of the global situation, not only on the working of the
conventions, but also of illicit production and traffic, and of abuse of drugs, that
attracts great interest and widespread comment.

The Specialized Agencies

The World Health Organization

The responsibilities of WHO under the conventions

WHO is the competent international health authority, being the specialized
agency for directing and coordinating work on all aspects of health care,
including prevention and health education. The WHO Constitution enumerates in great detail in its Article 2 the related functions, which also
include the prerogative to propose conventions, agreements and regulations,
and to make recommendations with respect to international health matters.
Article 19 gives the Health Assembly the “authority to adopt conventions or
agreements with respect to any matter within the competence of the
Organization". Such decisions require a two-thirds vote, and measures come
into force for each Member when it has ratified them. Article 21 gives authority
to the Health Assembly to adopt regulations concerning, inter alia, “(d)
standards with respect to the safety, purity and potency of biological,
pharmaceutical and similar products moving in international commerce; (e)
advertising and labelling of biological, pharmaceutical and similar products
moving in international commerce". Such regulations, under Article 22, come
into force upon notification of the Members by WHO, except for such Members
as may notify the Director-General of rejection or reservations. Furthermore,
according to Article 23, the Health Assembly has the authority to make
recommendations to Members on any matter within the competence of the
Organization.

Under this mandate, numerous resolutions have been adopted by the WHO
Executive Board, the World Health Assembly and the regional committees
between 1949 and 1982 to provide policy directives for the initiation and
conduct of activities in the field of both alcohol and drug dependence. Thus
resolution WHA28.80 of the Twenty-eighth World Health Assembly requested
the Director-General, inter alia, to develop the reporting programme on the
epidemiology of drug dependence; foster activities related to prevention,

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b WHO unpublished document MNH/78.21.
treatment and rehabilitation; assist governments to develop and apply integrated services for prevention, early detection, treatment and rehabilitation at the community level; develop monitoring of adverse side-effects of psychoactive drugs in relation to their risk of abuse and dependence potential; and foster activities to determine the dependence potential of chemical substances having an effect on mood and behaviour, and to prepare guidelines for the safe and effective use of psychoactive drugs. A summary of the objectives and current activities of WHO in the field of drug dependence is available. Projected activities in this field are set forth in paragraphs 262–266 of WHO's Seventh General Programme of Work covering the period 1984–89.

The conventions assign specific responsibilities to WHO in respect of changes in the control of substances and for placing them in appropriate schedules for control purposes and at adequate levels of control (see pp. 33–38). WHO has to assess the dependence liability and therapeutic usefulness of each substance and, after evaluating the seriousness of the public health and social problems related to its abuse, make a recommendation to the Commission on Narcotic Drugs for its control. This process, initiated by a notification to the Secretary-General of the United Nations by WHO or a party, rests on an extensive collaboration between the Organization and its Members in collecting all the necessary information (see below and p. 37).

WHO is not specifically mentioned in other articles of the conventions, but its mandate as the competent international health authority makes its role in advising and assisting the parties a central one in many of the activities undertaken by parties in attempting to fulfil the provisions of the conventions. Direct WHO involvement is evident in respect of measures concerning prescriptions (see p. 73), warnings in drug packages and advertising (see p. 84), and measures against abuse (see p. 48). In addition, there is indirect involvement in the measures against illicit traffic (see p. 124). However, the implicit responsibilities of parties for the whole general area of drug supply, distribution and control imply collaboration with WHO in national drug policy, drug laws and regulations, drug evaluation and registration, post-registration surveillance and prevention, especially through drug demand reduction.

Collaboration between WHO and parties for changing the scope of the conventions

Provisions of the conventions. The procedure for changing the scope of control of the conventions by adding a new substance to their schedules, or transferring a substance from one to the other, can be initiated either by a party or by WHO (see pp. 33 and 37). A notification with such a proposal to the Secretary-General will be transmitted to other parties and to WHO. The Organization will then
evaluate the need for international control of the substance, taking into account
the relevant articles of the conventions, and communicate the assessment to
the Commission on Narcotic Drugs together with recommendations on control measures. The final decision in the matter is made by the Commission.

The responsibilities of the three participants in this procedure are, in very
simplified form, the following. The party must include in its notification the
information collected in support of that notification. While the conventions do
not specify the type or extent of the information needed, it must obviously be
concerned essentially with the dependence-production liability of the sub-
stance, and the public health and social problems associated with its use and
abuse. Furthermore, when a notification from a party is circulated to other
parties by the Secretary-General, it is of paramount importance that all other
parties communicate to WHO their relevant experience with the substance in
question.

WHO’s evaluation will centre on the medical and scientific characteristics of
the substance, and on the assessment of the degree of its usefulness in medical
therapy versus the degree of seriousness of the public health and social problems
arising from its abuse. The Commission, in its final decision, will also be able to
consider such economic, social, legal, administrative and other factors as it may
consider relevant.

The experiences and investigations of the parties, whether scientific,
medical, epidemiological, social, legal or administrative, are obviously the basic
material on which—directly or indirectly—the Commission has to base its
decision. The implicit responsibility of a party to the conventions is therefore to
collect as much information on the psychoactive substances used in its territory
as is possible with its resources and capabilities. Every piece of such
information will be valuable in the final context of the assessments and
decisions of WHO and the Commission. Different possibilities for collecting
relevant material are discussed in Chapters 6 and 7.

The Commission, in its Seventh Special Session (February 1982), dealt with
the procedures for scheduling psychoactive substances in resolution 2 (S-VII),
which stated that the Commission, “concerned with the timeliness and
comprehensiveness of notifications, assessments and recommendations pursu-
ant to the provisions of the international drug control treaties, . . . invites
Member States to respond in a positive manner to requests by the Secretary-
General for information on the economic, social, legal and administrative
factors related to the abuse of substances being considered for possible
scheduling, and to supply as complete data as possible on any illicit trafficking
in the substances in question”.

The Director-General of WHO, in 1982, drew the attention of Member States
to resolution EB69.R9 and pointed out that the main concern of the Executive
Board was for the World Health Organization to work more closely with
Member States and other related United Nations organs in its very important
role in making recommendations on international control of narcotic drugs
and psychotropic substances under the conventions. Since the World Health
Organization's decision to recommend control was based on the benefit/risk ratio involved in the use of a substance, it was essential that Member States cooperate with WHO in providing data on usefulness and on public health and social problems associated with the use of psychotropic substances using, where possible, methods developed by the World Health Organization for the purpose.

Relevant areas of national study. A party, in taking steps to fulfil its responsibilities under the conventions, should, in so far as manpower and financial resources allow, assess and investigate the implementation and the effect of the national efforts for the control of psychoactive drugs. Many areas of societal activity can yield data and experiences that, in the context of all the assembled information, may prove valuable, even if those data alone would not be enough for an assessment. A broad discussion on this topic can be found in a report of the WHO Expert Committee on Drug Dependence, which deals especially with studies on the liability of substances to produce dependence and assessments of their therapeutic usefulness, and the report of the WHO Expert Committee on Implementation of the Convention on Psychotropic Substances, 1971.

The systematic collection of experiences and data on the use, dependence production and abuse of psychoactive drugs in the population presupposes a national coordinated programme. The central organizer of such a programme can be the ministry of health, working through a special committee, commission or institute or—the best alternative—a central drug control agency. The central organizer must assume responsibility for planning the programme, implementing its different projects, developing standardized data collection forms and procedures, and determining the reliability and validity of collected data, as well as establishing overall surveillance of the activities.

In its work to evaluate psychoactive drugs for international control, WHO must rely on collaboration with parties in obtaining vital information. The fundamental biological and medical scientific investigations on the psychoactive substances are made in national universities and industrial laboratories. Early warning signs of new drug abuse are recorded in health services, social welfare organizations and law enforcement units in the individual countries. A steady flow of up-to-date and reliable information from the parties to WHO and the Commission on Narcotic Drugs is of paramount importance in the effort to keep the conventions abreast of the development of drug use and abuse.

The efforts of a party to develop a programme for monitoring drug use and abuse can always, if necessary, find support from WHO, United Nations drug control organs, specialized agencies generally, and bilaterally from other parties.

National action programme for data collection on drug use and abuse. A number of sources of data on drug use and abuse are available in all countries. Thus studies of licit drug supply and consumption (see pp. 77–81) will give an
estimate of medical drug use. A trend towards increased use of a substance may be an indication of a dependence liability developing in the country. Increased supply through some part of the distribution system may indicate deviation from legal to illicit consumption. If the total supply to a country of a psychoactive substance is known, valuable comparisons between countries can be made that will be helpful in arriving at general national estimates of need.

The monitoring of adverse drug reactions can be extended in the case of psychoactive drugs to include observations of overuse, potential for dependence production and abuse (see p. 74). Since the degree or the risk of dependence production is difficult to ascertain in preclinical and preregistration testing, observations from clinical practice are especially important to the systematic collection of this information.

A number of indicators of health problems associated with psychoactive drug use can be utilized (see p. 90). Cases of drug dependence, drug overdose and drug psychosis can be diagnosed and reported from emergency departments, treatment units, mental hospitals, prisons or general practitioners' consulting rooms. Mortality statistics are most often available as a source of records of overdose deaths. Public health statistics on drug-related disease can be utilized to follow, for instance, the incidence of hepatitis and other infectious complications as an indicator of drug injection abuse. Analysis of traffic accidents for the role of psychoactive drugs and alcohol will give an indication of the types of drugs used and their side-effects. The emergency treatment centre, supported by toxicological analyses, is a source of information on many aspects of drug abuse that reacts rapidly to changes.

Drug-related social problems (see p. 98) are, of course, often very evident, but cannot usually be quantified with any precision. Even so, despite its subjectivity, very valuable information on drug use and abuse and its effects can be provided, for instance, by schoolteachers, family guidance centres, social workers and the police.

Finally, planned and systematic epidemiological assessments of drug dependence and abuse are possible (see pp. 86–90). Such assessments can utilize sources of informed opinion, organized data registers or field surveys; they often use relatively sophisticated social science techniques, requiring trained manpower, and therefore tend to be rather costly and time-consuming.

Since countries differ in available manpower, financial resources and—not least important—in type and extent of problems, each country will have to set up a suitable programme in harmony with its ambitions. In fact, a systematic, continuing, and methodologically high-quality programme that covers the whole area in a satisfactory sample is still not to be found in many countries.

An initial programme for monitoring the use and abuse of psychoactive substances might contain some or all of the following projects, depending on practicability:

— a study of national licit drug supply (import, export, national manufacture);
— a study of drug utilization in at least one large general hospital, and in at least one mental hospital;
— a study of prescriptions dispensed by a number of pharmacies;
a self-administered survey to a sample of the school and urban youth population;
the registration of drug overdose deaths from a large urban area;
an emergency department survey, with laboratory support, of drug-related conditions;
a traffic accident study with registration of drug and alcohol involvement;
a study of sources of informed opinion (school and university teachers, general practitioners, social workers, policemen);
the registration of types and quantities of psychoactive substances seized in the illicit traffic by police and customs.

The report on a WHO seminar on psychotropic substances and public health problems (Helsinki, 1982) contains guidelines for several of these projects in a simple form.\(^a\)

A national monitoring programme can obviously be developed in stages, using increasingly comprehensive and complex studies. Based on examples from certain countries, where great efforts have been made, the following components of a monitoring programme may be mentioned:

- a computer-based system to monitor the movements of drugs in manufacture, trade and distribution, e.g., the Drugs of Dependence Monitoring System, introduced in 1970 in Australia (see p. 80);
- broad utilization studies of licit drug use;
- repeated national interview surveys of drug use;
- a national alerting or warning system, supported by data from a nationwide range of major hospital centres, e.g., the Drug Abuse Warning Network organized by the National Institute on Drug Abuse in the USA (see p. 88);
- a national register for monitoring drug adverse reactions;
- a central case register of drug-related health and social problems, e.g., the Central Register of Drug Addicts in Hong Kong (see p. 88);
- repeated national field sample surveys of illicit drug use and abuse.

The central organizer and coordinator of such data collection programmes should be the national administrative body for drug control (see p. 62).

**United Nations Educational, Scientific and Cultural Organization**

UNESCO advises governments on ways and means of providing appropriate information and education in the field of drug abuse. It carries out studies on and promotes the knowledge and application of relevant techniques.

**International Labour Organisation**

ILO advises governments in developing appropriate policies and strategies in

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the fields of the vocational rehabilitation and social reintegration of drug-dependent persons. It assists in training staff and in setting up suitable vocational preparation, job placement and follow-up services. Emphasis is placed on encouraging the direct involvement of private, community-based groups in the rehabilitation and reintegration process.

**United Nations Fund for Drug Abuse Control (UNFDAC)**

UNFDAC, located in Vienna, Austria, is a voluntary trust fund, i.e., its activities are not funded by the regular United Nations budget; it is therefore wholly dependent on voluntary contributions. In recent years its budget has amounted to about US$ 10 million. UNFDAC is headed by an Executive Director and reports directly to the Secretary-General of the United Nations. The annual report of the Fund is discussed by the Commission on Narcotic Drugs, and its comments and recommendations provide UNFDAC with immediate policy guidance.

UNFDAC supplements the United Nations drug control bodies and the specialized agencies. It was created in 1971, when awareness of the growing worldwide drug abuse problem made it necessary to find means to strengthen the technical and financial resources for international collaboration in the fight against such abuse.

Since its inception, UNFDAC has provided resources for governments and international organizations in planning and implementing programmes to limit opium cultivation through integrated rural development and crop substitution; in improving national drug control administrations; in training national law enforcement and customs personnel; in developing programmes for prevention and for the treatment and rehabilitation of drug-dependent persons; in organizing regional cooperation in critical drug control areas; and in undertaking international research on drugs of abuse and the epidemiology of drug abuse.

In the implementation of country programmes UNFDAC collaborates with the United Nations Development Programme (UNDP), which is responsible for administrative and in-country coordination. UNDP and other United Nations bodies, including the Division of Narcotic Drugs, FAO, WHO, ILO and UNESCO, serve as executing agencies in the programme sectors related to their own fields of competence.

**Regional Cooperation**

**Association of South East Asian Nations (ASEAN)**

ASEAN, established in 1967 with headquarters located in Jakarta, has a membership of five States (Indonesia, Malaysia, the Philippines, Singapore and Thailand). The aim of the Association is to accelerate the
economic growth, social progress and cultural development of the region. There
is an annual Ministerial Conference, while standing committees meet in the
intervals between Conferences. Permanent committees are active in various
fields of economy and technology. ASEAN arranges and supports conferences
and seminars in the field of drug abuse, prevention and control, and issued a

The Colombo Plan

The Colombo Plan, founded in 1950, has at present 26 member States, mostly
from Asia but including Australia, Canada, New Zealand, the United Kingdom
and the United States of America. The Colombo Plan's discussions centre on
the economic and social development of its membership. The highest
deliberative body is a Ministerial Consultative Committee, meeting every two
years. The Colombo Plan Council meets twice yearly in Colombo, Sri Lanka, for
consultation and coordination in the field of technical cooperation among
member countries. The Colombo Plan Bureau is the permanent institution of
the Plan.

A Drug Advisory Programme was commenced in 1973 to assist in cooperative
programmes for national, subregional and regional efforts designed to eliminate
the causes and ameliorate the effects of drug abuse. The Programme
complements the efforts of international and other agencies actively involved in
this field, and its activities encompass all aspects of prevention and control,
with particular emphasis on the socioeconomic aspects of drug abuse. National
and regional seminars, workshops and conferences are sponsored on different
aspects of prevention and drug abuse.

The Commonwealth Secretariat

The Commonwealth Secretariat is an intergovernmental organization
servicing the 47 independent countries of the Commonwealth. The problems
associated with international drug control have been discussed at all levels
within the Commonwealth and there is concern to ensure that effective action is
taken in regard to abuse, both in the illicit and the wider sense. In view of the
width and depth of this concern within the Commonwealth, which is reflected
in the various divisions of the Commonwealth Secretariat, it is very difficult and
possibly misleading to attempt to describe briefly the role played by the
Commonwealth in this context. The various ministerial and other meetings held
under the auspices of the Commonwealth Secretariat have often addressed the
problem. For example, the Commonwealth Heads of Government Regional
Meeting (Asia and the Pacific) established a working group on illicit narcotics
that has met on several occasions and is actively pursuing a regional initiative.
Within the Commonwealth Secretariat a number of divisions are actively
concerned with problems related to various aspects of drug control (the Legal
Division, the Medical Division, the Office of the Special Adviser on Women and Development, and the Youth Division).

Specifically with regard to drug control, the Legal Division has commissioned studies relating to the enforcement of laws seeking to restrict supply and in particular penalizing organized criminal groups by confiscating their assets. A report has also been prepared that contains an analysis of the state of control and regulation within the Commonwealth, together with a model Act for those jurisdictions that have yet to enact laws in accordance with the various international conventions. It is hoped that this “accession kit” will encourage such jurisdictions to accede and enact the relevant legislation. The Commonwealth Secretariat has recently established an office charged with the special responsibility for coordinating and facilitating enforcement in relation to certain serious international crimes. This office, which works closely with other agencies interested in the general area of narcotics control, seeks to act as a catalyst in improving the level of cooperation in enforcement.

The Council of Europe

The Council of Europe was created in 1949 and now has 21 member States. Where a number of States wish to undertake activities in which not all their European partners want to participate, they can conclude a “partial agreement” that is binding upon themselves alone. Action with regard to drug abuse is conducted by the Council of Europe as a whole, and under two partial agreements, one of which, concluded in 1980, superseded the informal group to combat drug abuse and illicit trafficking in drugs (often referred to as the Pompidou Group). This group, which at the time of writing consists of the 10 Member States of the EEC, Norway, Sweden and Turkey, is specifically concerned with a multidisciplinary approach to the problem of drug abuse and is carrying out activities with regard to prevention, treatment and rehabilitation, illicit trafficking, etc. Several reports and recommendations of the Council of Europe on general drug control and on drug abuse have been published.

The Arab International Organization for Social Defence against Crime

In 1964, the League of Arab States set up the Arab International Organization for Social Defence with offices in Rabat. It has three branches:

1. The Pan Arab Bureau for Narcotic Affairs, established in 1951, is located in Amman, Jordan, with liaison officers in all the Arab countries. Its functions are: (a) to establish cooperation in the field of narcotics between Arab countries; (b) to establish cooperation between Arab countries and international organizations; and (c) to control the cultivation and production of narcotic drugs in Arab countries. The Bureau organizes conferences and develops long-
term plans for common activities, *inter alia*, to try to unify drug laws and to prepare a long-term strategy for drug abuse control in the Arab world. Current liaison activities include collecting information and initiating intercountry investigations on drug trafficking cases, and producing bimonthly reports and a quarterly analysis of the drug abuse situation for the whole Arab world.

(2) The Pan Arab Bureau of Crime Prevention located in Baghdad, Iraq.

(3) The Pan Arab Bureau for Police located in Damascus, Syria.

Furthermore, the Council of Arab Ministers of Health meets twice yearly to discuss projects in several areas of cooperation, including registration of drugs and inspection of pharmaceutical manufacturing units.

**The South American Agreement on Narcotic Drugs and Psychotropic Substances**

A South American Agreement on Cooperation within the framework of the international drug control treaties was drawn up in 1973 and came into force after ratification by seven countries in 1979. Ten countries are now party to the Agreement, namely Argentina, Bolivia, Brazil, Chile, Colombia, Ecuador, Paraguay, Peru, Uruguay and Venezuela. The headquarters are located in Buenos Aires, Argentina.

A main aim of the Agreement is to unify and harmonize drug legislation, while the emphasis in policy is on the coordination of scientific information on drug control activities, drug abuse control and the fight against illicit drug traffic. Annual conferences are held between the parties to the Agreement.

**Nongovernmental Organizations in Consultation with WHO**

A large number of nongovernmental organizations in consultation with WHO take an interest in the control of the use and abuse of psychoactive drugs as a part of their wider health activities. In particular, an active role is played by the International Council on Alcohol and Addictions (ICAA), which has a membership consisting of national organizations from a number of countries as well as individual members. ICAA has organized numerous international conferences, seminars and working groups in all parts of the world for discussion, information, evaluation and training concerning many aspects of the control of dependence-producing substances. ICAA cooperates very closely with WHO in its activities.

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*International digest of health legislation, 31: 961–966 (1980).*
CHAPTER 3

THE RESPONSIBILITIES OF THE PARTIES UNDER THE INTERNATIONAL DRUG CONTROL TREATIES

Scope of Control of the Conventions

The aim of international treaties is to ensure that the controlled substances are used exclusively for medical and scientific purposes and to assist governments in their efforts to prevent drug abuse and reduce its harmful consequences. For the treaties to be effective, independent governments must take voluntary decisions to apply the provisions of international conventions and to comply with their obligations towards other governments and international organizations.

The conventions contain provisions designed to ensure the safe use of a certain number of psychoactive substances. They do not define the general (pharmacological and clinical) characteristics of those substances, whether natural or synthetic, that might qualify for inclusion amongst the controlled substances, nor do they define the terms “narcotic drugs” or “psychotropic substances”, except by stating that in the conventions these terms apply exclusively to the substances listed in the schedules to those conventions. However, both conventions are based on the following concepts:

(a) these substances in general have legitimate scientific and medicinal uses that must be protected (there are certain obvious exceptions);
(b) their abuse gives rise to public health, social and economic problems;
(c) vigorous measures are necessary to restrict their use to legitimate purposes;
(d) effective measures require international cooperation in coordinated and universal action.

The conventions contain rules for deciding whether or not a psychoactive substance should be placed under their control regime. The substances originally listed in the schedules to the conventions can be used as examples with which a substance being considered for control may be compared, so that it may also be controlled if it “is liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or II” (Single Convention, Article 3, paragraph (iii)) or “in Schedules I, II, III or IV” (Psychotropic Convention, Article 2,
paragraph 4(a), (2)). The method of comparison with the substances earlier placed under control is the only one used as a qualification for the control of new substances under the Single Convention, and one of two alternative qualifications used in the Psychotropic Convention.

The other alternative for the Psychotropic Convention is described in Article 2, paragraph 4, where the requisite property is described as "the capacity to produce a state of dependence, and central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood".

Furthermore, the Psychotropic Convention states in the same Article 2, paragraph 4(b), that there must be "evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control".

Under these rules, WHO has the responsibility to communicate to the Commission on Narcotic Drugs an assessment of the substance from the point of view of "the extent and likelihood of abuse, the degree of seriousness of the public health and social problem and the degree of usefulness in medical therapy".

There is, however, a demarcation of responsibilities between WHO and the Commission under the Psychotropic Convention (Article 2, paragraph 5). Whereas the recommendations of WHO "shall be determinative as to medical and scientific matters", the Commission, in making its decision as to control for submission to the Economic and Social Council, is requested to take into account "economic, social, legal, administrative and other factors it may consider relevant."

The qualifications for control as laid down in the Psychotropic Convention are nowadays also used as guidelines for the WHO expert groups in assessing substances under the Single Convention. Thus WHO, in evaluating a substance, should always attempt to balance its medical usefulness against the seriousness of the public health and social problems of abuse to which it may give rise.

Levels of Control of Substances

General background

The stated general purpose of the conventions is that the parties shall limit, subject to a few special provisions, by appropriate measures, the production, manufacture, export, import, distribution and stocks of, trade in, and use and possession of controlled substances to medical and scientific purposes (Single Convention, Article 4(c), and Psychotropic Convention, Article 5, paragraphs 1 and 2).

In February 1982 the Single Convention listed 110 "drugs" (substances) whereas the Psychotropic Convention controlled 40 substances, in both cases divided into four schedules associated with varying levels of control. It should be pointed out, however, that the sets of schedules in the two conventions
correspond to different levels of control. While there is a certain broad parallelism between the controls exercised by the conventions, there are also significant differences in detail; a simplified description is therefore given below for each convention.

The placing of a substance in a particular schedule depends on the balance between its therapeutic usefulness and its abuse potential. The substances most strictly controlled have little therapeutic application; they are mainly used, if at all, in scientific research, and are furthermore liable to heavy abuse. In contrast, the least strictly controlled substances have wide therapeutic use and more limited abuse potential.

The schedules of the conventions

It will be useful at this point to outline the general scope of control of each of the conventions in turn, and in particular of the schedules of substances, so as to bring out the differences and their consequences.

The Single Convention

Schedule I. This is the major Schedule; it lists all substances in the opiate, cocaine and cannabis groups and subjects them to all the specified controls of the Convention. These may be briefly summarized as follows:

(a) estimation of drug requirements, including legitimate consumption for medical and scientific purposes; provision of details of manufacture and manufacturers, stocks held, and land used for opium poppy cultivation;
(b) provision of statistical data on: production and manufacture; utilization and consumption; imports and exports; seizures; stocks; areas of poppy cultivation;
(c) limitation of manufacture and importation to a quantity not exceeding legitimate use, plus quantity exported, plus quantity required for special stocks;
(d) controls over production of opium and concentrated poppy straw, in particular for international trade;
(e) licensing and control of manufacture of drugs, and of trade and distribution, including export and import;
(f) medical prescription of drugs and record keeping;
(g) labelling.

Schedule II. In general, this includes the drugs more commonly used for medical purposes and needing less strict control because of the smaller risk of abuse. The important differences, as compared with Schedule I, are that the controls of trade and distribution (see (e) above) are less strict (they include only the licensing of establishments for manufacture, and labelling and advertising controls). Medical prescriptions are required for Schedule II drugs.
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Schedule III. This includes preparations containing as ingredients Schedule II drugs in lower concentrations and in controlled proportions, as well as preparations that have been found by WHO not to be liable to abuse, that cannot produce ill effects, and from which the controlled drug is not readily recoverable. The trade distribution controls need not apply, and the information and statistics required relate only to quantities used in the manufacture of such preparations.

Schedule IV. This includes a few drugs regarded as having particularly dangerous properties but very limited therapeutic use, and in respect of which the parties may totally prohibit production, manufacture, export, import, trade or possession, the main exception to this prohibition being use in research under their control.

Special control measures. These are provided for opium and the opium poppy, poppy straw, the coca bush and the cannabis plant (Articles 24–28).

The Psychotropic Convention

Schedule I. This includes the hallucinogen group LSD, DMT, psilocybin, etc., which are drugs of a dangerous nature posing a serious risk to public health, and of doubtful, if any, therapeutic use. Controls over these drugs are of the strictest nature, and include special provisions under Article 7 for very firm controls to limit their use chiefly to research; to require special licences for manufacture, distribution, etc.; and to require close supervision to prohibit import and export without specific agreement and authorization. It is necessary to furnish full statistical reports to the International Narcotics Control Board. Requirements for medical prescription for the limited use permitted and for statistical reports and labelling are also mandatory.

Schedule II. This contains stimulant sympathomimetic drugs of the amphetamine type, of very limited therapeutic usefulness, but also certain narcotic analgesics such as phencyclidine, which is of no human therapeutic usefulness. These are all drugs known to be highly addictive, and the controls over them are generally the same as for Schedule I, but without the special control measures prescribed in Article 7. The control requirement is different in degree rather than in type.

Schedule III. This includes those fast- and medium-acting barbiturates that have been seriously abused, although they are therapeutically useful. The requirements are similar to those for drugs in Schedules I and II, but there is no requirement for import and export authorizations and for full statistics of production and use, etc., for submission to the International Narcotics Control Board. The conditions relating to medical prescription, labelling and licensing of trade, etc., are the same.

Schedule IV. This includes a variety of hypnotic, tranquillizing and analgesic drugs that have marked addictive properties, but are widely used therapeutically although, in a number of countries, some of them are not so used. A less strict degree of control is suggested for these drugs, although it is still not
insignificant. The requirements for prescription in accordance with sound medical practice, for labelling, and for the licensing of manufacture and trade still remain. It is possible for a party to vary the prescription requirement for these drugs where a supply difficulty might otherwise arise.

Control of preparations under the Psychotropic Convention and Schedule III of the Single Convention

If a preparation containing a psychotropic substance other than one in Schedule I of the Psychotropic Convention is compounded in such a way that it presents no risk of abuse, or a negligible risk, and the substance cannot be recovered by readily applicable means in a quantity liable to abuse, so that the preparation does not give rise to a public health or social problem, the preparation may be exempted from a number of control measures by a party (Psychotropic Convention, Article 3). Such exemptions under the Single Convention (Article 3) can be granted only by the Commission on Narcotic Drugs.

If a party decides to make an exemption under the Psychotropic Convention, Article 3, it must notify the Secretary-General thereof with all necessary details. The Secretary-General will transmit this notification to WHO, other parties and the International Narcotics Control Board. Such an exemption may be terminated by the Commission on Narcotic Drugs on the recommendation of WHO.

Adoption of stricter measures

The Psychotropic Convention states in Article 23 that “a Party may adopt more strict or severe measures of control than those provided for by this Convention if, in its opinion, such measures are desirable or necessary for the protection of the public health and welfare”. A similar but differently worded rule is contained in the Single Convention, Article 39.

Change in Control of Substances

The experience gained in the medical use of a psychoactive substance or of its nonmedical misuse may lead to the view that the substance should be controlled internationally under the conventions or, if already controlled, that its level of control should be changed. Information leading to such a decision may be gathered by a party or by WHO. A party or WHO may in such a situation notify the Secretary-General of the case, furnishing him with the necessary information for an evaluation of the substance, according to the rules described above (pp. 33–34). If a party has made such a notification, the Secretary-General sends it to WHO, which then carries out the necessary evaluation by means of an expert group and communicates to the Commission on Narcotic
Drugs its assessment of the therapeutic usefulness of the substance as well as of the degree of seriousness of the public health and social problems created by its abuse. At the same time, WHO also recommends that the substance should be placed in a particular schedule of the relevant convention, be moved from one schedule to another, or be removed from international control.

The Commission may then either follow WHO’s recommendation or decide not to follow it. In the latter case, it cannot alter the recommendation if it concerns the Single Convention. The Psychotropic Convention, on the other hand, states that WHO’s assessment shall be determinative as to medical and scientific matters, but that the Commission, bearing in mind the economic, social, legal, administrative and other factors it may consider relevant, may add the substance to any of the schedules of the Psychotropic Convention, transfer a substance already controlled to any other of the schedules, or remove it from the schedules.

A party can request a review by the Economic and Social Council of any such decision of the Commission within 90 days, for the Single Convention, or 180 days, for the Psychotropic Convention, of its being notified of that decision by the Secretary-General. Comments on this request with all relevant information can be submitted by any party and by WHO. The Council may confirm, alter or reverse the Commission’s decision, and its verdict is final (Single Convention, Article 2, and Psychotropic Convention, Article 2).

A similar procedure is used in changing the control of preparations under the Single Convention, Article 3. Under the Psychotropic Convention, a party itself decides to make exemptions, according to the rules laid down in the Convention. A party, or WHO, may invoke a termination of another party’s exemption by a notification to the Secretary-General (Psychotropic Convention, Article 3, paragraphs 3 and 4). The final decision, however, is made by the Commission.

Both conventions state that “Parties shall use their best endeavours to apply to substances which do not fall under the Conventions, but which may be used in the illicit manufacture of any controlled substance, such measures of supervision as may be practicable” (Single Convention, Article 2, and Psychotropic Convention, Article 2).

Prescriptions

The great majority of controlled substances, which are of medical usefulness, can only be dispensed or supplied for use by individuals on a medical prescription. This applies to substances listed in Schedule I of the Single Convention and Schedules II, III and IV of the Psychotropic Convention (Single Convention, Article 30, paragraph 2(b)(i), and Article 2, paragraph 1, and Psychotropic Convention, Article 9).

There are two possible but not obligatory exemptions to this requirement, one of which concerns individuals who may lawfully obtain, use, dispense or administer the relevant substances in connection with their duly authorized
therapeutic functions (Single Convention, Article 30, paragraph 2(b)(i), and Psychotropic Convention, Article 9, paragraph 1).

The Psychotropic Convention leaves open the possibility that a party may, if circumstances so require, but with appropriate precautions, authorize licensed pharmacists or other specially licensed retail distributors to supply without prescription substances listed in Schedules III and IV for medical purposes to individuals in exceptional cases and in small quantities (Psychotropic Convention, Article 9, paragraph 3).

Preparations of substances may also be supplied to individuals for medical use without prescriptions (Single Convention, Article 2, paragraph 3, and Psychotropic Convention, Article 3, paragraph 3). This also applies to substances controlled in Schedule II and preparations included in Schedule III of the Single Convention (Single Convention, Article 2, paragraphs 2 and 3).

International travellers may carry for personal use small amounts of preparations containing substances in Schedules II, III and IV of the Psychotropic Convention (Article 40). Each party must satisfy itself that these preparations have been lawfully obtained.

As previously mentioned, substances in Schedule IV of the Single Convention and Schedule I of the Psychotropic Convention can only be made available for scientific purposes to specially authorized persons in medical and scientific establishments, so that they cannot be supplied on a general medical prescription.

Furthermore, the Psychotropic Convention states explicitly in Article 9, paragraph 2—and this, of course, should also apply under the Single Convention—that the parties must take measures to ensure that prescriptions are issued in accordance with sound medical practice and are subject to such regulations, particularly as to the number of times they may be refilled and the duration of their validity, as will protect public health and welfare.

**Warnings in Packages and Advertising**

The Psychotropic Convention states in Article 10, paragraph 1, that a party must require that such directions for use, including cautions and warnings, as in its opinion are necessary for the safety of the user are indicated on the labels where practicable and, in any case, on the accompanying leaflet of retail packages of psychotropic substances. Such directions for use must take into account any relevant WHO regulations and recommendations. Recommendations relevant to this Article were made by a Consultation on the Convention on Psychotropic Substances—Review of Articles 3 and 10, convened by WHO, and were communicated to all Member States by the Director-General in 1978 (see pp. 66–67).

The Single Convention has no such general requirement for directions for use,
but does indicate the desirability of including the international nonproprietary name communicated by WHO in written or printed advertisements for the scheduled substances as well as in every kind of description literature relating to them. The label of the package is required to show the exact content of the substance by weight or percentage, but this requirement need not apply in retail trade and distribution of substances listed in Schedule II. A party can, furthermore, if it finds the measure necessary or desirable, require that the inner package, containing a substance controlled in the Single Convention, or its wrapping, shall bear a clearly visible double red band (Single Convention, Article 30, paragraphs 3, 4, 5 and 6).

In the Psychotropic Convention, Article 10, paragraph 2 states that: "Each Party shall, with due regard to its constitutional provisions, prohibit the advertisement of such substances (i.e., those controlled in the Psychotropic Convention) to the general public".

Labelling and advertising are discussed further on pp. 66 and 84.

**Licences and Inspections**

Both conventions require parties to exert formal control over persons and enterprises engaged in the manufacture, trade (including international trade) and distribution of all the controlled substances. All persons carrying on or engaged in these activities must be controlled, and the establishments and premises where the activities take place must be controlled under licence. The Single Convention exempts State enterprises from such licensing, presumably because other forms of control exist in such enterprises). The Psychotropic Convention specifies that the control of substances in Schedule I requires a special licence or prior authorization (Single Convention, Article 29, paragraphs 1 and 2(a) and (b); Article 30, paragraph 1(a) and (b); Article 31, paragraph 3; and Psychotropic Convention, Article 7(b) and (c); Article 8, paragraphs 1 and 2(a) and (b)).

Permits to manufacture under the Single Convention are required to be for a limited period only and to specify the kinds and amounts of controlled substances that may be manufactured (Article 29, paragraph 2(c)). However, the control of manufacture and trade as described above is not required for preparations in the Single Convention (Article 2, paragraph 3).

All control measures must also be applied in free ports and zones (Single Convention, Article 31, paragraph 2, and Psychotropic Convention, Article 12, paragraph 3(a)), with the proviso that more stringent control measures may be applied.

The control of manufacture of substances under the Single Convention must "prevent the accumulation in the possession of drug manufacturers, traders and distributors of quantities of drugs and poppy straw in excess of these required for the normal conduct of business, having regard to the prevailing market conditions" (Article 29, paragraph 3, and Article 30, paragraph 2(a)). The Psychotropic Convention provides that, for all establishments engaged in
manufacture and trade, such security measures must be taken as will prevent theft or diversion of stocks (Article 8, paragraph 2(c)).

Finally, both conventions require that all persons who obtain licences or are otherwise authorized in accordance with the control measures that they impose "shall have adequate qualifications for the effective and faithful execution of such (relevant) laws and regulations" (Single Convention, Article 34(a), and Psychotropic Convention, Article 8, paragraph 4).

Records

Both conventions require that records be kept of the flow and handling of the controlled substances in the whole area of manufacture, wholesale and retail trade, and in scientific and medical use. Less detailed recording is required, however, for the substances under less strict control. Thus the quantities manufactured and kept in stock (except for substances included in Schedule II of the Psychotropic Convention), and acquired and disposed of, must be clearly recorded for all substances in Schedules I, II and IV of the Single Convention and in Schedules I and II of the Psychotropic Convention. Records of the same type, but restricted to manufacture, wholesale trade and import and export, are required for substances in Schedules III and IV of the Psychotropic Convention, but retail distributors and medical and scientific institutions need only keep this information readily available. The last-mentioned records for Schedule IV of the Psychotropic Convention may be of a simpler form, as determined by each party, and such a record need not be kept by wholesalers. The records for Schedule III of the Psychotropic Convention in retail trade and in medical and scientific institutions need only give information regarding acquisition and disposal, taking into account the professional and trade practices in the relevant country (Single Convention, Article 34(b), and Psychotropic Convention, Article 11). Both conventions give a time limit, set at two years, for the preservation of such records (Single Convention, Article 34(b), and Psychotropic Convention, Article 11, paragraph 7).

The records kept and the reports furnished to the competent national authority must be at least sufficiently detailed to enable that authority to provide the International Narcotics Control Board with estimates of the total annual requirements of each controlled substance, and later with statistical data on the actual manufacture, international trade and consumption. Where countries wish to establish a quota system in order to relate supply needs to medical needs, additional data may be required.

Estimates and Statistical Returns System

The Single Convention

To achieve the aim of the conventions to limit the quantities of the controlled substances to be obtained by manufacture and/or import to a level
corresponding to the medical and scientific needs of each country, the Single Convention requires each party to operate an information and data collecting system for the control and recording of the flow of the substances controlled by that Convention. This is an intricate and fairly complex system, of which a simplified summary outline will be given (Single Convention, Articles 19, 20 and 21). The functioning of this system is guided and controlled at every step by the International Narcotics Control Board by means of reports to the Board on special forms.

Each year every party is required to furnish the Board with an advance estimate of the anticipated total requirements for each controlled substance in its territory, to include the following components:

(1) the quantities to be consumed for medical and scientific purposes;
(2) the quantities to be utilized for the manufacture of other substances;
(3) the stocks at the end of the estimate year and the quantities necessary to add to special stocks;
(4) the area and location of land used for cultivation of the opium poppy and the approximate quantity of opium produced;
(5) the number of industrial establishments engaged in the manufacture of synthetic drugs, and the quantities of such drugs manufactured by each establishment.

Total estimates for the coming year can be calculated for each narcotic drug, including opium, from these data. Seized substances released for licit use must be included and accounted for. A party may make supplementary estimates during the year.

At the end of each year, and not later than 30 June of the following year, each party is required to furnish the Board, on special forms, with statistical returns of the actual manufacture, international trade and consumption, which must include the following components:

(1) production or manufacture of substances;
(2) utilization of substances for the manufacture of other drugs (including quantities of poppy straw used);
(3) consumption of substances;
(4) imports and exports of substances and poppy straw;
(5) seizures of substances;
(6) stocks of substances at the end of the year covered by the report;
(7) area of cultivation of opium poppy.

The Board is then able to compare estimates and actual total use of each substance as reported by each party. Where there are differences in these figures as between consumption and statistically calculated available quantities or between estimates and actual use, the Board initiates a dialogue with the country or countries concerned in order to clarify the situation.
The Psychotropic Convention

Obligatory statistical data

The Psychotropic Convention does not require the parties to provide estimates of the quantities of its controlled substances needed for manufacture and consumption. There is, however, what may be called a "graded statistical returns system" in the form of annual statistical reports to the Board (Psychotropic Convention, Article 16, paragraphs 4 and 5). These reports are different for substances in the different Schedules, and are required to contain the following data:

1. for each substance in Schedules I and II, the quantities manufactured, exported to, and imported from each country as well as held in stocks by the manufacturer;
2. for each substance in Schedules III and IV, the quantities manufactured as well as the total quantities imported and exported;
3. for each substance in Schedules II and III, the quantities used in the manufacture of exempted preparations;
4. for each substance in Schedules II, III and IV, the quantities used in industry for the manufacture of nonpsychotropic substances or products.

Furthermore, the Board can request a party to furnish supplementary statistical information relating to future periods on the quantities of any individual substance in Schedules III and IV exported to and imported from each country. The party may request that this information shall be confidential.

Voluntary assessments and statistical data

After the Psychotropic Convention had been in force for only a few years, significant cases of diversion and attempted diversion were brought to the attention of the Board. The Board therefore, in its report for 1980, recommended that governments should consider adopting a number of voluntary measures designed to enhance the international control of the substances listed in the Psychotropic Convention. In 1981, the Board pointed out that, in contrast to the situation concerning narcotic drugs, in which there was virtually no diversion from the licit production and traffickers resorted to illicit production and manufacture, the priority international control problem with regard to psychotropic substances currently concerned the substantial diversion from licit trade. Exports had been made to certain developing countries, in some cases without the necessary import authorization, in other cases on the basis of falsified import authorizations.

In addition, exporting countries have a special responsibility to exercise vigilance, not only because they have long established drug control administra-
tions, but also because a supposedly importing country may not be aware that its import licences are being falsified. In case of doubt, exporting countries should ensure the authenticity of import certificates. Moreover, when large quantities of psychotropic drugs were involved, too large to be commensurate with the apparent needs of the countries of destination, exporting countries should not permit export unless queries to the designated authorities in the importing countries confirmed the import requests and authenticated the import certificates.

Finally the board believed that the aims of the Convention might be further advanced if governments were also voluntarily to take supplementary measures over and above those in the treaty. One such measure would be for governments from time to time realistically to assess their requirements for psychotropic substances, at least for those in Schedule II, and to furnish this information to the Board. The Board, in turn, could thereafter communicate those assessments to manufacturing countries so that they could serve as guidelines to ensure against overproduction and diminish risks of diversion. The Board wished to invite governments to indicate whether they would be prepared to furnish such assessments to the Board, at least in respect of substances controlled under Schedule II. Moreover, to enable the Board more effectively to monitor the trade and have a better understanding of the control situation worldwide, it would be beneficial if governments were voluntarily to provide to the Board quarterly statistics on imports and exports.

Concurrently, the Commission on Narcotic Drugs, at its 1981 session, unanimously recommended that the Economic and Social Council should adopt resolution 1981/7, which endorsed the proposals of the Board concerning supplementary measures for international trade. The Economic and Social Council recommended voluntary assessments to be furnished to the Board, and invited all governments to respond positively to the suggestion of the International Narcotics Control Board that they assess from time to time their medical and scientific requirements for substances listed in Schedule II of the Convention as well as for other controlled substances and to communicate this information to the Board for publication with a view to providing guidance for manufacture and export. The Council further invited all governments to consider the Board’s suggestion that they should voluntarily refrain from exporting Schedule II substances in amounts that exceeded countries’ assessments or that clearly exceeded the countries’ likely needs unless prior consultation with the importing country confirmed that the amount in question was desired.

In October 1981, the Board approved the distribution of new forms for voluntary assessments of annual medical and scientific requirements for substances listed in Schedule II of the Psychotropic Convention and for quarterly statistics of imports and exports of such substances. The Board decided to maintain each assessment for a period of three years, unless an amendment was transmitted in the interim. As of 30 June 1983, 89 governments and territories have submitted voluntary assessments and 57 quarterly trade statistics.
International Trade

The conventions require special controls over the import and export of controlled substances.

The substances in Schedules I, II and IV of the Single Convention and in Schedules I and II of the Psychotropic Convention are most strictly controlled (Single Convention, Article 31, paragraphs 4-16; and Psychotropic Convention, Article 12, paragraphs 1 and 3). Every party permitting the export or import of such substances must require separate export and import authorization on established forms for each export, whether it consists of one or more substances. Such an authorization must state the international nonproprietary name, the quantity, the pharmaceutical form, the name and address of both exporter and importer, and the period within which the export or import must be effected. The export authorization must also state the number and date of the import authorization as well as the issuing authority.

Before issuing an export authorization, the party must require an import authorization issued by the competent authority of the receiving country. Each consignment must be accompanied by a copy of the export authorization, and the government of the issuing country is required to send a copy to the government of the importing country. When the importation has been effected, the export authorization must be returned with an endorsement certifying the amount actually imported.

Exports of a consignment to a post office box, or to a bank to the account of a party other than the party named in the export authorization, are prohibited. Export to a bonded warehouse is also prohibited unless the import authorization certifies that the importing government has approved it. An alteration of the packing or a change in the nature of the substance is prohibited during storage in a bonded warehouse. Passage of the substances in question through the country of a party to another country is not permitted unless the export authorization is produced. In the case of an aircraft landing in transit, these provisions must be applied as circumstances require.

For the substances in Schedule III of the Psychotropic Convention (Article 12, paragraph 2) the exporter must for each export draw up a declaration in triplicate on an establishment form, containing the following information:

1. the name and address of exporter and importer;
2. the international nonproprietary name of the substance;
3. the quantity and pharmaceutical form of the substance and—in the case of a preparation—its name;
4. the date of dispatch.

Two copies of this declaration must be furnished to the authorities of the exporting country, and a third copy must be attached to the consignment. The authority of the exporting country must within 90 days send one of the copies to the authority of the importing country. The parties may require the importer, on receiving the consignment, to transmit the attached copy, with quantities and date of receipt noted, to the authorities of his country.
The Psychotropic Convention contains no provisions for the control of the actual transactions in international trade involving the substances in its Schedule IV (see below).

Both conventions (Single Convention, Article 32, and Psychotropic Convention, Article 14) permit the international carriage by ships or aircraft (the Psychotropic Convention also by other forms of international transport) of such limited amounts of controlled substances (the Psychotropic Convention with the exclusion of substances in Schedule I) as may be needed during their journey or voyage for first-aid purposes in emergency cases, without this being counted as import, export or passage through a country.

**Special Prohibitions and Restrictions of Export and Import**

A party to the Psychotropic Convention may, by a notification to the Secretary-General, prohibit all import into its country of one or more substances in Schedules II, III and IV. All other parties must then take measures to ensure that no export of such substances goes to the notifying country (Psychotropic Convention, Article 13, paragraphs 1 and 2).

By virtue of the provisions of Article 13, paragraph 3, of the Psychotropic Convention, a party may institute a system of special import licences for substances otherwise prohibited by it. Thus it may, for substances in Schedules III and IV of the Convention, institute an import certification scheme that approximates to the scheme required for Schedules I and II.

The parties to the Single Convention are required not to export any substances controlled by that Convention to another country, except in accordance with its laws and regulations, and the amounts exported must be within the limits of the total estimates that that country has sent to the Board (Single Convention, Article 31, paragraph 1).

In order to assist countries in their responsibilities under Article 13 of the Psychotropic Convention, the International Narcotics Control Board circulates, each year, an updated list of prohibitions and restrictions on the export and import of substances that have been notified by parties. This is contained in Part Four of the Annex to the Annual Statistical Form ("green list").

**Reports to the Secretary-General**

Both conventions require the parties to send reports to the Secretary-General, destined for the Commission on Narcotic Drugs through its secretarial body, the Division of Narcotic Drugs (Single Convention, Articles 18 and 35(f) and (g), and Psychotropic Convention, Article 16, paragraphs 1–3). The factual content of these reports can be summarized as follows (the wording of the two conventions is different in detail):

1. names and addresses of the government authorities empowered to issue import and export authorizations;
(2) information on changes in the laws and regulations promulgated to give effect to the conventions;
(3) information on developments in the illicit use or abuse of controlled substances;
(4) information on the development of illicit traffic within the country, including cultivation, production and manufacture;
(5) information on any particular case of illicit traffic where such case may throw light on new trends, increasing quantities, sources of substances, or methods employed by the traffickers.

Reports to the International Narcotics Control Board

Both conventions require that the parties send reports to the International Narcotics Control Board (Single Convention, Articles 19, 20 and 35(f) and (g), and Psychotropic Convention, Article 16, paragraphs 4–6). The content of these reports consists mainly of estimates of the national needs of the controlled substances, and statistical data on the actual cultivation, production, manufacture, wholesale and retail trade in, and consumption of, such substances. The detailed requirements are described on pp. 41–46.

It may be noted that the report of a party to the Secretary-General on various illicit drug activities according to the Single Convention, Article 35(f) and (g), goes to the Board as well as to the Commission on Narcotic Drugs.

Measures against Illicit Traffic

The parties to both conventions are required to undertake national and international activities against the illicit traffic in controlled substances, where the term "illicit traffic" in the conventions also includes cultivation, production and manufacture, in addition to its ordinary meaning of illicit trade and distribution (Single Convention, Article 35(a)–(e), and Psychotropic Convention, Article 21). The parties must take measures against such illicit traffic as follows:

(1) coordinate nationally preventive and repressive actions, and designate an appropriate agency for such coordination;
(2) assist each other and cooperate closely within the competent international organizations so as to maintain a coordinated campaign;
(3) ensure that international cooperation between their agencies is conducted expeditiously, including the transmittal of legal papers for purposes of prosecution.

The Single Convention additionally (Article 38 bis) recommends the establishment of regional centres for scientific research and education to solve the problems resulting from the illicit use of, and traffic in drugs. Such action can be promoted in consultation with other interested parties in the region and
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with the technical advice of the International Narcotics Control Board or the specialized agencies.

Measures against Abuse of Controlled Substances

Both conventions advocate far-reaching measures for the prevention of abuse and the treatment and rehabilitation of the persons involved (Single Convention, Article 38, and Psychotropic Convention, Article 20). Under the articles concerned, the parties must give special attention to, and take all practicable measures for:

1. the prevention of abuse;
2. the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, as well as coordination of such efforts;
3. the training of personnel in the treatment, after-care, rehabilitation and social reintegration of abusers;
4. assisting persons whose work so requires, to gain an understanding of the problems of abuse and of its prevention; and
5. promoting understanding of abuse problems and their prevention among the general public, if there is a risk that abuse will be widespread.

One of the functions of the regional centres recommended in the Single Convention (Article 38 bis) is to work on the problems resulting from the illicit use of drugs (see p. 47).

Certain resolutions adopted by the international conferences for the adoption of the conventions have a bearing on the recommended measures against abuse. Thus, the 1972 Conference recommends in the operative paragraphs of its third resolution on social conditions and protection against drug addiction that the parties “should bear in mind that drug addiction is often the result of an unwholesome social atmosphere in which those who are most exposed to the danger of drug abuse live”. Parties “should do everything in their power to combat the illicit use of drugs”, and “should develop leisure and other activities conducive to the sound physical and psychological health of young people”.

Penal Provisions

Both the Single Convention (Articles 33, 36 and 37) and the Psychotropic Convention (Article 22) require that a party, subject to its constitutional limitations, must treat any intentionally committed action contrary to the provisions of the conventions as a punishable offence, and that serious offences must be liable to adequate punishment, particularly by imprisonment or other penalties involving the deprivation of liberty. However, the party may, as an alternative or in addition to punishment of drug abusers, oblige them to undergo treatment, education, after-care, rehabilitation and social reintegration measures.
Each individual offence committed must be considered as a distinct offence. International participation in conspiracy, and attempts to commit such offences, as well as preparatory acts and financial operations in connection with them, must be punishable offences. All offences, wherever committed, must be taken into account in establishing recidivism. Offences committed either by nationals or foreigners, when serious, must be prosecuted by the party in whose territory the offence was committed, or by a party in the place where the offender is found, if extradition is not acceptable according to the laws of that party. Any substance and equipment used in, or intended for the commission of any offence contrary to the provisions of the conventions must be liable to seizure and confiscation.

All offences should be deemed extraditable offences in any extradition treaty between parties and should be included in any future treaties. If there is no treaty, the parties may recognize these offences as extraditable offences. Extradition should be granted in conformity with the law of the party to which application is made, and this party must have the right to refuse extradition if it considers that the offence is not sufficiently serious.

Special National Administration

Both the Single Convention and the Psychotropic Convention require a special administration to be maintained for the purpose of applying the provisions of the Convention. The Psychotropic Convention states that it is an advantage if it is the same as, or works in close cooperation with the administration established for the Single Convention (Single Convention, Article 17, and Psychotropic Convention, Article 6). The structure and functions of the administration are discussed later (see p. 62).

Technical Cooperation with and Financial Assistance to Parties

The question of assistance to parties desiring and requesting it was taken up by the Conference of 1961 in its first resolution on technical assistance on narcotic drugs. The operative paragraph of that resolution "expresses the hope that adequate resources will be made available to provide assistance in the fight against illicit traffic, . . . particularly in the form of expert advisers and of training, including training courses for national officials".

The Single Convention as amended by the 1972 Protocol treats this question in Article 14 bis on technical and financial assistance. The Article states that the International Narcotics Control Board, when it considers it appropriate, and in agreement with the government concerned, may recommend to the competent United Nations organs and to the specialized agencies that technical or financial assistance, or both, be provided to the government in support of its efforts to carry out its obligations under the Convention. The references to other articles make it clear that practically every aspect of drug control touched upon in the Convention is included in the range of possible support.
The Conference of 1972 itself took up the question in a special resolution on assistance in narcotics control. In the operative paragraphs of its second resolution, the Conference "declares that, to be more effective, the measures taken against drug abuse must be coordinated and universal; and declares further that the fulfilment by the developing countries of their obligations under the Convention will be facilitated by adequate technical and financial assistance from the international community".
CHAPTER 4

POLICIES AND REGULATIONS FOR DRUG CONTROL

National Legislation on Medicinal Drugs

General scope of a national drug law

A policy for drug supply and utilization is evidently an integral part of a national health care policy. Within this context the responsibility of the national authority is to ensure the needed supply of safe and effective drugs of good quality. A pertinent discussion on the development of national drug policies as part of comprehensive health policies can be found in a report by the WHO Executive Board's Ad Hoc Committee on Drug Policies.b

The basis of general drug control legislation is a national drug law, which regulates the supply of pharmaceutical products at all stages, including registration, manufacture, import, export, storage, quality control and distribution. It is intended to ensure that the consumer has access to a supply of safe and effective drugs of reliable quality, and that these drugs are promoted and used only for their intended purposes. In the latter context the law needs to cover the supply of accurate information both to the doctor and to the patient through advertising, labelling and information leaflets where appropriate. It is usual to establish a drug control administration and to define the boundaries of its responsibility. Where constitutional limitations apply, it may be necessary, for example, to define the respective responsibilities of central and regional authorities.

The brief description immediately following is intended to illustrate all the major components of such a law. However, it must be accepted that, in many countries, constraints on funds and manpower will limit the possibility of immediate implementation of all components. The system should be flexible, and suggestions for stage-wise implementation are made later.

A discussion on relevant subjects is found in a report on a consultation on basic elements of drug legislation and regulatory control for developing countries,c which also includes examples of forms used for the various procedures involved, as well as an extensive bibliography on descriptions of national

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a WHO unpublished document A35/7.
b WHO unpublished document DAP/81.3

c WHO unpublished document
legislation and regulatory control. If so requested by Member States, WHO can provide guidance on the development of appropriate regulatory systems.

**Specific provisions within a drug law**

**Registration**

The essential feature of a drug law is a system of registration, without which it is not possible for a country to control the supply and utilization of the drugs available within its jurisdiction. There are various possible types of registration system. The operation of such a system may be facilitated by collaboration or mutual consultation between countries at a regional or wider international level. An ideal registration system includes:

- evaluation of safety, efficacy and quality of pharmaceutical products;
- licensing, including the renewal, withdrawal and supervision of licences;
- allocation of drugs to different categories to provide for different levels of control, e.g., dispensing on prescription only, sale through pharmacies or other licensed retailers only, or general sale without prescription;
- supervision of the labelling of containers and outer packaging, and of the content of package inserts;
- post-registration surveillance.

Reference should be made to Chapter 5 for a detailed discussion of drug registration.

**Control of manufacture and importation**

The drug law will also provide the legal basis for the control of manufacture and importation. Appropriate regulations should be introduced to govern the suitability of premises and equipment, the professional and technical qualifications of the personnel engaged in manufacture and quality control, good practices in the manufacture and quality control of drugs, the maintenance of proper hygienic standards in manufacture, distribution and storage, the adequacy of storage conditions with particular reference to orderliness, temperature and humidity conditions, the keeping of records, and where necessary, the taking of appropriate measures to prevent theft or diversion into illicit channels. Such regulations should be enforced by suitably qualified inspectors, whose authority should be defined by the law. The WHO requirements entitled Good Practices in the Manufacture and Quality Control of Drugs are recommended as a valuable guide.a Information is available on quality assurance in pharmaceutical supply systems.b Many drugs will not be

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manufactured within the country but will be imported. In such cases much of the information will have to be obtained either direct from the manufacturer, or through the drug administration of another country. In the latter case, the WHO Certification Scheme on the Quality of Pharmaceutical Products moving in International Commerce, to which many countries subscribe, has been devised in order to give importers confidence that the control of manufacturing processes, etc., has been properly carried out.

Control of exports

The export of drugs is not usually made subject to specific control under the general drug legislation. However, countries may, if they so desire, adopt a general provision in their national drug law requiring exported drugs to satisfy either domestic requirements or the requirements of the country of destination. In view of the dynamic character of general drug legislation, it is desirable for such a provision to be implemented through some form of bilateral or multilateral agreement. The WHO certification scheme mentioned above may provide the basis for such an agreement.

Control of distribution at the national level

In order to ensure the supply of drugs of good quality to the consumer or patient, control of the distribution chain is necessary. Wherever possible, the wholesale and retail distribution of drugs should therefore be restricted to those persons and enterprises having adequate storage facilities at their disposal. Training consistent with the level of service to be given is essential, including knowledge of how to store, handle and dispense or distribute drugs. Whenever regulations call for dispensing on medical prescription only, or sale through pharmacists or other licensed retailers only, control of the national distribution network is an obvious prerequisite. Many drugs, indeed the majority, are not suitable for self-medication because of their therapeutic and toxic properties while, with psychoactive drugs, the risk of abuse exists. If practical considerations preclude effective government surveillance of the national distribution network, it may be desirable to provide such drugs only through hospital pharmacies or clinics with dispensing facilities. In rural areas without hospitals or clinics with dispensing facilities, a limited assortment of drugs for primary health care may be made available through medical or health workers.

The conventions require all persons and enterprises engaged in the manufacture, trade and distribution of the controlled substances to be licensed, and the establishments and premises where such activities take place to be controlled through inspections.

Supervision of information

The supply of accurate information to the medical and health professions and to the public is essential. The possibilities for misleading the community and for creating misuse, including dependence, whether intentionally or unintentionally, are obvious. Controls must cover promotional activities, advertising of drugs, and prohibition of advertising of cures for certain diseases, all of which are regulated in the laws of many countries. Most often the degree of control of such activities is linked to the various schedules of drugs of different types contained in the drug law (see p. 71).

Drug control administration

Of central importance to all the above is the drug control administration itself, whose tasks will be determined by the scope of the general drug legislation. These will usually include registration and control of the manufacture, importation, exportation and wholesale and retail distribution of drugs. In some cases, this administration may also be responsible for determining the range of drugs available for use in the public sector, and for pricing. The availability of analytical chemical services, preferably in the form of an official quality control laboratory working in conjunction with a university faculty, is a virtual necessity. Where registration and selection of drugs for use in the public sector involve an independent national scientific evaluation of efficacy and safety, expertise of academic level in internal medicine and other medical specialities, pharmacology and toxicology should be available to the administration, whenever possible in the form of an advisory panel, board or committee. In order to promote cooperation between the government and the medical and pharmaceutical professions, the active involvement of the corresponding professional societies in the implementation of national drug policies should be sought.

Other legal requirements

The drug law must deal clearly with such matters as offences, prohibition of specified activities, limitation of certain activities to prescribed individuals possessing certain specified qualifications, and penalties for offences. It must also specify the powers, if any, of the appropriate authorities to introduce rules and regulations on such matters, and clearly designate the person responsible. It should include, where necessary, provision for appeals against administrative decisions and interpretations, and procedures for the repeal of regulations or of provisions of the legislation, and should also specify any exemptions from the provisions of the law.
Special Legislation Relating to the Conventions

A country that is a party to the conventions will have to introduce, in addition to the general drug laws, certain other regulations required by the conventions. As should be clear from Chapter 3 on the responsibilities accepted by the parties, accession to the conventions means that special efforts have to be made in many areas, such as agriculture, industry, commerce, health, social welfare, education and law enforcement. However, in most of these areas the responsibilities are not such as to call for special regulations, and where such regulations are necessary, they can be restricted to certain situations and activities. The main aims of the conventions can be fulfilled by the parties if they take them into account when drafting such laws and regulations as would in any event be necessary in, e.g., health, social welfare and education, or if they adopt instructions and practices for relevant organizations and institutions that are in accordance with those aims.

There is, however, a specific requirement for administrative and legal control of the supply of psychoactive drugs in order to ensure proper medical and scientific use and to encourage rational social attitudes. Most of these drugs have dependence liability and many are actually abused; they therefore cause more problems to public health and to society in general than any other class of drugs. Control is therefore emphasized in the conventions and is aimed at preventing or reducing the hazards associated with these drugs, as well as preventing their diversion into the illicit market.

The scope of national drug legislation will have to cover the production, trade, distribution and control of the whole gamut of medicinal and related products. The necessary basic control of psychoactive substances can be included in this general legislation, provided that the need for differing levels of control is recognized; this will ensure both safety and quality in the functioning of the pharmaceutical supply system. However, a number of the provisions of the conventions go beyond the regulatory level generally needed and should be the subject of separate but complementary legislation. The conventions also provide that offences against such legislation should be punishable under national penal laws.

The basis for the special regulations provided for in the conventions is the listing of the controlled substances in schedules associated with different levels of control. These schedules provide the minimal level of control called for under the conventions, but the parties have the right to exercise stricter control and even to prohibit the use of certain substances. In passing it may be noted that, while the schedules contain a fairly large number of substances, the parties are under no obligation to use all of them in their health care. It is in many ways to the advantage of parties to register only those drugs that are necessary and appropriate to their individual circumstances and thereby greatly to reduce the special control work required. Many countries find this to be an appropriate way of administering drug controls.

The special regulations that are necessary can either be inserted in the corresponding parts of a national drug law, or be made the subject of separate
complementary legislation. In such legislation the controls provided for may, in
certain respects, be stricter than required by the conventions. The promulgation
of separate legislation is probably the more straightforward and clearer
alternative, and has been the one preferred by most parties.

In the context of the conventions, special legislation will be needed in the
following areas:

1. Insertion of the complete list of substances (drugs) in the schedules of the
conventions into the relevant provisions on the control of pharmaceutical
products (Single Convention, Article 1, and Psychotropic Convention, Article
1).

2. Licensing and inspection of all persons and enterprises in respect of all
controlled substances in manufacture, production, trade and distribution (see p.
40).

3. Control of international trade, including the requirement for import and
export authorizations for a number of the controlled substances (see p. 45).

4. The keeping of records on various aspects of manufacture, trade,
distribution and use of the controlled substances as a basis for reports to the
Secretary-General and the International Narcotics Control Board (see p. 41).

5. The use of medical prescriptions in dispensing the controlled substances
(see p. 38).

6. The labelling of controlled substances and the control of advertising (see
pp. 39, 66 and 84).

7. Penalties for actions contrary to the provisions of the conventions (see p.
48).

Control of the Cultivation of Opium Poppy, Coca Bush and Cannabis

The opium poppy, coca bush and cannabis plant are of limited importance as
a basis for the production of psychoactive substances useful to modern
medicine. The most important is opium, but many synthetic compounds
compete successfully with morphine and its derivatives in various fields of
medical therapy. The therapeutic uses of cocaine, extracted from coca bush
leaves, have been greatly reduced. The active substances of cannabis are being
investigated for possible therapeutic uses, but the outcome is still uncertain. In
contrast, both age-old and recent experiences convincingly demonstrate the
dependence-producing properties of these psychoactive substances and the very
serious public health and social damage resulting from their abuse. The Single
Convention therefore maintains very strict controls on the cultivation of these
plants and the production and use of their active substances, and aims both to
reduce their legal cultivation to the very minimum needed for medical and
scientific purposes and to prevent their illegal cultivation and illicit traffic. The
range of measures required by the Single Convention for their control is
summarized below, with references to the relevant articles.

The essentially restrictive attitude of the Single Convention is shown in
Article 22, which states that: “Whenever the prevailing conditions in the
country or a territory of a Party render the prohibition of the cultivation of the
opium poppy, the coca bush or the cannabis plant the most suitable measure, in its opinion, for protecting the public health and welfare and preventing the diversion of drugs into the illicit traffic, the Party concerned shall prohibit cultivation". Such prohibition should be coupled to appropriate measures for the destruction of illicit cultivation.

The Convention nevertheless permits the licit cultivation of the opium poppy for the production of opium. If a party permits such cultivation, it must maintain a National Opium Agency (Single Convention, Article 23) to designate the area of cultivation, license the cultivators and purchase and take physical possession of the total crops of opium. This Agency must furthermore have the exclusive right of importing, exporting, wholesale trading and maintaining stocks other than those held by the manufacturers of the products deriving from opium. The Agency, in other words, has a monopoly of the opium trade in the country. Because of this complicated and costly control system, only one country now produces opium for export.

Poppy straw is subject to the system of import certifications and export authorizations, and statistical information on its import and export must be furnished (Single Convention, Article 25).

The production of opium, both for national use and for international trade, is subject to certain limitations (Single Convention, Articles 21 bis and 24). Special estimates of the requirements must be furnished to the International Narcotics Control Board (Single Convention, Article 19, paragraph 1(e) and (f)), as well as statistical returns (Single Convention, Article 20, paragraph 1(d) and (g)). A party intending to initiate the production of opium must take into account the prevailing world need for opium in accordance with estimates published by the Board so that over-production will not result. However, a party that exported its nationally produced opium during the ten years immediately prior to 1 January 1961 may continue to export the opium that it produces. A party always has the right to produce opium sufficient for its own requirements, and to export opium seized in the illicit traffic to another party, provided that the requirements of the Convention are satisfied (Single Convention, Article 24).

The production of opium over the years has oscillated between world under- and over-production. Following debates and resolutions of the Commission on Narcotic Drugs and the Economic and Social Council, the Board has conducted consultations and investigations the results of which are published in its report for 1980, which gives a very complete picture of both the historical background and the current situation and contains recommendations aimed at ensuring a satisfactory situation in the future. The Board continues to monitor the balance between supply and demand in its yearly reports.

In recent years, poppy cultivation, often of specially bred types for the production of morphine alkaloids directly from the straw without opium as an intermediate stage, has become possible and there has been a trend towards this mode of production. Where poppy straw is produced, the manufacture of drugs

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9 Demand and supply of opiates for medical and scientific needs, New York, United Nations, 1981.
from it must be strictly controlled and a system of import and export certification introduced. Parties using such production methods voluntarily supply estimates of growing areas and production to the Board in the same way as other poppy growers. In addition the poppy straw concentrate used for the production of alkaloids is treated as a drug under Schedule I of the Single Convention and is subject to all appropriate controls.

The cultivation of the opium poppy for purposes other than the production of opium must be coupled with all measures necessary to ensure that opium is not produced from such poppies, e.g., there must be no lancing for the production of raw opium (Single Convention, Article 25).

A party may permit the cultivation of the coca bush and the use of its leaves for alkaloid production (Single Convention, Article 26), but the same controls as those applicable to the opium poppy (Single Convention, Article 23) must then be instituted. However, illegal cultivation must be destroyed and the wild growth of coca bushes uprooted, as far as possible. The same requirements apply to the licit cultivation of the cannabis plant for the production of cannabis or cannabis resin (both controlled under Schedule IV of the Single Convention: see p. 36).

A party may permit the use of coca leaves for the preparation of a flavouring agent, which must not contain any alkaloids and, to the extent necessary for such use, may permit the production, import, export, trade in and possession of such leaves (Single Convention, Article 27). In this situation, the party must furnish estimates and statistical information in respect of such coca leaves.

The cultivation of the cannabis plant exclusively for industrial (fibre and seed) and horticultural purposes does not fall under the Single Convention. However, all measures must be adopted to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant (Single Convention, Article 28).

National Policy for Drug Abuse Control

Background of drug abuse control

The major objective of any national policy for the control of psychoactive drugs is to limit their use exclusively to medical and scientific purposes and to ensure that available drugs of this type are safe, effective and of good quality.

The nonmedical and/or illicit use of psychoactive drugs must be prevented and/or prohibited, and such use—in a very simple and straightforward formula—constitutes “drug abuse”. Drug use and abuse are related, on the one hand, to the supply of drugs through licit distribution or illicit traffic, and, on the other, to the demand for drugs. The pattern of the resulting drug problems is not a uniform one for the world as a whole or the individual continents. In fact, every country and even different communities within a country have different profiles of drug use and abuse, and a national policy for drug abuse control will have to take the special situation of the country into account.

The complex and often confusing drug scene requires systematic discussion, e.g., in terms of the triad “substance—individual—society”. Obviously there is
in any drug abuse situation an interaction between a substance misused, an abusing individual, and a social situation (an environment) in which abuse occurs. The substance must be available, but increased availability does not necessarily lead to increased abuse, and reduced availability quite often leads to a switch to another substance, often difficult to understand from the pharmacological point of view. Multi-drug use is becoming more common. A general belief in the effectiveness of medicinal drugs for personal problem-solving — "a pill for every ill"—must surely also encourage experimentation with illicit drugs.

For the individual the wish for euphoria, "the kick", is one reason for taking a drug. Other reasons include efforts to deal with psychological problems creating anxiety, depression, frustration or stress, i.e., to seek symptomatic relief. For teenagers drug taking may seem to help in solving the problems of growing up, or it may be a symbolic act of aggressive protest against a harsh society or the authority of older generations. Drug taking leads sooner or later to social dysfunctioning, which should be noticed by relatives, teachers in the school or the foremen and friends in the work-place. Since the successive steps of the life history or "addict career" of an abuser lead to increasingly difficult medical and social situations, it is important that counselling and treatment activities should be focused on the early stages of drug abuse.

Society in the form of family, friends and work companions strongly influences the drug taking behaviour of an individual. The general cultural attitude to drugs sets the scene. Youngsters follow the example set by their peers in the street gangs, and fashions of drug taking spread in the youth subculture. Adverse social conditions, such as unemployment or poor housing, are risk factors. Every society has a criminal subculture, to a large extent involved in drug abuse, which serves as a recruiting mechanism.

An analysis of the national drug abuse situation must be followed by a plan for preventive or remedial action. If the actual action plans in different countries are considered, certain patterns or models for coping with drug-associated problems can be discerned.

In the legal model the greatest importance is placed on defining the moral and juridical limits of medical drug use and in making rules and laws against nonmedical, illegal drug abuse, so that law enforcement actions have priority.

The medical model considers that drug dependence is essentially a disease process. Drug abuse is caused by the attraction of body- and mind-damaging substances, and its spread can be compared to an epidemic of contagious disease. Medical treatment is essential, and prevention means eliminating or reducing demand for the substance and isolating the sick individuals.

The psychosocial model lays more stress on the psychological mechanisms operating in the drug taking individual and the interaction with social factors in the environment. The individual must be seen against the background of his total life situation. Actions to help the individual to rid himself of his abuse and also prevention programmes must be correspondingly broad and varied.

There is, of course, some truth in each of the three models. A national action programme should be based on a combination of all of them so as to achieve a
holistic approach, the causes and effects of drug abuse being seen as broad interactions between substance, individual and society.²

Factors in policy formation

A national policy for drug abuse control should encompass the objectives and instruments, inter alia, for controlling the licit production and movement of drugs, controlling and eradicating the illicit cultivation of plants containing psychoactive substances, prohibiting the illicit manufacture and diversion of psychoactive substances, combating illicit traffic—national or international—in drugs, data collection and reporting on the nature, extent and seriousness of drug abuse, and the treatment, rehabilitation and social reintegration of drug abusers, information and education, enforcement and penal law, the role of government at different levels of public administration, and intergovernmental cooperation. Such a policy will also constitute a basis for international cooperation.

Policy formation presupposes successive stages of policy development, programme planning and implementation. A chain of reasoning that takes into account the current nature of the drug abuse phenomena and the measures available to influence them requires the following basic information:

— the prevailing forms of drug abuse, the specific problems that arise and the changes that take place over time;
— the population groups involved in drug abuse and the measures to which these groups are most likely to respond; and
— the ability, within available resources, to design practicable programmes to modify the phenomena.

In designing such programmes it is necessary:

— to ensure that expectations as to their impact are realistic; and
— to select appropriate objective criteria for measuring the outcome.

Once a common, broad policy has been formulated, specific goals must be defined for each authority or other agency involved in its implementation. These goals should be defined and agreed on through a consultative process during the development of policies.

A strategy statement should be prepared as clearly as possible for each programme, in order to provide guidelines for each collaborating agency. The essential elements of such statements are the following:

— the general objectives of the programme;
— the goals of each programme component;
— a concise statement of programme priorities;
— the general responsibilities of each participating party;
— the timing and description of the major phases of the programme.

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While each programme is being implemented, communication channels should be maintained between the policy-making body and those who carry out the programme. Special regard should be given to serious difficulties encountered in programme implementation. The functioning and outcome of the programmes should be evaluated, and the findings reported to the policymaking body. The evaluation may be performed either by the programme staff, using some form of monitoring or outcome indicators, or by outside evaluators; the latter may provide a greater degree of impartiality but is more costly.

The background to policy formation and the mechanics of policy implementation have been broadly discussed in a Division of Narcotic Drugs publication.

National organizational structure for coordination

The type of institutional mechanism needed for policy definition, programme implementation and coordination is something that each country has to decide in relation to its own needs, priorities and resources. Some of the mechanisms used for developing and coordinating national drug policy and programmes are the following.

A commission of inquiry. Such a commission can prove useful, particularly at the outset of national programme development, in determining what kind of coordination might be effective at the national level. Although established by the national government, it is often independent in character, given specific terms of reference, and directed to inquire into particular phases of illicit drug use and to make recommendations to the government on policies and programmes. Although the independence of such commissions may increase impartiality in investigation, they are generally time-consuming and costly.

A committee. This is usually employed in jurisdictions in which drug programmes are coordinated at a single level of government, and is particularly useful in the early stages of policy formation and programming. A committee is usually either interdepartmental or interagency, and may include the permanent heads (or their designates) of the government agencies involved in controlling illicit supply and reducing illicit demand. Such a committee is unlikely to be responsible for allocating funds but must rely on the budgeting of the individual agencies. It will then be necessary for discussions on funds to take place at a higher level of government.

A national commission. The membership of this body is drawn from the relevant departments and agencies of government, but may also include individuals and representatives of nongovernmental agencies. The commission usually has a full-time secretariat and core staff, and the commission as a whole reports to a high level in the political structure, i.e., to a member of the cabinet, a cabinet committee or the head of the government. The commission may have greater autonomy than the interagency committee and may make direct

commitments, but is more costly and cannot integrate its activities with the full range of national programmes, since it lacks administrative responsibility.

A national institute. An institute, sometimes called a national centre, can function in a number of roles. It can serve as a resource centre, providing both financial means and guidelines to other jurisdictions, and thus coordinating at least the country’s major programmes. It can also function as a large programme agency, engaging in assessment of drug abuse, research, documentation, evaluation or administrative counselling. It may thus make available materials and services that cannot be provided by other bodies.

Structure and Functions of the Special Administration

As stated on p. 49, the parties are required to maintain a special administration for the purpose of applying the provisions of the conventions. The structure of such an administration may vary according to national needs, the scope of policies involved and the availability of suitable facilities, expertise and manpower. Where government intervention covers a wide range of activities falling within the competence of several ministries, the statutory tasks will be performed by the appropriate executive branches of government, coordination being ensured by an interdepartmental or interagency committee. The level of official membership of such a committee will, to a large extent, determine how effectively it functions. The committee will usually be served by a permanent secretariat, and policy guidance may be provided by a commission or institute, as mentioned previously.

If, on the other hand, a limited function is foreseen for such an administration, and its responsibilities are restricted to licensing and inspection in production, trade and distribution, to issuing export and import authorizations, to collecting and reporting data for the estimates and statistical returns system of the International Narcotics Control Board, and for reporting to the Secretary-General on illicit traffic and drug abuse, its role might be fulfilled by a department or a division in one of the ministries, preferably the ministry responsible for public health. Most of the functions mentioned are linked to the control of the registration and distribution of medicinal drugs in general. Data and statistical information on illicit traffic may be assembled through collaboration with the Ministry of the Interior or Home Affairs. The tasks of the special administration provided for by the conventions could therefore be usefully entrusted to the drug control administration mentioned earlier in this chapter (p. 54).
CHAPTER 5

REGISTRATION AND DISTRIBUTION OF MEDICINAL DRUGS

Registration of Drugs

Registration policy

Registration is the procedure whereby a medicinal product is released and licensed by the competent health authority for trade, subsequent distribution and dispensing to individuals. Registration of a pharmaceutical preparation is an administrative step, but it should never be a formality, a principle that applies equally to drugs in general and to psychoactive drugs. Registration is, in effect, an official statement by the national health authorities that evidence has been presented and evaluated on the quality, efficacy and safety of the drug, including its dependence-producing liability, and that the conditions of its marketing and use have been clearly defined.

In certain circumstances, some countries will also find it appropriate to consider the cost to the community. The evaluation and selection of medicinal products in the light of the health needs and priorities of a country is an important part of its national health care policy, and should be governed by clearly expressed principles.

Medicines play a very important role in protecting, maintaining and restoring health, and in recent years there has been a tremendous increase in the number marketed. For many reasons, and in particular to achieve optimal use of limited financial resources, the drugs available must be restricted; only those that are effective, safe and satisfy the health needs of the population should be permitted. WHO has, after extensive investigations and consultations, published a list of essential drugs (see p. 65). A restrictive policy with regard to the registration of medicines containing psychoactive substances is desirable, since most of them are dependence-producing and many are liable to abuse or are actually being abused. There are good reasons to believe that the larger the consumption of such drugs, the larger will be the number of people abusing them, whether the drugs are available as a result of licit dispensing or illicit traffic.
A useful analysis of the registration policies of a group of developed countries has been published.\textsuperscript{a}

**Drug evaluation and selection**

A comprehensive drug registration system requires adequate information on chemical, pharmaceutical, toxicological, pharmacological, therapeutic and clinical investigations. Such information should be provided by the manufacturer and importer, together with the application for registration, in a form to be decided by the registration authority. A series of important reports on these subjects has been published by the WHO Expert Committee on Specifications for Pharmaceutical Preparations, the latest in 1982.\textsuperscript{b} The specifications and analytical methods for testing the quality and stability of the product as well as information on special storage conditions may also be necessary. Certificates requested and issued in compliance with the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce\textsuperscript{c} will be of great assistance in ensuring that imported drugs are of the necessary pharmaceutical quality.\textsuperscript{c}

Since safety and efficacy requirements have become more stringent in recent years, the relevant information, including reports on clinical studies, is extensive. At the present time, most developing countries do not have adequate professional staff to handle such documentation. They do, however, need to import many highly potent and effective drugs so that their registration authorities need concise information on safety and efficacy. While such information may be provided by the manufacturer or the registration authority in the country of origin, it may be useful to obtain an opinion from another registration authority that has evaluated the drug. WHO has an important role to play in the collection and dissemination of information on new drugs, and of significant new data on existing drugs.

In some regions there is already an interchange of detailed evaluations and of reasons for decisions between the drug administrations of the various countries, thus maximizing the expertise available. Assistance may often be provided by more developed countries, and their advice will be particularly valuable where their geographic, climatic or social backgrounds are similar.

The selection of medicinal products for registration with a view to limiting the number of drugs available to a level appropriate to the health needs of the population is a process that will give a different result in different countries (see p. 65). The selection criteria should ensure that the process is unbiased and based on the best available scientific information, and yet allow for a degree of variation to take into account local needs and requirements.


\textsuperscript{c} Quality control of drugs, Geneva, World Health Organization, 1977.

In registering psychoactive drugs the same considerations apply in the evaluation of safety and efficacy as for other drugs, but some additional problems should also be taken into account. Special attention should be devoted to their liability to produce dependence and abuse, so that the preclinical studies of a psychoactive drug should be analysed for indications that it may belong to a therapeutic group, e.g., hypnotics, sedatives, tranquillizers, anorectics or analgesics, having dependence potential and/or abuse liability.

Model lists for registration

The extent to which a country restricts the number of drugs available for use by restricting registration is for that country to decide on the basis of its national health policy. As already pointed out, such an approach will give a different result in different countries, depending on many conditions. Thus the health needs of a country vary with the pattern of disease prevalence as well as with demographic and environmental factors. The type and qualifications of health personnel will also have to be taken into account in placing drugs in schedules for marketing, dispensing and sale. Financial resources may create other constraints.

WHO Expert Committees have published three reports on the selection and use of essential drugs. The resulting Model List of Essential Drugs contains only about 300 drugs, of which only about 30 are psychoactive ones. The list was revised after comments had been received from WHO experts, national health authorities and interested international and nongovernmental organizations. It is emphasized that the list can only provide a basis for the efforts of individual countries to identify their own priorities and make their own selection, and is a tentative identification of a "common core" of universally relevant and applicable drugs for basic health needs. The identification by health authorities of further local needs will make additions to the list necessary. The selection of essential drugs is, in addition, a continuing process, taking into account changing priorities for public health action and epidemiological conditions, as well as progress in medical knowledge.

WHO has also developed a list of essential drugs for mental disorders. This will not be applicable in every setting but represents a tool for use by national health authorities wishing to develop a list appropriate to their own situation. The development of such a list will require the cooperation of various professional groups of physicians and psychiatrists. A guiding principle in this work must be that limiting the use of a number of drugs with dependence

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*c* Document OMH/76.2.
liability will help to prevent drug abuse. Due regard and special emphasis should be given to the control requirements of the conventions; the stricter the control under the conventions the greater the risk of dependence production and abuse and at the same time the smaller the medical usefulness.

**Labelling**

The labelling of drugs is one of the most important and critical aspects of pharmaceutical manufacture, and includes not only the labelling of the containers and packages, but also the information given in the package inserts. Any mistake in labelling can lead to serious health problems, so that careful control must be exercised.

Both conventions require certain warnings to be provided. Thus the Psychotropic Convention states in Article 10, paragraph 1, that retail packages of controlled substances must be labelled or at least have an accompanying leaflet with such directions as in the opinion of WHO are necessary for the safety of the user. Such directions for use must take into account any relevant WHO recommendations.

The Single Convention has no such general requirement, but states in Article 30, paragraphs 3, 4, 5, and 6, that it is desirable in the case of controlled substances that the international nonproprietary name communicated by WHO should be indicated in written or printed offers, and that a clearly visible double red band on the inner package or its wrapping may be required. The package is required to show on the label the exact content of the substance by weight or as a percentage. This requirement need not apply to substances included in Schedule II, however, but the precise directions given by the prescriber should be included on the label.

A group of consultants has discussed the content of the cautions and warnings to be given. For substances and their preparations available only on prescription, a statement warning the physician on the dangers of abuse was found to be necessary, including:

(a) a brief description of the nature of the effect resulting from the abuse of the substance and its potential severity;
(b) a warning concerning the possible interaction of the substance with alcohol.

Certain substances and their preparations are directly available to the public, and it was noted that such drugs may be used for self-treatment following self-diagnosis of a condition. While it may be assumed that such products are not abused to a significant extent by the population, it is necessary to warn the patient that:

(a) the use of the drug, alone or in combination with alcohol, may produce effects (such as drowsiness) that make certain activities (such as driving or operating machinery) more dangerous than usual;

WHO unpublished document MNH/78.1.
(c) in certain cases, use of the drug may lead to certain physiological or behavioural changes and/or habit formation and, if such effects are noted, a physician should be consulted.

(b) an overdose should be avoided by not exceeding the limits of dosage as indicated on the label; and

The group of consultants also recommended that parties should consider placing some mark or symbol on the label and accompanying leaflet to indicate both that the substance is controlled under national regulations and the level of control. These recommendations were communicated to all Member States by the Director-General in 1978.

Furthermore, the World Health Assembly, in resolution WHA28.65, recommended that Member States should apply the revised requirements entitled *Good Practices in the Manufacture and Quality Control of Drugs*. These requirements may be said to satisfy the provisions of the conventions when they state that the labelling of all finished pharmaceutical products should bear and clearly indicate the following information:

1. the name of the drug;
2. a list of the active ingredients, showing the amount of each present, and a statement of the net content, e.g., number of dosage units, weight or volume;
3. the batch number assigned by the manufacturer;
4. the expiry date, if required;
5. any special storage conditions or handling precautions that may be necessary;
6. the directions for use, and any warnings and precautions that may be necessary;
7. the name and address of the manufacturer or the person responsible for placing the drug on the market.

In registering a drug, the drug control agency should call for complete information on labelling, including samples of package inserts, and should scrutinize them before granting approval so as to ensure that the information given corresponds precisely to the purpose for which registration has been granted. Information on indications, contraindications, side-effects, precautions and dose recommendations given on the insert should be subjected to particular scrutiny and approved along with the labels on the container and package. The text approved should be explicit, appropriate, and in the official language.

**Registration procedure**

As discussed in Chapter 4 (p. 54) a drug control administration—or its national equivalent—should be responsible, among other things, for drug

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Registration, expert advice being provided by an advisory committee. Registration policy and the various aspects of the registration function have been discussed earlier in this chapter.

In setting up a registration procedure, or complementing an existing one, over-ambitious attempts to introduce new rules and regulations simultaneously often fail because the manpower necessary to enforce them has been underestimated. A step-by-step approach is instead suggested, which should start with an inventory of the drugs on the market. Simple administrative procedures and forms should be worked out in this first phase which, for a regulatory agency, is mainly a question of coordination and documentation requiring accurate record-keeping of data on drugs on the market.

During the first, inventory phase, the essential feature of which is a notification procedure, all manufacturers and distributors should be requested to complete notification forms within a given period of time. All drugs for which this form has been received may continue to be sold while the incoming information is under review, unless the administration decides to stop the sale on the basis of glaring inadequacies in quality or safety. If a manufacturer or a distributor does not complete the required form for a drug that he is supplying, the sale of that drug must cease after a date fixed by the authority. The incoming forms should be given provisional numbers, classified and filed in a simple manner for ease of retrieval.

In a second phase, a licensing system should be brought into operation on the basis of appropriate regulations requiring manufacturers and importers to apply for registration of new drugs, i.e., those not previously on the market in the country. Such an application should include the documentation necessary for the evaluation and selection of drugs by the registration authority (see p. 64). The licensing procedure should continue with a review of the drug by the authority and its committees, including a comparison with similar drugs already on the market. If the drug is approved, a registration certificate is issued. The information that a drug is approved for sale in a country is usually published in an official gazette, together with the name of the product, the dosage form, strength, name and address of the manufacturer/distributor, composition and sales category (prescription, non-prescription, narcotic or psychotropic drug, other restrictions).

In the case of drugs donated by external agencies or bought on tender by a government central medical store or its equivalent, the same requirements have to be met as in the case of registered drugs, but a formal registration procedure may not be necessary.

The administration should have the power to cancel or suspend the registration of a drug if circumstances or the registration conditions have changed, if it is in the public interest to suspend or cancel the registration, or if registration was based on fraudulent or inaccurate information. Similarly, the conditions for registering a drug may be changed.

A comprehensive registration system, including evaluation of scientific data on safety and efficacy, calls for a large multidisciplinary staff of professionals
together with adequate resources for a well-developed filing system, generally including access to computer services. Even if a drug control administration can call on outside advisory national bodies or experts for support in evaluation procedures, the work to be carried out in preparing the documentation for the evaluation is extensive and time-consuming, requiring both administrative and professional services.

To avoid duplication of efforts and to save costs, drug control administrations in developing countries should pool their efforts through technical cooperation in the fields of evaluation, quality control and the training of professional personnel in registration matters. Information on conditions for the approval of registration in the country of origin of a drug will be helpful in decision-making. Developed countries may also have a contribution to make in fostering and, on request, participating in technical cooperation programmes.

When a drug has been approved for registration it must still be subject to whatever conditions are considered necessary. It may be released at various levels of control, so that its safety and efficacy can be still further evaluated, as follows:

   (a) **Trial basis**: The drug is released for use as a clinical trial drug to a designated or approved trialist, usually in hospital or specialist practice. Under such circumstances it is usual to lay down conditions for trials, or at least to approve them, in order that information can be collected in an agreed manner. A further decision may be made on the basis of this information.

   (b) **Limited monitored release**: The manufacturing company is allowed to supply the drug to approved hospitals or specialists, but is responsible for collecting either specified clinical data or information on reactions for the registration authority. It is usual to specify a period after which further consideration can be given to more general release.

   (c) **Release for use in individual patients only on approval from the registration authority**: In such cases quite substantial information on a drug may be available and it may have been concluded that its limitations or dangers require special conditions to apply, possibly relating to controls on administration or to the clinical conditions for which its use might be permissible.

   (d) **Release for use in hospitals**: This type of release is usually reserved for drugs when special monitoring of a known effect, e.g., by means of biochemical, haematological or other tests, is required.

   (e) **General marketing at various levels of control**: The drug may require special authority for prescription, e.g., to drug-dependent persons or for nominated diseases, or it may be available on medical prescription only, or on special monitored prescription; supply may be permitted by a pharmacist only (with or without recording), or the drug may be available for general "over-the-counter" supply.

These levels of control can obviously be varied and combined but their broad purpose is still either to restrict the use of drugs that have known effects or to provide feedback where the effect is uncertain. In this way, a body of knowledge will be built up on which proper decisions on levels of control can be based.
Conditions for the Sale of Drugs

Sales categories of drugs

The control of pharmaceutical products used for the prevention, diagnosis and treatment of diseases should be the subject of a special drug law, as already discussed in Chapter 4 (p. 51). The parties to the conventions will also have to introduce the special legislation considered in that chapter (p. 54), whether as part of a drug law or in some other way, based on the levels of control required for the different schedules of the conventions. The drug legislation of a party will have at least to incorporate all the substances contained in these schedules in corresponding lists in a drug law, although the allocation of substances to these different levels of control is liable to change from time to time. The legislation must be introduced in stages, possibly in the following manner:

1. Make provision in the drug law for the administrative authority (or the minister or his delegate) to have the power to make regulations for the control of pharmaceuticals and other hazardous substances at the point of sale to the consumer.

2. Include in the regulations an appropriate list of schedules, defining the controls to be applied at each level.

3. Allow also for additions to, or removals from these schedules by administrative order of the responsible officer (normally a senior official at the ministry).

The number of schedules will vary from country to country, but an outline is given in Table 1, for guidance, of the various groups of substances and the controls applied. This is not meant to be complete, nor may it be essential in every country to provide all of them.

Some of these groups of drugs can be combined if local manpower restrictions or other conditions make this desirable, e.g., where the range of drugs available is limited the number of control groups may be reduced correspondingly.

Preparations

The sale of preparations is surrounded in the conventions by rather complicated regulations and exemptions that have made several commentaries necessary. The Single Convention defines a “preparation” quite simply as “a mixture, solid or liquid, containing a drug”. The Psychotropic Convention gives the following definition:

“(i) Any solution or mixture, in whatever physical state, containing one or more psychotropic substances, or
(ii) One or more psychotropic substances in dosage form”.

The basic principle of the conventions is that a preparation containing a controlled substance is subject to the same control measures as the substance in question. Logically, if the preparation contains more than one such substance, it
### Table 1. Suggested drug schedules and controls

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Type of drug</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General household medicines in common use that are not a serious hazard (over-the-counter drugs)</td>
<td>Not usually necessary to restrict sales; proper labelling, especially of dosage, important</td>
</tr>
<tr>
<td>2</td>
<td>Medicines in general community use but where some advice from a health worker, clinic or pharmacy on their correct use may be valuable</td>
<td>Supply limited to pharmacies, clinics or health workers, as appropriate; labelling suggestions may be made</td>
</tr>
<tr>
<td>3</td>
<td>Drugs requiring more careful prescription by the hospital, doctor, or other trained health worker</td>
<td>Supply restricted to prescription by the hospital, doctor, or other trained health worker</td>
</tr>
<tr>
<td>4</td>
<td>Drugs requiring a very high level of specialist control</td>
<td>Supply restricted to prescription within a hospital or specialist clinic</td>
</tr>
<tr>
<td>5</td>
<td>Particularly dangerous drugs, e.g., the most addictive drugs named in the conventions</td>
<td>Prescriptions may be restricted in respect of the quantity to be supplied or the number of times (if any) that they may be redispensed. Special prescription may be used. The continued issuing of prescriptions may be subject to investigation by a senior health official. Official records will need to be kept in some instances, e.g., where the drug is controlled under the conventions</td>
</tr>
</tbody>
</table>

is controlled by the measures applicable to the most strictly controlled substance.

Under certain conditions preparations can be exempted from part of the controls, including the need for a medical prescription for dispensing. The Single Convention lays down rules for exemptions in Schedule III and in Article 2, paragraphs 3 and 4. According to the Psychotropic Convention, a party can itself decide to exempt preparations of substances listed in Schedules II, III and IV if the following qualifications are met (Article 3): the preparation is compounded in such a way that it presents no, or a negligible risk of abuse, and the substance cannot be recovered by readily applicable means in a quantity liable to abuse. A party must notify its exemptions with all necessary details to the Secretary-General, who transmits the notifications to WHO, to the Commission on Narcotic Drugs and to the other parties. WHO or a party may invoke a termination of another party's exemption by a notification to the Secretary-General, and such a termination can be decided by the Commission on Narcotic Drugs on the recommendation of WHO (see p. 38).

Since the interpretation of the rules for exemption under the Psychotropic Convention is in dispute, WHO has organized several studies of the related problems. The sixth Special Session of the Commission on Narcotic Drugs, which was held in February 1980 in Vienna, examined a WHO document on the exemption of preparations from certain control measures under the provisions.
of Article 3 of the Psychotropic Convention. The Commission decided that the guidelines proposed in the document were useful and members were asked to consider them when granting exemptions. Governments were also requested to exempt, in vitro, diagnostic agents, buffers and analytics containing standard substances in Schedules II, III and IV from the provisions of Article 2 of that Convention. Furthermore, in February 1981, the Commission urged WHO and the Division of Narcotic Drugs to report to it in 1983 with a further set of guidelines.

Following this request, WHO convened a Group Consultation in Brussels in November 1982, on the development of further guidelines for exempted preparations under Article 3 of the Convention on Psychotropic Substances, 1971. In its report, the Group maintained that the large number of possible compounds and combinations constituting exempt preparations under the Psychotropic Convention precluded strict quantitative guidelines such as those existing under the Single Convention.

The Group proposed that the total dose of dependence-producing substance(s) contained in an exempt preparation should be such that a state of dependence on that substance could not easily be induced. The Group defined two types of preparations as suitable for exemption, the first being those that have been marketed for long periods of time (i.e., prior to 16 August 1976, when the 1971 Convention came into force) and are not exported. This type does not require such rigorous control as the second, which comprises new preparations and those suggested for exemption from the provisions affecting certain international trade regulations. In the light of these considerations, the following was in summary proposed:

1. Preparations containing more than one psychotropic substance should not usually be exempted.
2. Preparations containing a psychotropic substance in association with a narcotic drug cannot be exempted.
3. Preparations containing a psychotropic substance together with a psychoactive drug of known abuse potential should not be exempted unless they satisfy the condition that dependence cannot easily be produced.
4. Exemption for export of preparations that contain a psychotropic substance listed in Schedule II of the 1971 Convention is undesirable.
5. Preparations exempted from the provisions of Article 9 (prescriptions) should not be exempted from the provisions of Article 10 (warnings and prohibition of advertising).
6. National authorities should not make use of their right to exempt preparations from the provisions of Article 12 (export authorizations for Schedule II substances and export declarations for Schedule III substances).

In addition, a number of factors concerning exemptions relating to international trade were raised for consideration.

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*WHO unpublished document MNH/78.1.
*WHO unpublished document MNH/82.51.
At its thirtieth regular session in February 1983, the Commission on Narcotic Drugs took a positive view of these proposals but refrained from taking a decision because of the short time available for studying them. They are now being circulated to members of the Commission and it is hoped that, at the next meeting planned for February 1984, a consensus may be reached, since such guidelines are greatly needed.

**Medical prescriptions**

As already emphasized, the basic goal of the conventions is to limit the use of the controlled substances to medical and scientific purposes; the great majority of them can therefore be dispensed or supplied to individuals only on a medical prescription signed by a physician. In view of the liability of these substances to produce dependence and abuse, this is a well-founded general safety precaution for their use.

There are, however, two exceptions, the first concerning individuals who may lawfully obtain, use, dispense or administer the relevant substances in connection with their duly authorized therapeutic functions. The Psychotropic Convention also permits, subject to certain precautions, licensed pharmacists or other licensed retail distributors to be authorized to supply substances in Schedules III and IV for medical purposes to individuals in exceptional cases and in small quantities. It is evident that these provisions can help to solve certain problems caused by geographical isolation or shortage of personnel.

In contrast, substances in Schedule IV of the Single Convention and Schedule I of the Psychotropic Convention cannot be supplied merely on a prescription and are limited to scientific use by specially authorized persons only in medical and scientific establishments, under the control of, and duly approved by the government.

The Psychotropic Convention states explicitly in Article 9, paragraph 2—and this, of course, also applies to the Single Convention—that parties should take measures to ensure that prescriptions are issued in accordance with sound medical practice and subject to such regulation, particularly as to the number of times they may be refilled and the duration of their validity, as will protect the public health and welfare. This recommendation is a reminder to the parties not only to regulate, but also to make new information available on the use and control of psychoactive drugs as part of the continuing education of physicians. This will be discussed in more detail in Chapter 6 (p. 82).

Certain minimum information should be recorded on a prescription for a psychoactive substance in order to ensure proper control, and incidentally to protect both the prescriber and the consumer, namely:

- the name and address of the prescriber
- the date of the prescription
- the name and address of the person for whom the drug is prescribed
- the preparation to be supplied, its strength and the total number of units to be supplied (tablets, ampoules, etc.)
—the directions for use
—where appropriate, the number of times the prescription may be repeated
—the signature of the doctor.

Many countries find control easier if a prescription for such drugs cannot be repeated. Other simple identifiers, such as an official prescriber’s reference number or stamp, have also been used.

The duration of validity of a prescription for a narcotic or psychotropic substance is frequently specified in drug regulations, while the maximum quantities to be prescribed may also be laid down.

Two special controls have been included in the laws of some countries and are worthy of mention:

1. **Pharmacist check.** The pharmacist or person dispensing the narcotic or psychotropic substance takes full responsibility for the validity of the prescription. Unless he is familiar with the signature of the doctor concerned, he must check personally with him before dispensing.

2. **Numbered prescriptions.** Serially-numbered and accountable prescriptions are supplied by the government to the doctor, one copy being retained by the prescriber for record purposes, one retained by the dispensing pharmacist and one forwarded to the drug administration. It should be remembered that such prescriptions are liable to be stolen and must therefore be kept in a safe place.

**Monitoring Adverse Drug Reactions**

As is well known, unsuspected adverse reactions to a new drug will occur, no matter how broad the preclinical assessment has been. It is therefore necessary to establish a reporting system to make it possible to collect and analyse observations of such reactions.

A national register to monitor the side-effects of drugs should be set up by the central drug control administration, possibly organized on a voluntary basis, although in some countries notification is a statutory requirement. Physicians and dentists send in notifications when they diagnose or suspect a harmful side-effect. Excessively detailed notification forms, as used in some countries, may deter reporting so that forms should be as brief and simple as possible, particularly in the initial stages of such a reporting system. Confidentiality should be emphasized. Forms should be pre-addressed and prestamped so that they only require folding before sending. Acknowledgement of receipt of forms is rewarding, and a feedback mechanism in the form of an annual report is most helpful.

When this system is used for the clinical monitoring of psychoactive drugs it is, of course, essential that the guidelines on notification clearly state that drug abuse and drug dependence are adverse side-effects and should be reported. Such notifications make doctors more aware of the possibility that psychoactive drugs may cause dependence and abuse among their patients, which in turn should lead to better medical practice.
In some countries the medical leadership and management in individual hospitals has encouraged the medical personnel, by providing special information, to report adverse side-effects of drugs and has organized an institutional reporting system that has proved very effective. Further information on this subject has been published\(^a\) and a model notification form has been produced and may be obtained from WHO.

International monitoring of drug side-effects has been stimulated and supported by WHO in a number of ways. The WHO project on the international monitoring of adverse reactions to drugs serves as a vehicle for collecting and analysing reports and data from national drug monitoring centres. The results of this work are regularly reported back to the health authorities of all Member States. The reports should include cases of dependence production, with or without tolerance development, and the consequences of such dependence. However, few data have so far been reported, which indicates the need for more information on ways of collecting such data and on the importance of this kind of reporting in the control of psychoactive drugs.

The WHO Collaborating Centres for the Study of Psychotropic Drugs in various countries are paying special attention to adverse reactions encountered in psychopharmacotherapy. These centres can contribute to the early detection of the dependence and abuse liability of a drug, whether observed during clinical trials or in routine clinical practice. Similarly, WHO's study on the effects of psychotropic drugs in different populations, involving 11 centres in nine countries, can also provide useful information on the subject.

Furthermore, WHO regularly issues Drug Information Circulars, pursuant to resolutions WHA16.36 on the clinical and pharmacological evaluation of drugs, WHA23.48 on drug efficacy, and WHA26.31 on the quality, safety and efficacy of drugs,\(^b\) and governments are invited to communicate immediately to WHO any decision to prohibit or limit the availability of a drug already in use if such a decision is taken by the government as a result of serious adverse reactions. A decision to place a substance under national control (e.g., limitation of prescribing, special prescription forms, etc.) on account of its potential for dependence production or abuse liability should also be communicated to WHO, since such effects constitute a special kind of adverse reaction. Though reporting under this scheme might in some instances duplicate the obligation of parties to report on changes in laws and regulations under Article 16 of the Psychotropic Convention and Article 18 of the Single Convention, it may in other cases generate relevant new information, and the scheme also covers non-parties. WHO has so far sent 200 Drug Information Circulars to its Member States, and these have included a few related to the subject under discussion.

Both conventions charge WHO with important responsibilities in placing new psychoactive substances under international control and in changing the


level of control for those already listed in their schedules. Either WHO or a party can initiate such a procedure, but it is WHO's duty in both cases to evaluate the risks and benefits in using the substance as a medicine and to make a recommendation to the Commission on Narcotic Drugs as to the control necessary. The basic information required for this process will clearly have to be supplied by the parties to WHO in various ways. The prompt reporting of adverse reactions to the use of a drug, including observations on dependence production and abuse liability, to WHO and a continuing dialogue between Member States and WHO, using the different special communication channels established for the purpose, may be one of the most important and productive means of fulfilling the obligations under Article 3 of the Single Convention and Article 2 of the Psychotropic Convention for adapting the scope of control of the conventions to the rapid development of psychopharmacology and the increasingly extensive use of psychoactive drugs.
CHAPTER 6

SURVEILLANCE OF SUPPLY AND USE OF PSYCHOACTIVE DRUGS

General Background

The parties, in ratifying the conventions, have explicitly accepted the responsibility to give effect to, and implement their provisions within their own territories and to cooperate with other States in so doing. Furthermore, the parties have explicitly accepted the responsibility to limit the production, manufacture, export, import, distribution of, trade in, use and possession of the controlled substances exclusively to medical and scientific purposes (Single Convention, Article 4, and Psychotropic Convention, Article 5).

The parties are also responsible for communicating to the Secretary-General (and through him to WHO) any information that may require placing a psychoactive substance under international control or changing its level of control in the schedules of the conventions (Single Convention, Article 3, and Psychotropic Convention, Article 2). Such a notification must be based on facts concerning the dependence-producing liability of the substance and the public health and social problems it has caused.

A party, in taking steps to fulfil these responsibilities, will have to monitor the national manufacture, import, trade and use of psychoactive drugs (see pp. 27–28). In what follows a review is presented of the means that may be employed to this end. The basic nationwide collection of data, with access to relevant, often confidential data, should be the task of a public authority.

National Drug Supply Studies

Psychoactive substances can be monitored in various ways for different purposes. The methods used for collecting information should provide a continuous stream of data so as to fulfil the requirements of the conventions. Such methods will produce aggregate statistics, but will also show trends when viewed longitudinally, and changing trends may suggest the advisability of short- or long-term action in connection with a specific category of drug. The following methods may be mentioned:
(a) **Import/export and national production statistics.** These data will show net alterations in the total availability of different categories of psychoactive substances over time. The data will also broadly indicate the relative cost of psychoactive drugs to a country, as compared with that of other drugs. Such data are usually available, but they may be collected by a number of different national agencies.

(b) **Statistics on wholesalers, sole distributing agents, and major purchasing establishments.** In most countries, psychoactive drugs can be traced after import or manufacture to the next stage in the distribution channel—usually either wholesale or distributing agents or, in some countries, where the health services are operated by governments themselves, their purchasing organizations. Monitoring will indicate whether any major unintended diversions are taking place at this early level.

(c) **Statistics on purchases of drugs by state or private hospitals.** In many countries the third level of distribution may involve bulk purchase of drugs from distributing agents. In others, where governments subsidize health care, they may be supplied by its own purchasing agencies. It would be possible to monitor the flow of psychoactive drugs at this level also, so as to detect diversions.

(d) **Statistics on purchase for retail distribution by state, hospital or privately owned pharmacies.** This is the level at which problems will arise, as the number of such outlets is particularly high, they can be widely dispersed, and they are sensitive to local prescribing habits. They can also become agents for channelling legally obtained psychoactive drugs to the illicit market. In some countries it may be worthwhile evaluating some of the existing procedures in this area on a sample of 2–10 pharmacies, so as to test both the efficiency and the effect of intervention.

(e) **Data on product sales collected by pharmaceutical companies.** In all parts of the world, pharmaceutical companies monitor the sale of their own and competing products on the market. In developed countries this activity is well organized and directly supported by the industry; in other parts of the world, though not so well organized, it is still carried out entirely by the industry for its own purposes. A mechanism is required to ensure that the industry provides this information to the appropriate national authority on a confidential basis, so that trends in consumption of specific psychoactive drugs may be monitored from the public health standpoint, either routinely or whenever necessary.

### Studies of Prescribing and Dispensing

The following methods have been used, though none permits accurate assessment of actual consumption, so that any associations made between distribution figures and the social and public health consequences of use require additional study:

(a) **Prescription registry data.** These may be for total populations or for selected segments of populations (e.g., the elderly, social welfare recipients, union members). This method also allows an examination of trends and patterns in prescribing practices, whether of individual physicians or groups of physicians.
(b) **Prescriptions dispensed through pharmacies.** If the prescriptions are adequately sampled and if the studies are repeated over meaningful periods of time, trend data can be collected. The value of such studies is determined by the size and quality of the sample selected. It is difficult to discern patterns, i.e., whether many are receiving a few drugs each or a few are receiving many drugs, unless all outlets are sampled.

(c) **Physician practice prescribing studies.** Such studies can provide trend data on drug prescribing.

(d) **Studies of drugs dispensed to institutionalized populations.** This method focuses on the inmates of hospitals, prisons and nursing homes. Such studies are of particular value as these populations are frequently given prescriptions for psychoactive drugs and are overlooked by other methods of assessment.

(e) **Assessment through distribution systems where medications are wholly or partly sold without prescription.** This will include pharmacies in locations where prescriptions are not required, as well as other types of shop or outlet where drugs are sold or dispensed to the general public. Such sources could provide a rapid means of identifying new drugs on the market and, if sampled frequently, can provide trend data. In addition to traditional methods of acquisition of sales data, observers who are themselves involved in the drug subculture ("participant observers") or community-based informants can be utilized.

**International Studies of Drug Supply**

The International Narcotics Control Board provides annual reports on the licit production, export, import, and medical consumption of drugs controlled under international conventions for most countries of the world (for party responsibility to provide national data to the Board, see Chapter 3, p. 47). This series of reports contains the following annual publications, where "narcotic drugs" are those substances listed in the Single Convention and "psychotropic substances" refer to those listed in the Psychotropic Convention:

(a) **Report of the International Narcotics Control Board for . . .**, which is a survey of the world situation;

(b) **Estimated world requirements of narcotic drugs in . . .**;

(c) **Comparative statement of estimates and statistics on narcotic drugs for . . . furnished by governments in accordance with the International Treaties**;

(d) **Statistics on narcotic drugs for . . . furnished by governments in accordance with the International Treaties**;

(e) **Statistics on psychotropic substances for . . . furnished by governments in accordance with the 1971 Convention on Psychotropic Substances, resolution I of the United Nations Conference for the Adoption of a Protocol on Psychotropic Substances and resolution 1576(L) of the Economic and Social Council**.

The Board has also produced a special report entitled *Demand and supply of opiates for medical and scientific needs.*

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WHO has formed a so-called Drug Utilization Research Group which has collected material describing national sources of information and how they have been used in various countries in monitoring the use, prescription and control of drugs. 

In 1970, the Government of Australia introduced the Drugs of Dependence Monitoring System, a computer-based system to monitor the movement of drugs covered by the Single Convention on Narcotic Drugs, 1961, and a variety of other dependence-producing drugs, from the moment of import or manufacture until the drug reaches its final distributor, i.e., retail pharmacies, medical practitioners, etc. The system requires all reporting authorities (i.e., drug firms licensed to import, export, manufacture, formulate or distribute specified drugs) to report their transactions each week. At present nearly 400,000 transactions are monitored each year. Based on this information a variety of routine and special reports are produced by the Department of Health for information and analysis, resulting in prompt indication of the development of new and unusual trends in drug consumption. The Australian authorities state that no really accurate figures were available on Australia's consumption of dependence-producing drugs before this monitoring system was introduced. Data are now readily available for reporting to the International Narcotics Control Board, as required by the international conventions.

The Governments of the Nordic Countries (i.e., Denmark, Finland, Iceland, Norway and Sweden) have long-standing arrangements for cooperation in the field of drug legislation and control, and have set up a joint Nordic Council on Medicines to act as an advisory and coordinating body to their health authorities. The Council's aims are conformity of legislation and administration in the field of medicines; coordination of medical statistics; more effective inter-Nordic reporting of adverse reactions; increased cooperation on drug information; and continued cooperation in the field of the pharmacopoeia.

The Council has published Nordic Statistics on Medicines/nordisk läkemedelsstatistik, I and II, Helsinki and Oslo, 1979. The first part contains, inter alia, the range of medicines, and information on production, import, export, the number of pharmacies, turnover at pharmacies, reimbursements for medicines, and other data essential as a background to the statistics. The second part is a Nordic Index on Medicines and contains a list of registered pharmaceutical specialities in the Nordic countries, with classification code and defined daily dose.

**Studies of Use of Psychoactive Drugs**

Most studies of consumption rely on self-report methods, in which problems of validity are of particular importance since the consumer of the substance can be identified. These methods offer a better possibility of linking consumption to

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*BERGMAN, U., ET AL. Studies in drug utilization. Methods and applications, Copenhagen, WHO Regional Office for Europe, 1979 (WHO Regional Publications, European Series, No. 8).*
social and health problems associated with use. Care must be taken to protect the confidentiality of replies and the identities of the individual respondents. The following methods are available:

(a) National and cross-national self-administered questionnaires or interview surveys of drug use. These methods give a measure of reported consumption and enable high-risk segments of the population to be identified. If a similar or the same sample is tested over time and identical questions are asked, trend data can be collected. Surveys can show that consumption data and health and social problems are correlated but add little to an understanding of why particular associations exist.

(b) Surveys of selected populations. These may be surveys of particular high-consumption groups, such as youth, minority groups, women or the elderly, and they share the advantages and disadvantages of self-report and interview data, as well as obviously being restricted to only a part of the population.

(c) Natural history studies of patterns of use. This method, which can be applied to either individuals or groups, permits free expression of experience and opinion since it does not utilize prestructured questions. While the method suffers from sampling limitations, it can provide information on potential social and public health problems that can subsequently be studied by more systematic methods. Such studies are more suited to addressing the issue of causality than other methods, but have the disadvantage of requiring skilled interviewers and may be slower and more costly than structured interviews.

Information and Education Concerning Use of Drugs

Information on drugs and pharmaceutical products is essential at all health care levels in order to ensure adequate supply, rational dispensing and proper utilization; this applies equally to drug control administrations, health care professionals, and consumers. The extent to which each type of information is required at different levels will, of course, vary. Information couched in general terms cannot yield adequate results. The use of any drug in the absence of adequate knowledge on the part of either prescriber or consumer may be dangerous.

Drug control administrations

A central drug control agency, which in most cases will be part of, or closely associated with the national health authority, requires relevant scientific and technical information covering extensive areas of the pharmaceutical and medical sciences in its task of evaluating, registering and controlling drugs. The problems involved have been discussed in Chapter 5 (see pp. 63-69).

The international bodies with responsibilities for control of drug use and abuse have arranged regional and national conferences, seminars and symposia for the information and continuing education of administrators and health
officials involved in drug abuse control, e.g., the International Narcotics Control Board organized a regional seminar for African countries in 1981 in Mauritius and another in 1982 in Mexico for Latin American countries. Nongovernmental organizations have also been active in this field.

The fight against illicit traffic is discussed in Chapter 10 (pp. 124–127), where the information and education activities of the international drug control organizations in that field are also treated.

Health care professionals

Physicians, dentists, nurses, pharmacists, and other health personnel are the last link in the chain of drug distribution to the consumers. Their actions and attitudes to drug use are based on their knowledge of benefits and risks in drug therapy. They are all-important in preventing overuse and misuse as well as the diversion of drugs into illicit traffic and nonmedical use. In countries where physicians are scarce and some areas are geographically isolated, nurses and pharmacists, and sometimes less highly trained personnel, will have to take over the duties of doctors, which makes special training to enable them to deal with the situation even more important. Continuing education and information about new developments in medicine and new drugs are necessary.

The education of health care professionals about drugs should begin early in their training. There is a need in many countries to improve this training at all levels, especially in relation to the proper use of narcotic and psychotropic drugs. Information on the dependence-producing properties of drugs should be introduced at the earliest stages of pharmacological training and should continue throughout clinical training wherever the adverse effects of drugs are discussed. Some textbooks are deficient in these matters.

Physicians have a key role to play. The vast majority of the substances controlled by the conventions can only be dispensed on prescription, and this requirement is underlined by Article 9 of the Psychotropic Convention, which states that "the Parties shall take measures to ensure that prescriptions are issued in accordance with sound medical practice". It is necessary to provide a mechanism whereby physicians receive up-to-date information on registered drugs and the problems associated with them, as well as on action taken to increase or decrease controls on particular drugs. Such information, in an accurate and unbiased form, should be gathered, analysed, collated and distributed by an organization closely linked to a central drug control agency, possibly a drug advisory expert committee whose members represent not only relevant scientific disciplines but also professional bodies, such as the national medical association, and the pharmaceutical industry. Such a committee could also be a source of guidance to the pharmaceutical industry in preparing promotional literature and information intended for physicians and other health professionals, with the aim of ensuring accuracy and encouraging the more effective and safer use of psychoactive drugs.

An important part in the continuing education of health professionals is
played by medical and pharmaceutical journals, which should be encouraged by
the health authorities to publish relevant material. Also of value are series of
lectures arranged by the various associations of health professionals and
devoted to drug therapy and medical practice in general, with appropriate
emphasis also on psychoactive drugs and clinical psychopharmacology.

The international health and drug control organizations also have a role to
play in providing information and training for the health professions
emphasizing the need for caution in prescribing and distributing psychoactive
substances and in the management of associated problems.

WHO has organized international training seminars for physicians and other
health professionals on the implementation of the conventions, namely three in
the USSR with participants from Asian and African countries and one in the
framework of the Pan American Health Organization for the Americas.*
National interdisciplinary training seminars have been held in Thailand, the
Philippines and the United Kingdom. A centre has been established in Hong
Kong to train physicians in the management of drug-dependence disorders.
Such courses can be made available to government representatives who may
require them, and the experience and course materials can be made available for
use at the national level. The explosion of drug abuse education material and
literature during the past few years provides a wide variety of resource
materials.

Consumers

In the chain of drug distribution, the general public and the consumers
represent the final level of utilization. The consumer-patient has the right to
expect that medicines, when he needs them, will be safe, effective and
appropriate. Information on the effects and the risks associated with these
medicines should be given when the drug is prescribed and also with the drug
itself. Ideally, the consumer should have enough of a general educational
background to understand the raison d'être of drug therapy as well as its
limitations.

The physician has a duty to inform the patient of the aim of the drug therapy,
the effects of the drug and the possible adverse reactions. In prescribing
psychoactive drugs, the physician should be particularly careful to explain the
risk of overuse and the liability of the substance to produce dependence. The
patient should be warned of the potentiating effects of alcohol, and the risk of
possible impairment of driving ability must be pointed out.

Pharmacists will often be asked by patients for additional information on
prescribed drugs, and will be even more important as advisers to consumers
buying preparations not requiring prescriptions or other over-the-counter drugs.
They should have adequate training for providing this service and be regularly
supplied with new information. This function is, of course, even more important

* WHO unpublished document MNH/81.34.
if the authorities have used the possibilities of exempting certain psychoactive substances from the requirement of medical prescriptions, as provided for in Article 9, paragraph 3 of the Psychotropic Convention. These functions are also more important in countries where the numbers of physicians and pharmacists are limited, so that their respective duties are transferred to less highly qualified persons. In such situations special efforts must be made by the health authorities to provide additional information and training.

The consumer-patient should be given the opportunity to inform himself on the drug therapy to which he is subjected in as much detail as he can reasonably be expected to grasp. In addition to the information given by the physician and the pharmacist, the consumer should also be given adequate and easily understandable information on the label of the drug package or on an insert (see p. 66). Pamphlets or other informational material, preferably simple and free of charge, may be prepared about the various diseases and the appropriate drug therapy, to be distributed by the physician or in the pharmacy. This kind of informational material is especially important for the psychoactive drugs, where the consumer may not understand the function of the drug and underestimate or ignore its risk.

At a more general level the methods and materials of health education need to be used to give consumers, i.e., the general public, the factual background to health maintenance and the medical treatment of disease. Based on such an understanding, it should be possible to sensitize people in general to the dangers of the careless or excessive use of psychoactive drugs. An educated public would make the work of physicians and pharmacists easier by reducing the pressure often exerted by patients for more and newer drugs. The mass media could help in a responsible way in this process, if alerted to the dangers of existing or potential drug abuse and if informed in a factual and nonsensational way of the effects and risks of various psychoactive drugs.

In every country a general attitude to the use of medicines and drug-taking exists that might be called "the level of acceptance". If there is little or no awareness of the hazards of consuming large amounts of drugs and a fairly regular consumption is thought of as normal, drug dependence and abuse will be a greater risk than would otherwise be the case. The idea that "there is a pill for every ill" is dangerous. Such cultural and social laissez-faire attitudes must be counteracted by health education and by strengthening the opposing point of view.

Advertising

The Psychotropic Convention in Article 10, paragraph 2, gives the following guidance on advertising: "Each Party shall, with due regard to its constitutional provisions, prohibit the advertisement of such substances to the general public".  

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*See Principles and methods of health education, Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies 11).*
It was considered in the Consultation on the Convention on Psychotropic Substances: Review of Articles 3 and 10 that no recommendations for the implementation of this provision were necessary, since the above statement was seen as a clear directive (see also p. 39). It was also noted that an appreciable number of replies from parties indicated that such advertising was currently prohibited.

Although the Single Convention has no corresponding provision, the pharmacological and medical conditions determining the use and control of its "narcotic drugs" are such as to lead to a similar conclusion concerning advertising. In several WHO seminars on the implementation of the conventions the participants also took this view, based on the ease with which the risk of overuse and abuse of psychoactive substances can be increased, and the essentially commercial interests responsible.

A more general discussion on the forms and controls on the advertising of drugs of all categories can be found in the report of a Consultation on Basic Elements of Drug Legislation and Regulatory Control for Developing Countries, 1981. The report states, *inter alia*, that:

"The drug control agency must exercise appropriate control over advertising of drugs so that correct information is provided by the industry to the health profession and to the public. Claims made for a drug should be in accordance with the labelling approved for registration of that drug and complete information should be available to the doctor. Exaggerated claims or claims of a general nature should not be allowed. Where applicable, information on necessary precautions should be given. It is also advisable to exercise control on free drug samples. For proper control of advertising, a multidisciplinary committee consisting of persons from:

- the drug control agency
- the pharmaceutical manufacturing industry
- the pharmaceutical profession
- the medical profession
- the news media
- the advertising agency

is recommended for review of proposed advertising materials. The committee may consider the ethics of the pharmaceutical practice, within the constraints of the law, in approving, amending, or rejecting any advertising material."

Legal provisions for the control of advertising in accordance with this recommendation should be flexible and also permit the total prohibition of certain types of advertisement to the general public while permitting appropriate advertising to the health professions. Such prohibition may cover substances listed in certain schedules of a drug control act, e.g., psychoactive substances, including those listed in the conventions. Some countries prohibit all advertisements for the drug therapy of certain diseases and conditions, for instance tuberculosis, neurological and psychiatric disorders, sexually transmitted diseases, impotence, etc. The specific health situation of the country will indicate to the controlling authority the extent and type of regulation of advertising necessary to control the public promotion of pharmaceutical products.

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* WHO unpublished document MNH/78.1.
* WHO unpublished document DAP/81.3.
CHAPTER 7

ASSESSMENT OF DRUG DEPENDENCE AND ABUSE

General Background

The assessment of drug dependence and drug abuse in a population requires the collection and analysis of data on the incidence, prevalence and other characteristics of nonmedical and/or illicit drug use and abuse. A planned and systematic approach to assessment is necessary because drug use and abuse are complex and continuously changing phenomena. The assessment will have to cover a broad range of epidemiological characteristics, such as age, occupation and social status, the psychoactive substances, or their combinations, in nonmedical and illicit use, and the attitudes of various groups of users.

In such systematic assessment, however, differences in culture, the structure of society, resources and available expertise in the communities to be studied make it impracticable to apply a single set of standards or research procedures. Nationally, agreement should be reached in advance on the definitions and criteria to be used in the various studies. The concepts of "nonmedical use" and "drug dependence" offer a particular challenge. Here guidance can be found in a number of WHO publications. A broad range of existing investigative techniques and strategies must also be considered. To develop an effective and coordinated data collection programme, it is important to establish a centralized agency responsible for overall surveillance, for the development of standardized data collecting forms and procedures, and for determining the reliability and validity of the collected data. The central national drug control agency, or its equivalent, may be such an institution (see p. 54).

The Division of Narcotic Drugs has published two manuals on drug abuse assessment. The same topic has also been treated by the United Nations. Furthermore, a number of publications on this topic have resulted from the

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WHO project on Research and Reporting on the Epidemiology of Drug Dependence. a

Some indicators of drug-related health and social problems can give information on trends and types of misuse and abuse though without defining the actual magnitude of the specific problems. A number of such indicators, generated in the normal functioning of institutions for health and social work, are reviewed below (pp. 90–100).

For the systematic assessment of drug dependence and abuse over time in order to follow the changing nature of these phenomena, several methods can be employed to collect data from a range of sources. In what follows various methods of data collection will be discussed, such as studies of professional informed opinion, establishing central data registries or data collection networks, or conducting field surveys. In the international area, the Division of Narcotic Drugs sends annual reports to the Commission on Narcotic Drugs on the extent, patterns and trends of drug abuse (see p. 20).

Studies of Informed Opinion

In all communities there are individuals who, because of their professional, occupational or other social roles, are in a position to provide informed opinions regarding the existence and nature of illicit drug use. The precise roles of these persons may vary from culture to culture, and even from community to community. A variety of such sources of informed opinion should be sought out. Some examples are given below.

In the health field there are personnel working in hospitals and community health clinics and physicians in private practice, in education there are teachers in universities or in colleges and schools, and student representatives, and in the social services there are social workers or family counsellors. In the criminal justice system much knowledge is to be found in the law enforcement personnel, the police and the prosecutors. Personnel in industry are concerned with safety and health. Ministers of religion come in contact with young people and their parents.

No single method or investigative technique can be reliably used to gather information from all of the informed individuals in a community. Different individuals will be in possession of facts on, and have opinions about different facets of the phenomenon, e.g., the types of drugs, population groups and ages involved, problems arising from drug abuse, individuals and groups at risk, and factors influencing prevention, treatment and rehabilitation.

Data will be collected by questioning, either by means of simple structured

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interviews or questionnaires, or in small round-table discussions. The information collected will be useful in helping to build up a picture of the situation.

Central Data Registers

A central case register is a formal record of defined "cases" maintained by a central agency. A "case" may be a patient with diagnosed illness, a person presenting certain symptoms, someone taking dependence-producing drugs, or someone who has been arrested or similarly involved with the authorities. To add cases to such a register, specially selected persons or institutions must report specified information to the central agency. The data must be recorded in standard form. The records of a hospital or an individual researcher are not considered to constitute a central case register. An example of a central case register is the Central Register of Drug Addicts in Hong Kong, which has been maintained since 1976; in 1982 it contained some 40,000 cases.

Such registers have sometimes proved to be useful tools in determining epidemiological factors or in achieving effective control programmes, as well as in estimating the magnitude of drug dependence in the community. However, it is difficult to ensure that registers are reasonably complete. A major complication is the need to ensure the confidentiality of the contents of the register and of the sources of information.

The usefulness of the data in central case registers can often be enhanced by record-linkage, i.e., the bringing together of two or more separate documents or sets of information concerning particular individuals. This process is indeed often carried out to advantage even in the absence of a central case register. When record-linkage is undertaken, the problems associated with the confidentiality and security of records are naturally both compounded and increased and are a major complication.

Some countries have set up reporting networks of institutions for the reporting of specific drug-related cases. One such system has been organized by the National Institute on Drug Abuse (NIDA) in the USA. Under the name of Drug Abuse Warning Network (DAWN) it collects data from more than 800 hospitals in 26 major metropolitan areas and from a national panel of hospitals outside these areas, and in addition from medical examiners/coroners in the same 26 metropolitan areas, on drug-related morbidity and mortality. Through this system it has been possible over a number of years to follow the type and magnitude of the medical drug problem in the USA. Another reporting system operated by NIDA is the Client-Oriented Data Acquisition Process (CODAP), which collects data on the drug abuse treatment of persons admitted to all federally funded treatment programmes in the USA.

It is evident that the setting up of national reporting systems that systematically and routinely collect drug-related epidemiological data requires close consultation and good coordination between the reporting institutions and the central agency. Important factors are as simple as possible forms of data,
and as rapid as possible use of data, with arrangements for the feedback of results to the contributors. Such systems require good organization and they tend to be rather costly. Limited versions with less ambitious reporting systems are, of course, more manageable, but also less informative.

**Field Surveys**

Analysis of existing data may point to aspects of the national drug abuse problem about which additional information will be useful. This can be obtained through field surveys conducted in normal social settings.

In the sample survey a certain number of people belonging to a specified population are selected, scientific sampling methods being used to ensure that the sample thus obtained is representative of the larger population. Information is then gathered from the sample, usually by means of self-administered questionnaires or interviews. In designing and implementing sample surveys of illicit drug use, information may be sought on a large number of variables. Most drug surveys focus on the prevalence of drug use, the characteristics of the drug users, including their drug use history, and factors associated with drug abuse, such as the attitude of the users toward laws on drug use and control and knowledge of the effects of the various drugs.

In the use of the sample survey technique, the technical and manpower resources needed must be identified at the outset. Four steps in the implementation are particularly technically demanding, namely the design of the population sample, the design of the survey instrument, survey procedures, and the analysis of the collected data. It is important that trained researchers be involved in the design and supervision of sample surveys. In some countries these individuals may be on the staff of the coordinating agency; in others it may be necessary to retain them as consultants.

Sample surveys are costly and are also frequently time consuming. The findings of a sample survey cannot be generalized to population groups other than the one surveyed. Normally, a research instrument for sample surveys must be validated again and modified before it can be applied in settings other than the one for which it was originally designed. Because a sample survey portrays the situation only at a single point in time, changes will have to be monitored by means of subsequent surveys.

Field surveys of a type that may be called studies of natural groups can be used in conjunction with findings obtained by other forms of assessment. Like the sample survey, studies of natural groups for the assessment of illicit drug use require the use of relatively sophisticated social science techniques, so that trained manpower will be essential for their design and supervision, although their cost is generally lower than that of a sample survey.

A number of investigative techniques are employed for these purposes. In "content analysis of small group discussions" drug users discuss their values, attitudes towards society and, on occasion, particular aspects of their lives in the drug subculture. In "participant observation" a trained observer or observers
maintains close contact with a particular drug-using group (perhaps even living with members of the group) in order to obtain information about aspects of the subculture. Finally, in "long-term anthropological studies of drug use" in particular drug-using groups (e.g., occupational or professional groups) data are drawn from both interviews and existing sources.

The limitations of studies of natural groups are that they generally yield little quantitative information on drug use, focusing rather on particular aspects of the phenomenon, and that they seldom yield information that can be extrapolated to other population groups.

Some Indicators of Drug-related Health Problems

General background

While it is important to follow the extent and pattern of drug supply and use, it must be borne in mind that total or per capita rates of drug consumption cannot be equated with magnitude of drug-related problems. Further indicators of the magnitude of drug supply or changes in the quantities of drugs used are necessary to appreciate the extent and types of misuse and abuse of psychoactive drugs. Information on the utilization of health services together with selected health indicators generates data on health problems that, because of the known pharmacological effects of the psychoactive drugs, can be related to their acute or chronic use. Such data are derived from morbidity and mortality statistics, emergency room records, or statistics on traffic and occupational accidents. Although the causal relationship between the use of psychoactive substances and social problems cannot be precisely established, the mere association of such use with social problems can be the basis for further analysis.

Most of the data collected on drug-related health and social problems will not enable the actual magnitude of the specific problem to be defined. Their function is rather to serve as an indicator that drug use and misuse are producing certain problems, that misuse is spreading to new population groups, or that new drugs are appearing on the drug scene and new methods of nonmedical use are establishing themselves. Such findings will give an indication of trends and serve to orientate further investigations. Since many of these data are generated as part of the normal functions of health and social work institutions, they can be collected promptly and routinely, and at relatively low cost. They may therefore be helpful in directing the efforts of drug control authorities.

Morbidity

Drug dependence

Even though the term "drug dependence" cannot be exactly defined in scientific terms, an empirical approach taking into account the many features of
a “case” will make it possible to assess in a practical sense when an individual is dependent on drugs. For example, according to the drug the person is using, he is defined as a “barbiturate user”, a “heroin user”, or a “multiple drug user” in terms of the stated criteria of dosage level and frequency of use over a given period. A variant of the empirical approach is to “add up” the components of the adverse consequence of use so as to yield “problem scores” or to define a “problem drug user” category.

Drug dependence may be diagnosed in individuals in a variety of different settings—drug dependence treatment units, mental hospitals, prisons, remand homes, general practitioners’ consulting rooms, emergency departments. If accurate data are to be accumulated, all of the staff involved in the above settings must be aware of their obligations to diagnose drug dependence and to record the diagnosis. It would be very useful for countries to set up some machinery whereby all known cases of dependence on psychoactive substances are notified without identification to the appropriate health authority. As psychoactive drugs become used more frequently and new substances are introduced, particularly by individuals seeking psychic effects, any dependence liability is then likely to be exposed. An awareness of this likelihood and an alert approach to the diagnosis of dependence would mean that the delays of earlier years might be avoided or at least reduced. It will be remembered that it took 30 years and 50 years respectively for the dependence-producing potential of amphetamines and barbiturates to be appreciated.

Drug overdose

In numerical terms, the most serious form of morbidity currently associated with the use of psychoactive substances in many countries is that of drug overdose. The victims include those who take the drugs accidentally, those who take them deliberately in a suicide attempt, and those who take them in the course of drug dependence.

The majority of cases of drug overdose are seen in hospital accident and emergency departments, facilities that exist in all systems and offer several advantages from the point of view of research into drug-related problems (see pp. 93–95). A choice probably has to be made between the study of incidents or of individual patients. The latter choice poses difficult problems of confidentiality that cannot be satisfactorily dealt with in a large survey, while at the same time providing valuable information, which probably cannot be obtained in any other way, about the hard core of drug misusers with particularly serious drug problems.

A study of cases of drug overdose would increase knowledge of the inappropriate use of drugs, suicide attempts with drugs, the symptoms and effects of drug dependence, and the episodes and outcome of acute drug intoxication.
Drug psychosis

Psychoactive drugs, when taken in excess or in combination with other drugs, can cause adverse psychological reactions. Acute reversible toxic psychotic reactions may be caused by some psychoactive substances, e.g., LSD, cocaine, and amphetamines, but their frequency is almost impossible to ascertain. Many such reactions are probably dealt with satisfactorily by companions participating in the drug-taking experience and only the more serious ones ever come to medical attention. Furthermore, as some of these psychotic reactions may be very difficult to distinguish from schizophrenia and other psychotic illnesses, an accurate diagnosis may be difficult.

For all these reasons, drug psychosis is unlikely ever to be an accurate epidemiological indicator. Nevertheless, if cases were recorded by psychiatric hospitals, psychiatric outpatient clinics, and accident and emergency departments, etc., in a systematic and accessible way, a more complete picture of the relevant syndromes might begin to emerge.

Amphetamine psychosis is a good example of how an alert attitude to diagnosis can increase epidemiological information. Although the condition was unrecognized until 1958, large series of cases have since been reported by many physicians, with the help of chemical tests for drug detection, probably because they were looking for them specifically.

Public health statistics on drug-related disease

One way of assessing the morbidity resulting from the use of psychoactive substances is to monitor public health data indicating the frequency with which various types of pathology are reported, such as poisoning, viral hepatitis, fetal damage, etc. The assumption is, of course, that these conditions are closely enough linked to drug consumption to be reasonable indicators of it.

The advantage of this method is its simplicity and low cost. However, these advantages are offset by the lack of specificity of certain conditions as indicators of psychoactive drug use. In most of the conditions of interest, the relevant cases will be of low frequency in a multi-centre reporting system, where case definition and case recognition will probably vary from centre to centre and from time to time.

Because of such difficulties, attempts to develop direct indices of drug misuse, similar to those developed for alcohol, are unlikely to succeed, although specific types of morbidity can be useful in providing early warning of misuse of new drugs or of the geographical spread of misuse. Some drug-related health problems to which particular attention should be paid are considered below.

Hepatitis is an example of a complication of drug abuse, due not to any particular drug but to the method of drug administration. It frequently occurs in opiate, barbiturate and amphetamine addicts as a result of dirty injection habits, including the sharing of needles, and is usually attributed to infectious (serum type B) hepatitis. Even if changes in injection habits, for instance, can
influence the frequency of this complication, it is nevertheless worthwhile screening drug-dependent patients for hepatitis and maintaining a register of those suffering from it. It is an unreliable quantitative indicator of drug abuse, but is a serious drug-related health problem. If it is monitored and recorded routinely and systematically at the local level, an extension of the practice of drug injection to new areas will be easily detected.

Other infectious complications occur characteristically as a result of nonsterile injection techniques. They include septic injection sites, abscesses, pneumonia, septicaemia, and endocarditis. These complications often present atypically in addicts and can be difficult to treat, as they may be caused by uncommon organisms. Again, if information about any such complications were recorded in a systematic and easily accessible fashion, it would be of service in monitoring injection activity.

Analgesic nephropathy is an example of how medical case reports may draw attention to a previously overlooked condition and thereby provide reliable epidemiological information. The consumption of different minor analgesics is common. Though they are not listed in the conventions, those who misuse them resemble in many important ways those who misuse psychoactive drugs. A patient often denies misuse of analgesics, and many go to considerable lengths to conceal it. Many also misuse other drugs and admit that they take analgesics for the feelings of wellbeing that they induce. Analgesic misuse is a very serious drug problem in numerical terms and one that does not fit neatly into any category. Cases should be recorded systematically.

Drug-related problems affecting the newborn are, of course, an area of particular concern. Drug withdrawal syndromes have been described in infants born to mothers dependent on opiates, barbiturates, and possibly amphetamines. Two illicit drugs, LSD and cannabis, are suspected of being teratogens, but unfortunately unequivocal evidence has not been published. This serious health problem requires adequate evaluation. Since there is a tendency to use psychoactive drugs indiscriminately at times, possible teratogenic effects should always be borne in mind, particularly when the drugs have been used by drug-dependent mothers. Gradual routine accumulation of data on psychoactive substances will enable more rational conclusions to be drawn and will point the way to further drug control measures.

The notification of adverse drug reactions has been discussed in Chapter 5 (p. 74).

**Monitoring drug-related problems in emergency treatment services**

Emergency centres are capable of monitoring a wide range of drug-related health problems and thereby identifying trends in drug abuse in the general population. They can thus serve as “early warning” systems. The treatment team will handle cases of poisoning, suicide attempts, traffic and occupational accidents, acute toxic reactions, toxic psychosis, as well as drug overdose and drug dependence. Some form of emergency treatment services exists in all
health care systems. Although their organizational structure varies in different countries, standardization of examinations and records should permit the collection of comparable data.

Prospective studies are necessary because notes made in an emergency situation are rarely sufficiently detailed to allow comprehensive data to be obtained retrospectively. Questionnaires should be brief and simple, and a copy should be kept with the hospital notes so as to save staff time. All emergency staff should be provided with instructions on completing the questionnaire, and any special terms used should be carefully defined. Where possible, blood and urine samples should be obtained for drug analysis. A "key person" should be identified to supervise and coordinate the study, and regular feedback of the findings is important in order to maintain team involvement. Medical confidentiality must be guaranteed.

The report of the WHO seminar on public health problems and psychotropic substances, held in Helsinki in 1982, contains a plan for an emergency department survey with forms for the necessary questionnaires and guidelines for their completion. The plan is simple and is structured in such a way that it should be possible to use it in any accident and emergency department.

A number of studies of this type have been carried out in different countries and the results have been summarized in a report.

The federal authorities in the United States of America have organized a nationwide collection of emergency department observations in the form of the Drug Abuse Warning Network (see p. 88).

Toxicological, forensic and clinical chemical analyses can provide important information on the assessment of drug-related health problems. Methods have been developed for both qualitative and quantitative measurement of drugs in body fluids and tissues. Such analyses will be helpful in diagnostic and therapeutic work in treatment and rehabilitation institutions, and at least a simple laboratory programme should be part of an emergency department study as discussed above. Many hospitals in developed countries carry out such analyses as a part of routine medical care. In some countries, toxicological analyses are also performed in other situations, e.g., in the physicians' offices. If laboratories are available for routine analyses, they provide a cost-effective method of gathering basic data on drug-related health problems. Analytical toxicological facilities can generate data of crucial value in establishing the validity of other data on the role of psychoactive drugs in morbidity and mortality. Some caution is naturally necessary in the interpretation of the results because certain drugs may have been taken for legitimate reasons, or because of sampling problems or the conditions surrounding the client's drug use. As always, a careful medical history and confirmatory data, such as possession of drugs liable to abuse, are vital to the interpretation of the total situation.

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In some countries national or regional central laboratories have been set up, such as the Regional Toxicology Centre in the University of Padova, Italy, or the Center for Disease Control in the State of New York in the United States of America. Such comprehensive laboratories carry out a number of activities, and are equipped and staffed for sophisticated analytical work. The establishment and functions of such a central laboratory are discussed in the report on the 1982 Helsinki seminar referred to above.\textsuperscript{a}

Therapeutic drug monitoring involves not only straightforward identification of psychoactive substances in body fluids and tissues but also monitoring, for instance, the plasma concentration of the drug during periods of treatment. Diagnosis of acute poisoning involves the rapid identification of the toxic agent in, e.g., blood, urine and gastric fluid, followed by an assay of the agent itself. The methods employed require a special laboratory. In the field of clinical rehabilitation, laboratory data will be useful in the control of drug-free programmes and also in connection with therapeutic regimes including the use of drugs such as methadone, as well as for monitoring follow-up and after-care programmes.

The laboratory needs of the law enforcement system may be met by collaboration with a regional laboratory of the type under discussion or special forensic laboratories may be set up. However, in the latter case, where technical expertise is in short supply, it is important to make arrangements for collaboration and the exchange of services in order to avoid duplication.

In each of the areas described, good laboratory practices are fundamental. To encourage the positive development of the available analytical services, quality control programmes have existed for some time in Europe and in the United States of America.

**Mortality**

The national cause-of-death statistics are the basic sources of data on overdose deaths from psychoactive substances. For a comprehensive view, all such deaths, whether accidental, suicidal, homicidal, of undetermined cause, or due to dependence, should be surveyed together.

Mortality among the young, leading to large losses of potential years of life, deserves special attention. For comparative purposes, the main focus should be on certain young age-groups, say those aged 15–34 years, since the majority of overdose deaths are likely to occur in these age-groups in many countries, and death certification is likely to be more reliable in these groups than in older age-groups owing to the higher frequency of autopsies and toxicological examinations. National data of this type may be reasonably representative, but their publication may often be delayed for several years. However, the frequent lack of reliability or specificity of data for this purpose should be stressed.

\textsuperscript{a} IDÅNPIÄN-HEIKKILÄ, J. \& KHAN, I., ed. *Public health problems and psychotropic substances*, Helsinki, the Government of Finland, 1982, p. 98.
A valuable complementary source of data may be the analysis of series of forensically examined cases of deaths associated with psychoactive substances. This method can quickly indicate changes in the trends of mortality from uncommon causes, such as deaths from specific psychoactive substances. A scrutiny of cases may suggest new associations between various drugs and causes of death. The information gained from such series is relatively reliable, because major changes in diagnostic practices or in the thoroughness of examinations are unlikely over the periods covered. If a forensic examination is not indicated in the case of drug-related deaths occurring in hospitals, results from relevant hospital autopsies should be included. In addition, deaths certified by clinicians might be included. A disadvantage is that results from a forensic series are valid only for relatively small areas. For more broadly representative information, an analysis of official statistics is needed.

Deaths in which psychoactive substances are a contributing factor can be studied in two ways. National cause-of-death registers may include data on underlying causes of death in cases where overdose or abuse of psychoactive substances is given as a contributory cause on the death certificate. However, the accuracy of data from national statistics should be further evaluated. Variation in thoroughness of cause-of-death inquiries and in diagnostic practices may introduce bias. As the 9th revision of the International classification of diseases (ICD-9) is neither unambiguous nor easy to apply, studies of mortality might benefit from an additional, supplementary classification of "deaths induced by psychoactive substances". Special consideration should be given to poisoning due to multiple drug use.

Psychoactive drugs in traffic accidents and other accidents

Traffic accidents are a major cause of morbidity and are responsible for a wide variety of social problems all over the world. The causes of such accidents are generally multifactorial and include components related to the road, the vehicle and the user involved. In the present context the behaviour of the road user and the driver of a vehicle is of interest, and this can also be influenced by many factors, e.g., age, experience, diseases and emotional status. Recent advances in pharmacological-toxicological studies, especially in connection with driving tests, have shown that, in addition to alcohol, other drugs and especially the psychoactive drugs can impair mental and physical functions and thus contribute to accidents.

Psychoactive substances belonging to all the therapeutically used groups of such substances and a number of illicitly used ones are capable of producing impairment of driving. In a list of drugs published by the Nordic Committee on Drugs and Traffic, a nearly 200 psychoactive substances were classified as

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"potentially hazardous" for drivers, and of these just over 100 were considered "especially hazardous".

The risk factor in using psychoactive drugs varies for different groups, according to various pharmacological and epidemiological studies which, however, do not yet seem to be either conclusive or exhaustive. For sedatives/hypnotics available data show that their use may more than double the risk factor. There seems to be reliable evidence on stimulants and antidepressants, whose effects on driving performance are known at therapeutic doses. The antihistamines deserve particular attention for their known sedative effect as well as their potentiating effect when associated with other drugs. Opiate users do not seem, according to epidemiological data, to be at special risk of road accidents, and the use of tranquillizers is so widespread that the few available epidemiological studies are not conclusive. Cannabis users constitute a significant proportion of the victims or survivors of traffic accidents according to recent studies in North America and Italy, and several laboratory studies have also furnished evidence that cannabis impairs driving performance. The intake of alcohol usually potentiates the effects of psychoactive drugs.

After proposals from the Nordic Committee on Drugs and Traffic, the Nordic Council has recommended a system for ensuring that warnings are included on the labels of drugs considered dangerous for drivers. Lists have been produced of drugs that should be labelled by the pharmaceutical manufacturer with a red triangle to serve as a warning. A similar label must also be affixed by the pharmacist when a prescription is dispensed. Moreover, if a physician or dentist considers that a drug not included in the lists may pose a problem, he is entitled to direct the dispensing pharmacist to affix a warning label. In addition to this label, the patient also receives a leaflet in which the situation is explained to him. The patient is urged to consult his or her physician as to the possible effects that the treatment may have on driving ability, the operation of complex machinery or in a job with a high risk element. Such information is expected to reduce the risk of accidents caused by the therapeutic use of the drugs concerned to a minimum. The Nordic Council has recommended that this system should be implemented in all Nordic countries from 1 January 1983, and it was introduced in Norway on 1 April 1981.

Studies of injured survivors of road accidents including, among other things, a systematic analysis of blood or other biological specimens for the presence of drugs present certain advantages. A high and statistically valid number of cases can be obtained in a short period of time, and a great deal of valuable data can be collected through questionnaires answered by those concerned. There are, however, difficulties in selecting the place of examination (accident site, hospital centre) and the statistical problem of selecting one or all of the health care facilities in a given locality.

Examination of post mortem cases from road accidents will produce data both from hospitals and from forensic services. In some countries victims found

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*See also The influence of alcohol and drugs on driving: Report of a WHO Ad Hoc Technical Group, Copenhagen, World Health Organization, Regional Office for Europe, 1981 (EURO Reports and Studies No. 38).*
dead at the site of an accident are referred directly to the forensic pathology service so that two sets of data have to be combined. A lengthy period may be required for collecting a significant case series. Too important a role in altering driving behaviour may be attributed to specific substances if they are found in a high percentage of a relatively small group of subjects, whereas the much greater number of persons involved in accidents but not injured are ignored.

A WHO Expert Committee has recommended that WHO should strengthen its programmes for investigating the relationship between the use of alcohol and psychotropic substances and injury, disability, and death from road accidents. Knowledge and methodology developed for this purpose should be extended to the investigation of industrial and other accidents.

The report on the WHO seminar on public health problems and psychotropic substances deals in detail with the methodology of relevant epidemiological studies. Another publication reviewing related performance and epidemiological investigations is in course of preparation.

Drug-related Social Problems

Behavioural problems

Causal relationships between the use of psychoactive substances and social problems cannot be established with very great precision. An association between social problems and chronic drug use is, of course, very evident, and such a correlation has been found to exist even among casual users of illicit drugs, but such problems are not necessarily caused by the drug consumption and, indeed, drug use may be symptomatic of pre-existing functional difficulties faced by these individuals. On the other hand, it is certainly true that a problem exists when an individual is ostracized by society or has legal difficulties because of his or her drug use, regardless of the existence of any deleterious pharmacological effect.

Adolescents are continually expected to develop new skills and acquire new knowledge, both in school and in their social environment outside school. Laboratory experiments with animals and humans have demonstrated that a variety of psychoactive drugs impair the learning process. The acute effects of administration of cannabis upon memory have been extensively investigated and have been found uniformly to result in impairment. Since memory and other cognitive functions are so essential to learning, it seems clear that frequent ingestion of psychoactive drugs does have serious consequences.


It has often been suggested that drug use in adolescents impairs normal maturation and development in a wider area than that of formal education. It is argued that drugs are used as a means of escaping the emotional problems of youth so that their resolution is postponed or prevented. Drug use is also said to result in an amotivational syndrome, and hence a lack of interest in other pursuits. While these hypotheses appear plausible, they are more difficult to prove than is the impairment of learning ability.

In general, the fact that someone is intoxicated while at work is usually sufficient to establish that efficiency and work quality are reduced. Such behaviour is also likely to result in dismissal, with its associated economic and other problems.

Another behavioural problem, whose existence may be readily established, is the effect of drug use by military personnel on the exercise of their duties. Again, the demonstrated capacity of most drugs of abuse to impair judgement and their adverse effects on mental and physical functioning in general make it reasonable to conclude that such effects on behaviour may represent a serious problem.

Finally, alcoholism and drug abuse have long been known to have a disruptive influence on marital relations and parental responsibility and, for some illicit drugs, spouses of dependent individuals also run a high risk of developing dependence.

**Criminal behaviour**

A number of cross-sectional studies of non-narcotic drug use in Western countries have found that users show a higher rate of other forms of deviance than nonusers. There is an association between crime and even modest use of illicit drugs. Where the cost of compulsive drug use exceeds the average income from legitimate sources, funds are likely to be derived at least in part from crime, e.g., prostitution and small-scale robberies.

There is some evidence that the use of drugs contributes to crime directly by potentiating impulsive and violent behaviour. The overall significance of drug use as a contributing factor in crime should, however, be considered in the perspective of the association between alcohol consumption and crime. Although statistics are inadequate it seems fairly certain that the relative contribution of drugs is small.

**Socioeconomic effects**

To some extent, the socioeconomic effects of drug abuse may be thought of as the aggregate of the individual effects. However, they also include the cost of societal responses, such as prevention and health care, as well as the indirect consequences of control policies, such as organized criminal networks that feed on the profits of illicit trafficking. The threat of drug abuse to the economy is
likely to vary considerably from one society to another, e.g., a fully employed society whose main resource is the work force may be seriously threatened by increasing drug abuse among its youth, whereas one with a chronic high rate of unemployment will not be affected to the same degree. Finally, it needs to be stressed that many of the socioeconomic costs, such as drug-related crime, organized drug trafficking, and corruption of officials, cannot be separated from the control policy adopted.

Where enforcement costs are assessed, they normally include police, court, and incarceration costs. Treatment costs include those directly related to nonmedical drug use, such as the costs of overdose and other emergency treatment, detoxification, long-term rehabilitation, and maintenance. Indirect medical costs are less easily assessed. They may include those attributable to the treatment of hepatitis and other illnesses spread by nonsterile injection, by malnutrition, or by poor health practices. Drug abusers also typically suffer high accident rates.

An indirect economic cost is the “foregone production”, reflecting the work productivity that is lost for various reasons. In the case of drug abuse it may be related to absenteeism, hospitalization, incarceration, premature death, or general drug-related incapacity. Where compulsive drug use persists under strict prohibition policies, income-generating crime to obtain money to purchase the drug is often one of the major social costs.

There are also “intangible costs” of drug abuse that cannot be assigned a monetary value but should still obviously be considered in the overall evaluation. Such costs include the damage suffered by the children and spouses of drug abusers, the spreading of abuse to young people and other nonusers through peer contact, the contribution to cycles of deviance in subsequent generations, the fear and general deterioration in the quality of life caused by drug-related crime, the contribution to prostitution, gambling, etc., and the support provided to organized crime and the associated corruption of government officials.

In the broader sense, the social and economic consequences of the abuse of psychoactive substances extend well beyond those attributable to the rather small proportion of the population that the dominant culture defines as drug abusers. Throughout history, societies have recognized the importance of drug abuse and have made use of religious, legal, and social sanctions and pressures in efforts to discourage and prevent it.
CHAPTER 8

TREATMENT AND REHABILITATION OF DRUG-DEPENDENT PERSONS

The Conventions

In both conventions, in the area of the treatment and rehabilitation of abusers, the parties are urged to give special attention to, and take all practicable measures for "the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, as well as coordination of such efforts".

The conventions give no details as to the institutions or establishments necessary for these efforts, nor do they describe the methodology or the techniques to be used. The parties are responsible for acquainting themselves with various possibilities and then establishing, or modifying and expanding, the relevant organizational and institutional framework, within the limits imposed by existing manpower and financial resources. Thus the conventions envisage a degree of flexibility in the arrangements that may also make such efforts adaptable to the cultural, religious and social attitudes of the population.

Early Identification

Drug abuse cannot be separated from drug use in any general way because of the different cultural and legal attitudes to drugs in different countries. In different situations, therefore, drug abuse may mean anything from sporadic experimentation with a forbidden substance out of curiosity, to long-term heavy injection of hard narcotics. The early identification of "abusers" will obviously consist of quite different activities in the various environments in which some form of programme for the provision of advice, help or care is envisaged.

The very early stages in experimentation and the use of drugs should be noted by the family members, friends (young or old), schoolteachers, social workers, workmates, or any other contact of the person involved. The prerequisite for early identification of this kind is a knowledge of the symptoms of drug use and of the changes to be expected in the behaviour of the drug user. To promote such early identification, the continuing education of the professional contacts of drug users is necessary (see p. 82). In the family and for other personal contacts,
an understanding of the situation can be promoted by general health education on the dangers and damages of nonmedical drug use. Such education is, in fact, part of one type of general prevention activity (see p. 83).

A characteristic phenomenon in drug abuse is a vacillation between feelings of desire for the drug and positive assertion of the drug-taking behaviour at certain times, and at others a realistic understanding of the dangers of the situation and a serious wish for treatment or just to give up the habit. It is important to be able to make contact with the abuser in the latter mood. Several methods are used for this purpose in various environments. Social workers or volunteers, singly or in pairs, can move in localities frequented by users, at suitable times of the day and night, so that they are known and looked upon as friendly. When contacted, they can discuss the situation and suggest alternatives for action. The social or health services of the community, or a voluntary association, will have to keep an office open to assist each new client to reach a suitable source of help.

Another possibility is to make available to drug abusers the outpatient counselling or treatment facilities of the health and social services, as well as of voluntary associations, through which the abuser may make easy sporadic contact. Such facilities can be set up specifically for this purpose, or they can be used also for related activities. The less official and the more informal such contacts are, the better, and anonymity should be respected, at least in the initial stages. The existence of the arrangement must be as widely publicized as possible. It is self-evident that all normally functioning health and social welfare outpatient institutions should be ready to give such early consultations and advice. This is particularly important in primary health care centres, where physicians and nurses should be alert to, and also adequately trained to pick up abusers who do not advertise their situation.

An objective method of identification of drug use, also in the early stages, is by toxicological laboratory analysis of body fluids for dependence-producing drugs. Modern chemical analytical methodology exists in relatively simple form, e.g., urinalysis, for most of the important drugs of abuse. After a positive identification the diagnosis of “abuse” will have to be made on the basis of a locally accepted current definition. However, the realistic application of such methodology for large-scale early identification, such as the screening of large groups of the population for abusers, is more theoretical than practical because of the ethical problems involved and the probable ensuing opposition from an antagonistic public opinion in most countries. A limited application may be in establishing the diagnosis of drug use in arrested persons involved in drug-related crimes, or in investigating the status of persons taken into drug-free prisons or other health or social establishments where a drug-free environment is the rule. The logical aim of such procedures under the circumstances is to initiate enforced abstinence and compulsory treatment.

**Treatment**

The treatment of drug-dependent persons consists of a number of steps, all of which may or may not be applicable in an individual case. No fixed terminology
exists, but this procedure often consists of steps such as crisis intervention, detoxification, maintenance therapy, psychotherapy and after-care. While the term "treatment" has a medical connotation, "rehabilitation" is something of a borderline area, being to some extent an aspect of medical therapy but also, and especially in the later stages of a case, clearly the responsibility of special social and welfare establishments.

It must always be remembered that not all abusers need treatment and that many of them only need part of the total range of therapeutic possibilities. Many young experimenters only need counselling and support from their family and friends. Many stop their drug use spontaneously. Some may need psychotherapy and, for instance, educational support. Only a minority of drug abusers need intensive and repeated interventions, but they are, on the other hand, the most difficult and labour-consuming cases. The possibility of referral from the criminal courts to the treatment services is important in some cases and needs to be considered in accordance with the recommendations of the conventions.

**Intervention in drug abuse crises**

Crisis intervention is a treatment for drug-dependence complications of a life-threatening character, such as drug overdose, accidental abrupt withdrawal emergency, and severe drug-related psychotic emergency. Specific and differentiated treatment is necessary for the different dependence-producing substances. The personnel of emergency treatment centres, psychiatric hospitals and primary health care centres must be trained to deliver such care. After such an emergency it must be always possible to make a referral for consultations for continued treatment and rehabilitation, even if the patient does not express a desire to seek further help.

**Detoxification**

Detoxification is the elimination of a drug from the human body and is normally conducted in a manner that avoids the dangers and discomforts of abrupt withdrawal. This can be achieved by the administration of gradually decreasing amounts of a drug having cross-tolerance with the drug of dependence, for instance, methadone in the case of opiates, or by the use of nondependence-producing drugs. Detoxification can also be carried out without medication in the so-called "cold turkey" method where the patient experiences withdrawal symptoms, in some countries with the support of acupuncture. Detoxification can be performed in institutions or in the outpatient setting, depending on the type of patients involved, and is the necessary first step towards more intensive treatment and rehabilitation programmes. In a few highly motivated individuals this may be sufficient to prevent them from relapsing into drug abuse, but in many cases total cessation of drug use should not be expected immediately. Continued treatment and contact with the patients, through medical or social personnel or through counsellors, are necessary for successful social reintegration.
Maintenance therapy

Maintenance therapy with drugs is used for patients who are so dependent on a drug that total abstinence is an unrealistic objective, at least in the short term. The therapy provides an opportunity to rehabilitate the patient, improve his health and stabilize his life. The abuser need no longer be involved with the black market, and crime and urban unrest are diminished. Treatment to achieve drug-free rehabilitation is then begun.

Maintenance therapy has been provided using opium (in traditional opium-using countries such as Iran and Pakistan), heroin (in the United Kingdom, where its use is legal), methadone (a more long-acting opiate favoured in the United States of America), or narcotic antagonists (e.g., naltrexone, which prevents the euphoria of opiates, has been used experimentally).

The merits of large-scale maintenance therapy are first and foremost social, in reducing such undesirable side-effects of drug abuse as robbery and other crimes. The aim of the therapy should be to gradually reduce the maintenance drug until the patient is drug-free. This proves in practice to be difficult, first because of a lack of adequate treatment and rehabilitation establishments, and secondly because patients often continue taking dependence-producing drugs additional to the therapy, and the drug of maintenance is often diverted into the black market. In order to minimize these risks, maintenance therapy should be given only under adequately controlled conditions of patient selection, taking into account their health, age and social situation, and provided that periodical health and social behaviour checks are carried out and the dispensing of the drug of maintenance to individual patients is controlled. The necessary resources for social rehabilitation should also be available.

Psychotherapy

The elimination of physical dependence through detoxification is not the end of the process but rather the first step in the more difficult process of helping the individual to remain in a drug-free state. A prerequisite for the continuing psychological and social-conflict-solving work with the patient is often to restore his or her physically run-down condition. Heavy drug abuse is often accompanied by infections, dental decay, malnutrition and general lack of health care. Such deficiencies must be corrected and a satisfactory general physical condition built up as a part of the treatment process.

Since the causes of drug abuse are multiple and often involve individual psychological problems as well as social conflicts in the family and at work, the treatment will have to help the patient to solve such problems and support his self-development so as to make it possible for him to cope with life's problems without recourse to drugs. Many therapeutic techniques can be used for this purpose. Individual psychotherapy is a standard form of treatment and group psychotherapy can also prove helpful. Family therapy is often used with youthful drug abusers with the aim of solving internal group problems and
securing family support for the rehabilitation. Behaviour modification, self-hypnosis, relaxation exercises and meditation are also being used.

It is clear that the measures and techniques described above have a place in the whole long process of treatment and rehabilitation. Drug treatment programmes must be linked from the outset to the broader measures leading towards social reintegration. Such treatment, including psychotherapy, can be institutional or consist of various types of outpatient programmes. While institutional care allows for the intensive treatment often necessary in the initial stages and can strongly influence the motivation for treatment, it can also in the long term be counter-productive and should usually be fairly limited in time. In many countries the need for, and utility of, institutional care may be questioned. It may be argued that outpatient and noninstitutional care is more appropriate because of its lower cost, its ability to rehabilitate people in the community, and its acceptability to the largest number of drug-dependent persons.

Where treatment facilities fall within the ambit of different agencies and institutions, coordination in utilization is essential. Special institutions and programmes for the care of drug-dependent persons are necessary in some instances, and especially where large numbers of persons must be cared for. However, suitable care can, in appropriate cases, be provided either in primary health care centres, general hospitals or psychiatric hospitals.

**Compulsory treatment**

Enforced abstinence and compulsory treatment are based on the assumption that society has a duty to protect an individual against inflicting serious harm on himself when his mind is seriously damaged, and also that society has a right to protect itself from socially threatening behaviour, including drug abuse. The idea that drug-dependent persons must be confined and isolated from their source of drugs has a strong appeal, particularly to those who see an element of moral transgression in drug abuse. Indeed, in some developing countries, where general medical services are scarce, to place abusers in prisons, mental hospitals or special establishments for some kind of rehabilitation may be one of the very few options available.

Experiences from many countries do not support the belief that even long-term confinement with restricted access to drugs, combined with psychotherapy, will render abusers drug-free after discharge. The primary problem appears to be that, while the individual can function well in the institutional setting away from exposure to drugs, as soon as he is returned to his community and its temptations, he has no resources to help him to abstain. It seems clear that the motivation to discontinue drug use cannot be created through the use of compulsion. To be effective, assistance to an individual in the form of treatment and rehabilitation will have to be provided in dynamic interaction with the community environment in which he has to live.

The role of compulsion in treatment was reviewed by a WHO Expert Committee, which came to the following conclusion: "The Committee
considered that the clinical evidence was not sufficient either to support or to refute the case for various forms of compulsory treatment, but noted that, in spite of considerable experience, compulsory detention alone had not been shown to be beneficial . . . The Committee also noted that there is some evidence to indicate that some compulsion involving parole, after-care and supervision might be of value, but that conclusive evidence is lacking . . .

**Therapeutic communities**

The term “therapeutic community” refers to a wide range of programmes, but a concept common to all of them is that the individual is primarily responsible for his recovery from drug dependence, and that the therapeutic community guides and supports the individual in his efforts to achieve this recovery. The objectives are to achieve abstinence, to create a new life-style and eliminate socially destructive patterns of behaviour, and to encourage the acquisition of positive attitudes of honesty and responsibility. These processes can take many months, and the whole therapeutic community helps through confrontation, group pressures and rewards, e.g., by advancement in the group’s social structure. The ex-addict staff members serve as role models and as living evidence that drug dependence can be overcome.

Only a small nonresident staff is needed in therapeutic communities, and their facilities and equipment are relatively simple. In many countries they are supported by governmental or private sources. The success rate in restoring individuals to an adequate level of drug-free functioning is said to be relatively high, though the drop-out rate in early phases of the programme is considerable, and only the most highly motivated clients are accepted.

**After-care, Rehabilitation and Social Reintegration**

The terms describing the process of restoration of an individual’s physical, psychological and social functioning are often used interchangeably and are therefore difficult to define. “Rehabilitation” may be said to involve a range of educational, psychological, vocational and social measures aimed at making the drug-dependent person capable of coping with the situations encountered in his community, and at helping him to take advantage of the opportunities available to people of his age in it. “Social reintegration” denotes the final stages of this process, with the achievement of a successful result, i.e., the person is again integrated into the community and partakes of its life. “After-care” denotes measures to stabilize, through occasional actions, the results of treatment and rehabilitation. In this context the concept of “continuing community inter-reaction” developed in the Hong Kong rehabilitation programme, in which the

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ex-abuser is involved in self-help groups, thus reinforcing his social integration, deserves to be mentioned.

While residential programmes are sometimes needed in rehabilitation, they should not be the sole, nor even the primary, modality. Indeed, a major goal is to integrate a person into society, not into an institution. The responsibility for organizing rehabilitation programmes falls primarily on the social and welfare authorities and voluntary associations in the local community. However, a successful and continuing contact with medical-treatment centres is necessary for the purposes of after-care consultations, when needed. Good contacts are also needed with job-placement services and housing agencies in the community.

In the period following detoxification and medical treatment, persons need help in maintaining a drug-free life. Such help and reorientation can be initiated in a residential setting. In a sheltered milieu, the client is expected to accept some responsibility for the orderly functioning of the accommodation, and to maintain acceptable interpersonal relations with others. During this period the counsellor has an opportunity to explore the client's underlying difficulties and to propose realistic and positive alternatives, while psychotherapy can also be continued. There are many examples of the use of such residential groups for treatment, rehabilitation and counselling purposes.

Persons leaving institutional care or residential programmes can stay in half-way houses as a means of facilitating their integration into society. Some 8–12 persons and a staff member in charge of the management can live together with the residents, and are collectively responsible for operation and maintenance. The house should be located at a reasonable distance from places to which the residents have to go regularly (e.g., school, training facility, workplace). The length of stay should be sufficient to provide the resident with an opportunity for his phased reintegration into society, but not so long as to create dependence on the half-way house.

Outside the traditional institutions, the client with few acquaintances in a drug-free milieu may be given support by a "drop-in" centre, where the informal social environment and counselling services provide a point of reference. A drop-in centre should be located more or less centrally in the community and contain, for instance, a reading room and library, recreational materials (television, musical equipment), meeting rooms and private rooms for counselling. All drop-in centres should forbid the consumption of alcohol and the possession or sale of drugs on the premises. Social and financial support from the community is necessary.

The effects of a disturbed background in the life of young persons can, in a number of cases, be alleviated by placing them in a suitable foster-family setting during the period of rehabilitation, in this way assisting them to form a social link at an early stage in this process. The matching of a particular client to a particular family can make it possible for him to find understanding and support. A good relationship must be established between the contacting staff member, the foster family and the client. It should be noted that too marked a change may increase the problems rather than alleviating them.
Younger clients are often in need of educational upgrading; this applies especially to those who have dropped out of education and who have the potential to improve their educational qualifications, since better qualifications will increase their self-esteem and their chances of finding rewarding employment. They can attend regular schools or follow specially designed courses.

Various types of vocational training will improve the work habits of clients and increase their chances of finding employment and leading an orderly life. Course designs must take account not only of prevailing conditions in the local labour market and the economy of the community, but also of the industrial and commercial needs and standards and the possible obsolescence of particular skills.

Because of their limited contact with society, most persons undergoing rehabilitation after drug dependence require assistance from a job-finding and placement programme, the objectives of which are to determine the skills and capacities of clients, to identify employment opportunities in the community, and to facilitate contacts between clients and employers. Special efforts may be needed to overcome the negative attitudes of employers towards former drug-dependent persons and to promote the acceptance of trained clients.

In some places community work projects have been organized at the local level, particularly for younger, formerly drug-dependent persons, and can help them to integrate into the local society, promote community understanding of their needs, and diminish the antagonistic attitudes of community members. Such projects may include, for instance, environmental and conservation projects, assistance in museums or agricultural work, or assistance to older citizens in the community. Clients should be informed of the duration of the project and be encouraged and prepared to look for other work when it has been completed.

International Collaboration

Several of the United Nations bodies and the specialized agencies are responsible for advising, assisting and collaborating with the Member States in the area of general treatment and rehabilitation. Nongovernmental organizations also assist in these tasks.

World Health Organization

WHO has a central role in international collaboration in the treatment and medical rehabilitation of drug-dependent persons. Although the conventions do not expressly mention WHO as the central agency in such international collaboration, the Organization has this role de facto. Numerous resolutions of the Executive Board, World Health Assembly and regional committees between 1949 and 1975 provide policy and priority directives for the initiation and
conduct of activities in the field of both alcohol and drug dependence. Relevant references are given in a report\textsuperscript{a} which describes WHO's views on the general characteristics of the problem, together with considerations on the planning and implementation of a national programme. The report also mentions the following relevant current activities, \textit{inter alia}, in the field of drug dependence:

\begin{itemize}
  \item \textit{(a)} collaboration with countries in planning, managing and evaluating services and facilities for the prevention of drug dependence and alcohol-related problems and the treatment and rehabilitation of those affected;
  \item \textit{(b)} evaluation of specific programmes of prevention and treatment such as "maintenance"; pharmacotherapy by itself or in combination with other therapeutic measures; rehabilitation and after-care;
  \item \textit{(c)} organizing epidemiological studies in both developed and developing countries as part of the planning process for programme development;
  \item \textit{(d)} study of the utilization of internationally controlled drugs in relation to measurable parameters (morbidity; mortality; state of development of health services).
\end{itemize}

Other WHO programmes are intended to collaborate in strengthening the activities of the drug-dependence programme. Thus the Mental Health Programme deals with the development of mental health services and the prevention or reduction of psychiatric, neurological and psychosocial problems, including those related to alcohol and drug dependence. The Primary Health Care Programme in several countries constitutes a component of community development aimed at preventing and curing drug dependence. The country health programming activities provide a stimulus to ensure that drug-dependence activities are planned and coordinated with the existing health and social care delivery system. Furthermore, a coordinating group for the WHO Mental Health Programme is formulating and implementing a programme in which Headquarters, regional and country activities complement each other and jointly present a coherent response to the varying needs of countries.

A number of the reports of the WHO Expert Committee on Drug Dependence have discussed various aspects of the treatment of drug-dependent persons, e.g., maintenance therapy,\textsuperscript{b} while the Committee's eighteenth report contains a broad discussion on the management and treatment of drug dependence.\textsuperscript{c} A seminar in Penang (1981) dealt with the assessment of treatment methods of drug dependence in developing countries (project 01/04/01). A comparative study of the legal framework for, \textit{inter alia}, the treatment of alcoholism and drug dependence has been published.\textsuperscript{d}

\textsuperscript{a} Document MNH/78.21.


International Labour Organisation

ILO has from the outset been concerned with the improvement of social conditions and the protection of workers and has paid special attention to the employment needs of the handicapped. Thus, with the adoption in 1955 of ILO Recommendation No. 99 concerning the vocational rehabilitation of the disabled, comprehensive international guidelines for action were laid down that still remain relevant today. Vocational rehabilitation comprises a number of services, such as job counselling and guidance, pre-vocational preparation, and vocational training and selective placement. The methods and techniques of vocational rehabilitation are particularly useful where joint community efforts are aimed at the social reintegration of the drug-dependent person. If vocational services are lacking or are badly organized, rehabilitation programmes are unlikely to be very successful.

In addition to helping to develop such services, ILO can also play an important role in the creation of job opportunities for the drug-dependent and in ensuring that they can find employment. This includes the creation of workshops, cooperatives, and small-scale industries and the setting up of rural and handicraft activities. Vocational rehabilitation workers are chiefly concerned with helping to bring about a change in self-defeating, drug-taking behaviour, and with developing the social and job skills and knowledge necessary to adapt to modern society.

As ILO's structure is based on the tripartite system (collaboration between governments, employers and union representatives) its action in the field of drug dependence attempts, wherever possible, to encourage the participation of these sectors. At the 58th Session (1973) of the International Labour Conference a resolution invited ILO Member States and workers' and employers' organizations “to do their utmost in their own countries”, inter alia, “to promote effective tripartite or as appropriate, trade union-management consultations at all stages of the elaboration and implementation of programmes of treatment and rehabilitation”, and “to promote positive attitudes such as the recognition of alcoholism and drug dependence as illnesses for which there is help and treatment, and to provide the best possible treatment and rehabilitation facilities in all communities”.

ILO continues to collect and analyse information on vocational rehabilitation programmes for drug-dependent persons in various parts of the world.

United Nations Educational, Scientific and Cultural Organization

The General Conference of UNESCO, in resolution 16 C/1.202, 1970, requested the Director-General “to develop, in co-operation with international non-governmental organizations concerned with education and youth, a programme of study and action ... aimed at promoting the contribution of social science research, education and the media of mass communication to the solution of the problems of drug abuse”. Programmes and projects have been undertaken in various parts of the world to further these aims.
Division of Narcotic Drugs

The Commission on Narcotic Drugs, at its Fourth Special Session, 1976, requested the Division of Narcotic Drugs to undertake a study on measures to reduce illicit demand for drugs; this was carried out in collaboration with relevant international bodies. The report on the study, which takes the form of two publications, includes chapters on policy development, treatment, rehabilitation and social reintegration, while sources of information and extensive references are provided.a,b

Nongovernmental organizations

The International Council on Alcohol and Addictions (ICAA) has held several consultations with regard to social policy in its relationship to drug dependence.

Manpower Training

The conventions

Both conventions (see p. 48) include manpower training as one of the requirements for efficient action against the abuse of controlled substances. The relevant articles include such activities among the measures for the prevention of abuse, and for the treatment and rehabilitation of the persons involved. The parties are required to give special attention to, and take all practicable measures for “the training of personnel in the treatment, after-care, rehabilitation and social re-integration of abusers”. It should be noted that there is no mention of the categories of personnel that are needed, or of the forms of training necessary. Each country has evidently to find the organization, content and method of implementing the manpower training that best suit its planned structure in the prevention of drug abuse and in the treatment and rehabilitation of drug abusers.

In planning and implementing manpower training, the parties can make use of the international experience collected and the expertise available in the international organizations and especially in WHO. The WHO Constitution, in defining the responsibilities of the Organization as the directing and coordinating authority on international health work, specifically mentions as one function “to promote improved standards of teaching and training in the health, medical and related professions”. An overview of policies for health manpower training has been published.c

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a Study on measures to reduce illicit demand for drugs, New York, United Nations, 1979.
Phases of manpower training

Prevention, treatment and rehabilitation in the area of drug dependence should be based on the corresponding activities in general health care and social work, to which they are complementary. In the same way, manpower training for work with drug-dependent persons will have to be integrated into national structures for the training of personnel in general health and social work, which will have to be expanded or complemented as necessary.

For all categories of personnel in health and social work, three phases of training and education may be distinguished, namely basic training, advanced professional and vocational training, and continuing education.

Basic training

Basic training lays the scientific foundations and provides the practical methodology for the specific category of personnel involved. Since drug dependence and the problems of drug abusers will be encountered in all areas of health and social work, attention should be paid to such problems in the basic training of all types of personnel to an extent proportional to the probable involvement of the category concerned in drug-related work. A specially interesting area is that of primary health care in both developing and developed countries on account of the need for skilled personnel for handling drug-related problems in such work.\(^a\)

In WHO, the health manpower development programme deals with all aspects of manpower training, including planning, teaching methodology, implementation, programme evaluation and scientific research. WHO Headquarters and the regional offices are involved in, and organize collaboration with, and assistance to, Member States concerning relevant problems. Twenty-seven examples of training programmes from developing and developed countries, providing alternatives oriented to community health needs, have been described.\(^b\) Information is available on request.

Advanced professional and vocational training

Advanced training and specialization are necessary in many areas of health and social work. In most such educational programmes there is a need for a component on drug-abuse-related problems. WHO country health programming activities are of special interest in this respect, since Member States may need WHO's collaboration and assistance to ensure that drug-

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dependence activities are taken into account in developing the existing health and social care functions.

For some aspects of prevention, treatment and rehabilitation in relation to drug dependence, special types of professional and vocational training programmes will need to be instituted with a view to providing specialized personnel for such work. The WHO Mental Health Programme is concerned with the development of mental health services and with furthering the appropriate utilization of mental health skills and knowledge. The study carried out by the Division of Narcotic Drugs previously mentioned deals with manpower development and training for programmes to reduce the illicit demand for drugs. The identification of needs, planning and implementation are discussed, and selected references are given.

Continuing education

No educational programme can guarantee the continued competence of its graduates; reassessment and retraining are necessary because specific skills become obsolete and social patterns change. Continuing education may take many forms, but its objective is always to assist those who have undergone special training to maintain and extend their professional competence, something that also applies to personnel working in programmes for drug abuse prevention, and the treatment and rehabilitation of drug-dependent persons. Training programmes for such personnel should, from the beginning, include a continuing education component. While no guidelines are available on continuing education programmes on drug dependence, WHO has published several related studies.

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b WHO Technical Report Series, No. 534, 1973 (Continuing education for physicians: report of a WHO Expert Committee); Continuing education of health personnel (document ICP/HMD 029); Continuing education of health personnel as a factor in career development, Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies No. 6); Continuing education of health personnel and its evaluation, Copenhagen, WHO Regional Office for Europe, 1980 (EURO Reports and Studies No. 33).
CHAPTER 9

PREVENTION AND DRUG DEMAND REDUCTION

General Background

The conventions

A national policy for drug abuse control should include and define specific preventive activities as part of the overall pattern of control measures. The background to, formation and national coordination of such a national policy has been discussed in Chapter 4 (p. 58). This policy must also include the necessary arrangements for supporting preventive and drug abuse control measures at the community level.

Both conventions include certain aspects of prevention among the measures to be taken against the abuse of controlled substances (see p. 48). Thus the parties are requested to give special attention to, and take all practicable measures for the prevention of abuse, the provision of assistance to persons, whose work so requires, to gain understanding of the problems of abuse and of its prevention, and the promotion of an understanding of abuse problems and their prevention among the general public, if there is a risk that abuse will be widespread.

The conventions do not define the term “prevention” or give concrete examples of activities which would be effective in preventing drug abuse. The parties are required to develop and institute, nationally or in collaboration with international organizations, such measures against drug abuse as would be appropriate in the particular situation in each country.

The scope of prevention

Since the aim of the conventions is to limit the use of psychoactive drugs to exclusively medical and scientific purposes, all the activities required to achieve this end should form a prevention system. The provisions of the conventions do
indeed form a system of interlocking activities each of which will be ineffective individually unless supported by the others. In reality, however, it has not been possible in any country to prevent all nonmedical use of drugs, and drug abuse has resulted, fed by licit or illicit supply. While parties are required to fulfil all their responsibilities under the conventions, the term “prevention” thus refers to special activities against existing drug abuse in each country.

Drug abuse can only occur if a drug is supplied to meet the demand of the misusing individual; it can thus be fought by diminishing the supply of misused drugs and/or curtailing the demand for these drugs. Efforts to reduce drug supply will be treated in Chapter 10, while the discussion here centres on prevention through drug demand reduction. Furthermore, psychoactive drugs can be overused or misused even when legally distributed, either through carelessness in prescribing them or lack of knowledge among the public. Measures to prevent this have been discussed in Chapter 6 (p. 81).

In a more limited sense prevention of drug abuse may be seen as: (1) preventing those who do not take drugs from doing so; (2) preventing those who are occasional users from becoming chronic ones; (3) preventing or reducing the number and severity of problems associated with nonmedical use; and (4) preventing the worst effects of chronic drug abuse by means of treatment and rehabilitation (see Chapter 8). The activities mentioned in items (3) and (4) correspond to what, in public health terminology, is commonly called “secondary” and “tertiary” prevention.

The many reasons for drug use and abuse (see p. 58) and the complexities of drug-taking behaviour may make it unrealistic to hope for a “primary prevention” of drug abuse that would eliminate all nonmedical drug use. There is the danger that, if one type of drug abuse is reduced, another substance will be misused. In most countries, in view of the magnitude of the problem, a kind of “scale of undesirability” is applied to the different psychoactive drugs (for instance, heroin injection compared to overuse of sleeping pills). The attitude of physicians to a specific drug-taking pattern may not be at one with the self-perception of the potential or actual drug takers themselves.

In setting up prevention programmes with a view to reducing demand it is therefore necessary to look carefully at the types of drugs misused in the community, try to define the groups of abusers and their different environments, and take into account a wide range of social attitudes to the problem. Any discussion on prevention must be couched in terms of flexible responses to actual situations. Reduction of demand can then be studied in specific situations and in terms of specific drugs, and the goal of prevention will be seen as the limitation of the more individually and socially harmful effects of drug use. It must be understood that effective prevention programmes require sustained, long-term efforts. Limited efforts over short periods usually do not achieve the desired result and may even be counterproductive. Several different channels of communication will generally have to be used in a well coordinated programme. Evaluation of prevention programmes is obviously very difficult on account of the many interacting causal factors behind drug-taking behaviour.
Measures Aimed at Individuals

Preventive programmes directed to individuals are based on information and education. The assumption underlying all such programmes is that it is possible to change present and anticipated behaviour by using persuasion to modify knowledge, attitudes and values. To have this effect the programmes must be well structured and used for defined purposes with known target groups, and should be designed as part of a general education programme aimed at promoting an understanding of the many personal and social problems with which man is beset.

Information and education are not, however, to be equated; each is a tool that must be used with understanding of its basic concepts.

Information on the appropriate use of drugs

Drug information is a form of communication that simply imparts factual knowledge. Information activities essentially involve a one-way flow of messages from sender to hoped-for receiver: there is ordinarily no opportunity for the receiver to raise questions, express his own interests or concerns, or resolve any anxieties that may have been generated by the information. It is a fairly limited process in which the main elements are usually information concerning the drugs themselves, their (harmful) effects upon people, the nature and extent of the social problems associated with drug abuse, and instructions regarding drug control legislation and other forms of social control.

To be effective, whatever information is made available must be accurate and believable, i.e., it must be consistent both with basic pharmacological knowledge and with the actual experience of users. Actual or potential users do not, however, require complete information about the possible pharmacological effects of specific drugs. Information must also be adapted to the levels of psychological and social development of the individual in question, the likely risk to which he is exposed, and the meaning and functions he and his peers assign to drug use. The capacity for absorbing information must also be taken into account: someone who is bombarded by more stimuli than he can process tends to insulate himself from those stimuli and to ignore them.

“Scare” techniques are not effective except under certain very limited and specific conditions where they may reinforce current community attitudes. This is only likely where direct knowledge and experience of drug abuse is lacking. They are often counterproductive, since the mere repeated presentation of information on drugs, however negatively, may be enough to increase their attractiveness and thus produce an effect contrary to what is intended. To a group that values danger and daring, the more dangerous a drug, the more attractive it may be.

Most parents of children who have reached the age of potential drug use do not need detailed pharmacological information about specific drugs but rather a basic understanding of what drugs are and how they act, the many reasons for
their use, the social factors that facilitate or inhibit such use, and the importance of maintaining open lines of communication and a relationship that will encourage their children to share and think through the decisions they face about drug use. Overemotional reactions must be avoided.

It is evident that the knowledge needed by different groups will differ, depending on their functions and the extent to which, as a consequence, they may need “to gain a deeper understanding of the problems of abuse and of its prevention”, to use the words of the conventions. Professionals, especially health professionals, need accurate information about the pharmacodynamic action of the various dependence-producing drugs, the manifestations of all types of drug-related problems, including societal responses, and the treatment and rehabilitation of drug-dependent persons. All professionals involved in activities during which drug-related problems may arise need to know the dynamics of the “drug scene”, the general attitudes and behaviour of various types of dependent individual, the role and functions of their drug use, and the ways of reaching drug-using individuals.

The mass media, whether newspapers, radio or television, are often said to stimulate demand for drugs by arousing an interest in them that did not previously exist. Sensationalism in reporting should obviously be avoided. A negative side of mass media information, even if well prepared, is that it reaches many groups for which it was not necessarily intended. Different individuals may “hear” it in unintended ways. It is probably not a good idea for a mass media campaign to be focused on the potential user, with the broad aim of persuading him to avoid abuse; such campaigns may be more effective in helping to stop the spread of abuse and in limiting its drug-related problems, i.e., in the words of the conventions, in helping to “promote understanding of the abuse problems and their prevention among the general public, if there is a risk that abuse will be widespread”. The mass media have the ability to disseminate accurate information to large audiences, and this can be a helpful adjunct to other preventive programmes.

Informational programmes may make use of a wide variety of means of communication that are most effective when they support and complement each other. Printed materials can be distributed, focusing ideally in concentrated and simple form on basic facts about drug use and the services available for giving advice and help. Films and poster campaigns can convey short, simple and informative messages. Radio, television and newspapers can play a responsible role in realistically allaying unfounded fears, in alerting and informing the community about existing abuse problems, and in explaining the national drug policy and the activities of the authorities to the general public. While information campaigns are important, and sometimes all that is available, because of limited facilities or manpower, it must be remembered that, as indicated above, they have limitations. However, poster displays, films, pamphlets, etc., may be more effectively utilized as “primary” materials for formal and informal discussion groups. It is important that, whenever possible, the message is reinforced and the audience given the opportunity to clarify their impressions. Personal contacts of this kind in endangered physical or social
environments, or discussions with groups of persons working in contact with
drug users, should be used to advantage.

An attempt should be made to evaluate information programmes, difficult
though this may be, in order to correct errors and increase the effectiveness of
future campaigns. At the simplest level, questionnaires can be designed as a
form of “market research” in order to test whether the message has been clearly
understood by the audience. A more informative level of investigation is
possible in an area where a more prolonged information or teaching campaign
has been carried out in order to test whether there have been attitude changes
towards drugs or whether knowledge has really been increased. At an advanced
level of investigation it may be possible to demonstrate behavioural change by,
for example, an increase or decrease in the use of services or in the workloads of
community volunteers. It must be remembered, however, that such changes can
only be seen in the long term, after prolonged informational and educational
efforts, and that when behavioural change occurs the reasons are likely to be
multifactorial, i.e., also influenced in part by social and environmental factors.

Drug education

Drug education is not just the dissemination of information but an activity
that allows for two-way communication leading to learning and resolution of
feelings. It is directed either at individuals separately or within the context of
the family, the peer group, the school class, a circle of colleagues, or the
community. The educational process utilizes the possible social pressures or
control of such groups to modify the individual behaviour concerned, or, in the
words of a UNESCO report: “Drug education is a broad range of concerted
activities relating to teaching/learning situations and experience which
attempts to maximize opportunities for the intellectual, emotional, psychologi­
cal and physiological development of young people.”

A wide variety of approaches can be used within the framework of drug
education programmes. The general aim of such programmes is to enhance
decision-making skills, clarify values and translate them into action, and
develop coping skills. Motivation, attitudes and behaviour are influenced. The
programmes include appropriate information, and their activities are tailored to
the developmental level, social and cultural background, and interests of the
participants. They can be used individually or in a group setting, or integrated
into other education programmes or curricula.

Ideally, drug education should be conceived as part of a balanced health
education programme, due regard being paid to the age-groups and background
of participants. If health education programmes are already in operation, this is
a low-cost approach. Special drug education courses or seminars may also be
arranged in the context of broad health education programmes.

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* Report of meeting on education in more-developed countries to prevent abuse, Paris, 1972 (UNESCO document
  ED/MD/26).
Programmed teaching is based on a set curriculum or at least on structured study material. Used by an individual, this permits him to arrive at his own conclusions, to which he may then be more strongly committed. Special programmes have been developed, aimed at young people, emphasizing personal development with a view to individual improvement (self-esteem, social skills, mental health), clarifying personal values (demonstration of conflicts between values and actual behaviour), or encouraging positive values (improved self-perception, improved decision-making skills).

Special personnel, who will have to receive extensive training, are needed for the development of such programmes; their implementation will thus be costly.

Programmed teaching can also be used in group participation and counselling, i.e., with youth groups, parent groups, teacher-children groups, or any other group in the community. Such participation is often preferred to individual studies.

It is probably more efficient, for children and young people of school age, to provide drug education as an integrated programme in the school curriculum, incorporated into the corresponding parts of the regular subjects, such as biology, social studies and civics.

**Community Measures**

Prevention of drug abuse through drug demand reduction is, by definition, dependent on a change in the behaviour of the individual. The family, the school, the workplace and the circle of friends form the social fabric that supports this change as part of a local community. The most effective instrument for preventing drug abuse by individual demand reduction is undoubtedly the social control of behaviour. Man is a social being, and has to function in a community, where his social role is determined both by his own capabilities and by the needs of the community. Loss of relationship between the individual and his group often entails loss of earlier behavioural norms. Treatment and rehabilitation are focused on the return of the affected individual to an environmental setting in which he can again function according to his own wishes and those of his community.

The community therefore has a major part to play in drug abuse prevention, especially if prevention is aimed at preventing both nonusers and occasional users from becoming chronic ones, as well as reducing the individual and community problems associated with nonmedical use. Community measures with such aims are manifold, and must be adapted to individual needs and local traditions, culture, and social and economic conditions. Prevention in this sense borders on, and overlaps early identification, treatment, rehabilitation and social reintegration (see Chapter 8).

The community authorities, in discussing, planning and implementing preventive measures against drug abuse, may be greatly helped by an advisory committee, recruited from among those who have experience of drug-related health and social problems, and who are in contact with groups of drug abusers.
The members of such a committee might come from parents' organizations, medical and social services, youth leaders, educational establishments, voluntary associations (sports, adult education, politics, religion), the police and the judiciary, and the community authorities. Such an advisory committee can also collect and evaluate information on the drug abuse situation in the community.

Among possible community measures for the prevention of drug abuse are informational and educational programmes of the general types discussed above. These programmes should, of course, be tailored to suit the actual situation in the community in question, and may be directed to parents, management personnel in industry, labour unions, professional groups, youth groups, or any other community group where prevention may be promoted through information and education.

An information resource centre may be set up as a central facility for providing information on all aspects of drug abuse to members of the community. A library, a collection and distribution service for relevant information material, and guidance on existing prevention, treatment and rehabilitation services may be provided.

Advice and counselling centres may be helpful, especially for young people. They can function independently or be part of other social or health institutions, but must be both easily accessible and informal.

Drop-in centres create an informal environment and can provide a point of reference, especially for young people who wish to take part in activities outside a drug-using milieu. Facilities for reading and for recreation, including games and music, and small meeting rooms are essential. A drug-free environment must be maintained. Counselling for purposes of referral to treatment and rehabilitation is one of the functions of such centres.

The provision of shelter for homeless drug-dependent persons as a means of drawing them into treatment and rehabilitation should be encouraged. The modalities (age, length of stay, types of services) are a matter for the local authorities.

Worthwhile and rewarding alternative activities, outside the drug-using environment, should be developed for persons in risk groups or already engaging in illicit drug use; whatever the sphere of interest, this is best done in collaboration with already existing voluntary associations.

Many drug-dependent persons, even after rehabilitation, are unemployed or have unsatisfactory jobs. Unemployment among young people is a risk factor for drug abuse, so that job placement, counselling and training services are needed to identify job opportunities for them and advise and train them for such opportunities. Existing services for these purposes can, in general, be utilized. The aim of such services is to increase self-respect and give a purpose to living.

In the wider range of community policy, it has been argued that such measures as slum clearance, housing development, and housing renewal will promote prevention, the underlying notion being that, besides attacking the demand for drugs directly, it may be profitable to attack the conditions in which demand seems to thrive.
International Collaboration

WHO is organizing a pilot project on the development of strategies and guidelines for prevention of drug dependence,¹ and UNESCO organizes seminars and working groups in the area of prevention of drug abuse.²

The Division of Narcotic Drugs of the United Nations has organized a project on the utilization of community resources for the prevention and reduction of drug abuse that will continue for several years. Four seminars have been held so far, the latest in December 1981 in Vienna.³

The Division reports to each session of the Commission on Narcotic Drugs on preventive and treatment measures to reduce demand for illicit drugs. A survey of national programmes to reduce such demand was undertaken in 1976 and reported to the Commission in October 1977.⁴ A follow-up was undertaken in 1981, and replies from 66 countries were obtained.⁵ Two other publications of the Division also contain information on prevention and reduction of demand.⁶

¹ See also WHO Technical Report Series, No. 551, 1974 (Twentieth report of the WHO Expert Committee on Drug Dependence).
² See also Report of meeting on education in more-developed countries to prevent abuse, Paris, 1972 (UNESCO document ED/MD/26).
CHAPTER 10

REDUCTION OF DRUG SUPPLY AND LAW ENFORCEMENT

General Background

Drug use and abuse are, on one hand, related to the supply of drugs through licit distribution or illicit traffic and, on the other, to the demand for drugs. The supply-demand equation indicates that a reduction of either should result in diminished use and/or abuse. Everybody would agree that increased demand for psychoactive drugs will lead to increased use and probably also to increased abuse, partly through licit distribution but especially through illicit traffic, since that deals with more dangerous substances. Preventing or reducing drug abuse through activities promoting demand reduction is therefore an accepted and even a favoured drug control policy, though admittedly a difficult one, and has been discussed in Chapter 9.

Dependence-producing psychoactive drugs are supplied through the legal distribution system for medical and scientific use, whereas the illicit traffic provides abusers with prohibited drugs in addition to quantities of legally produced and diverted drugs. Trafficking in drugs in the latter category seems indeed to have increased in recent years. The relationship between increased abuse and increased supply is not a simple one, but a liberal supply is in all likelihood a factor that may stimulate experimentation, which may, in turn, lead to dependence. There seems also to be little doubt that traffickers are always actively marketing drugs. A reduction in supply, unless it is very short term, must therefore lead to diminished use and abuse. Efforts to reduce the supply of misused drugs are thus an established means of drug control.

To reduce supply, it is first necessary to analyse the various ways in which misused drugs are distributed. One possible route is via the legal distribution system through, for instance, incautious prescribing by physicians or immoderate buying of over-the-counter drugs. Another route is by diversion from legal manufacture into illicit traffic, e.g., by patients selling their licit drugs or by trade sales to irregular distributors or traffickers. The third is an entirely illicit chain of cultivation, manufacture and distribution to abusers, feeding the most widespread and dangerous forms of drug dependence. A national drug control strategy must take into account the possibility that misuse and abuse may have both licit and illicit supply channels.
The conventions deal mainly with the control of registered psychoactive drugs through a licit system of cultivation, manufacture, trade and distribution, with the tacit understanding that, if the required rules and regulations are implemented effectively, there will be no oversupply. The relevant provisions of the conventions have been described in Chapter 3 (pp. 33–46), the articles in question laying down detailed requirements for the implementation of a control system with a view to restricting the use of controlled substances exclusively to medical and scientific purposes. However, even with such a well-thought-out control system there will be cases of abuse of controlled substances, and provision is accordingly made for far-reaching measures to prevent abuse and to reduce it through the treatment, rehabilitation and social reintegration of the persons involved (see p. 48). Drug demand reduction is thus treated as an important part of national drug control policy.

The conventions require the parties “to take measures to fight the illicit traffic of the controlled substances” (see p. 47). This effort to control the illicit supply side of drug abuse covers cultivation, production, and manufacture as well as illicit trade and distribution. Parties should coordinate these activities, both nationally and internationally, assisting each other and cooperating with the international organizations in maintaining a coordinated campaign. The need for a national coordinating agency is underlined. The existence of national law enforcement organizations is assumed, but the nature and organization of the police and customs authorities are not treated in the conventions. The parties are requested to treat intentional acts against the provisions of the conventions as punishable offences (see p. 48). There can be no doubt that the conventions also view drug supply reduction through control of illicit traffic as a major factor in preventing drug abuse.

This is fully accepted by the Commission on Narcotic Drugs, which devotes a large part of its work to promoting the national and international control of the illicit drug traffic. Recently, the Commission, in Resolution I of its Seventh Special Session (February 1982), dealt with measures to improve international cooperation in preventing illicit drug traffic; this resolution, later adopted by the Economic and Social Council, contains the following operative paragraphs:

1. **Urges** all Governments, whenever necessary, to strengthen their customs and drug control bodies with a view to promoting the interdiction of substances diverted to illicit channels, by means which include the provision of timely relevant information and cooperation to the fullest extent possible with national and international organizations working in this area;

2. **Appeals** to all States to develop means of more effectively monitoring shipments of controlled drugs within and across their borders, and particularly within free trading zones;

3. **Calls upon** States, subject to their constitutional limitations, their legal systems and domestic law, to pass and enforce laws that make the deliberate misrepresentation or mislabelling of controlled narcotic drugs or psychotropic substances punishable offences, or to take other suitable measures for their control;

4. **Invites** all Governments to respond positively to the Board’s suggestion that a list be made of the precursors and reagents most widely used in the illicit manufacture of narcotic drugs and psychotropic substances, by submitting this information to the Secretary-General at his request, and bringing the list to the attention of their police, customs and other control authorities.

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GUIDELINES FOR THE CONTROL OF NARCOTICS

Reduction of Licit Drug Supply

The progress of psychopharmacology and the active industrial development of psychoactive drugs have led to a rapid increase in the numbers of such drugs marketed. As already pointed out, experience has shown that oversupply of the licit market with these drugs tends to produce medically inappropriate overuse and abuse. There are therefore not only medical, but also economic reasons, in view of the high cost of drugs generally, to limit the licit distribution of psychoactive drugs to what is required for demonstrated public health needs.

The national health policy will also have to include a national drug policy for the supply and distribution of licit psychoactive drugs. The development and implementation of such a policy and its supervision through a central drug control agency as well as the necessary laws and regulations have been treated in Chapter 4 (pp. 51–56).

A prerequisite for achieving an adequate and appropriate supply of psychoactive drugs to the population is the establishment of mechanisms and procedures for the registration of drugs; this has already been described in Chapter 4 (p. 52).

Even if all possible precautions in evaluating registered drugs are taken, their actual use in medical practice will sometimes reveal the potential for dependence production and other less desirable effects. Post-registration surveillance must therefore be instituted to follow the sale, utilization and eventual adverse reactions of individual drugs, as discussed in Chapter 5 (pp. 70 and 74). Of prime importance in keeping the licit use of psychoactive drugs at a medically correct level is the development of an adequate knowledge of their risks among both health professionals and the general public, as described in Chapter 6 (p. 81).

During recent years an increasing number of sometimes large seizures have been made of legally manufactured controlled substances that have been diverted into the illicit traffic. Some of these deviations from licit trade have been made possible by means of false import and export authorizations, so that the drugs have passed into the wrong hands. In other instances repeated transactions between drug wholesalers make control difficult and irregular sales may go unnoticed, something that is, of course, especially liable to happen in countries that are not parties to the conventions. The estimates and statistical returns system of the conventions, administered by the International Narcotics Control Board, is an important tool in checking such deviations (see p. 41); the necessary national controls in terms of regulations, licensing and inspections have been described in Chapter 4 (pp. 51–56).

Reduction of Illicit Drug Supply

National efforts to control illicit drug supply

National action against illicit drug traffic involves the judicial system and the police and customs authorities. Most countries of the world have experienced a
rapidly growing illegal traffic during recent years, as witnessed by the reports on seizures and arrests published by the Division of Narcotic Drugs. This trend has also reached the developing countries, nourished by the spread of new forms of heavy misuse of heroin and cocaine in the classical cultivation countries. In other parts of the developing world, abuse of the industrially produced psychoactive drugs is creating a problem, the abusers being supplied from deviations of legal large-scale manufacture in developed countries or from the legal drug distribution system of the country itself. The situation in many developed countries is characterized by increasing abuse of both classical narcotics and new synthetic drugs. The very large sums of money derived from this traffic have turned smuggling into a highly organized and technical area of large-scale crime that also leads to corruption.

These serious developments have forced most countries to expand their police and customs organizations and invest large resources in their equipment and training. Different organizational models are used, with either integrated or independent drug control units. The conventions leave the structure and working conditions of the law enforcement units to be determined by each party; good internal coordination and effective international cooperation in maintaining an effective campaign are what they require.

Bilateral collaboration in the exchange of information, the training of new cadres and the provision of equipment to them has increased in different parts of the world. International cooperation has focused on the same aspects, and especially on information on new trends in the routes and techniques used by illicit drug traffic, and on stimulating regional collaboration in the training of senior law enforcement officers and administrators.

Division of Narcotic Drugs

Some aspects of the work of the Division of Narcotic Drugs have already been discussed (see p. 20). In addition, the Division collects statistical material on the extent, patterns and trends of drug abuse and on seizures from illicit traffic; summaries of this material are produced regularly and analysed in reports to the Commission on Narcotic Drugs. The Commission has also discussed “counter-measures against the illicit traffic”, on the basis of a document containing suggestions from a number of governments as well as observations on, inter alia, exchange of information, reduction of supply, routine application of well-tried law enforcement control techniques, traffickers’ financial assets, and adequate punishment for serious offences.

In other recent useful documents produced by the Division, a number of governments reported on national actions and discussed possible international initiatives as well as a number of measures that might facilitate investigation of financial activities involving illicit drug trafficking and lead to the prosecution of major traffickers. The relationship between “drug trafficking and other
crime" is discussed in two Division documents, which contain recommendations for international action and national enforcement capacity.\textsuperscript{a}

The Division organizes, services, reports and follows up regional and subregional law enforcement training courses and seminars for police officers and administrators. Five to six such seminars have been organized annually in recent years in Asia, Africa and South America. The experience gained from such activities was discussed together with the International Criminal Police Organization (ICPO/Interpol) and the Customs Co-operation Council (CCC), and a number of recommendations were made as to the arrangement and localization of law enforcement training, necessary study materials and future policies.\textsuperscript{b}

The Division provides secretarial services to, and organizes regional and subregional meetings to coordinate national actions against the illicit drug traffic. The Sub-Commission on Illicit Traffic in Drugs and Related Matters in the Near and Middle East brings together regularly delegations from Afghanistan, Islamic Republic of Iran, Pakistan, Sweden and Turkey. Annual meetings involving a number of countries in the Far East take the form of the Meeting of Operational Heads of National Narcotics Law Enforcement Agencies, Far East Region.

The Division is the implementing agency, at the request of the countries concerned, for a number of UNFDAC-funded law enforcement country programmes aimed at supporting the build-up, equipping and training of relevant cadres. In other countries feasibility studies have been undertaken in response to governments’ needs and fellowship programmes have been arranged.

The Division’s Narcotics Laboratory carries out research on drugs of abuse and organizes a fellowship programme for the training of scientists to strengthen analytical laboratories in developing countries.

International governmental law enforcement organizations

The International Criminal Police Organization (ICPO/Interpol) has the following aims, as stated in Article 2 of its Constitution:

(a) to ensure and promote the widest possible mutual assistance between all criminal authorities within the limits of the laws existing in the different countries in the spirit of the Universal Declaration of Human Rights;

(b) to establish and develop all institutions likely to contribute effectively to the prevention and suppression of ordinary crimes.

According to Article 3 of its Constitution, it is strictly forbidden to undertake any intervention or activity of political, military, or religious or racial character.

In the execution of these aims the International Criminal Police Organization is concerned with all criminal police matters, including the police aspects of drug abuse.

\textsuperscript{a} United Nations documents E/CN.7/657 and E/CN.7/657/Add.4.

\textsuperscript{b} United Nations document E/CN.7/660 (Part One)/Add.2.
The Customs Co-operation Council (CCC) is an international organization for promoting collaboration between the customs authorities in a number of countries.

**International Narcotics Control Board**

Some of the functions of the International Narcotics Control Board have already been discussed (see p. 21) but, in addition to administering the estimates and statistical returns system, the Board has a general responsibility to watch over the world drug control situation to help ensure that the provisions of the conventions are fulfilled. It prepares an annual report on its work, with observations on drug trafficking and drug abuse in various regions and countries, as may be appropriate.

If the Board finds that the aims of the conventions are endangered by the failure of a party or country to carry out their provisions, it can start consultations and suggest studies to assess the matter. The government may be asked to propose remedial measures. If the situation is serious, and if cooperative action is needed at the international level, the Board may call this to the attention of the parties, the Commission on Narcotic Drugs and the Economic and Social Council, which may even put the matter before the United Nations General Assembly. This procedure is, of course, very rarely applied, and most of the steps are confidential. However, it opens up the possibility of examining dangerous situations caused by illicit traffic and starting a serious discussion on remedial measures.
ANNEX I

LIST OF PARTIES ADHERING TO THE LATER INTERNATIONAL DRUG CONTROL TREATIES

Single Convention 1961

The following 115 States are parties to this Convention: Afghanistan; Algeria; Argentina; Australia; Austria; Bahamas; Bangladesh; Barbados; Belgium; Benin; Bolivia; Brazil; Bulgaria; Burma; Byelorussian SSR; Canada; Chad; Chile; Colombia; Costa Rica; Cuba; Cyprus; Czechoslovakia; Denmark; Dominican Republic; Ecuador; Egypt; Ethiopia; Fiji; Finland; France; Gabon; German Democratic Republic; Germany, Federal Republic of; Ghana; Greece; Guatemala; Guinea; Haiti; Holy See; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Ivory Coast; Jamaica; Japan; Jordan; Kenya; Kuwait; Lao People’s Democratic Republic; Lebanon; Lesotho; Libyan Arab Jamahiriya; Liechtenstein; Luxembourg; Madagascar; Malawi; Mali; Malaysia; Mauritius; Mexico; Monaco; Morocco; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Republic of Korea; Romania; Rwanda; Saudi Arabia; Senegal; Singapore; Solomon Islands; South Africa; Spain; Sri Lanka; Sudan; Sweden; Switzerland; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Ukrainian SSR; Union of Soviet Socialist Republics; United Kingdom of Great Britain and Northern Ireland; United Republic of Cameroon; United States of America; Upper Volta; Uruguay; Venezuela; Yugoslavia; Zaire; Zambia.

1972 Protocol

The following 72 States have become parties: Argentina; Australia; Austria; Bahamas; Bangladesh; Barbados; Benin; Brazil; Canada; Chile; Colombia; Costa Rica; Cyprus; Denmark; Ecuador; Egypt; Fiji; Finland; France; Germany, Federal Republic of; Guatemala; Haiti; Holy See; Honduras; Iceland; India; Indonesia; Iraq; Ireland; Israel; Italy; Ivory Coast; Japan; 

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* Entry into force: 13 December 1964.

b Entry into force: 8 August 1975.
ANNEX 1

Jordan; Kenya; Kuwait; Lesotho; Libyan Arab Jamahiriya; Luxembourg; Madagascar; Malawi; Malaysia; Mexico; Monaco; Niger; Norway; Panama; Papua New Guinea; Paraguay; Peru. Philippines; Portugal; Republic of Korea; Romania; Senegal; Singapore; South Africa; Spain; Sri Lanka; Sweden; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; United Kingdom of Great Britain and Northern Ireland; United Republic of Cameroon; United States of America; Uruguay; Yugoslavia; Zaire.

1961 Convention as amended by 1972 Protocol*

In addition to the 72 States listed above, the following four States have become parties directly to the 1961 Convention as modified by the 1972 Protocol: Bolivia; Gabon; Nigeria; Rwanda.

Psychotropic Convention 1971**(b**

The following 76 States have become parties: Algeria; Argentina; Australia; Barbados; Benin; Brazil; Bulgaria; Byelorussian SSR; Chile; Colombia; Costa Rica; Cuba; Cyprus; Denmark; Dominican Republic; Ecuador; Egypt; Ethiopia; Finland; France; Gabon; German Democratic Republic; Germany, Federal Republic of; Greece; Grenada; Guatemala; Guyana; Holy See; Hungary; Iceland; India; Iraq; Italy; Jordan; Kuwait; Lesotho; Libyan Arab Jamahiriya; Madagascar; Malawi; Mauritius; Mexico; Monaco; Morocco; Nicaragua; Nigeria; Norway; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Republic of Korea; Rwanda; Saudi Arabia; Senegal; South Africa; Spain; Sweden; Syrian Arab Republic; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Ukrainian SSR; Union of Soviet Socialist Republics; United Republic of Cameroon; United States of America; Uruguay; Venezuela; Yugoslavia; Zaire.

* Entry into force: 8 August 1975. Only those countries are listed which adhered directly to the 1961 Convention as amended.

** Entry into force: 16 August 1976.
ANNEX 2

SOURCES OF FURTHER INFORMATION

A complete bibliography has not been attempted. The WHO documents and publications cited contain numerous further references, relevant to their respective subjects.


A collection of United Nations documents from the General Assembly, the Economic and Social Council and the Commission on Narcotic Drugs, relating to international drug control since 1946, is contained in the looseleaf publication entitled Compilation of resolutions, decisions and recommendations of the United Nations drug control organs (New York, United Nations, 1980 and continued).


An amended list of the narcotic drugs controlled by the Single Convention, 1961, as Amended by the 1972 Protocol, established by the Commission on Narcotic Drugs as of 8 February 1982, has been published by the United Nations (sales No. E.77.XI.3, July 1982). An analogous list for the psychotropic substances controlled by the 1971 Convention has also been published (sales No. E.78.XI.3, July 1982).

SUMMARY

The WHO study

The Thirty-third World Health Assembly, after having reviewed Executive Board resolution EB65.R7 on the abuse of narcotic and psychotropic substances, adopted resolution WHA33.27 on action in respect of international conventions on narcotic and psychotropic substances. After acknowledging WHO's role and responsibilities in relation to the abuse of such substances, the Assembly affirmed that drug abuse constituted a serious health hazard of steadily growing proportions in both developing and industrialized countries. The Assembly invited Member States, as they developed their national strategies for health for all by the year 2000, to give serious consideration to the inclusion of components that could deal effectively with the growing incidence of drug abuse.

Resolution WHA33.27 in its operative paragraph 7(3) requests the Director-General “to promote the initiation and strengthening of national and international programmes for the assessment, scheduling, control and appropriate use of narcotic and psychotropic substances, including those of plant origin, and to support such programmes by the development of appropriate guidelines in consultation with the United Nations Division of Narcotic Drugs, International Narcotics Control Board and other United Nations organs concerned”.

In the light of this resolution, the WHO Division of Mental Health carried out a study to formulate such guidelines for the implementation of the international treaties for the control of narcotic and psychotropic substances. Three working groups of experts from both developing and developed countries held consultations, basing their deliberations on relevant published reports and investigations by WHO, the Division of Narcotic Drugs and other United Nations organizations. Additionally, country reports specially planned to support the study were available from 13 countries, focusing on the development and functioning of national drug policy, drug laws and drug control systems, and the assessment of actual drug use and abuse.

United Nations global strategy and policies for drug control

Appropriate objectives of guidelines in the context of the conventions were further defined by United Nations General Assembly resolution 36/168 of 16
December 1981, entitled International drug abuse control strategy. The international and national actions to be included in drug control strategies for use by governments and international organizations are as follows:

(a) improvement of drug control systems;
(b) achievement of a balance between demand for, and supply of narcotic drugs and psychotropic substances for legitimate purposes;
(c) eradication of the supply of drugs from illicit sources;
(d) reduction of the illicit drug traffic;
(e) reduction of demand for illicit drugs and prevention of inappropriate or illicit use of licit drugs;
(f) treatment, rehabilitation and social reintegration of drug abusers.

The international drug control treaties

The worldwide control of psychoactive substances is based on the international treaties concluded between 1912 and 1972 with the aim of ensuring that the controlled substances are used exclusively for medical and scientific purposes. The operation of the international system is based, in turn, on national control by individual States within the limits of their jurisdiction. To comply with the provisions of the treaties, parties are obliged to adopt appropriate legislation, introduce necessary administrative and enforcement measures and cooperate with the international drug control organs, as well as with other countries.

The earlier treaties were summed up, revised and strengthened by the Single Convention on Narcotic Drugs, 1961, and the 1972 Protocol Amending this Convention. The resulting Convention, as amended, provides for strict controls of cultivation of the opium poppy, the coca bush and the cannabis plant as well as their products. It also regulates the use of a considerable number of opiate-like dependence-producing substances, synthesized by scientific methods and manufactured industrially. The Convention stresses the need for treatment, rehabilitation and social integration measures, and emphasizes prevention, drug information and education activities. As of July 1983, the Single Convention, 1961, as amended by the 1972 Protocol, has been ratified by 76 States.

The Convention on Psychotropic Substances, 1971, extends the international drug control system into new areas of psychoactive substances, such as central nervous system stimulants (e.g., amphetamines), sedative-hypnotics (e.g., barbiturates) and hallucinogens (e.g., LSD and mescaline). The controlled substances are subjected to varying degrees of control in trade, manufacture, distribution and use, depending on the balance between therapeutic usefulness and risk of dependence-production and degree of public health and social problems of abuse. There are special provisions for treatment, rehabilitation and social reintegration of abusers, and for prevention. As of July 1983, the 1971 Convention has been ratified by 76 States.
The United Nations drug control organs

The Economic and Social Council is responsible for formulating United Nations policies, coordinating drug control activities, supervising the implementation of international conventions, and making relevant recommendations to governments. It is assisted by the Commission on Narcotic Drugs, which is one of the Council's six functional commissions, established in 1946 and at present consisting of 40 members representing countries elected by the Council so as to achieve equitable geographical representation and also include States with special experience of problems of illegal drug production and consumption. The Commission advises as to what changes may be required in the existing machinery for international drug control and prepares such draft international conventions as may be necessary. A central function of the Commission is to make decisions on bringing new substances under the control of the conventions, as well as determining the level of control required. In this respect, the Commission can accept or reject WHO's recommendations or in addition, in the case of the Psychotropic Convention, change them.

The treaty functions entrusted to the Secretary-General of the United Nations are handled by the Division of Narcotic Drugs located in Vienna. The Division is a part of the United Nations Secretariat under the direct authority of the Secretary-General. It also acts as secretariat to the Commission. The Division is the central repository in the United Nations system of professional and technical expertise in drug control. The texts of all laws and regulations promulgated by the parties to the conventions in order to give effect to their provisions are reported to the Division, which also advises on the administrative machinery necessary to coordinate and give effect to national drug control efforts, including law enforcement training, and training in laboratory analytical techniques in its narcotics laboratory.

The International Narcotics Control Board, located in Vienna, is an independent United Nations body, established in its present form by the Single Convention, and elected by, and reporting to the Economic and Social Council. A major responsibility of the Board is to endeavour, in cooperation with governments, to limit the cultivation, production, manufacture and utilization of drugs controlled by the conventions to amounts necessary for medical and scientific purposes. To this end, it administers a system of forecasts and statistical returns, assisting governments to achieve a balance between supply and demand, and ensuring that the quantities of these substances necessary for legitimate purposes are available.

International organizations and bodies

The World Health Organization is the competent international health authority, being the specialized agency for directing and coordinating work on all aspects of health care, including prevention and health education. Within this mandate, numerous resolutions have been adopted by the Executive Board,
World Health Assembly and regional committees between 1949 and 1983 that provide policy directives for the initiation and conduct of a wide range of activities in the field of both alcohol and drug dependence. Collaboration between WHO and the parties to the conventions in fulfilling their provisions is important in a number of health activities, including national drug policy, drug laws and regulations, drug evaluation and registration, post-registration surveillance, and prevention, especially through drug demand reduction.

The conventions assign specific responsibilities to WHO in the selection of new substances for control and in placing them under adequate levels of control. It is WHO's responsibility to assess the dependence liability and therapeutic usefulness of each substance and, after evaluating the seriousness of the public health and social problems related to its abuse, to make a recommendation for its control. The process is initiated by a notification to the Secretary-General by WHO or a party. Extensive collaboration between WHO and its Member States is needed in order to collect all the necessary information.

The specialized agencies play a role in assisting parties to fulfil the provisions of the conventions, even though they are not specifically mentioned in them. UNESCO is concerned with the social and cultural aspects of drug abuse and with prevention, especially as regards drug information and education. The International Labour Organisation (ILO) is active in the field of the vocational training and rehabilitation of drug-dependent persons. Several nongovernmental organizations in consultative status with WHO make important contributions in the area of drug abuse control and prevention. The United Nations Fund for Drug Abuse Control (UNFDAC) provides resources for limiting the cultivation and production of narcotic drugs, training administrative and law enforcement personnel, developing programmes for prevention and for treatment and rehabilitation, and research on drugs of abuse and the epidemiology of drug abuse.

A number of regional groupings of countries are actively collaborating in fighting the illicit traffic, and coordinate their efforts for the control of drug abuse. The United Nations drug control organs assist such regional groupings as an important component of their international drug control strategy.

**Responsibilities of parties under the conventions**

In ratifying the conventions, a party agrees to limit the use of the controlled substances exclusively to medical and scientific purposes. Since all these substances are dependence-producing and liable to abuse that may cause both public health and social problems, the aim of the conventions is to assist governments in preventing drug abuse and in reducing its harmful consequences. A government can achieve these purposes through appropriate measures relating to the substances controlled by the conventions and governing production, trade, distribution, illicit traffic and use. A special administration has to be established for the purpose of applying the provisions of the conventions.
The conventions list the controlled substances in a number of schedules associated with different limitations on use, depending on the balance between therapeutic usefulness and the risk of abuse. As of July 1983, the Single Convention listed 104 “drugs” (substances), whereas the Psychotropic Convention controlled 44 substances. Special control measures are provided for opium and the opium poppy, poppy straw, the coca bush and the cannabis plant.

The large majority of controlled substances can be dispensed only if prescribed by a physician. Exemption from this rule is possible under the Psychotropic Convention where the geographical situation or limited manpower resources make it necessary to extend the right to dispense such substances to other categories of health personnel. Preparations containing a low dose of the active substance in a form that is not easily retrievable and has a low risk of abuse can be sold without a prescription and are also exempt from a number of other controls. If a party or WHO finds it necessary to place a new substance under control, a notification is sent to the Secretary-General with all available relevant information. The notification initiates a WHO evaluation procedure, leading to a recommendation for control to the Commission on Narcotic Drugs, which takes the decision.

Policies and regulations related to the conventions

A major objective of a national drug policy is to ensure that good quality, safe and effective psychoactive drugs for which there is a need are available, while limiting their use exclusively to medical and scientific purposes, and preventing their non-medical and illicit use and abuse. Such a policy will have to include measures aimed at reducing the demand for psychoactive drugs, and for curtailing their illicit supply. The manifold causes of drug abuse and the special circumstances of the national drug scene must be taken into account in the setting up of a national action programme that recognizes the broad interactions between substance, individual and society.

Important components of a national action programme are concerned with assessing the extent and forms of drug abuse, prevention through information and education, treatment and rehabilitation measures, reduction of supply of abused drugs through law enforcement actions against illicit manufacture, diversion and traffic, and eradication of illicit cultivation for drug production. Such a programme constitutes a basis for international cooperation. Organizational machinery is needed for programme implementation and coordination, different arrangements having been employed in individual countries, adapted to their constitutional structures.

National control over the general supply of medical products at all stages of registration, manufacture, trade, distribution and use by means of a national drug law is of particular importance. Such a law is the necessary basis for a number of special regulations in the areas mentioned to safeguard the supply and use of the psychoactive substances controlled by the conventions. These
regulations can be inserted in the corresponding parts of a national drug law, but the promulgation of separate complementary legislation is probably the more straightforward and clearer alternative, and has been the one preferred by most parties.

When psychoactive drugs are registered, special attention should be devoted to their liability to produce dependence and abuse. A number of WHO Technical Reports give guidance in this respect. While relevant information will be provided by the manufacturer, it may also be useful to obtain information from other registration authorities that have evaluated the drug. In some regions such detailed evaluations and experiences are already being exchanged, thus maximizing the expertise available in the whole area of drug evaluation. The WHO action programme on essential drugs supports national efforts to reduce the risk of overuse of such drugs by limiting them to those required for meeting basic health needs.

In its simplest form, a national administration for applying the provisions of the conventions may take the form of a department or a division in one of the government ministries, and preferably in the Ministry responsible for Public Health, working in cooperation with the Ministry of the Interior or Home Affairs. A more complex structure would comprise a central drug control agency, responsible for drug registration, the licensing and inspection of manufacture, trade, distribution, drug information, and the drug control laboratory, with advisory and expert technical committee support. The reports required by the conventions would be compiled by this agency.

Post-registration surveillance

The number of psychoactive drugs in licit therapeutic use has increased rapidly during recent decades, and the quantities used in many countries appear to exceed those needed for medical purposes, so that there is a risk of their overuse and abuse. If careful records of their manufacture, trade and distribution are kept, the total quantities used can be seen and irregularities and diversions detected. Such records are also necessary to provide the International Narcotics Control Board with estimates of needs and statistics of use for many of the controlled substances. The trends in total use can be followed by means of national drug supply studies.

A continuous flow of up-dated information about psychoactive drugs to all professionals in the health care system is necessary in order to ensure adequate supply, rational dispensing and proper utilization. Physicians have a key role to play, since they are the last link in the chain of distribution to the consumers; they must safeguard the dispensing of drugs against overuse and abuse. Physicians should therefore receive accurate and unbiased information on new developments from the national drug control agency, as well as through medical and pharmaceutical journals and from their professional associations. Patients- consumers also need appropriate information, and the physician has an obligation to inform the patient of the aim of the therapy, and the effects and
possible adverse side-effects of the drugs he has prescribed, including their liability to produce dependence. Pharmacists are also important advisers to the consumer, especially for over-the-counter drugs. Information material on the drug therapy of the relevant disease condition is also useful. Health education programmes can help the consumer—the general public—to understand the dangers of careless or excessive use of psychoactive drugs.

The Psychotropic Convention states that a party, with due regard to its constitutional provisions, must prohibit the advertisement of the controlled substances to the general public. Although the Single Convention does not contain a corresponding requirement, the pharmacological and medical conditions determining the use of "narcotic drugs" would lead to a similar conclusion. Legal provisions for the control of advertising in accordance with these recommendations should be flexible and provide for the total prohibition of certain types of advertisements to the general public, while permitting them in appropriate form to the health professions. Such prohibition could cover, for instance, the substances controlled by the conventions. Some countries also require all advertisements for the drug therapy of certain diseases and conditions, for instance neurological and psychiatric disorders, to undergo scrutiny before publication.

It is well known that unsuspected adverse drug reactions will occur during the use of a new drug, no matter how extensive the preclinical assessment has been. A reporting system, either voluntary or based on a statutory requirement, is therefore necessary to collect and analyse observations on drug side-effects. The forms used for this purpose should be brief and simple. In the clinical monitoring of psychoactive drugs it is essential that guidelines for reporting should clearly state that drug dependence and drug abuse are adverse reactions to the use of such drugs, and that such effects should be reported. The WHO project on international monitoring of adverse reactions to drugs serves as a vehicle for collecting and analysing reports from national monitoring centres.

**Indicators of drug-related problems**

Health services activities generate data on health problems related to the acute or chronic use of psychoactive drugs. Most such data will not define the actual magnitude of a health problem but will serve, rather, as an indicator that drug misuse is spreading to new population groups, that new drugs are appearing on the drug scene, and that new methods of abuse are establishing themselves. In other words, they provide guidance on trends. Since many of these data are generated in the normal functioning of institutions for health and social work, they can be collected promptly and routinely, and at relatively low cost.

Drug dependence may be diagnosed in mental hospitals, prisons, general practitioners' consulting rooms, emergency departments, etc. Information on cases of dependence can be communicated without identification to the appropriate health authority. The most serious form of morbidity associated
with psychoactive drug use in many countries is drug overdose, the victims including those who take drugs accidentally, deliberately in a suicide attempt, or in the course of drug dependence. The majority of cases are seen in hospital emergency departments. The possibility of drug abuse should be remembered in dealing with victims of traffic accidents, and the necessary investigations carried out. A study of such cases would increase knowledge of the inappropriate use of drugs and changes in trends. If cases of drug psychosis were recorded in psychiatric care units and emergency departments, a more complete picture of the toxic reactions to psychoactive drugs would be obtained. Public health statistics on drug-related disease can yield data indicating the prevalence of different types of drug abuse and trends in such abuse.

Causal relationships between the use of psychoactive substances and social problems cannot be established with great precision, although the association between such problems and chronic drug use is, of course, very evident. There are, however, indications of drug-related behavioural problems. A variety of psychoactive drugs, among them cannabis, impair the learning process and are liable to hinder the acquisition of new knowledge and the development of new skills by adolescents, both at school and in the social environment outside school. Drug taking during work usually reduces efficiency and work quality. Drug abuse and alcohol have long been known to have a disruptive influence on marital relations and parental responsibility. Teachers, social workers, foremen in factories, clergymen, and many others are in a position to provide useful information, even if not of a quantitative nature, in this field. Drug-abuse-related crime is another indicator of the social effects of drug taking.

The assessment of drug dependence and drug abuse in a population calls for the collection and analysis of data on the incidence, prevalence and other characteristics of non-medical and/or illicit drug use. A planned and systematic approach to assessment is necessary because drug use and abuse are complex and changing phenomena. The assessment will have to cover a broad range of epidemiological characteristics, such as age, occupation, substances used, types of use, and the attitudes of various groups of users. General social science methodology can be employed. Studies of informed professional opinion utilize the experience of individuals who, because of their professional, occupational or other social roles, are in a position to provide information regarding the existence and nature of illicit drug use. Such individuals include teachers, policemen, social workers, ministers of religion, etc.; their experience may be sampled, for instance, by simple structured interviews or group discussions.

Central case registers are formal records of defined "cases" maintained by a central agency, covering, for instance, patients with diagnosed drug-related illness or persons involved in drug-associated crime. Selected persons or institutions report cases to the register. Another method is to establish reporting networks of institutions, e.g., hospitals, for reporting specific types of drug-related cases. Such collected case series provide the basis for a continuous epidemiological survey of specific aspects of national drug abuse. Yet another method of assessment is to conduct local or nationwide sample surveys of a specified population. The sample will provide information on various aspects of drug abuse, usually through self-administered questionnaires or interviews.
Treatment and rehabilitation of drug-dependent persons

Treatment of drug abusers is one of the measures against abuse of the controlled substances required by the conventions. A number of stages can be identified in the treatment process, though in practice these overlap with one another. Special efforts must be made to identify abuse at an early stage, so as to bring the person experimenting with, or using a dependence-producing drug to counselling and treatment before serious damage has occurred. Both social and professional contacts should be utilized. Treatment of an abuser may initially involve intervention in a drug abuse crisis of a life-threatening character, such as overdose or abrupt withdrawal syndrome. Emergency service centres, psychiatric hospitals and primary health care centres must be equipped to deliver such care. The dangers of abrupt withdrawal can normally be avoided by short-term medication. Detoxification is the elimination of a drug from the human body, and is the essential first step towards more intensive programmes of treatment and rehabilitation.

Maintenance therapy with narcotic drugs is used for patients who are so drug-dependent that abstinence is an unrealistic objective, at least in the short term. Such therapy allows addicts to divert their attention from the need to obtain illicit drugs to activities aimed at solving personal problems contributing to their drug-dependent behaviour; medical and social assistance is needed for this purpose. Maintenance therapy may thus reduce drug-abuse-related crime. Adequate measures to prevent the diversion of the drug of maintenance into the black market are necessary. Psychotherapy of drug abusers has a place in the whole process of treatment and rehabilitation, since it aims at solving underlying individual and social psychological problems. Institutional care is often necessary for intensive treatment in the initial stages, whereas outpatient care is suitable for the longer process of rehabilitation in the community.

Rehabilitation and social reintegration involve a range of educational, psychological, vocational and social measures aimed at making the drug-dependent person capable of coping with the situations encountered in society. Support for the individual during this process can be provided in many ways. Half-way houses allow a small group of residents to live together and have collective responsibility for maintaining them. A drop-in centre enables clients with few acquaintances in a drug-free milieu to obtain the support of an informal social environment. A suitable foster-family setting may, especially for younger persons, assist in forming social links at an early stage in the rehabilitation process. Various types of vocational training will improve the work habits of clients and give them a better chance of finding employment. Persons undergoing rehabilitation will require the assistance of a job-finding and placement programme.

Manpower training is indicated by both conventions as one of the requirements for efficient action against abuse of controlled substances. Special attention must be given to personnel concerned with the whole area of treatment and rehabilitation. Manpower training for work with drug-dependent persons should be integrated into the national structure for the training of personnel in general health and social work, which will have to be expanded and
complemented where necessary. General instruction on drug dependence and the problems of drug abusers should be incorporated in the basic training of all types of health and social welfare personnel and in their professional and vocational training, in proportion to their probable involvement in drug-related work. Special training should be provided for personnel in the mental health services. The planning of continuing education is of particular importance in order to improve the professional competence of personnel working in programmes for drug-abuse prevention, and for the treatment and rehabilitation of drug-dependent persons.

Prevention and drug demand reduction

“Prevention” of drug abuse is not defined by the conventions. However, curtailing the demand for abused drugs is one way of diminishing abuse. Demand reduction programmes should be flexible responses to actual situations, taking into account the types of drugs misused, the groups of misusers and the wide range of social attitudes to the problem. One component of such programmes is information on the appropriate use of drugs and their dangerous effects. Drug information implies the imparting of factual knowledge in a one-way flow, usually with no opportunity for the receiver to raise questions. The information imparted must be both accurate and believable. “Scare” techniques are seldom effective. The mass media should obviously avoid sensationalism but, with appropriate planning, their campaigns may be effective in helping to stop the spread of abuse.

Drug education denotes an activity that is not just the dissemination of information but allows for two-way communication, with learning and resolution of feelings. A general aim of drug education programmes is to clarify values and translate them into action, and to develop coping skills. Motivation, attitudes and behaviour are influenced. Programmed teaching approaches are based on a set curriculum or at least on structured study material. This approach can be used with individuals or with groups, for instance, of parents or youths, or community groups. Drug education integrated into the school curriculum is an effective method. Health education programmes can incorporate drug education components.

Finally, community measures for demand reduction are important. The most effective instrument for preventing drug abuse by reducing demand is undoubtedly the social control of behaviour, and the community therefore has a major part to play in drug abuse prevention. Community measures with such aims are manifold. The community authorities, in planning and implementing preventive measures, may be given valuable support by an advisory committee made up of members from parents' organizations, youth leaders, the medical and social services, the police and religious groups. Information and education should be utilized, based on an information resource centre. Advice and counselling centres are helpful for young people, while drop-in centres create an informal drug-free environment. Drug-dependent persons may need to be
provided with shelter to draw them into the rehabilitation process, and alternative activities for persons in risk groups should be developed. Since unemployment, particularly among young persons, is a risk factor for drug abuse, job placement, counselling and training are needed.

**Reduction of drug supply and law enforcement**

A reduction in the supply of abused drugs should result in diminished use and abuse. The conventions require the parties “to take measures to fight the illicit traffic of the controlled substances”, which includes cultivation, production and manufacture as well as illicit trade and distribution. Such measures presuppose the existence of law enforcement organizations but the nature of such police and customs authorities is not covered by the conventions.

There is a risk of oversupply of licit drugs because of the rapid increase in the numbers of psychoactive drugs marketed. This can be avoided by means of a realistic national drug policy, whereby drug registration is designed to ensure an adequate and appropriate supply. Post-registration surveillance of the level of drug use and abuse can help detect diversions from licit trade into illegal traffic, and the study of indicators of drug-related public health and social problems can also provide a warning system for new trends in the abuse of licit drugs.

The illicit drug traffic seems to be rapidly increasing, a trend that has also reached the developing countries. Both classical cultivated narcotics and new synthesized manufactured drugs are involved in this highly organized and technical area of large-scale crime. These serious developments have forced most countries to expand their police and customs organizations and invest large resources in their equipment and training. In the United Nations, the Division of Narcotic Drugs is the central repository for professional and technical expertise in drug control. The Division advises governments on legal and administrative matters relating to illicit drug control, and organizes, services, reports on, and follows up regional and sub-regional law enforcement training courses and seminars for police officers and administrators. The international law enforcement organizations concerned are the International Criminal Police Organization (ICPO/Interpol) and the Customs Co-operation Council (CCC).
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Efforts to provide an international legal framework for the control of psychoactive drugs, begun by the International Opium Commission in Shanghai in 1909, have resulted in a number of international treaties. The formulation of the 1961 Single Convention on Narcotic Drugs, with its 1972 amending Protocol, and the 1971 Convention on Psychotropic Substances are the major achievements in the development of coordinated international control of dependence-producing drugs.

The present guidelines have been prepared in an effort to support WHO Member States in promoting the rational use of psychoactive drugs and in directing their administrations to areas where action may be required. The guidelines explain the obligations of parties to the conventions on the control of narcotic drugs and psychotropic substances, and clarify how they should formulate their national drug policies and legislation to conform with the aims and purposes of the international drug conventions. The guidelines also indicate ways and means whereby the parties can seek technical collaboration with WHO and the relevant United Nations bodies when implementing the provisions of the conventions, and constant reference is made to the relevant WHO technical documents and publications.