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Annotation

Addiction and After

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The development of the British response to 'the drugs problem' since the 1960s does not lend itself readily to any optimistic interpretation. The initial wave of enthusiasm for clinics during the latter years of the 1960s soon faded. The clinic system was deprived of sufficient support, and many staff became disillusioned and burnt out. Treatment and responses gradually changed, not as the result of any clearly thought-out policy, but as the result of a vague drift of views.

During the 1970s, politicians of all persuasions were avoiding the problem while the number of opiate users was continuing to increase, and other, more worrying developments were taking place. New forms of illicit heroin were being imported in massively increased quantities, and consumed by inhalation rather than the initially more daunting process of injection. Then, suddenly and surprisingly, in the early 1980s the television screens were full of earnest Members of Parliament trying to be the most concerned about the drugs problem. Soon, the government asserted that the problem of drug abuse was "the most serious peacetime threat to our national well-being" (House of Commons Home Affairs Committee, 1985). The newly found urgency was maintained by the appearance of HIV infection and the association between needle-sharing and the spread of infection. So money was duly thrown at the problem, and predictably, drugs 'experts' suddenly abounded and opinions could be had for the asking. Any sort of evidence based upon careful research was less readily available. Neither in the panic of the 1960s, nor in the neglect of the 1970s, was there any national effort to plan and conduct the research that might guide future responses. Even those clinical questions that could have been tackled relatively easily and cheaply were left unanswered – and mainly unasked.

It is hardly possible to pose a simpler question than "What happens to addicts after treatment?", but the problem has only recently been researched, in the Maudsley Relapse Study of opiate addicts. This is now reaching its final stages and the first reports are being prepared, one having already been published (Gossop *et al*, 1987). The latter was concerned with relapse (or continued abstinence) among a group of 50 people who were treated for opiate dependence at the Bethlem Royal Hospital, and a pre-condition of entry to the study was that subjects should have achieved abstinence. Fortunately, the success rate of the withdrawal phase of treatment is high, as has been reported elsewhere (Gossop *et al*, 1986), and more than 80% of the patients who enter the programme go on to become drug-free, as was the case in this study.

Gossop *et al* (1987) reported two main findings. The first was that a considerable number of people use opiates within a matter of days of discharge from treatment. The second (and more encouraging) observation was that this initial lapse does not inevitably herald a full-blown relapse to daily and dependent use. The number of subjects who were abstinent from opiates gradually increased throughout the 6 months after discharge, until at the 6-month follow-up interview, a total of 26 subjects were opiate-free. Since two of these were receiving some form of residential treatment for drug dependence and three were in prison, it would be potentially misleading to include these subjects in any 'final reckoning' of the abstinence rate. When these five were excluded, 47% of those who were living in everyday settings without external restraints upon their access to drugs were opiate-free. The initial lapse rate is striking. On the day of discharge from the unit, seven people used opiates, on the next 2 days another 11, and by the 6-week interview, about three-quarters of the sample. It is this sort of apparently dramatic 'failure of treatment' which is easily observed without any systematic follow-up procedures. Many treatment agencies are informed, either by the patient, or by relatives or friends of the patient, that such a "collapse" has occurred, and this is a powerful reinforcer of the idea that treatment is ineffective, and that even after weeks or months of intensive treatment the end result is failure.

Day-to-day clinical work with addicts is not always the most rewarding of tasks. The speed with which most addicts apparently resume opiate use has undoubtedly contributed to the disillusionment of many workers in the field. The problem of 'burn-out' among clinical staff has been, and remains, a problem in the maintenance of a satisfactory service. Our results suggest that the outcome for addicts after treatment is better than has been previously believed. The ease with which initial lapses are reported back to the clinic creates a false perspective. A more systematic follow-up procedure, such as that adopted

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in the Relapse Project, demonstrates that it is incorrect to regard the initial lapse as an inevitable marker for readdiction, and illustrates the benefits of comparatively straightforward monitoring procedures in relation to clinical practice.

This view about the inevitability of relapse has been stated by many people in the literature. Schur (1963) commented that "even optimistic practitioners recognise that relapse to the further use of drugs is the rule rather than the exception", and that "the likelihood of accomplishing permanent cures is slim". The editor of the *International Journal of the Addictions* also observed that, regardless of the type and intensity of treatment, "the great majority of addicts simply resume drug use" (Einstein, 1966). A review article by Callahan (1980) noted that "traditionally, the treatment of heroin addiction has been singularly unsuccessful".

Low expectations about treatment outcome are not surprising, as addictive behaviours are inherently prone to relapse. Possibly, clinical interventions offered to addicts as 'treatment' over the past 20 or 30 years have not been appropriate, and our understanding of the 'treatment' process as it relates to the addictions is extremely rudimentary even now. Also, the evidence for resumption of drug use is easier to obtain than that relating to abstinence.

However, the glee with which the initial lapse data from the Maudsley Relapse Project were seized in certain quarters, and the resistance to the evidence about subsequent abstinence is disappointing. It looks as though there is a vested interest among some of those employed in the addictions in the perpetuation of the idea that addicts seldom recover from their addiction and that treatment is worthless, which is sad.

The Relapse Project is not a treatment-evaluation study, nor is it a 'natural history' study of a random or 'representative' sample of addicts. It is a study about the return to opiate use (or not) of a group of addicts who have been successfully withdrawn from opiates. Its data should not be overinterpreted, but they cannot be neglected. Of particular interest is a previously unreported tendency for substantial numbers of subjects to move towards abstinence during the first 6 months after leaving treatment. Although large numbers of people used opiates after discharge, many of these people did not become readdicted. At the 6-month interview, about half of the sample were abstinent from opiates. Similarly, if patterns rather than single episodes of use are examined, the results show that the abstinence rate rises steadily from 34% in the first 2 months, to 42% in months 2–4, and 50% in the last 2-month period. If occasional (less than daily) users are included in the calculation (i.e. of those who were not readdicted), the 6-month figure rises to 68%. These results are supported by very high concordance rates between self-reported opiate use and objective procedures for the screening of these drugs in urine specimens, and by evidence that there was very little substitution of one type of drug problem for another. Only one of the abstinent subjects at 6 months was drinking heavily, for instance. Although among the most encouraging yet reported, the results do not permit complacency. About half the subjects are abstinent at 6 months and about two-thirds not readdicted to opiates, but the final outcome of treatment cannot easily be judged on the basis of measures taken at some fixed point in time, as the drug-taking behaviour of addicts (or ex-addicts) is complex and changeable. What happens to addicts after treatment over a longer period is an important question and it is to be hoped that a further research project will continue the study.

In view of the current concern about HIV infection, it is perhaps worth mentioning one minor aspect of the study. At admission to treatment the majority of our subjects were using opiates by injection, but after treatment, the injection of drugs was considerably reduced. The results show that only 17 subjects injected opiates at any time during the entire 6-month period. Although why this change occurred is not known, it is nonetheless another encouraging feature of the study. However, as more than a third of the entire sample had used opiates within 3 days of leaving the unit, and three-quarters within 6 weeks, not only is there no room here for complacency but this should cause great concern among all those offering treatment services. The period immediately after leaving a residential treatment programme is clearly a point of massive risk for the ex-addict, but one where services are conspicuously lacking. Few treatment centres can offer anything remotely approaching an adequate aftercare service, and some, none at all. Nor are there sufficient resources in other concerned agencies. As in-patient treatment services are expensive, it is foolish not to be able to maintain the momentum when an addict has reached a point of willingness to change and has successfully passed through a treatment programme. Ways of reducing the risks of this swift return to opiate use must be found. But no matter how effective the treatment programme itself can be made, there remains a desperate need for adequate aftercare services for the support of patients after leaving treatment, as addiction cannot be cured by a specific process administered by experts to a passive recipient. Addiction is not that sort of

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problem. The events and circumstances of the real world outside the hospital gates are of at least as much importance as anything that may have occurred within the treatment programme: to maximise the chances of success, treatment needs to be extended after discharge from hospital.

This is the first British study of its kind, and the results deserve attention because firstly they provide data where there were previously only impressions and opinions, and secondly they provide encouragement about treatment outcome among opiate addicts to counter common pessimistic preconceptions.

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