In most cases addiction begins with a clinical need. In the official returns for addicts, what may be termed "therapeutic addicts" were by far the biggest number in Great Britain—approximately 75 per cent of all cases.

The Dangerous Drugs Act has been a success, because we are a law-abiding population, with a law-respecting medical and pharmaceutical profession, an efficient law enforcement body, and a wise, and prudent team of men in the Home Office. In Great Britain, drug addiction is not a crime—the crime consists in the illegal obtaining of the drug.

The pharmacist is in a special position; he might notice certain types and categories of drugs being prescribed for particular patients where either the amount begins to rise or repetition becomes more frequent. Although certain patients might continue in a mild type of addiction for a long time, there are other factors to be considered such as the danger to others. Any person driving a car when under the influence of an addictive drug is a potential menace to himself and to others, his judgment, his work, and his reactions are all affected.

Although cures for addiction are frequently claimed, so far as dangerous drugs are concerned, relapses frequently occur. An addict can only be considered cured when for 5 years he has been able not only to do without drugs, but also has no desire for them. The patient should have the will to co-operate and a moral regeneration is required.

There appears to be no moral, scientific or professional reason why a given drug should be removed from therapeutics because in some countries it has been misused.

SUMMARY OF

THIRD INTRODUCTORY ADDRESS

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APART from alcohol, morphine and cocaine are the oldest established drugs of addiction, other drugs are the barbiturates, amphetamines, dihydromorphinone, levorphanol, pethidine, methadone and phenadoxone, while more recently, though to a lesser extent, addiction has occurred after taking methylpentynol, carbromal, bromvaletone and paraldehyde.

The craving for morphine may induce criminal behaviour in an attempt to obtain a supply. Heroin has a shorter duration of action than morphine and therefore prescriptions are presented more frequently than those for morphine. When introduced, pethidine was free from control and was hailed as the morphine substitute which did not produce addiction, and many of the present addicts acquired their habit as a result of taking the drug during this period. In the case of methadone,

the interval between its introduction and its inclusion in the Dangerous Drugs Schedule was fortunately much shorter.

Addiction to amphetamine and related drugs has been curbed as a result of legislation, but inhalers which are available without control are sometimes purchased in excessive and frequent quantity by addicts.

When regular requests are made for 2 or 3 bottles of vasoconstrictors at a time or when repeated quantities of chlorodyne are sought, the customer should be persuaded to seek medical advice, while joint action by all the pharmacists in the district in limiting supplies might further this aim.

Ether should never be supplied unless the pharmacist is satisfied that a *bona fide* reason exists for its use. Paraldehyde can become a drug of addiction and bromide intoxication still exists, but the total extent of drug addiction in Great Britain is not large. The pharamcist exercises considerable legal authority under the Pharmacy and Poisons Act, and the Dangerous Drugs Act, and together with the other persons entrusted with the control, manufacture, supply and prescribing of drugs of addiction, he shares a public and moral responsibility.

Discussion

On the invitation of the Chairman, Dr. Cedric Wilson opened the discussion by describing an experiment in which groups of patients in the Merseyside area were given either coloured or white tablets containing dexamphetamine and a barbiturate, or a placebo. Analysis of the patients answers to a questionnaire showed that a significant number were neurotic introverts. Sixty-one per cent stated that the "dummy" tablets were of benefit. The others were pharmacologically dependent on the drug and, on Professor Macdonald's definition, were habituated though he (Dr. Wilson) did not agree with this.

Other points made were:

Attention was drawn to the means adopted to extract drugs from ampoules in hospital practice; minute holes or cracks were induced, the drug extracted and the ampoule either refilled with water or claimed not to be full. It was observed that drugs available in hospital were solely for the treatment of patients in that hospital. Drugs which might lead to addiction were being obtained through laxity of Schedule 4B. Patients receiving amphetamines could be classified in four groups: (*a*) those who could give up the drug when treatment ceased, (*b*) those who had a dependence upon a drug not because it was needed but because it was thought to be needed, (*c*) those who found it necessary to increase the doses for therapeutic reasons, (*d*) those who had a compulsive need for a drug in increasing quantities and who were prepared to go to extreme lengths to get it. The latter group was considered to be very small. Official guidance was sought on the problem of recovery and handling of dangerous drugs from deceased patients and from those who no longer needed them. One procedure which had been found acceptable to some local authorities was the destruction of the drug by the pharmacist in the

presence of the local DDA officer who then issued a certificate stating what had been done. Guidance was also needed on the correct interpretation of the phrase "reasonable steps to ensure a prescription is genuine" and the term "possession" relating to the key of the DDA store. The possibility that barbiturate habituation was the result of a fashion in drug prescribing, coupled with a delay in stopping medication, was suggested. The continued use of cocaine was deprecated.