In British drug history no document has more claim to the term 'classic' than the 1926 report of the Rolleston committee. Under pressure from the Home Office the eminent physicians on the committee claimed their right to prescribe even if it meant maintaining addicts to the grave. It all happened in the wake of the First World War; in the post-AIDS era Rolleston's analysis is still relevant.

Beginning here and continuing on page 14 we reprint extracts from the report. On the opposite page is an analysis of the background to the report with an assessment of its status today.

"ADDITION TO MORPHINE or heroin is rare in this country and has diminished in recent years. Cases are proportionately more frequent in the great urban centres, among persons who have to handle these drugs for professional or business reasons, and among persons specially liable to nervous and mental strain. Addiction is more readily produced by the use of heroin than by the use of morphine, and addiction to heroin is more difficult to cure.

Use of the drug in medical treatment was considered by the witnesses, with but one exception, to have been the immediate cause of addiction in a considerable proportion of the cases they had treated. Some regarded it as the cause in from one-fourth to one-half of their cases, and one thought that it accounted for the majority... Cases in which the addiction took its origin in the use of the drug through mere curiosity or search for pleasurable sensations... appear to be exceptional, and may be expected to become even less prevalent through the operation of the restrictions on supply.

The 'disease' of addiction

In the present report the term 'addict' is used as meaning a person who, not requiring the continued use of a drug for the relief of the symptoms of organic disease, has acquired, as a result of repeated administration, an overpowering desire for its continuance, and in whom withdrawal of the drug leads to definite symptoms of mental or physical distress or disorder.

There was general agreement among medical witnesses that in most well-established cases the condition must be regarded as a manifestation of disease and not as a mere form of vicious indulgence. In other words, the drug is taken in such cases not for the purpose of obtaining positive pleasure, but in order to relieve a morbid and overpowering craving. The actual need for the drug in extreme cases is in fact so great that if it be not administered, great physical distress culminating in actual collapse and even death may result, unless special precautions are taken such as can only be carried out under close medical supervision, and with careful nursing.

It is true that there is a certain group of continued on page 14"
How the Rolleston report set the course of addiction treatment in Britain

Mike Ashton

addicts formed a subculture through which surplus drugs circulated creating more addicts. The doctors were losing their grip on the addiction disease — now described as a "socially infectious condition". Spiralling addiction statistics bore witness to the virulence of the drug habit in the 'liberated' sixties.

The resulting public spectacle with queues of 'junkies' forming outside all-night chemists helped justify the 1968 curbs on the professional freedoms established by Rolleston. But to this day Britain is unique in allowing injectable heroin to be indefinitely prescribed for no other reason than that the patient has been diagnosed by a doctor as being addicted to the drug. This 'treatment' is reserved to a few specialists, but even the GP can prescribe injectable methadone on a similar basis. The argument is still alive over whether prescribing should become more or less restrictive.

British drug workers are now attempting to bridge the social and ideological gulf between drugtakers and society to increase the penetration of HIV preventive efforts among injectors. Rolleston's report was written at a time when this gulf was non-existent. In this sense its analysis is more relevant now than at any time since the '60s.

But Rolleston's legacy is sometimes misunderstood. The committee never posed maintenance as a 'treatment' for addiction — but, more modestly, as a potentially "medically advisable" intervention if repeated attempts at treatment (ie, withdrawal) had failed. In justifying this option the report repeatedly refers to the lack of suitable institutions in which to effect a "residential cure. Had these been widely available at a price most people could afford, and with the powers to detain addicted patients, then, the committee argued, perhaps everyone could be treated and maintenance would be unnecessary (and probably improper).

The committee's speculation might just have been a clever way to achieve consensus ('We disagree on whether everyone is curable in theory but at least we can agree that in practice it is impossible'). However, it does provide ammunition for the argument that a well-resourced NHS/voluntary sector treatment service might eliminate the need for long-term prescribing.

Rolleston's report is one that still repays reading. For thoroughness of analysis and simple humanity it outshines most if not all later reports. But the humanity is there because authors wrote with themselves — their own class, often their own profession. At its heart Rolleston was a defence of privilege — of private doctors and their private patients. The social upheavals of the '60s changed all that. The AIDS crisis of the '80s could be moving us back to search for ways Rolleston's 'user-friendly' approach can be adapted for today.

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Humanity there was, but at its heart Rolleston was a defence of privilege

The Rolleston report, or more properly the Report of the Departmental Committee on Morphone and Heroin Addiction was published by HMSO in 1926 as a report to the Minister of Health. It is available for reference in ISDD's library and photocopies can be purchased for £5.60.
When treatment fails

Apart from the cases dealt with in the preceding two paragraphs (those in pain due to organic illness and addicts being treated for their addiction by gradual withdrawal), we are satisfied that any recommendations for dealing with the problem of addiction at the present time must take account of and make provision for the continued existence of two classes of persons, to whom the indefinitely prolonged administration of morphine or heroin may be necessary.

(a) Those in whom a complete withdrawal of morphine or heroin produces serious symptoms which cannot be treated satisfactorily under the ordinary conditions of private practice; and

(b) Those who are capable of leading a fairly normal and useful life so long as they take a certain quantity, usually small, of their drug of addiction, but not otherwise.

Most of the witnesses admitted the existence of these two classes of cases, though in some instances with reluctance. Some physicians of great experience believed that if thorough treatment could be carried out in all cases it would very rarely, if ever, be found necessary to provide any addict with even a minimum ration of drug for an indefinite period.

It must be borne in mind, however, that those witnesses who were most sanguine as to the proportion of permanent cases that could be obtained under the best possible treatment, recognised that the results they described could only be secured by treatment in institutions.

Looking to the small number of such institutions in this country, as well as the cost of the treatment which, reasonable as it usually is, is beyond the means of some of the patients, and the impossibility under the law as it stands, of compelling persons suffering from addiction to become inmates of institutions, it is clear that under present conditions there must be a certain number of persons who cannot be adequately treated, and whom it is impossible completely to deprive of morphine which is necessary to them for no other reason than the relief of conditions due to their addiction.

Further, many of the witnesses were of the opinion that, even were it possible to treat thoroughly all cases, there would still exist a certain number of persons who could be grouped in one or other of the two classes above enumerated. Where, therefore, every effort possible in the circumstances has been made, and made unsuccessfully, to bring the patient to a condition in which he is independent of the drug, it may, in the opinion of the majority of the witnesses examined, become justifiable in certain cases to order regularly the minimum dose which has been found necessary, either in order to avoid serious withdrawal symptoms, or to keep the patient in a condition in which he can lead a useful life.

It should not, however, be too lightly assumed in any case, however unpromising it may appear to be at first sight, that an irreducible minimum of the drug has been reached which cannot be withdrawn and which, therefore, must be continued indefinitely. Though the first attempt entirely to free a patient from his drug may be a failure, a subsequent one may be successful.

The need for rehabilitation

It was specially insisted upon by several witnesses that the actual withdrawal of the drug of addiction must be looked upon merely as the first stage of treatment, if a complete and permanent cure is to be looked for. As one witness put it, the real gain to the patient by withdrawal of the drug is to enable him to make a fresh start in new and more favourable circumstances, and little more than that can be expected from the actual treatment itself, whatever the method employed. A permanent cure will depend in no small measure upon the after-education of the patient’s willpower, and a gradual consequent change in his mental outlook.

To this end it was regarded as essential by one witness that full use should be made of psycho-therapeutic methods, both during the period of treatment and in the re-education of the patient. It was not considered that a lasting cure could be claimed unless the addict had remained free from his craving for a considerable period — one and a half to three years — after the final withdrawal of the drug.

Scarce as important than psychotherapy and education of the will is the improvement of the social conditions of the patient, and one physician informed us that he had made it a practice, wherever possible, to supplement his treatment by referring the case to some social service agency.

It was also regarded as important that the physician in charge of the case should, while the patient is under his care, undertake a study of the causes, pathological and other, which originally led the patient to take drugs, and try to remedy them. Pain, insomnia or other physical malady must be suitably treated before the patient is released from observation.