The ROLLESTON *legacy*

In British drug policy history, no document has more claim to the term 'classic' than the Rolleston report. Eighty years later, Britain is revisiting its arguments over for how many and for how long maintenance prescribing would be needed if withdrawal and rehabilitation were given greater priority. On pages 20–21, extracts from the report. Below, an assessment of its lasting significance.

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Commentary by
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This report is dedicated to the memory of 'Bing' Spear who not only administered but embodied the 'British system'. It also owes a considerable debt to the work of the historian Dr Virginia Berridge of the London School of Hygiene and Tropical Medicine, who more than any other scholar has revealed the roots of addiction policy in Britain.

"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.[1] Sir Humphry[i] Davy Rolleston (Bart., KCB, MD, President of the Royal College of Physicians) – leading exponent of the disease view of alcoholism – chaired the committee behind the report published in 1926 which set the course of twentieth-century opiate addiction treatment policy in Britain.

What they did was to secure, in international terms, a uniquely extensive space for clinical discretion in the medical response to opiate addiction, as the tightening up of drug controls initiated during the First World War threatened to intrude in to the consulting room.[2,3,4,5] Their formula lasted more or less unaltered until 1968 and remains an important legacy, underpinning the highly unusual right of British doctors to prescribe heroin to heroin addicts. The key was to enshrine the view that addiction itself was a disease distinct from base craving, indulgence or habit, and therefore a fit target not just for treatment but also for compassion. From this flowed the conclusion that, as with any other disease, doctors should be free to respond as they saw fit.

THE ESSENCE OF THE 'BRITISH SYSTEM' IS THAT IT ALLOWS THE DOCTOR TOTAL CLINICAL FREEDOM TO DECIDE HOW TO TREAT AN ADDICT PATIENT

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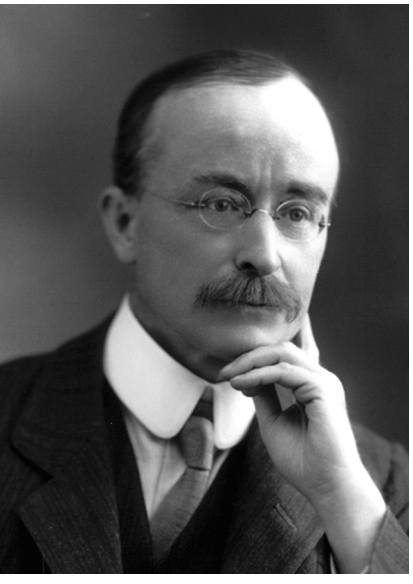
Background text

Sir Malcolm Delevingne of the Home Office, architect of post-World War I dangerous drugs regulations



JUST WHAT *is* MEDICAL PRACTICE?

Home Office Under-Secretary Sir Malcolm Delevingne had led the drive towards regulation potentially affecting both doctors and patients, but when it came to treatment, the rights of both seemed safeguarded by regulations issued in 1921. Under these any doctor was authorised to possess and supply dangerous drugs (including cocaine, morphine and heroin) "so far as is necessary for the practice of his profession or employment [as a medical practitioner]."

But just what was *bona fide* medical practice? The crux was the position of patients who it was claimed could not cope without continuing supplies of otherwise prohibited drugs, not because these were needed (at all or any longer) to subdue pain or to counter a physical malady, but simply because they had become reliant on the drugs. Was a continuing, non-reducing supply merely gratifying their addiction, when 'real treatment' in the form of a withdrawal-based cure would have been possible?

Such questions were the accepted purview of the medical profession. To answer them, in 1924 a committee of nine medical men was convened under Rolleston's chairship. Two years later the outcome was a set of government-endorsed guidelines which supported doctors in continuing 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 drugs, but not without.

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.

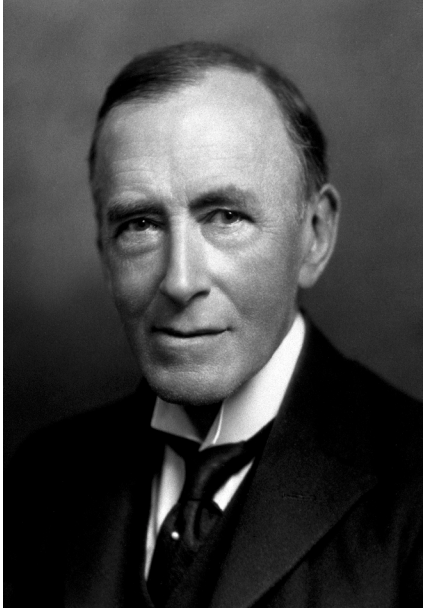
That contrast was not uncontested – if your addiction problem had been as big and as bad as ours, then you'd have gone penal too, said some Americans. Some British commentators agreed: it was the fact that our addicts were few and socially integrated that allowed us to be liberal, not our liberality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

The other big difference lie in the degree of regulation imposed on doctors engaged in addiction treatment. In rejecting the implications of the term 'British system', the late Bing Spear, formerly Chief Inspector of the Home Office Drugs Branch, put it this way: "'System' and 'programme' suggest coordination, order and an element of (state) planning and direction, all totally alien to the fundamental ethos of the British approach, which is to allow doctors to practice medicine with minimal bureaucratic interference ... The essence of the 'British system' is that it allows the individual doctor total clinical freedom to decide how to treat an addict patient."[6]

LIBERATED SIXTIES BREAK THE MOULD

After in 1955 surviving a US-inspired attempt to ban medical use of heroin, the next test of the 'British system' came during the social upheavals of 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 inalienable right.

Even in the 1920s, the physicians on the committee had been working within the enforcement-oriented system established by the 1920 Dangerous Drugs Act; drug control was "very largely a police



Sir Humphry Rolleston, chaired the committee which endorsed doctors' freedom to prescribe opiates for addiction.

matter" was how Delevingne put it. When eventually the addicts no longer behaved discreetly and the doctors failed to control them, the system closed in to control both through legal and administrative measures.

By 1968, all but a few hundred doctors specially licensed, not by the health department, but by the Home Office, were barred from prescribing heroin or cocaine for addiction. All doctors had to notify addicts to these drugs to the Home Office – a way of tracking addiction and preventing double-prescribing, but also of keeping tabs on the doctors. This was made easier by concentrating treatment and licensed practitioners in psychiatric hospitals run directly by the NHS rather than in independent practice either as GPs or in the private sector.

'BEATNIKS' AND DELINQUENTS

What had changed? First and foremost, it was the addicts. Doctors had been and still were mostly respectable middle and upper class citizens. In the pre-NHS days of the 1920s, so too were their private addict patients. Indeed, many were themselves doctors or in other professions specially vulnerable to addiction due to easy access to drugs. Though sometimes eccentric, hypersensitive, or pathetic 'broken' men, addicts of the '20s generally shared the same social stratum as the committee which looked in to their plight and 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 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."[7] The premise on which the Rolleston accomodation had been reached – that maintenance sustained the excessively febrile and/or enabled a continued contribution to society – no longer applied. These delinquents were not sensitive souls held together only by continued narcosis and even before becoming addicted, a "fairly normal and useful life" had eluded many. The chances of a conversion to mainstream lifestyles must have seemed remote, with or without a steady drip feed of heroin.

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' habits. The mismatch led doctors to police addicts through carrot-and-stick controls, and addicts to the underdog's tactics of manipulation and deceit, tactics they successfully employed to extract excessive doses from a few niave, unscrupulous or over-generous doctors.

THE COMMITTEE'S SPECULATION BRINGS US UNCANNILY UP TO DATE WITH CURRENT DEBATES ON THE LEGITIMACY OF MAINTENANCE PRESCRIBING

No longer isolated in their homes, the addicts formed a subculture through which surplus drugs circulated, creating more addicts. The doctors were losing their grip on the addiction disease, described in the 1960s successor to Rolleston as a "socially infectious condition".[8] Spiralling addiction statistics bore witness to the virulence of the drug habit in the liberated sixties.

MISUNDERSTOOD LEGACY

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. Still, until the 1990s when experiments began in mainland Europe,[9] Britain remained unique in allowing injectable heroin to be indefinitely prescribed for no other reason than that the patient had been diagnosed by a doctor as being addicted to the drug. This option had become reserved to a few specialists, but even today any GP can prescribe injectable methadone on a similar basis, an unusual degree of freedom.

Rolleston's legacy remains, but it is often misunderstood. The committee never posed maintenance as a 'treatment' for addiction but, more modestly, as potentially a "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).

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'), but it brings us uncannily up to date with current debates on the legitimacy of maintenance and the argument that abstinence-oriented, and in particular, residential services, have been under-emphasised.[10 11] Today too, the argument is being advanced that well-resourced rehabilitation and social reintegration services might greatly reduce the need for long-term prescribing.

For this reason alone, Rolleston's report retains relevance, but there are other reasons to revisit its pages. For thoroughness of analysis and simple humanity, it outshines most if not all later reports. The humanity is there because the authors were talking in a sense of themselves; their own class, often their own profession.

Rolleston was a defence of a privileged individual relationship between private doctors and their private patients. Extending this across society through the NHS as addiction spread to the delinquent working class and those who rejected their middle class origins, was harder to sustain. Control (of addiction itself and then of disease and crime) became the priority. Rolleston's individualised response to the patient, allowing – even demanding – that this be supported by the full range of opiates available from any doctor they chose to attend, became narrowed down to oral methadone from state-licensed psychiatrists, a mass, collectivised response to a social problem. But the space the committee opened up has never been fully closed. It continues to be probed by those who want to restore it to at least to its previous dimensions and by those who believe it needs tightening further.

NOTES

i Opinions differ on whether the name is Humphry or Humphrey. I have chosen the form which appeared in the report itself.

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1 *Report of the Departmental Committee on Morphine and Heroin Addiction*. HMSO, 1926.

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ROLLESTON

Extracts from

The Report of the Departmental Committee on Morphine and Heroin Addiction, 1926

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.

MINUTE OF APPOINTMENT OF THE COMMITTEE.

I hereby appoint—

Sir Humphry D. Rolleston, Bart., K.C.B., M.D., F.R.C.P.,
Sir William H. Willcox, K.C.I.E., C.B., C.M.G., M.D., F.R.C.P.,
J. W. Bone, Esq., M.B., C.M., B.Sc.,
R. W. Braithwaite, Esq., C.B., M.D., D.P.H.,
C. M. Chadd, Esq., M.D., B.Sc., M.R.C.P.E.,
Professor W. E. Dixon, M.A., M.D., F.R.S.,
John Fawcett, Esq., M.D., F.R.C.P.,
A. Fenton, Esq., M.B., B.C.,
J. Bates Williams, Esq., M.R.C.S., L.R.C.P.,

to be a Committee to consider and advise as to the circumstances, if any, in which the supply of morphine and heroin (including preparations containing morphine and heroin) to persons suffering from addiction to those drugs may be regarded as medically advisable, and as to the precautions which it is desirable that medical practitioners administering or prescribing morphine or heroin should adopt for the avoidance of abuse, and to suggest any administrative measures that seem expedient for securing observance of such precautions.

I hereby further appoint Sir Humphry D. Rolleston to be Chairman, and E. W. Adams, Esq., C.B.E., M.D., and R. H. Crosfie, Esq., to be Secretaries of the Committee.

(Signed) JOHN WESTLEY.

30th September, 1924.

I hereby extend the Terms of Reference to the Committee as follows:—

To consider and advise whether it is expedient that any or all preparations which contain morphine or heroin of a percentage lower than that specified in the Dangerous Drugs Acts should be brought within the provisions of the Acts and Regulations and, if so, under what conditions.

(Signed) NEVILLE CHAMBERLAIN.

19th February, 1925.

The cost of this Inquiry (including the printing of this Report) is estimated at £85 5s. 6d.

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 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.

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.

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 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.

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.

* Subheadings not in original.