Understanding British addiction statistics

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In the continuing debate over drug policy, the major alternative to America's heroin prohibition has been the British model of medical control. The British experience is impressive in part because of the quality of statistics issued by the British Home Office and the Department of Health and Social Security (DHSS). Yearly statistics issued by these agencies showed a threatening rise in heroin addiction from 1962 to 1968, provided the basis for a change in law and social policy toward heroin and cocaine, and documented the declining legal prescription of these drugs since 1968.

Publications presenting detailed statistical information about British opiate policy are not easily available. Yet procedures for counting addicts, data on the number of addicts, kinds of opiates prescribed, age of addicts, and number of opiate convictions are relevant toward an understanding of British and perhaps American drug policy. Therefore, this article will present detailed British drug statistics available as of 30 November 1973, [1] to a wide audience of professional readers. It will also describe changes in British opiate use and policy during the past 25 years and illustrate some areas of controversy about this policy.

Before turning to the data, two major caveats are in order. In the first place, interpretation of official statistics is difficult; statistics do not speak for themselves. Although some "official" commentaries are available (Spear, 1969; Glancy, 1972; Cahal, 1973), British statistics are presented by governmental agencies without comment or attempts at interpretation (Oatham, 1974). Various interpretations are possible. When confronted by the same data, Americans supporting the present heroin prohibition (Brill and Larimore, 1960, 1965, 1971; Bissell, 1971; BNDD, 1971; Glazer and Ball, 1971; Josephson, 1973; Lewis, 1973) arrive at very different interpretations than Americans urging changes in opiate policy (Brecher, 1972; Cuskey, Klein and Krasner 1972; King, 1972; Zinberg and Robertson, 1972; Cuskey and Krasner, 1973).

Secondly, American readers have different connotations for the term "addict" than do British readers. In British statistics (U.N. Reports, 1968-1972; British Information Service, 1973; DHSS, 1973; Home Office, 1973), the term "addicts" or "narcotic addicts" includes persons who use heroin *or* methadone, other medical opiates (morphine, pethidine (Demerol), etc.), or cocaine. For Americans, the term "addict" describes regular heroin users only. Those using methadone daily, especially patients in methadone

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[1] The Home Office (1974) Press Release and U.N. Report for 1973 (1974) became available on Nov. 1, 1974, after this article had gone to press; however the 1973 data have been included in the tables presented herein. The trends noted in the text of the article generally continue in 1973. The number of addicts notified during 1973 increased about 80 cases above 1972. The number receiving prescriptions at year end increased by 200 (table 1), mainly because of increased prescribing of methadone-with a slight increase in heroin also. The number of addicts under 20 continues to decline (table 3). With the exception of heroin, convictions for almost all other drugs increased substantially during 1973 (tables 4-7). The particularly large increase in convictions for "other manufactured drugs" (table 6) tends to support the hypothesis of a continuing or increasing demand for opiates.

maintenance programmes, are considered "ex-addicts" (Hughes, 1971, 391; Dole, 1972, 367). While this article will not attempt to determine whether persons stabilized on methadone are "addicts" or "ex-addicts", please note that many British "addicts" might be considered "ex-addicts" in the U.S.; if a stable dose of injectable methadone is considered as roughly equivalent to a stable dose of oral methadone, a majority of British addicts would be "ex-addicts" in American parlance.

Furthermore, the British concept of "addict" includes persons addicted during medical treatment (therapeutic addicts) and physicians addicted to medical opiates (morphine, pethidine, etc.). While such persons are occasionally included in American statistics, drug and law enforcement agencies rarely count therapeutic addicts or prosecute physicians for drug law violations (Winick, 1962; O'Donnell, 1969; Brecher, 1972; Greenwood, 1972; BNDD, 1973). Thus, English statistics are more systematically inclusive than similar American statistics.

For the sake of clarity, this article will adopt the official British definition of addiction presented in the "Misuse of Drugs (Notification of and Supply to Addicts) Regulations 1973:" "a person shall be regarded as being addicted to a drug if, and only if, he has as a result of repeated administration become so dependent upon the drug that he has an overpowering desire for the administration of it to be continued." This definition is the same as the first official definition of addiction presented in the 1926 Rolleston Report (Interdepartmental Committee on Drug Addiction, 1926).

This article will use "heroin addict" to describe a person who repeatedly uses heroin (British approved name: diamorphine). A "methadone addict" will refer to the person who repeatedly uses methadone. The terms "addict" or "opiate addict" will refer to a person repeatedly administering heroin *or* methadone. The few regular users of other opiates (morphine, pethidine (Demerol)), smoking or eating raw opium) or cocaine will be referred to as "narcotic addicts." The American reader should note that most British "addicts" are not "heroin addicts" (table 1).

The following British data document (*a*) how addiction statistics are collected; (*b*) a striking rise, although small by American standards, in the use of heroin between 1960 and 1968; (*c*) an even swifter reduction in the number of heroin addicts since 1968; (*d*) a relatively stable number of new opiate addicts despite (*e*) a continuing, and possibly increasing, demand for heroin, opiates, and other drugs.

Collection of statistical data

Almost all American observers (Brill and Larimore, 1960, 1965, 1971; Glazer and Ball, 1971; Brecher, 1972; Josephson, 1973; Judson, 1973; Lewis, 1973) agree that the annual statistics issued by the British Home Office (1973) are of high quality and include a larger proportion of actual addicts than most American statistics. These Home Office statistics have historically been based upon two different collection techniques. Prior to the "Notification of Addicts" regulations (cited below) in 1968, the Home Office made periodic inspections of pharmacy records. During and after 1968, the statistics were mainly derived from data generated by the special drug treatment centres.

1. *Prior to 1968*

Since the early 1950s, what Cahal (1970), a Medical Officer of DHSS, calls "a persistent myth" has existed—that a person may become a "registered drug addict". This myth has been used by some addicts to coax physicians into providing them with opiates; these addicts have also demanded an approved or higher dosage and insisted that they have the "right" to obtain heroin. From the medical profession's and the

public's point of view, being a "registered drug addict" has implicitly legitimized the addict's demand for opiates because he was receiving "treatment" by a doctor (Glazer and Ball, 1971, 1178) and possibly inflated the number of addicts reported to the Home Office.

In actual fact, the Home Office has never registered drug addicts; rather, addicts have been "known" or "reported" to the Home Office. A legal prescription is a privilege, not a right; doctors can refuse to prescribe to reported addicts. To a limited extent, the "registered addict" myth still persists because the Home Office has not publicly explained how its statistics are collected. Detailed explanations of data collection are usually provided by police (Jones, 1968) or American observers (Larimore and Brill, 1960; Judson, 1973; Johnson, 1975).

Before 1968, an addict could become "known" or "reported" to the Home Office from two basic sources. (1) A few voluntary reports were submitted by prison doctors and general practitioners when they detected addicts or began prescribing for them. (2) The main information came from biennial inspections of pharmacy registers by local police, or, in large cities, by special narcotics squads. The police were instructed to watch for regular supplies of opiates; such information was turned over to regional medical officers of the DHSS who investigated further and determined whether a person was addicted (Larimore and Brill, 1960; Jones, 1968). However, during the period 1963-1968, no more than six doctors provided large prescriptions of heroin and morphine to some addicts. Many of these addicts sold "surplus" heroin at £1 ($ 2.40) per 60 mgs, to others, both addicts and non-addicts (Second Brain Report, 1965; May, 1972; Judson. 1973). Those who became addicted to such diverted heroin would not be recorded in pharmacy registers and thus would not generally be included in Home Office statistics (de Alarcon and Rathod, 1968).

2. *Notification of Addicts*

In response to growing heroin use and the Second Brain Report (1965), the Dangerous Drugs Act of 1967 was passed. To implement this law, the Home Office sent all medical practitioners the following "Notification of Addicts" Regulations which took effect on 22 February 1968:

> "They require any doctor to notify in writing the Chief Medical Officer of the Home Office, within seven days of his attendance upon a patient, the name, address, sex, date of birth, National Health Service number, date of attendance and name of the drug(s) concerned if he considers or has reasonable grounds to suspect, that the person has as a result of repeated administration ... become so dependent upon the drug that he has an overpowering desire for the administration to be continued." (Cahal, 1970, 35.)

In other words, physicians are required to notify the Home Office of persons whom they suspect of addiction. To ensure safety from legal penalties, some physicians report persons who are not addicted (U.N. Report, 1968; Connell, 1971; Lewis, 1973), thus inflating the statistics somewhat.

The "supply to addicts" regulations took effect on April 16, 1968; they prohibited general medical practitioners from providing heroin or cocaine to addicts for maintenance purposes (Cahal, 1970; Judson, 1973; Woodcock, 1973) unless the physicians obtained a special licence. The Home Office has generally given these licenses to doctors working in special Drug Treatment Centres (DTCs) or in special clinics or hospitals concerned with addiction (Cahal, 1970). General practitioners still have the right to prescribe maintenance doses of methadone, morphine, and pethidine to addicts; but most practitioners refer persons addicted to these drugs to the DTCs.

Since 1968, the DHSS has urged regional hospital boards to establish outpatient treatment centres; there are 16 DTCs in London, which treat almost 80 per cent of Britain's non-medical opiate addicts (DHSS, 1973; Blumberg, 1974). This has caused a major shift in methods of collecting addiction statistics. Those applying for admission to these clinics are examined by experienced psychiatrists for needle marks; the doctors also test for the presence of heroin and methadone in several urine samples (Connell, 1971; Blumberg, 1974). In addition, general practitioners, prison doctors, and the clinics phone the Home Office to determine whether an applicant is already known; he may be trying to obtain duplicate prescriptions or trick the doctor into providing additional drugs or dosages. If the person is proven addicted and admitted to treatment, he will visit the clinic at least every second week for further consultation, treatment, or change in dosage. Although there is some diversity in dispensing drugs, the psychiatrist usually mails an addict's biweekly prescription to a pharmacy in his neighbourhood; the pharmacist dispenses the indicated dosage to the addict on a daily basis, except on weekends when a two-day supply is provided (Connell, 1971; Judson, 1973; Johnson, 1974; 1975).

Although police still inspect pharmacy registers, few cases now come to light this way. Instead, the formal notification procedures and Home Office statistical routines (see Johnson, 1975) provide the basis for statistics on addiction since 1968-69.

Unfortunately, the annual data issued as a press release, "U.K. Statistics of Drug Addiction" (table 1), is very misleading because it confounds two reasonably different ways of counting addicts. In table 1, the heading "As at Dec. 31" refers to the number of addicts *receiving prescriptions*, valid on Dec. 31, for the indicated narcotic drugs (see footnote 1, table 1). Briefly, the Home Office, on a bimonthly basis, sends out a form to each DTC listing the names from the previous report of all addicts receiving prescriptions. For each addict, the DTC psychiatrist reports what drug(s) has been prescribed at the end of the period. In addition, he removes the names of those who have left the DTC and adds the names of new or recidivating patients. However, the heading "Year Total" (table 1) indicates the drug(s) a person is "last known to be taking" (Oatham, 1974) and includes: (1) those receiving prescriptions on Dec. 31; (2) those having received prescriptions at some time during the year but not on Dec. 31; and (3) those "notified" to the Home Office but never receiving a prescription. "Notification" is probably best defined as the *reported use* of particular drugs. There are three major sources of official notification: DTC psychiatrists, prison physicians, and general practitioners. When any of these sources is confronted by a person who wishes to receive a legal opiate prescription, who claims to be using an opiate, who shows evidence of recent needle marks and/or provides a urine test which is opiate positive, the physician will phone the Home Office and submit the required written notification (see Notification of Addicts regulation above). However, in many cases the patient either will not return to the clinic or will be denied a prescription by the doctor (Connell, 1971; Judson, 1973; U.N. Reports, 1968-1972; Blumberg, 1974; Johnson, 1975). Nevertheless, such a notified, but not-prescribed-to person will be included as addict in the "Year Total" according to the drug(s) which the notifying physician reported him to be using.

Thus, the shift to formal notification and bimonthly reporting of DTC prescriptions has probably improved the quality, reliability, validity, and detail (Johnson, 1975) of British addiction statistics. These statistics, which have greatly impressed American visitors (Glazer and Ball, 1971; Brill and Larimore, 1971; Lewis, 1973; Judson, 1973; Josephson, 1973), are mainly based upon the efficient functioning and reporting of DTCs, which these same visitors ignore or feel have few implications for America (*British Medical Journal*, 1971). Further, all British statistics depend upon reports of

physicians and not upon the voluntary, and frequently suspect, reports of police statistical divisions as in U.S. federal statistics (BNDD, 1973).

British addiction statistics apparently include most of the long-term, daily users of heroin and methadone since few addicts first come to attention by opiate overdose death or by arrest. In 1969-70, there were 98 narcotic related deaths; only four were of users unknown to the Home Office (Lewis, 1973, 545). A similar comparison shows that about one out of two deaths by overdose occurs among persons unknown to New York City's Narcotic Register (Baden, 1970). It should be noted that there may be an unknown number of reasonably regular (fixing opiates on daily basis for a two-week period) users who are unknown to the Home Office (Blumberg, 1974), although it is difficult to ascertain whether they are addicted.

A mini-heroin epidemic

Table 1 shows statistics on addiction released by the Home Office for 1958 to 1972. These data illustrate how a minor problem developed into a mini-epidemic of heroin use but was apparently contained and decreased by the establishment of treatment centres and notification of addicts. The year 1960 probably represents the pattern of British opiate addiction tracing back to the Rolleston report of 1926. There were few addicts, 437, with less than a quarter using heroin; three-quarters were of therapeutic origin and generally addicted to morphine and/or pethidine (Demerol). More than half were female and a few were from the medical professions.

In the following years, there was *no* increase or decrease in addicts from the medical profession or of therapeutic origin. Nor was there a significant change in the number addicted to morphine or pethidine. Further, there was only a negligible increase in the number of addicts aged 35 and older.

As table 1 clearly shows, the mini-epidemic began in the early 1960s. In 1962, the first signs of increasing narcotic addiction occurred; from 532 in 1962 to 927 in 1965 and 1,729 in 1967. This increase was due to the non-therapeutic use of heroin, which rose from 175 to 1,299 between 1962 and 1967. Cocaine use also increased, but not as rapidly as heroin.

In 1962, heroin use was mainly confined to those aged 20-34. But thereafter, addiction to heroin among those under 20 increased rapidly. In 1962, less than 2 per cent of all heroin addicts were young; by 1965, it was 25 per cent, and in 1967 about 30 per cent. Furthermore, the male-female ratio changed from 1:1 in 1962 to 3:1 in 1967. Thus, the data provide striking documentation of a mini-epidemic of heroin use between 1962 and 1967. Although the numbers of addicts are small by American standards, the rise was sufficient to alarm the English public and cause a change in British heroin policy (Zinberg and Robertson, 1972; Josephson, 1973; Judson, 1973).

Declining heroin addiction

In the spring of 1968, the Notification of Addicts and the Supply to Addicts regulations came into effect. In March and April of 1968, most non-therapeutic addicts were transferred to drug treatment centres from private prescribing physicians. These two regulations and the transfer to DTCs had the effect of identifying many previously unknown addicts in the 1968 statistics; the number of heroin users increased by about 1,000 between 1967 and 1968 (U.N. Report, 1968, 9). But since 1968, the number of opiate addicts known to the Home Office has remained relatively stable, between 2,600 and 3,000.

TABLE 1

United Kingdom statistics of drug addiction

Drug addicts	*1958*	*1959*	*1960*	*1961*	*1962*	*1963*	*1964*	*1965*	*1966*	*1967*
TOTAL NUMBER	442	454	437	470	532	635	753	927	1,349	1,729
DRUGS [a]										
No. taking heroin	62	68	94	132	175	237	342	521	899	1,299
No. taking methadone	12	60	68	59	54	55	61	72	156	243
No. taking cocaine	25	30	52	84	112	171	211	311	443	462
No. taking morphine	205	204	177	168	157	172	162	160	178	158
No. taking pethidine [b]	117	116	98	105	112	107	128	102	131	112
ORIGIN										
No. of therapeutic origin	349	344	309	293	312	355	368	344	351	313
No. of non-therapeutic origin	68	98	122	159	212	270	372	580	982	1,385
No. of unknown origin	25	12	6	18	8	10	13	3	16	31
AGES										
Under 20	—	—	1	2	3	17	40	145	329	395
Under 20 taking heroin [c]	—	—	1	2	3	17	40	134	317	381
20-34	—	50	62	94	132	184	257	347	558	906
20-34 taking heroin [c]	—	35	52	87	126	162	219	319	479	827
35-49	—	92	91	95	107	128	138	134	162	142
35-49 taking heroin [c]	—	7	14	19	24	38	61	52	83	66
50 and over	—	278	267	272	274	298	311	291	286	279
50 and over taking heroin [c]	—	26	27	24	22	20	22	16	20	24
Age unknown	—	34	16	7	16	8	7	10	14	7
Age unknown taking heroin [c]	—	—	—	—	—	—	—	—	—	1
SEX										
No. of male addicts	197	196	195	223	262	339	409	558	886	1,262
No. of female addicts	245	258	242	247	270	296	344	369	463	467
PROFESSIONAL CLASSES (Medical or Allied)										
Total number	74	68	63	61	57	56	58	45	54	56

	Year Total						*As at 31 December*				
Drug addicts	*1968*	*1969*	*1970*	*1971*	*1972*	*1973*	*1969*	*1970*	*1971*	*1972*	*1973*
TOTAL NUMBER	2,782	2,881	2,661	2,769	2,944	3,025	1,466	1,430	1,555	1,619	1,818
DRUGS [a]											
No. taking heroin	2,240	1,417	914	959	868	866	499	437	385	339	380
No. taking methadone	486	1,687	1,820	1,927	2,171	2,247	1,011	992	1,160	1,280	1,440
No. taking cocaine	564	311	193	178	178	194	81	57	58	46	51
No. taking morphine	198	345	346	346	292	268	111	105	103	90	84
No. taking pethidine [b]	120	128	122	135	98	81	83	80	73	59	50
ORIGIN											
No. of therapeutic origin	306	289	295	265	244	207	247	231	218	180	174
No. of non-therapeutic origin	2,420	2,533	2,321	2,457	2,659	2,631	1,196	1,177	1,313	1,413	1,505
No. of unknown origin	56	59	45	47	41	187	23	22	24	26	139
AGES											
Under 20	764	637	405	338	279	253	224	142	110	96	84
Under 20 taking heroin [c]	709	598	365	304	260	226	221	136	111	95	83
20-34	1,530	1,789	1,813	2,010	2,262	2,368	897	959	1,123	1,221	1,415
20-34 taking heroin [c]	1,390	1,709	1,705	1,912	2,178	2,262	872	921	1,088	1,195	1,375
35-49	146	174	158	156	178	185	116	112	112	120	137
35-49 taking heroin [c]	78	101	95	94	126	129	69	69	73	87	95
50 and over	260	241	253	226	204	214	204	195	179	165	181
50 and over taking heroin [c]	20	46	50	47	42	49	40	39	35	36	42
Age unknown	82	40	32	39	21	5	25	22	23	17	1
Age unknown taking heroin [c]	43	26	18	19	7	3	13	10	9	5	1
SEX											
No. of male addicts	2,161	2,295	2,071	2,134	2,272	2,345	1,067	1,053	1,135	1,197	1,371
No. of female addicts	621	586	590	635	672	680	399	377	420	422	447
PROFESSIONAL CLASSES (Medical or Allied)											
Total number	43	43	38	44	33	29	26	26	22	23	15

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64	1965	1966	1967
3	927	1,349	1,729
2	521	899	1,299
1	72	156	243
1	311	443	462
2	160	178	158
8	102	131	112
8	344	351	313
2	580	982	1,385
3	3	16	31
3	14	329	395
0	13	317	381
7	347	558	906
9	319	479	827
8	134	162	142
1	5	83	66
1	29	286	279
2	16	20	24
7	10	14	7
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	558	886	1,262
4	369	463	467
3	45	54	56

at 31 December			
0	1971	1972	1973
0	1,555	1,619	1,818
7	385	339	380
2	1,160	1,280	1,440
7	58	46	51
5	103	90	84
9	73	59	50
1	216	180	174
7	1,313	1,413	1,505
2	24	26	139
2	110	96	84
5	111	95	83
1	1,123	1,221	1,415
	1,088	1,195	1,375
	112	120	137
	73	87	95
	179	165	181
	35	36	42
	23	17	1
9	9	5	1
	1,135	1,197	1,371
	420	422	447
	22	23	15

The most important facts in table 1 concern the number of heroin users in Britain since 1968. There has been a *decline* in the numbers of notified heroin users; 2,240, 1,417, 914, 959, and 868 between 1968 and 1972. But the decline in heroin use is even more striking when one examines data at the end of each year. The statistics in table 1 do not provide information about the number of persons receiving heroin at the end of 1968. However, a government report, *The Rehabilitation of Drug Addicts* (Advisory Committee, 1968, 25), shows that 950 persons were receiving heroin prescriptions on 31 May 1968 (the end of the first full month in which clinics began treating all heroin addicts). Thus, although 2,240 heroin users were notified to the Home Office attention in 1968, the number of persons receiving heroin prescriptions in any one month probably did not exceed 1,000. This figure had been cut almost in half (to 499) at the end of 1969, with continuous but lesser decreases on 31 December 1970, 1971, and 1972.

Of course, most heroin addicts have not been "cured"; they have been switched to methadone as the result of intentional substitution by most prescribing doctors in the clinics (Glatt, 1972; Judson, 1973; table 1, footnote). As in the United States, the use of methadone is a relatively recent phenomenon. Through 1965, less than 100 addicts were using methadone (called physeptone in Britain); only about 500 addicts were using the drug during 1968. (There is a discrepancy, see Johnson, 1975.) It was in late 1968 and 1969 that the clinic doctors began to substitute methadone for heroin. The number of persons reported to be taking methadone increased from 486 in 1968 to almost 1,700 in 1969 and to almost 2,200 in 1972. Methadone was actively being prescribed to 1,000 persons on 31 December 1969, and to about 1,300 persons on 31 December 1972.

Clinic attendance patterns

Table 2 provides detailed data about the number of outpatients receiving prescriptions in the DTCs. Since 1968, the number of patients receiving treatment remained relatively constant, between 1,100 and 1,200, from September 1968 to December 1970. The numbers were cut back by nearly 100 in 1971, but increased to over 1,400 by the end of 1973. Whether this cutback and the apparent increase in addicts is significant or represents a change in prescribing has yet to be determined (Johnson, 1975).

New addicts

Table 2 also reports information about the number of "new" addicts. A "new" addict may be operationally defined as a written notification on a person not previously notified to the Home Office. Thus a person is a new opiate addict if an inspector of pharmacy records reports a new name, or if a general practitioner, prison physician, or treatment clinic submits a written notification (Connell, 1971; Bransby, 1971). The term "first notification" is usually employed by the Home Office to describe new addicts. The apparent disparity between columns B and C for 1968 is due to the fact that

(Footnotes to table 1)

NOTE. — The statistical data from 1969 is presented differently from the preceding years. Previously these statistics had been based on the total number of addicts coming to the notice of the Home Office during the course of the year. New recording procedures have made it possible to give details of these addicts known to have been receiving supplies of drugs at the end of the year as well as the total number of cases coming to notice during the year.

[a] These figures refer to drugs used alone or in combination with other drugs. Thus an addict using both heroin and cocaine will be included under both drugs, and it must be pointed out that all but a handful of the cocaine addicts shown are also using heroin.

[b] U.S. proprietary name—Demerol.

[c] From 1969 this figure is for addicts to *heroin and/or methadone*. The reason for this is that as a result of a deliberate policy adopted by hospital clinics in the treatment of heroin addiction by weaning patients from heroin on to methadone, methadone has supplanted heroin as the drug most commonly used by addicts.

TABLE 2

A = Number of out-patients attending drug treatment centres/ hospitals in England and Wales at the end of each period.
B = Number of in- and out-patients notified for the first time [a] by hospitals and private clinics in England and Wales.
C = Total number of first notifications in Britain (England, Wales, Scotland, and Northern Ireland) during each year. [b]

Bi-monthly Year period	A Out-patients attending DTCs at end of each period			B Patients first notified by clinics during period			C Yearly number of first notifications in Britain
	London	Elsewhere	Total	London	Elsewhere	Total	
1961							129
1962							159
1963							209
1964							246
1965							332
1966							633
1967							664
1968							
Jan.-Feb.	325	83	408	287	56	343	
Mar.-Apr.	687	111	798	533	87	620	
May-June	799	224	1,023	310	97	407	
July-Aug.	868	204	1,072	182	65	247	
Sept.-Oct.	896	234	1,130	157	72	229	
Nov.-Dec.	921	218	1,139	103	50	153	
Total	DNA	DNA	DNA	1572	427	1,999	1,476
1969							
Jan.-Feb.	894	236	1,130	111	54	165	
Mar.-Apr.	927	232	1,159	102	45	147	
May-June	936	234	1,170	95	53	148	
July-Aug.	924	212	1,136	77	30	107	
Sept. Oct.	922	257	1,179	88	51	139	
Nov.-Dec.	903	243	1,146	64	29	93	
Total	DNA	DNA	DNA	537	262	799	1,030
1970							
Jan.-Feb.	909	248	1,157	68	21	89	
Mar.-Apr.	947	227	1,174	61	24	85	
May-June	966	170	1,136	45	21	66	
July-Aug.	992	168	1,160	64	29	93	
Sept.-Oct.	985	178	1,163	55	34	89	
Nov.-Dec.	956	177	1,133	44	24	68	
Total	DNA	DNA	DNA	337	153	490	711
1971							
Jan.-Mar.	835	185	1,020	73	39	112	
Apr.-June	817	181	998	75	36	111	
July-Aug.	831	201	1,032	62	37	99	
Sept.-Oct.	828	214	1,042	72	26	98	
Nov.-Dec.	839	248	1,087	64	28	92	
Total	DNA	DNA	DNA	346	166	512	777
1972							
Jan.-Feb.	894	277	1,171	66	36	102	
Mar.-Apr.	972	295	1,267	50	30	80	
May-June	967	298	1,265	59	30	89	
July-Aug.	948	292	1,240	58	19	77	
Sept.-Oct.	969	308	1,277	56	30	86	
Nov.-Dec.	970	323	1,293	42	37	79	
Total	DNA	DNA	DNA	331	182	513	801
1973							
Jan.-Feb.	997	332	1,329	n.a.	n.a.	89	
Mar.-Apr.	1,010	332	1,342	n.a.	n.a.	80	
May-June	1,027	332	1,359	n.a.	n.a.	119	
July-Aug.	1,050	346	1,396	n.a.	n.a.	103	
Sept.-Oct.	1,079	330	1,409	n.a.	n.a.	114	
Nov.-Dec.	1,106	336	1,442	n.a.	n.a.	88	
Total	DNA	DNA	DNA			593	807

approximately a quarter or more of the 1,999 patients first entering the newly formed DTCs were previously known to the Home Office.

However, after 1968, as the DTCs settled into a normal routine, the mandatory check with the Home Office has apparently meant that most "patients" first notified by clinics are new addicts although the precise proportion is not indicated. An addict's ability to conceal his identity and receive duplicate prescriptions (Reeves, 1974), might reduce the number of actual new addict somewhat, but would probably not substantially affect change from year to year. Columns B and C of table 2 indicate that the clinics provide the first notification for over 60 per cent of all addicts; only 200 to 300 of the first notifications come from private or prison doctors, or inspectors of pharmacy records. The number of new outpatients has declined from over 160 in the first two months of 1969 to about 80 bi-monthly in 1972.

Youthful addicts

TABLE 3

Ages of "under 20" addicts known to Home Office
(Home Office, 1974)

	14	15	16	17	18	19	Total
1960	—	—	—	—	—	1	1
1961	—	—	—	—	1	1	2
1962	—	—	1	—	—	2	3
1963	—	—	2	2	2	11	17
1964	1	—	1	8	11	19	40
1965	—	8	5	19	42	71	145
1966	1	17	26	68	111	106	329
1967	—	3	38	82	100	172	395
1968	—	10	40	141	274	299	764
1969 Total	—	—	24	83	218	312	637
1970 Total	—	1	9	49	117	229	405
1971 Total	—	—	10	45	114	169	338
1972 Total	1	1	7	27	85	158	279
1973 Total	—	—	7	39	78	129	253
12/31/69	—	—	6	33	73	112	224
12/31/70	—	1	1	18	30	92	142
12/31/71	—	—	2	13	34	69	118
12/31/72	—	—	3	13	24	56	96
12/31/73	—	—	2	9	24	49	84

A major concern of both British and American observers is opiate addiction among adolescents. The Home Office (1973) reports detailed statistics on known addicts under the age of 20 (reproduced in table 3). The data show striking increases in the number of youthful addicts from three in 1962 to 395 in 1967, including an all-time high of

(Footnotes to table 2)

Sources: (DHSS, 1973; Derbyshire, 1974; U.N. Reports, 1968-73; British Information Services, 1973).

NOTE. — DNA = Does Not Apply; n.a. = not available.

[a] Addicts first notified by DTC, hospital or private clinic; they may have been previously notified from other sources.

[b] Column C apparently includes data which are not included in Column B from Scotland and Northern Ireland as well as notifications from general practitioners, prison physicians and inspectors of pharmacy records.

764 when the Notification of Addict regulations went into effect in 1968. Since that time, however, there has been a steady decline to 279 (1972) in the number of youthful addicts known to the Home Office; only a small proportion, about one-third, of notified youthful addicts were receiving opiate prescriptions at the end of the year. Home Office (1973) data not presented here show only 3 persons "under 20" receiving heroin prescriptions on 31 December 1972.

Drug convictions and continued demand for opiates

The British Criminal Justice System has three unique aspects. First, when a person is arrested on a drug charge, both the police and a magistrate (lower court judge) may fix bail. A suspect may be released in his own recognizance or be granted "police bail" (generally less than £50) at the station house if police trust him to appear before a magistrate at a later date. The police decision to grant bail is usually made on the defendant's stability of residence and/or job, the minor nature of his offence (e.g., drug possession), and the probability that the case will be settled in a court of "summary" jurisdiction. Schofield (1971) alleges that the police occasionally pressure the defendant to admit his guilt before granting police bail and/or opposing bail before a magistrate. As in the American system, magistrates have the right to set bail and do so in most cases. Nevertheless, some drug arrestees are held in jail because they cannot make bail. Thus, arrestees for minor possession cases may spend up to a month in jail while chemical tests on the seized drugs are performed (Schofield, 1971); although these cases are swiftly handled afterwards in a magistrate's court.

At the time of initial appearance before a magistrate, the police or prosecutor generally indicate whether they plan to seek an indictment against the defendant. An indictment means that the police consider the case to be a serious offence, carrying a maximum sentence of more than one year in prison, and that the case will probably be tried in a Crown Court (higher) by jury. However, even if the police indicate a willingness to seek a summary conviction, the defendant may elect to have a trial by jury.

The second unique feature of British law is the summary conviction. The Dangerous Drug Act of 1965 provides two different penalties *for the same offence*. Thus, a person arrested for unlawfully supplying (selling) heroin, (1) if tried and convicted in a cour of summary jurisdiction (usually a Magistrate'Court), could be imprisoned for up to 12 months and/or fined £250 ($625), but (2) if convicted at a jury trial after indictment could be sentenced to up to 10 years and/or fined £1000. Maximum penalties were raised in the Misuse of Drugs Act of 1971, which went into effect in July 1973: summary —£400 and/or 12 months; indictment—unlimited fine and/or 14 years. The apparent function of having two different penalties for the same offence is to keep most cases out of higher courts (Home Office, 1974). Since there is probably some reluctance by the Crown Court to accept all cases presented by police, many moderately serious cases are probably tried in the Magistrate's Court. Thus, most drug cases are resolved in the Magistrate's Court.

When the police are not seeking an indictment and the defendant does not insist upon a trial by jury, a summary conviction may occur in two ways. (1) If the defendant appears before a magistrate and admits his guilt, he is then found guilty by the court and sentenced. (2) If the defendant initially pleads not guilty, a later date for trial is set. On that date, a trial is held before the magistrate, who makes a finding of guilt or innocence; if the verdict is guilty, a variety of sentences may be imposed.

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Misuse of Drugs

The third feature of British justice is the low potential and actual sentences imposed in British courts by comparison with American courts. There are no mandatory minimums and the maximum prison sentences are considerably less severe than prescribed by American federal laws and, especially, the recent Rockefeller drug law of 1972 in New York State. Even in "big" cases the maximum sentence in Britain (10 years) is seldom imposed (U.N. Reports, 1968-1972; tables 6 and 7): a seizure of nearly 7 kgs of heroin from Hong Kong in 1972 apparently resulted in a sentence of 4 years (U.N. Report, 1972) for unlawful importation. Further, the low potential sentences of the summary conviction and sentencing policy of magistrates apparently makes plea and sentence bargaining (reduction or substitution of charges in exchange for a lesser sentence) relatively uncommon, speeds up court processing, minimizes defendant-inspired delays,

TABLE 4

Offences involving drugs controlled under the Dangerous Drug Act — 1965

(Home Office, 1974)

	Cannabis	*Opium*	*Manufactured Drugs*	*Drugs (Prevention of Misuse) Act 1964*
1945	4	206	20	
1946	11	65	27	
1947	46	76	65	
1948	51	78	48	
1949	61	52	56	
1950	86	41	42	
1951	132	64	47	
1952	98	62	48	
1953	88	47	44	
1954	144	28	47	
1955	115	17	37	
1956	103	12	37	
1957	51	9	30	
1958	99	8	41	
1959	185	18	26	
1960	235	15	28	
1961	288	15	61	
1962	588	16	71	
1963	663	20	63	
1964	544	14	101	
1965	626	13	128	958 [a]
1966	1,119	36	242	1,216
1967	2,393	58	573	2,486
1968	3,071	73	1,099	2,957
1969	4,683	53	1,359	3,762
1970	7,520	66	1,214	3,885
1971	9,219	55	1,570	5,516
1972	12,611	98	2,068	5,284
1973	14,119	244 [b]	8,497 [c]	

NOTE. — From 1945 to 1953 inclusive the figures relate to prosecutions. From 1954 onwards the figures relate to convictions.

[a] This figure is in respect of the period 31 October 1964 to 31 December 1965.

[b] Includes Medicinal Opium.

[c] Includes offences under the Dangerous Drug Act 1965, the Drugs (Prevention of Misuse) Act 1964 and the Misuse of Drugs Act 1971 which came into force on 1 July 1973 and which repealed the 1965 and 1964 Acts.

etc. Unpublished statistics seen at the Home Office (1974) showed that there were 11,625 persons prosecuted under the Dangerous Drug Act of 1965 during 1972; of these, 864 were not convicted; 6,595 were fined only; 692 were imprisoned (and perhaps fined); and the rest received varying sentences (conditional discharge, probation, borstal—for a young offender, suspended sentences, etc.).

Thus, the fact that 11-12 per cent of all prosecutions end in no conviction (U.N. Reports, 1968-1972), that most cases are settled in a Magistrate's Court in a fairly rapid manner, and that defendants are usually convicted of the offence they are charged with probably means that the following conviction statistics provide a reasonably accurate indicator of contact between lawbreakers and police. Also, they may be the best reflection of trends in illicit drug use given the absence of representative drug surveys in England.

Previous tables have indicated a decrease in the legal prescription of heroin and increase in methadone. The following conviction statistics suggest there is probably an increasing use of and demand for cannabis (also see *Journal*, July 1973; Glatt, 1973), as well as a continuing or perhaps increasing demand for heroin and other opiates.

Table 4 shows a striking increase since 1960 in the number of cannabis convictions, possibly indicating a very strong demand for cannabis. There has been no increase in the number of convictions for "opium" (raw or smoking), but there was a significant increase in convictions for offences of laws regulating manufactured drugs (morphine, cocaine, heroin, methadone, and other synthetic opiates). There have also been sizable increases in offences of the Drugs (Prevention of Misuse) Act 1964 regulating LSD, some other hallucinogens, and amphetamines, with a slight decline in 1972.

TABLE 5

Numbers of persons [a] found guilty of an offence involving drugs or groups of drugs
(Home Office, 1974)

Drug	*1970*	*1971*	*1972*	*1973*
Raw opium	25	19	28	186 [b]
Prepared opium	32	33	60	
Heroin	226	500	532	460
Cannabis (including cultivation of plant) (Marihuana)	802	1,922	2,619	11,246
Cannabis resin (Hashish)	5,880	6,290	6,697	
Cocaine	112	107	179	194
Other drugs controlled under the Dangerous Drugs Act, 1965 (Methadone, Morphine, etc.)	577	594	709	[c]
Lysergide (LSD 25)	744	1,537	1,306	1,273
Other drugs controlled under the Drugs (Prevention of Misuse) Act 1964 (Mainly Amphetamines) (Other Controlled Drugs [c])	2,181	2,810	2,480	3,286 [c]

[a] A number of persons were found guilty of one or more offences involving different types of drug. Such persons will appear in the table under each type of drug.

[b] Includes medicinal opium.

[c] Combined under the Misuse of Drugs Act, 1971.

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60	186 [b]
32	460
19	
97	11,246
79	194
09	[c]
06	1,273
80	3,286 [c]

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Table 5 provides more detailed information about specific drug convictions. The number of persons guilty of "one or more" offences related to heroin increased from 226 to 532 between 1970 and 1972. Increases for other drugs are noted, particularly cannabis, cocaine, "other drugs" (morphine, methadone, and other synthetic opiates). Although large absolute increases are involved, the relative change in number of persons convicted for violations involving hashish (cannabis resin), LSD, and amphetamines is small or shows slight decreases in 1972.

Specific offences

Tables 6 and 7 contain very detailed data abstracted from reports to the United Nations which have been obtained from the Home Office. A few definitions seem indicated. Arrests for "possession" may occur when a suspect has: (1) a controlled, or illicit, drug on his person or nearby; (2) a prescribed drug but no proof that the drug was legally prescribed to him (i.e., a clinic doctor or general practitioner denies prescribing that particular drug to the suspect); or (3) a urine test which is positive for opiates or cocaine (Home Office, 1974). Prior to 1973, there were no laws regulating legally prescribed opiates; thus, no charges could be pressed if the police discovered a clinic patient holding a month's supply of legally prescribed heroin and presumably intended for illicit sale. However, the 1971 Misuse of Drugs Act—which went into effect on 1 July 1973—includes a new offence, possession with intent to supply unlawfully to another, which provides some controls over legally prescribed opiates. Unlawful "supply" occurs when the suspect is observed giving or selling drugs to others, including legally prescribed drugs. An occasional unlicensed doctor who prescribes cocaine or heroin may be prosecuted for unlawful supply (Home Office, 1974). Unlawful "import" occurs when someone smuggles in supplies of a controlled drug from a foreign country. "Theft" occurs when a suspect steals controlled drugs from a chemist's shop (pharmacy) or from a person legally supplied by a DTC. The "theft" entry in the table also includes "fraud" such as altering a legal prescription. "Procuring" is such a vague offence that it has been dropped under the Misuse of Drugs Act of 1971, but apparently included trying to trick a druggist or legally prescribed addict to provide a drug which the suspect is not authorized to have, as well as doctors who obtain a prescription for a patient but use it themselves. Arrests for unlawful "premises" occur when the occupier or person concerned in the management of any premises knowingly allows certain activities, including the smoking of cannabis or opium, to take place on the premises. (N.B. These "smoking" offences are the only ones which specifically involve the actual consumption of a controlled drug.) "Other offences" are mainly the contravention of regulations governing the manufacture, distribution, and retail prescription of controlled drugs.

Understanding data in table 6 is difficult because of unclear trends. There was a decline in heroin-related convictions between 1968 and 1970, and an increase from 1970 to 1972. Convictions for cocaine and manufactured drugs remained relatively constant between 1969 and 1971 but showed sizable increases in 1972. For each narcotic, the increase in 1972 was due, in large part, to convictions for theft, although possession of cocaine and manufactured drugs increased also.

There seem to be three possible interpretations of these data. First, police may have been somewhat lax in enforcing narcotic laws from 1969 through 1971, but for some unknown reason began serious enforcement in 1972. Second, the clinics may be ineffective in containing heroin and other opiates; addicts are resorting to the illegal market to obtain their drugs with more arrests and convictions resulting. Third, the clinics are relatively effective in switching many addicts from heroin to methadone or in refusing to provide heroin or injectable methadone to new or recidivating addicts (Johnson, 1975). Since many addicts really want heroin, they sell methadone for heroin

TABLE 6

Number of convictions for offences involving opiates and cocaine under Dangerous Drug Act, 1965 (1968-1972) and Misuse of Drugs Act, 1971 (1973) as well as penalties and amount seized in illicit trade

(U.N. Reports 1969-1974)

		Number of Convictions for :								
	Year	Unlawful possession	Unlawful premises	Unlawful supply	Unlawful import	Theft	Procuring	Others	Total	Amount seized in illicit trade (gm)
Total : all opiates and Cocaine	1968	705	4	65	3	241	61	93	1,172	6,952
	1969	752	1	11	6	417	53	72	1,412	14,708
	1970	609	1	66	6	486	46	66	1,280	10,700
	1971	906	2	117	7	409	85	99	1,625	9,281
	1972	1,250	2	80	2	682	55	95	2,166	20,940
	1973	1,754 [c]	1	130	40	1,017	34	276	3,252	18,257
Heroin	1968	391	[b]	40	0	33	36	38	539	435
	1969	200	[b]	36	1	77	26	1	341	561
	1970	157	[b]	20	1	93	9	1	281	1,600
	1971	439	[b]	54	0	71	15	1	580	1,140
	1972	471	[b]	33	1	134	20	6	665	13,100
	1973	427 [c]	[b]	61	7	92	6	35	628	3,265
Cocaine	1968	56	[b]	3	0	40	1	11	111	417
	1969	50	[b]	1	0	85	3	1	140	147
	1970	59	[b]	2	0	99	2	0	162	200
	1971	48	[b]	6	1	70	1	0	126	266
	1972	99	[b]	3	0	143	0	0	245	590
	1973	165 [c]	[b]	8	4	88	1	27	293	6438
Other Manfactured Drugs	1968	197	[b]	19	0	168	24	41	449	<100
(Morphine,	1969	455	[b]	73	3	255	24	68	878	2,000+
Methadone,	1970	346	[b]	38	0	294	35	58	771	400
Pethedine, etc.)	1971	379	[b]	55	1	268	69	92	864	15
	1972	593	[b]	44	0	405	35	81	1,158	1,350
	1973	1,028 [c]	[b]	55	11	765	27	201	2,087	3,098
Opium (Raw or Prepared)	1968	61	4	2	3	[a]	[a]	3	73	6,000
	1969	47	1	1	2	[a]	[a]	2	53	12,000
	1970	47	1	6	5	[a]	[a]	7	66	8,500
	1971	40	2	2	5	[a]	[a]	6	55	7,200
	1972	87	2	0	1	[a]	[a]	8	98	5,900
	1973 [d]	134 [c]	1	6	18	72	[a]	13	244	5,500
Range of Fines (£s)	1968	1-100	200	10-100	5-50	10-100	5-100	5-100	1-200	
	1969	1-200	0	1-30	5-100	5-100	5-450	3-50	1-450	
	1970	5-250	0	5-150	100	5-175	5-50	2-50	2-250	
	1971	5-200	50	25-50	5-100	5-100	1-50	5-100	1-200	
	1972	1-200	10-50	1-75	0	3-120	1 30	3-50	1 200	
	1973	Not available in U.N. Report (1974)								
Prison Sentences	1968	1m-6y	0	3m-30m	1y	3m-2y	6m-15m	6m-30m	1m-6y	
(Range) d = days,	1969	1d-7y	0	3m-3y	0	1m-4y	6m-18m	3m-7y	1d-7y	
w = week,	1970	1m-4y	9m	3m-3y	0	3m-5y	1m-3y	1m-py	1m-5y	
m = month,	1971	1w-7y	0	3m-5y	1y	1w-5y	3m-2y	2m-18m	1w-7y	
y = year)	1972	2w-5y	0	6m-8y	4y	2w-5y	3m-2y	3m-6y	2w-8y	
	1973	Not Available in U.N. Report (1974) - Maximum: 10 years for heroin supply								

[a] Not an offence for opium under the Dangerous Drug Act, 1965 but is an offence under Misuse of Drugs Act 1971.
[b] Not an offence for manufactured drugs under the Dangerous Drug Act, 1965.
[c] Includes convictions for possession with intent to supply unlawfully (Misuse of Drugs Act, 1971).
[d] Includes medicinal opium ; source : Derbyshire (1974).

or money to buy heroin; thus they are more exposed to arrest. Underlying the second and third interpretations is an assumption of a continuing, and perhaps increasing, demand for heroin and opiates.

The correct interpretation, if there is one, is undoubtedly much more complex. The rising number of narcotic thefts (table 6) indicates that those receiving legal prescriptions are being robbed by those without scripts. However, the sharp rise in

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penalties and amount

Others	Total	Amount seized in illicit trade (gm)
93	1,172	6,952
72	1,412	14,708
66	1,280	10,700
99	1,625	9,281
95	2,166	20,940
276	3,252	18,257
38	539	435
1	1	561
1	81	1,600
1	580	1,140
6	665	13,100
35	628	3,265
11	1	417
1	40	147
0	162	200
0	126	266
0	245	590
27	293	6438
41	449	<100
68	878	2,000+
58	771	400
92	864	15
81	1,158	1,350
201	2,087	3,098
3	73	6,000
2	53	12,000
7	66	8,500
6	55	7,200
8	98	5,900
13	244	5,500
-100	1-200	
-50	1-450	
-50	2-250	
-100	1-200	
-50	1-200	

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heroin possession convictions between 1970 and 1971 may indicate increasing police attempts to control heroin from the Far East region (Wolman, 1972; Judson, 1973; Johnson, 1975). The increase in possession of manufactured drugs between 1971 and 1972 may indicate increasing diversion of methadone ampoules (DHSS, 1973; Johnson, 1975). Nevertheless, it seems reasonable to conclude that the DTCs are containing the supply of legal heroin. It is less clear, however, that illegal supplies are being contained, since the amount seized in 1972 (13.1 kg) is almost as much as was legally prescribed (DHSS, 1973; Josephson, 1973; Blumberg, 1974; Johnson, 1975). Thus, given that conviction statistics indicate a continuing or increasing demand for heroin, the general policy of DTCs of reducing the number of persons receiving heroin may have the negative effect of supporting a growing illegal market (Judson, 1973; Josephson, 1973).

Table 7 is much easier to analyse. Cannabis convictions are on the increase, and probably indicate an increasing demand for the substance. A contrary interpretation, that the convictions reflect increased police concern about cannabis, is somewhat dubious. Public concern, and hence political pressure, upon police to control cannabis users seems much less extensive than in the period 1968-70 (Schofield, 1971; Zinberg and Robertson, 1972).

The bottom of tables 6 and 7 indicate the minimum and maximum fines and prison sentences handed out for specific offences in different years. Probably the most striking feature is that the maximum fines imposed for cannabis offences are usually larger than those for the same offences regulating narcotics and that the legal maximum fine (£1000) is almost never imposed for narcotic offences. Furthermore, maximum prison sentences imposed are generally less than the legal maximum (10 years) and roughly equivalent for narcotics and cannabis for the same offence.

Summary

The statistical data issued by the Home Office and Department of Health and Social Security are quite detailed and generally valid measures of hard core addiction in Great Britain (Judson, 1973). Since 1968, the main basis of these high quality British statistics is the routine reports filed by Drug Treatment Centres. The well-trained, experienced staff of these clinics make knowledgeable decisions about a client's addiction, efficiently regulate dosage, and otherwise exert some degree of control over addicts (Judson, 1973; Johnson, 1974). The co-operation of police, courts, prison physicians, and general practitioners is also valuable in collecting data on drug addiction and convictions.

Information presented in the tables above indicates that a rising problem of heroin addiction between 1962 and 1967 was arrested by the introduction of the treatment clinics in 1968. Further, legally maintained heroin addiction has been reduced by almost one-third since 1968, since many heroin addicts have been transferred to injectable methadone. The decline in heroin prescribing and the relatively steady number of narcotics addicts has apparently occurred in the face of a continuing, and perhaps increasing, demand for heroin and other opiates.

With few exceptions of a minor nature analysis of various tables suggests that the official statistics are internally consistent. There are apparently few "hidden" addicts, since few unknown addicts die of overdoses or are arrested by police (Lewis, 1973), although Blumberg (1974) indicates that some unknown users may exist. In addition, many opiate users not officially notified are known by clinic doctors as friends of addicts receiving prescriptions (Judson, 1973; Home Office, 1974). In brief, official British drug statistics seem to be generally valid and demonstrate that heroin and perhaps methadone addiction has been well contained by the treatment clinics.

TABLE 7

Number of convictions for offences involving Cannabis (Marihuana and Hashish) under Dangerous Drugs Act, 1965 (1968-1972) and Misuse of Drugs Act, 1971 (1973) as well as penalities and amounts seized in illicit trade

(U.N. Reports, 1968-1970)

	Year	Number of Convictions for : Possession	Premises	Supply	Import	Cultivation	Others	Total	Amount seized in kilograms
Cannabis.....	1968	2,663	193	87	77	6	45	3,071	1,125
	1969	4,094	225	147	122	5	90	4,683	544
	1970	6,545	340	319	171	43	102	7,520	1,178
	1971	7,837	474	394	224	99	191	9,219	3,068
	1972	10,986	570	453	243	246	113	12,611	5,921
	1973	11,911[a]	586	661	478	387 [b]	96 [c]	14,119	9,265
Range of Cannabis Fines: (£s).....	1968	2-500	5-350	5-200	5-100	10-25	3-100	2-500	
	1969	1-250	2-150	2-200	1-350	10-75	3-100	1-350	
	1970	1-1,000	5-150	3-250	4-200	3-200	5-100	1-1,000	
	1971	1-3,000	5-500	5-200	8-4,000	5-100	2-250	1-4,000	
	1972	1-500	1-200	3-200	3-1,000	2-200	5-100	1-1,000	
	1973	Not available in U.N. Report (1974): Maximum - £750 for Import.							
Prison Sentences, Cannabis (Range) .. (d = day, m = month w = week y = year)	1968	1m-5y	6m-7y	3m-5y	9m-7y	0	3m-3y	1m-7y	
	1969	1d-5y	3m-6y	4m-3y	9m-7y	0	1m-10y	1d-10y	
	1970	1d-7y	3m-5y	1m-6y	6m-7y	0	1m-30m	1d-7y	
	1971	1w-7y	1m-5y	3m-5y	3m-7y	3m-1y	1d-7y	1d-7y	
	1972	1d-6y	1m-3y	1d-7y	3m-6y	1m-3y	1m-5y	1d-7y	
	1973	Not Available in U.N. Report (1974)							

[a] See footnote *c* of table 6.
[b] Source: Derbyshire (1974).
[c] Includes 53 convictions for procuring and 7 for theft or fraud under Misuse of Drugs Act 1971.

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								3m-1y	1-3y
							9m-7y	6m-7y	3m-6y
						4m-3y	1m-6y	3m-7y	3m-6y
						3m-6y	3m-5y	3m-5y	1d-5y
						1m-5y	1m-5y	1m-5y	1d-7y
						1m-3y	1w-?	1d-	1d-
1969	1970	1971	1972	1973	Not Available in U.N. Report (1974)				

(d = day, m = month, w = week, y = year)

[a] See footnote c of table 6.
[b] Source: Derbyshire (1974).
[c] Includes 53 convictions for procuring and 7 for theft or fraud under Misuse of Drugs Act 1971.

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