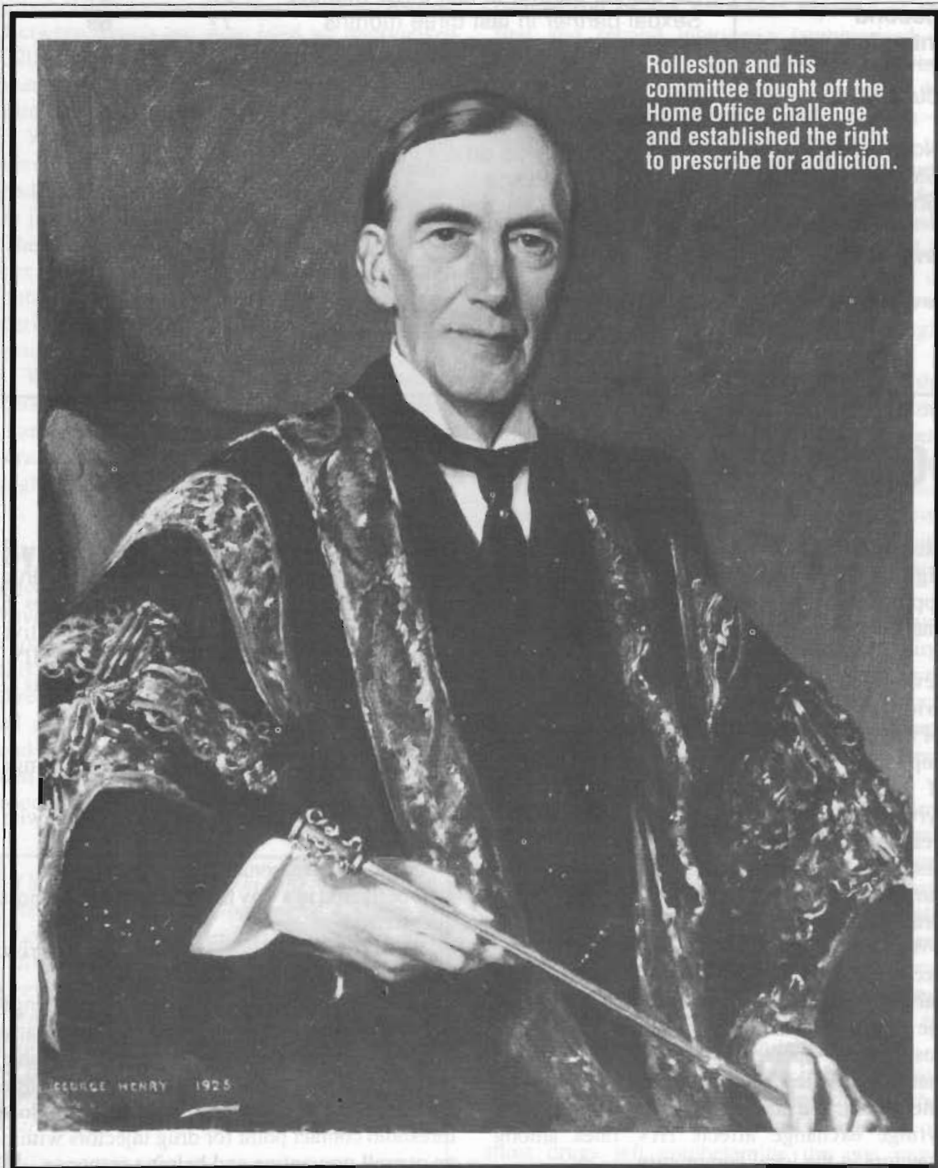
ROLLESTON: THE DEFENCE OF THE RIGHT TO PRESCRIBE

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.



Rolleston and his committee fought off the Home Office challenge and established the right to prescribe for addiction.

Royal College of Physicians

'ADDICTION 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

"THE COST OF THIS Inquiry (including the printing of this Report) is estimated at £65 5s 6d," announced the Departmental Committee on Morphine and Heroin Addiction in its report to Neville Chamberlain, then Minister of Health. Sir Humphrey Rolleston (Bart., KCB, MD, PRCP — President of the Royal College of Physicians), leading exponent of the disease view of alcoholism, chaired the committee of nine doctors behind the bargain-basement report that set the course of twentieth-century opiate addiction treatment policy in Britain.

What they did was to reach an accommodation with the penal line emerging out of the crackdowns initiated during the First World War. Home Office Under-Secretary Sir Malcolm Delevingne had led the attack, aiming for an interpretation of the 1920 Dangerous Drugs Act which would outlaw long-term prescribing.

But the outcome was a set of government-endorsed guidelines which allowed doctors to continue to supply opiates not just to *treat* addiction, but also to *maintain* addiction in patients who could lead a "fairly normal and useful life" with the drug, but not without it. For 40 years these words formed the unamended basis of the 'British system' for dealing with opiate addiction — world-renowned for its humanitarian medical approach. A common contrast was with the absolute prohibition on heroin across the Atlantic, which created criminals out of addicts who could have led law-abiding lives in Britain.

That contrast was not uncontested — if your addiction problem had been as big and as bad as ours, then you'd have gone penal too, said some Americans. Some British commentators agreed — it was the fact that our addicts were few and socially integrated that allowed us to be liberal, not our liberality that kept the addiction problem small.

Variations on this chicken-and-egg argument are still alive. Would it help today's heroin problem if doctors went back to maintenance *en masse*? Or are we now in the US situation of the '60s, with an illicit market so well established that doctors prescribing more opiates would only end up feeding the market rather than undercutting it? Apart from these questions of social policy, is it ever in the individual patient's best interests to ease their addiction lifestyle problems by providing a legal supply of drugs?

The first real test of the 'British system' came in the 1960s. What happened then supported the view that Rolleston's liberalism was a concession granted to doctors and addicts on condition of 'good behaviour', not an outright victory for the medical lobby.

The eminent physicians on the committee had cleared for themselves a wide space in which to exercise their medical discretion — but they had done it within the enforcement-dominated system established by the 1920 Dangerous Drugs Act. When eventually the addicts no longer behaved discreetly and the doctors failed to control them, then the enforcement system closed in to control both addicts and doctors through legal restrictions. By 1968 all but a few hundred doctors specially licensed not by the DHSS but by the Home Office — the state's enforcement arm — were barred from prescribing heroin or cocaine for addiction. All doctors had to notify opiate addicts to the Home Office — a way of tracking addiction and preventing double-prescribing, but also a way to keep tabs on doctors engaged in addiction treatment.

What was so different? First and foremost, it was the addicts. Doctors had been and still were mostly conventional and respected middle and upper class citizens. In the pre-NHS days of the 1920s, so too were their private addict patients. Indeed, a disproportionate number were themselves doctors or in other professions specially vulnerable to addiction due to their easy access to drugs. Many of the addicts of the '20s were of the same exclusive ilk as the committee which looked into their plight, and most shared the same social stratum as the doctors they consulted. With mutual understanding they played the doctor-patient game, each accepting addiction as an illness and causing no more angst to the wider society than do elderly heart patients today.

By the 1950s this cosy consensus was cracking and by the early 1960s — for those who had eyes to see — it had disintegrated. From 1960 on the Home Office noted that new cases of addiction "included increasing numbers initially of beatniks (mainly from the upper socio-economic classes), and latterly ... members of the working class, many with a considerable record of juvenile delinquency."

A social gulf had opened between doctors and their new addict patients. From now on they were going to be playing different games: "vicious indulgence" would have been Rolleston's verdict on the roots of the new drug users' addiction. The ideological mismatch forced the doctors into policing addicts through carrot-and-stick controls, and the addicts into the underdog's tactics of manipulation and deceit, tactics they successfully employed to extract maximum dosages from unprepared doctors.

No longer isolated in their own homes, the 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 prevention 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 mused, perhaps everyone could be treated and maintenance would be unnecessary (and probably improper).

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

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 an 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 the authors were talking in a sense of 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. ■

The Rolleston report, or more properly the Report of the Departmental Committee on Morphine 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 £3.60.*

▸continued from page 12
persons who take the drugs in the first instance for the sake of a new and pleasurable sensation, eg, the 'underworld class, who often use heroin for this purpose as a snuff. But even among these a morbid need for the drug is acquired and the use is maintained not so much from the original motive as because of the craving created by the use.

The conclusion to which we think the evidence points [is] that addiction may be acquired by injudicious use of the drug in a person who has not previously shown any manifestation of nervous or mental instability, and that, conversely, due care in administration may avert this consequence even in the unstable.

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.

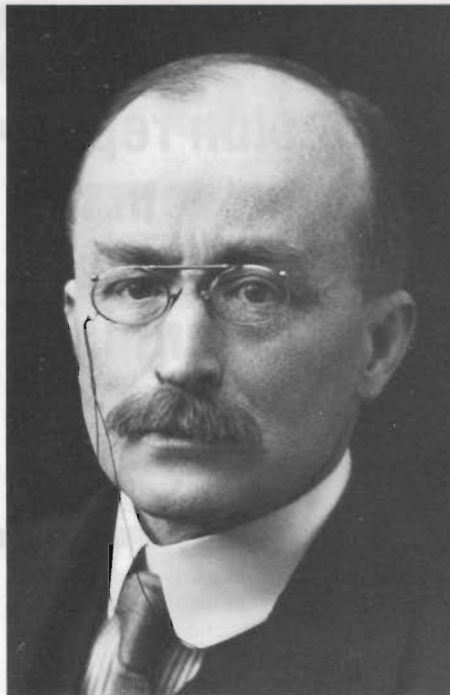
Most of the witnesses admitted the existence of these two classes of cases, though in some instances with reluctance. Some physicians of great experience believed that if thorough treatment could be carried out in all cases it would very rarely, if ever, be found necessary to provide any addict with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

Administration of heroin may be necessary for those capable of leading a fairly normal and useful life so long as they take their drug of addiction

It must be borne in mind, however, that those witnesses who were most sanguine as to the proportion of permanent cures 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. When, 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.



Sir Malcolm Delevingne of the Home Office wanted Rolleston's committee to ban long-term prescribing to addicts

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.

Prescribing safeguards

A practitioner when consulted by a patient not previously under his care, who asks that morphine or heroin may be administered or ordered for him for the relief of pain or other symptoms alleged to be urgent, should not supply or order the drug unless satisfied as to the urgency, and should not administer or order more than is immediately necessary. If further administration is desired, in a case in which there is no organic disease justifying such administration, the request should not be acceded to until after the practitioner has obtained from the previous medical attendant an account of the nature of the case.

The practitioner should endeavour to gain his patient's confidence, and to induce him to adhere strictly to the course of treatment prescribed, especially as regards the amount of the drug of addiction which is taken. This last condition is particularly difficult to secure, as such patients are essentially unreliable and will not infrequently endeavour to obtain supplementary supplies of the drug. If, however, the practitioner finds that he cannot maintain the necessary control of the patient, he must consider whether he can properly continue indefinitely to bear the sole responsibility for the treatment.

When the practitioner finds that he has lost control of the patient or when the course of the case forces him to doubt whether the administration of the drug can, in the best interests of the patient, be completely discontinued, it will become necessary to consider whether he ought to remain in charge of the case, and accept the responsibility of supplying or ordering indefinitely the drug of addiction in the minimum doses which seem necessary. The responsibility of making such a decision is obviously onerous, and both on this ground and also for his own protection, in view of the possible inquiries by the Home Office which such continuous administration may occasion, the practitioner will be well advised to obtain a second opinion on the case.

In all such [apparently incurable] cases the main object must be to keep the supply of the drug within the limits of what is strictly necessary. The practitioner must, therefore, see the patient sufficiently often to maintain such observation of his condition as is necessary for justifying the treatment. The opinion expressed by witnesses was to the effect that such patients should ordinarily be seen not less frequently than once a week. The amount of the drug supplied or ordered on one occasion should not be more than is sufficient to last until the next time the patient is to be seen.

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 psychotherapeutic 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.

Scarcely less 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 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, make a thorough 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.