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The Roles and Problems of the Narcotics Addict Reporting System

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Abstract

Article 58 of the Narcotics and Psychotropics Control Law states that medical doctors must promptly report the private information of patients to the prefectural government when they are diagnosed as a narcotics addict.

In this paper, the author outlined the history and details of the narcotics addict reporting system, and further examined its roles and problems. In this examination, the author found that this system may limit the patient's access to medical treatment and abuse their human rights. However, it enables effective intervention in areas where conventional mental health systems cannot reach such as "environmental clean-up".

Based on the above problems, the author recommends that medical doctors carefully diagnose narcotics addicts. Additionally, the author recommends that this system be revised to a new system consistent with the principles of psychiatric care and community mental health welfare in Japan.

Keywords: narcotics, Narcotics and Psychotropics Control Law, narcotics addicts, forcible hospitalization, drug dependence

Introduction.

The murder of a disabled person in Sagamihara, Kanagawa Prefecture, in July 2016, raised an important issue regarding the intervention of psychiatry in drug problems. This is because, although marijuana was detected in the urine of the assailant who was arrested after the incident, a simple test also confirmed the presence of marijuana in the urine of the assailant when he was admitted to a hospital five months before the crime.

In the beginning, some people criticized that even though the use of marijuana was not punishable under the Marijuana Control Law, there was the potential for the perpetrator to be reported as a narcotic addict under the Narcotics and Psychotropic Substances Control Law (hereinafter referred to as the Marijuana Control Law). Later, a committee established within the Ministry of Health, Labour and Welfare (MHLW) decided that the assailant's marijuana use was not at the level of a narcotic addict, and that it was appropriate for the medical institution to which the patient was admitted not to report the incident. However, this author felt dismayed that the narcotic addict reporting system attracted attention in this way. This is because this system contains a problem that may shake the very foundation of drug addiction treatment.

The narcotic addict reporting system is not intended to prosecute patients for criminal acts, but rather to promote medical care. However, it should be noted that this does not guarantee that patients under treatment will not be subject to investigation. In this sense, if the narcotic addict reporting system becomes widely known to the public, it may well inhibit access to medical care for people with drug problems and prevent patients from being honest in clinical situations.

Furthermore, even if there is a legitimate reason, the physician has no discretion over the report. If it is a police report, there is enough room for the doctor's discretion due to the confidentiality obligation stipulated in the Penal Code. However, this is not the case with the notification of drug addicts. It is compulsory for doctors to report such cases, and there are penalties if they fail to do so while diagnosing patients.

How should psychiatrists, especially those who specialize in the treatment of drug addiction, deal with this narcotic addict reporting system? Based on this awareness of the problem, we conducted a study entitled "Research on Standardization and Collaboration of Specialized Medical Care for Substance Abuse and Dependence in Psychiatric

Emergencies and Acute Care" (Principal Investigator: Naoya Sugiyama) as part of the "Policy Research on Quality Improvement of Psychiatric Emergency and Acute Care" (Research Project for Comprehensive Research on Policies for Persons with Disabilities) funded by the MHLW from 2009 to 2008. In this study, we summarized the significance and issues of the reporting system for narcotic addicts and examined the points to be noted in its current operation.

Here, we would like to report a summary of the results.

I. The history of drug control in Japan

1. What is the “narcotics”?

The Narcotics Control Law prohibits the possession, export/import, manufacture, preparation, transfer/acceptance, application, and use of narcotics by anyone other than drug suppliers licensed by the MHLW (drug manufacturers, preparers, and distributors) and drug users licensed by prefectural governors (users for research and medical treatment).

It is important to note that the “narcotics” is not a medical concept, but a legal concept. In other words, narcotics can only be legally defined as "drugs as defined in Article 2, Section 1 of the Narcotics Control Act", without any medical basis. Drugs classified as narcotics include opium alkaloids, such as heroin and morphine, cocaine, chemical compounds such as LSD and MDMA (ecstasy), and even magic mushrooms. There is no commonality between their chemical structures or pharmacological actions, and they exist as a kind of "Galapagos" concept.

Historically, the “narcotics" can be traced back to the International Opium Convention, the world's first international treaty on drug control, signed in 1912. The treaty initially applied the term "narcotic" to opium, morphine, cocaine, and their derivatives, but was later expanded to include marijuana and marijuana preparations at the urging of the United States. This definition was taken over by the Single Convention on Narcotic Drugs (1961) after World War II, and has become the international definition of narcotics today. Therefore, the international term "narcotic drugs" refers to the three types of narcotics designated in the Single Convention on Narcotic Drugs: opiates, cocaine, and marijuana.

In this sense, Japan’s “narcotics” are different from the international concept of narcotics. First and foremost, cannabis is not included. This is due to the fact that Japan has traditionally had a hemp fiber industry, which led to the decision to separate cannabis-based drugs from narcotics and regulate them under a separate law called the Cannabis Control Law. The law also

includes chemical compounds such as LSD and MDMA, which are classified as "psychotropic drugs" rather than "narcotics" by international standards. The result is a unique concept of narcotics that has a Galapagos-like aspect to it, as mentioned above.

2. Strengthen anti-drug measures and their success

In the early 1960s, heroin abuse became a transient social problem in Japan. It is said that this was due to the fact that, after the enactment of the Methamphetamine Control Law, it became difficult to obtain methamphetamine due to stricter regulations, and therefore heroin became available on the streets as a substitute drug. In particular, the area around Hinode-cho, Yokohama City, attracted heroin users from all over the country and became a public safety problem.

In the midst of this situation, a situation known as the "Yokohama-Hinode-cho Incident" occurred in July 1962. In a bizarre scene, many people were found lying on the street in a coma. This was caused by a temporary interruption in the supply of heroin due to stricter regulations and weather conditions, and heroin addicts, exhausted by the pain of withdrawal, took large amounts of sleeping pills to drown their pain.

In response to this situation, the government not only tightened the control of narcotics, but also judged that medical measures for those who fell into drug addiction were necessary. As a result, the Ministerial Council for Narcotics Control and the Headquarters for Promotion of Narcotics Control were established in 1962. In the following year, 1963, the Narcotics Control Law was extensively revised, and it was decided to establish distinct diagnosis and hospitalization measures, a system of counselors for narcotic addicts, and specialized medical facilities for narcotic addicts. This was the origin of the reporting system for narcotic addicts, the subject of this paper. This system covered both supply reduction (tightening of regulations) and demand reduction (treatment of addiction), and was an internationally advanced approach, at least at the time.

Ironically, by the time the nine specialized medical facilities for narcotic addicts were established, the problem of drug abuse in Japan was practically over. This was due to the success of the tightening of drug regulations. This experience was an important success story for the government, which has since been the basis for Japan's supply-reduction-oriented drug policy.

II. Notification and aftercare of narcotic

addicts

Before discussing the significance and issues of the reporting system for narcotic addicts, I would like to review the contents of this system.

1. Definition of notifiable narcotics and narcotic addicts

Article 58-2 of the Narcotics Control Act states that When a physician diagnoses a person as a narcotic addict as a result of a medical examination, the physician shall promptly notify the prefectural governor of the person's place of residence, as well as the person's name, address, age, sex, and other matters specified by an Ordinance of the MHLW.

Note that narcotics here include heroin, morphine, cocaine, LSD, MDMA, etc., which are regulated under the Narcotics Control Act, as well as opium, marijuana, etc., which are regulated under other laws.

The concept of "narcotic addict" in the Narcotics Control Law is defined as a state of mental and/or physical dependence on narcotic drugs, in which a person develops mental and physical cravings for narcotic drugs and finds it difficult to control these cravings by themself. It does not necessarily require the presence of subjective or overt withdrawal symptoms (MHLW, Notification of the Director-General of the Pharmaceutical Affairs Bureau, 1966).

2. Notification/Reporting - Contacting prefectural pharmaceutical affairs division

When a doctor diagnoses a patient as a narcotic addict, he or she must first contact the pharmaceutical department or public health center of the prefecture by telephone. Then, the prefectural governor is notified (Article 58-2 of the Narcotics Control Law), and the prefectural government registers the patient in a registry of narcotic addicts. At the same time, the prefectural government also reports the case to the MHLW through the Drug Control Division of the Regional Health and Welfare Bureau. In principle, the contents of this report are not shared with the police.

3. Environmental investigation by narcotics officers

Then, a narcotics officer (a judicial police officer with arresting authority), who is a member of the prefectural government's drug division, goes to the hospital where the patient is attending or being hospitalized, meets the patient, and conducts an environmental survey. The purpose of this environmental survey is to determine the necessity of a medical examination by a designated mental health physician (Article 58-6). Narcotics officers have authority as

judicial police officers belonging to the local government, but the environmental survey is not an interrogation. Rather, this survey is an evaluation of the need for medical care and protection and the patient's willingness to undergo treatment, as well as an "environmental cleanup" to identify the source of drugs and to keep the patient away from drugs by investigating and exposing traffickers.

4. Examination of narcotic addicts (Article 58-6) and hospitalization measures (Article 58-8)

If the prefectural governor deems it necessary as a result of the environmental investigation, a consultation by a designated mental health physician will be conducted (Article 58-6, 7). If, as a result of the medical examination, the prefectural governor recognizes that the patient is a narcotic addict and that there is a significant risk of repeated use of narcotics, marijuana, or opium due to his/her narcotic addiction if the patient is not hospitalized in light of his/her symptoms, behavior, and environment, the patient may be placed in a hospital designated by the MHLW (medical facility for narcotic addicts). In this case, the designated mental health physician shall determine the period of hospitalization necessary for treatment during an initial 30-day hospitalization period, with a limit of three months (Article 58-8). If, during the course of treatment, it becomes necessary to extend the period of hospitalization, the patient may apply to the Narcotics Poisoning Review Board of the local government for an extension of up to two months each time, provided that the total period of hospitalization does not exceed six months (Article 58-9).

If the patient is already undergoing inpatient treatment under the Mental Health and Welfare Law, or if the patient is determined to be sufficiently motivated for treatment and can be treated on an outpatient basis from the standpoint of their residential environment and psychiatric symptoms, the aftercare described below will be implemented immediately.

5. Aftercare by narcotic addict counselors (Article 58-18)

During the post-discharge period, narcotic addict counselors provide regular observation and guidance. Narcotic addict counselors are part-time local government employees who do not have the authority to make arrests (non-judicial police officers) and who are obliged to maintain confidentiality (in fact, many of them work concurrently with probation officers). When a person reuses drugs, they provide assistance and guidance of medical treatment.

This observation and guidance will

continue until the listing in the registry is removed.

6. Release of observation and guidance

If the addict achieves cleanliness (drug-free life) for five years or more in the aftercare by the narcotic addict advisor, and is recognized as rehabilitated, the Drug Affairs Division will apply to the MHLW for termination of the care. If the decision to terminate the program is made as a result of the examination, the person's name will be removed from the local government's register of narcotic addicts.

III. Problems with the narcotic addict reporting system

The narcotic addict reporting system established in 1963 was, as already mentioned, a system containing advanced elements by the standards of the time. In addition, there were some interventions, such as environmental cleanup, that promoted the recovery of narcotic addicts, which were difficult to implement under the mental health welfare scheme, and this can be evaluated as a positive aspect of this system.

However, since it has not been reviewed or revised for a long time, it has become an unrealistic system in light of today's standards for addiction treatment and recovery support.

The problems with this system can be summarized in the following four points.

1. Vagueness of the definition

The definition of narcotic addicts mentioned in the previous section is very vague. It is possible to broadly assume that the condition is similar to "dependence (syndrome)" in the WHO ICD-10 classification of mental disorders, but the divergence from the medical terminology has reached a level that cannot be overlooked.

The first and foremost problem is the Japanese term "chudoku" for meaning addiction. The Japanese term "chudoku" is used today only for acute intoxication, not for "a state of mental or physical craving for narcotics that is difficult to control". The term "mental and/or physical dependence" is also not used in medical terminology. It is not clear whether this expression means "psychological and physical dependence", "psychological dependence or physical dependence", or a clinical concept different from either of these.

2. Inhibiting access to treatment

Unlike a police report, the notification under this system does not involve the patient as the target of an investigation. However, it is true that the process does involve a judicial police officer, a narcotics control officer, and the patient is placed under his or her surveillance.

During the course of treatment for narcotics addiction, the reuse of drugs occurs commonly, and it cannot be denied that the risk of arrest at the time of reuse may be higher than usual due to this surveillance. In this sense, it is a different story from that of notifying the prefectural government of a person who has contracted some kind of infectious disease.

In this sense, it seems that medical institutions are unwillingly forced to function as "branch offices or sub-branches of investigative agencies" under this system. It is not surprising that this system restricts access to medical care for those suffering from drug problems and alienates them from treatment and recovery support.

3. Possibility of excessive human rights violations

Once a person's name is listed in the local government's narcotic addict registry, it is not easy to have it removed.

According to interviews with prefectural health administrators, the reality is that many people listed in the registry are removed upon their death. The reason for this is that it is unlikely that a person will be removed simply because he or she has been clean for five years or more, but rather because the person must be in regular employment and have a stable social life. This means that those who have no choice but to accept non-regular employment due to economic stagnation or lack of occupational skills, or those who have to live on welfare due to physical or mental disabilities, cannot expect to be removed from the register and may be placed under observation and guidance for the rest of their lives.

The period of observation and guidance under this system is significantly longer than that of criminal punishment such as probation or treatment under the Medical Observation Law for the Insane, and may constitute a serious violation of human rights. Given that drug addiction is also a mental disorder listed in the Mental Health and Welfare Law, there should be no discrepancy in human rights protections afforded to this condition.

4. Divergence from the actual situation of drug abuse

This system initially envisioned drug addiction as an addiction to heroin, which lacks the pharmacological effects to induce psychosis, but has extremely strong physical dependence. For example, methamphetamine users can be hospitalized by the Mental Health and Welfare Law as a measure of psychiatric treatment, when there is a risk of self-harm or other harm based on induced psychotic disorder.

On the other hand, it is difficult to introduce opioid users, such as heroin

addicts, into treatment. In Japan, where opioid substitution therapy such as methadone or buprenorphine is not available, physical isolation from the drug by involuntary hospitalization is required to withdraw from the addictive drug. In this sense, hospitalization was necessary for the heroin scandal of the early 1960s.

However, today, most patients with drug-related disorders in psychiatric institutions in Japan are treated with stimulants, which are not covered by the Act, and with the exception of marijuana, there are very few patients with disorders related to drugs covered by the Act 5). When patients with drug-related disorders are admitted to the hospital for treatment, the Mental Health and Welfare Law, which uses the risk of self-harm or other harm based on psychotic symptoms as an indicator, should be sufficient. In fact, since 1990, the number of patients who have been hospitalized under the Act has been about 0 to 2 every year, and since 2008, the number has been 0 to date 1) (Fig. 1). In this sense, it could be said that, at least in Japan today, the significance of hospitalization under the Law is extremely limited.

IV. How should we deal with the narcotic addict reporting system?

1. "Dead " system

Looking at the problems of this system listed in the previous section, especially the problem of human rights violations, some people may wonder why such a system with so many problems still exists. Perhaps the reason why these problems have not been discussed is that this system is not well known to the medical profession and is rarely used, as evidenced by the number of hospitalizations under the Narcotics and Psychotropics Control Law.

Recently, the authors conducted an annual survey on drug-related psychiatric disorders in psychiatric facilities nationwide, which covers approximately 1,600 psychiatric facilities with beds. Among 2,609 cases of drug-related psychiatric disorders treated as outpatients or inpatients at psychiatric facilities with beds in Japan in September and October 2018, we examined the number of patients who were known by their physicians to have been reported as narcotic addicts.

The results showed that 6 cases (0.2%) were reported as narcotic addicts. We also estimated the number of potential narcotic addicts among the total of 2,609 cases, including 69 cases of dependence syndromes of narcotics and marijuana, and suggest that only 8.7% of the potential addicts were reported. These results suggest that psychiatrists may not be aware of this system in actual psychiatric practice, or even if they are aware of it, they may be very reluctant

to implement it.

Then, how are psychiatrists who specialize in the treatment of narcotic addiction utilizing this system? The author has conducted a questionnaire survey on the operation of the Narcotics Anonymous Notification System among psychiatrists who specialize in the treatment of narcotic addiction in an MHLW study 3) conducted between 2005-2006. As a result, we found that all of them were familiar with the system, and that a few said that they actively report patients from a therapeutic standpoint when mental dependence becomes apparent and the diagnosis of addiction is confirmed, but that the majority of them said that they report patients who abuse highly addictive drugs, such as heroin, and treat them by hospitalization. However, the majority of the respondents were reluctant or extremely cautious about reporting, saying, "For patients abusing highly addictive drugs such as heroin, we will report them and treat them, but for patients abusing marijuana or MDMA, we will first treat them and then make a decision on a case-by-case basis", or "We will not report them at all because they do not fit the actual situation and the criteria are not clear".

What we can infer from the above is as follows. Many general psychiatrists do not know much about this system, and those who do are reluctant to report patients. Considering these circumstances, we must say that this system is practically a "dead" system in today's narcotic addiction measures. In the very near future, it will be necessary to make major changes to the system to bring it in line with today's standards of psychiatric care and community mental health welfare.

2. Operational considerations in the current situation

Although future amendments may be necessary, for the time being, the current system has to be used. As such, it should be noted that the diagnosis of narcotic addicts should be made with caution, taking into account various issues related to the protection of patients' human rights, such as the length of the supervision period and the possibility of involvement of judicial police officers, as well as the significance of the existence of laws and regulations today. At the very least, a single examination based on limited information, much less a half-automatic diagnosis of "addiction syndrome = narcotic addict" based on manipulative diagnostic criteria such as the ICD-10, should be avoided.

When diagnosing a narcotic addict, it is advisable to first consult a psychiatrist with expertise in narcotic addiction and to receive supervision. After that, a decision should be made

based on the patient's history of treatment. In any case, we should refrain from making a snap judgment in the field of primary care or general emergency medicine.

Conclusion.

This paper outlines the history and background of the establishment of this system, as well as the contents of the system as a whole, and examines its significance and problems, based on the discussions of the MHLW research group on the reporting system for narcotic addicts. As a result, it was found that the current aftercare system for narcotic addicts is beneficial in that it includes elements that promote recovery, such as environmental purification, which is not possible with conventional mental health welfare support schemes, but that it also restricts patients' access to treatment and may constitute an excessive violation of patients' human rights. The results of the study are as follows.

In light of the above problems, we suggested that for the time being, the diagnosis of narcotic addicts requires extremely careful consideration. We then argued that the system should be reviewed in the near future and modified to be consistent with current thinking on psychiatric treatment and community mental health welfare in Japan.

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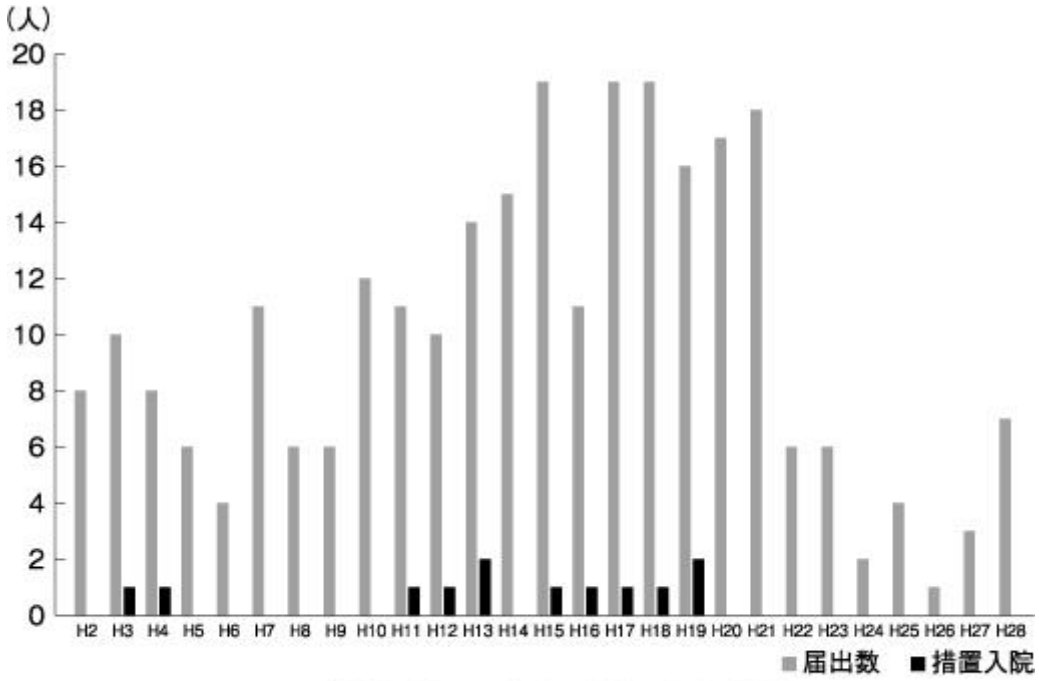

図 1 麻薬中毒者の届出数・措置入院数の推移
(文献 1 より引用)
Figure 1