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The First 100 Referrals to a Scottish Drug Addiction Treatment Centre*

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Summary

This is a report on the first 3 years' experience at the Drug Addiction Treatment Centre which was established at the Royal Edinburgh Hospital in April, 1968, The statutory requirements, and the hospital policy for dealing with persons addicted to dangerous drugs are outlined, followed by a demographic and social analysis of the 100 probands including childhood circumstances, work record, delinquent background, and known record of non-drug offences. Drug taking habits are surveyed, together with medical and pyschiatric complications reported. The reasons given for coming to hospital, and the attitudes of these drug-takers are presented in detail, showing the problems of management to which they give rise. Local difficulties impeding social rehabilitation are also discussed. It is questioned whether hospital addiction centres, as at present organised, can be effective in the treatment of young unmotivated drug misusers.

Introduction

In April 1968 a Drug Addiction Treatment Centre for the South East of Scotland was officially set up at the Royal Edinburgh Hospital. From that date on, all heroin addicts in the area were to be referred to the Centre for investigation and treatment, including maintenance supervision where required. Addiction patients had of course been treated at the hospital before; but the introduction of the Dangerous Drugs Regulations (1968) called for a much more structured regime. It became compulsory for all addicts to be notified to a central Home Office index, on a special form provided; and the prescribing of heroin was restricted to named consultants at the Treatment Centre.

The aim of the scheme was to identify addicts and prevent their obtaining DDA drugs from more than one official source. Though it was also hoped that rehabilitation would be more successful when carried out by a specialised unit, there was no provision in Edinburgh for the establishment of additional medical, nursing or social work staff, nor were separate premises available. Treatment of addicts was therefore undertaken in course of normal hospital duties.

As well as the statutory requirements, certain policies for dealing with addiction patients were adopted by the six named consultants licensed to prescribe DDA drugs. These policies were: (i) no heroin was to be prescribed for out-patients; (ii) addticts were not to be admitted as Compulsory patients unless they had psychotic symptoms; (iii) addicts were to be offered informal admission for assessment and withdrawal under methadone cover; (iv) if possible, not more than one addict should be admitted to any one ward at the same time; (v) if admission was declined, then daily attendance for methadone linctus was offered with dosage gradually reduced. How this experimental scheme worked in practice over a 3-year period, is the subject of the present report.

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Changes in Type of Patient

It was not possible to extract from the Royal Edinburgh Hospital records the figures for addiction (barbiturate, amphetamine, or opiate) before 1968. But in an old register dating from 1935, for Jordanburn Hospital (extension of the main hospital, opened in 1929 for voluntary patients) a diagnosis had been entered for every admission. Over the 23 years from 1935 to 1958, when the separate register was discontinued, out of an average annual admission rate of 240 ,the total of narcotic addicts was 13. Of these 11 were doctors, 1 a medical student, and 1 a woman of 68. A later report from another Scottish hospital showed that of 120 addiction patients admitted during the 12 years, 1949 to 1960, 65 were doctors or nurses.[1]

Today the whole pattern of drug addiction has changed. We still see a few of the familiar 'professional' addict patients (there are 2 in the present survey), but with the epidemic of illicit drug-taking among younger and younger age groups, they are vastly outnumbered. In 1950, 'professional' addicts made up 31% of the total known to the Home Office. In 1960 the proportion had dropped to 14%, and by 1970 it was down to 1·42%.

Source and Limitations of Material

The survey was retrospective from hospital case records, whose content varied from brief statements to an extensive history. Of the 100 patients referred, 83 were on notifiable drugs, 17 on cannabis, LSD, and other non-notifiable drugs. Barbiturate and amphetamine addicts were excluded, also takers of cannabis alone. The hospital's Young People's Unit, a separate department, was not included in the survey. Information was largely self-reported, though in a few cases some was available from other hospitals, probation officers, a general practitioner or a previous admission to the Royal Edinburgh Hospital (15 patients). Offences of all types were likely to be an underestimate: no check was made with police sources. No consistent follow-up was attempted, but news of relapse or of further Court appearance was noted for a number of patients. Within these limitations, the survey provides a broad picture of a Scottish hospital's experience with drug-takers referred for treatment.

Demographic Background

28 patients came in the first 12 months (April 1968 to March 1969), 23 in the second, and 49 (total 100) in a final 14 months. 79 were male: 21 female. 60 were born in Edinburgh, 20 elsewhere in Scotland. 14 were born in England, 2 in Ireland, other countries 4. 68 were single, 12 married, 9 separated or divorced. 11 were living in various types of irregular unions. There were 3 cohabiting pairs where both partners were on drugs. More than threequarters of the group were under age 25.

Table 1. *Age Distribution*

15–19 years	31	(82%)
20–24 years	51	
25–29 years	12	
30–34 years	2	
35–40 years	4	
Total	100	

The 4 who were over 35 included 1 'professional' addict (a staff nurse), 1 'therapeutic' addict (woman with chronic back pain), and 2 men with a long criminal record. Social Class was assigned according to the last job the patient had held. Parental occupation, where known, was predominantly semi-skilled or unskilled.

Table 2. *Social Class*

I	2
II	2
III	26
IV	14
V	41
Student	8
N.K.	7
Total	100

Of the 8 students, 4 were at Edinburgh University, 3 at other Scottish Universities, and 1 was a student nurse.

Table 3. *Source of Referral*

G.P.	41
Royal Infirmary	19
Self Referral	16
Student Health Service	4
Drug Treatment Centre in London	3
Police	3
Psychiatrist	3
Friend	3
Other local hospital	2
Miscellaneous	6
Total	100

To judge from the referring letters, the G.P. involved often knew little or nothing about the patient, who might have come on a temporary registration, or been brought along by worried parents when drug-taking was first discovered. Those referring themselves to the Centre usually claimed to be 'registered' addicts (or asked to be 'registered') so that they might be prescribed drugs. The 19 referrals from general hospital were all overdoses or psychotic episodes.

Families, School and Work

Table 4. *Childhood Circumstances*

Broken Home (all causes)	41
Institutional upbringing	13
Illegitimate	4
Adopted	1
Parents unknown	1
Reared by Grandparents	4
No information	9

Almost half the group had a disturbed family background. As children they grew up in poverty in loveless homes, characterised by parental 'arguments', drunken quarrels, and scenes of violence. The death of one or other parent (9 cases), divorce (9 cases) and separation or desertion (17 cases) added to insecurity. Stepmothers were remembered as unkind; life in children's homes unhappy. Education had ceased at 15 for 57 of the group; for the majority, schooldays had been endured rather than enjoyed. Remarks such as 'hated school' 'didn't do well, took no exams' 'truanted a lot' 'didn't like school, was very bored' recurred in the notes. 6 of these reluctant scholars were recorded as 'below average' or 'borderline' intelligence; a 7th was a certified defective. 3 had been expelled from school. Their subsequent work record was poor. Most had done odd jobs such as van boy, portering, shop assistant, casual labouring. Some had started apprenticeships but given up. At the time of referral to hospital, 73 (60 men, 13 women) were unemployed. They lived on Social Security or were supported by parents. 33 had left home and were sharing flats or rooms with other drug-takers.

Their sexual lives were promiscuous and amoral. Sexual intercourse had begun early (ages of 11, 12 and 13 were reported), followed by a series of casual relationships sometimes resulting in pregnancy, illegal abortion, or the birth of an illegitimate child. Girls were seen as objects, not as persons; and the tally of sexual conquests a matter of masculine gratification.

(Case 17, age 18) "First intercourse at 16, says he had a lot of girls since. Lived with one in her caravan for a while, left after she told him she'd become pregnant. Did the same to another girl, about 3 months ago. Now says he wants to get a job, settle down, and 'get myself a decent chick'."

Marriages, when embarked on, were ill-starred and frequently broke up, condemning yet another generation of children to repeat the cycle of their parents' insecurity.

(Case 40) "Married at 21, wife then pregnant. Marriage broke up after 6 months, he went to live with another woman. Appears to have lived intermittently between the two homes. Wife and other woman both pregnant by him at the same time. He also has a 3-year-old child by the cohabitee."

Further evidence of social disorganisation was seen in delinquency and crime. 49 patients had a known criminal record: 22 of these had been in trouble before age 16 (remand home, juvenile court, approved school). 32 had served prison sentences, several of them more than once. 80 had been convicted of drug offences. 41 had committed non-drug offences (mainly theft, house-breaking, assault, shop-breaking, breach of peace and drunkenness) before their first conviction for drug a offence. These findings are similar to those of other surveys.[2]

Drugs Used

Information was almost entirely self-reported and of dubious accuracy. There was no way of verifying a patient's claims. However, the cumulative picture which emerged was one of multiple and indiscriminate drug misuse, rather than 'hard core' opiate addiction.

As the Table shows, these Edinburgh patients took everything they could get. 'I think it is true to say that she has tried every drug on the market' (discharge letter

Table 5. *Drugs Used*

Users of 1 opiate drug only (or synthetic opiate)	5
Users of non-opiate drugs (LSD, barbiturates, mandrax, cannabis, etc.)	17
Multiple drug misuse (Opiates with other drugs)	78
Total	100

to G.P.) 'You name it, I've taken it' (first out-patient interview). Here are some examples:

(*Male, age 18*) Morphine, heroin, pethedine (all I.V.); valium, physeptone, cannabis, LSD, Palfium, DF 118

(*girl, age 20*) Morphine I.V.; heroin, cocaine, amphetamines, barbiturates

(*Male, aged 23*) Heroin, morphine, opium, pethedine, physeptone (all I.V.); mandrax, cannabis, nembutal, LSD

(*girl, age 20*) Morphine and nembutal (I.V.); Palfium, LSD, mandrax, cannabis.

Improbable concoctions were reported. One man resorted to omnopon, DF 118, and scoline (I.V.), the latter with (to him) unexpected results. A girl took paracetamol in milk, then 'fixed' prednisoline. A student used nutmeg and a nasal decongestant. Someone else tried mescaline, artane, and PMA. One girl, on physeptone, methedrine and tuinal, said her mother accepts that she is on drugs and has helped her to have her 'fixes' at home.

17 admitted to 'pushing' drugs, recently or in the past. Not all were involved in 'hard drugs': the sellers of cannabis appeared to do so for social reasons, and did not consider themselves 'junkies'. 40 patients said they first took drugs before they were 17 (6 of them before 15); a further 39 between 17 and 18. The 24 who recounted their progression usually started on amphetamines ('pep pills in dance halls' 'purple hearts at 14'), went on to cannabis and barbiturates, then to 'mainlining' whatever opiates came their way ('amphetamines at 17, cannabis at 18, heroin and cocaine at 19'). A recent survey in London describes the same pattern of progression.[3]

Compared with the type of patient reported from other treatment centres, few of those seen in Edinburgh conformed to the stereotype of a 'real' heroin addict. None were extremely ill or at the point of death; withdrawal symptoms were the exception (see page 236); although a few admitted 'break-ins' at chemists' shops none appeared desperate enough to attack and rob complete strangers to get money for a 'fix'. The Edinburgh patients fell roughly in two categories: those who gave a credible history of continued use of opiates (45 cases); and those who experimented with any and every drug available. The majority of the 'experimenters' were local young people, who had drifted into drug-taking as a current fashion. In this group, being 'registered' appeared to confer a kind of status symbol.

Among the confirmed opiate-takers, there was evidence that contact with London was of noxious significance. Of the 45 so assigned, 37 were native-born Scots who had stayed in London for varying periods: the remaining 8 had been born in London or the South. An association was also observed between these 'hard-core' addicts, life in London, and a known criminal record. This constellation of factors was found

in 22 out of the 45 cases, and would probably have been higher had full criminal histories been available.

Medical Complications

Table 6. *Medical Complications*

Jaundice/Hepatitis	20
Overdose	19
Psychotic Episode	12
Phlebitis/Venous Thrombosis	8
Abscesses	2
Burns	1
Peripheral neuritis	1

Information in the hospital case records about drug-induced morbidity was far from complete. The true extent is likely to have been much greater. Even so, the table indicates what a heavy load these drug experimenters place on general hospitals and casualty departments. 18 of the 19 overdose patients had been resuscitated in the Royal Edinburgh Infirmary before being transferred to the Addiction Treatment Centre (3 of them on more than one occasion). 9 of the 12 psychotic episode cases were similarly transferred. Treatment in London hospitals was reported by 25 patients. 10 of them had had 2 admissions, 5 had 3, and 1 had 4. 7 said they had received treatment in prison. Withdrawal symptoms were frequently claimed by patients who came to the Edinburgh Centre: on clinical examination, symptoms had been observed in only 10 cases, and in only 1 were they recorded as 'severe'.

Treatment Experience at the Royal Edinburgh Hospital

Table 7. *Admission and Discharges*

Admitted to Wards	64
Seen at Out-Patients only	36
Total	100
Outcome	
Admission offered but refused	19
Took own discharge from ward	30
Discharged to police custody	2
Absconded	2
Discharged as unco-operative	2

Admission for in-patient treatment proved distinctly unpopular—a reaction not peculiar to Edinburgh. At one London drug dependence clinic where admission was offered to all patients at first attendance, only 9 out of a series of 107 accepted.[4] Even among the 64 Edinburgh patients who agreed to come in, few remained for any length of time. 18 discharged themselves in less than a week, 13 left in under 2 weeks, 12 in under 3, and 8 in under 4. 21 of the 30 who took their own discharge did so against medical advice; in the remainder discharge was recorded as 'at the patients's request' or because the patient was 'bored' or uninterested. 18 were re-admitted during the 3-year period, 5 of them more than once.

Out-patients proved to be birds of passage. Of the 36 who were seen and told about the methadone treatment available, 25 never re-appeared. The others attended irregularly, fading away when the daily dosage was reduced or (presumably) because they had access to illegal supplies.

Why Did They Come?

Four main reasons brought these half-hearted patients to hospital. First, they thought they would get drugs, or get the drug of their choice. Tactics adopted to this end were claiming withdrawal symptoms, claiming they were 'registered' addicts (usually in London), or demanding to be 'registered'. Some said they had run out of supplies; a few complained that their G.P. wouldn't prescribe any more for them.

(Case 33) 'he states that he doesn't want treatment but requires to be registered as an addict so that he may receive a "legal" supply of drugs.'

(Case 62) 'He said he wished to be given a prescription for drugs as he had been registered an as addict 18 months ago at Charing Cross Hospital. He indicated that since Dr. Petro was no longer in business, he could no longer obtain "fixes".'

Those whose requests were refused did not mute their disappointment and annoyance.

(Case 29) 'G, came to out-patients with his girl friend S. They were hostile, demanding prescriptions for physeptone I.V. with frequent reference to the Home Office. When told this was not the hospital's policy, they both left with much cursing and swearing.'

(Case 37) 'This young man made it clear that he did not want to come off his drugs and when I suggested that he come for a daily dose of methadone, he flatly refused. In fact, he asked whether I would provide him with a supply of syringes and needles. When this was refused, he said he would just have to go on using his dirty needle and give himself hepatitis. When I tried to explain that my aim was to get him off his drug dependence, rather than foster it, he replied, "Well in that case, I think I'll go back to London".'

The second reason for coming was because they were on a Court charge, or in trouble with the police.

(Case 30) 'He got over his withdrawal symptoms in two days, and we learnt from his solicitor that he had a charge pending for possession and was due to appear in Court on June 5th. Because he was in hospital, his Court appearance was postponed to the middle of July. As soon as he heard this, Mr. F. asked for his discharge.'

(Case 6) 'It is becoming plain that the patient wishes us to give a psychiatric report to Court stating that he must not be sent to prison but that he needs treatment. He hints in a roundabout way that he will not serve a prison sentence, i.e. he will commit suicide.'

Third, there was some social crisis. Their parents had put them out; there were debts or rent arrears; their wife or girl friend had left; they had nowhere to live.

(Case 54) 'He says the reason why he came to Edinburgh is that he had a quarrel with his wife. "She tried to reform me or something, so I just walked out." He said all he needed was drugs, no treatment.'

Fourth, they had had a fright. This could be a 'bad trip' on LSD with recurrent hallucinations, or an amphetamine psychosis.

(Case 57) 'Miss B. had a breakdown last night and started screaming. She says she used to be very quiet but now raves all the time, especially when on acid. Or she gets "paranoid" and gets the "horrors". She always dreams about bodies with blood pouring out of their eyes.'

(Case 36) 'She had hepatitis which scared her and she wanted to get off drugs'. But 'does not consider herself physically or mentally addicted to any drugs and does not seem to think she should give up all drugs to be cured. ("I thought you would give me some Librium").'

A few patients came of their own accord because they were feeling ill (septicaemia, jaundice, phlebitis). They rarely stayed once their symptoms were alleviated.

Attitude to Treatment Among in-patients

The expressed wish for help in coming off drugs tended to evaporate soon after admission. Withdrawal of opiates, when undertaken, could be achieved without diffieulty: the problem was to sustain motivation and persuade the patient that the effort would be worthwhile. Few took kindly to ward requirements, and tolerance of any structured situation was low. After the first few days, they began to complain of boredom, were visited by 'hippie' friends, left the hospital without permission, and were occasionally found taking drugs again. They did not establish good relationships with either staff or other patients, and had a disruptive influence on ward morale. Behaviour and attitudes closely resembled those of an earlier group of offenders on probation with a condition of psychiatric treatment.[5]

(Case 80) 'When I saw him he did not appear anxious or depressed and my main impression was of indifference and apathy. He said it was his mother's idea that he came and that she was concerned about his drug-taking.'

(Case 81) 'While on the ward Miss B. was not motivated to stop drugs nor did she show any enthusiasm for rehabilitation and employment.'

(Case 58) 'He had requested admission because his supply of drugs was drying up and he thought he would take the chance of trying to come off them. . . He had agreed that he would not go out of the ward for the first week of his stay; but after only 48 hours he started asking for his clothes. We allowed his girl friend to visit him, but at the week-end he demanded his clothes. When he was reminded of his promise not to go out of the hospital, he told us we had no right to keep him in the ward, which was quite true.'

Motivation was little better among the 7 University students admitted. Although they stayed rather longer (3 of them for 6 weeks, and 1 for 2 months) the outcome was hardly more successful. Their medical notes contained such comments as 'says she has no intention of stopping drugs but feels she can control her intake' 'while on the ward, maintained contact with the 'drug scene', via 'phone calls to his drug-taking friends' 'left against medical advice with a girl from the ward who was also on LSD.' 2 others were discharged because of failure or refusal to cooperate. One of the 7 students, who had had a long period of out-patient psychotherapy before his short (3-week) hospital admission, did make good in the end and was reported off drugs 5 months later. In the interim, he had taken an overdose, and also had a Court appearance.

Recidivism and Relapse

Drug addicts are notoriously elusive, and resistant to contact after discharge. Even at the Nottingham Addiction Unit, where a full-time research worker was available, approximately one-third could not be traced; and of those who were, 17 per cent refused to take part in the follow-up study.[6] No such study could be attempted of the Edinburgh group, but incidental information was gleaned from Court reports in the local press, from ex-patients seen at hospital, and from patients re-admitted. When this was collated about 4 months after the survey closed, the situation was as follows:

Nothing known: 56 cases (many of these were believed to have gone back to London, or gone off there);

On a further Court charge: 21 (drug offences 13, non-drug offences 8);
Known to be still on drugs: 21

Off drugs: 2 (the University student and a day-release technical college student).

Questions arising

It will be apparent that the scheme for hospital treatment of addicts, outlined by the 1968 Act, is not working effectively at the Edinburgh Centre. In practice, unforeseen difficulties were encountered; and the hoped-for rehabilitation and employment, as envisaged by the Advisory Committee on Drug Dependence, failed to take place.[7] The best efforts of the hospital staff came to naught, when trying to deal with an almost totally unmotivated group whose reasons for coming had little to do with accepted medical treatment, and who were not subject to any kind of compulsion.

It could be that the designation of one area in the hospital as a specialised addiction unit, instead of the policy of dispersal of patients to different wards, would have given more useful results. As things were, a patient could come under the care of any one of 6 independent clinical teams; and 11 wards in 3 separate buildings shared the 64 admissions. This made it difficult to get a general picture of what was happening.

Of the 83 opiate takers, 63 were formally notified, 20 were not. The remaining 17, in the cannabis/LSD/non-opiate group, were not subject to notification. Failure to notify arose from a number of circumstances. The addict might present himself late in the evening, or at the week-end when no records staff were available to remind the Duty Doctor about the form. Or the addict could be given an appointment next day, when the form would be filled; but didn't come back. Another reason was the variation among individual doctors in choice of diagnosis. Even if a patient was known to be taking drugs, some doctors preferred to record the underlying psychopathology, i.e. 'adolescent crisis' or 'personality disorder', rather than the symptom (drug addiction). And in one or two cases, it appears that the doctor felt that a diagnosis of addiction conveyed a stigma, which they did not wish attached to a particular patient.

In view of the freedom addicts have to discharge themselves from hospital centres, should compulsion form part of the treatment? Some psychiatrists experienced in running addiction units [8 9 & 10] have posited the value of an initial period of compulsory detention, as providing a complete break with former haunts and habits, and opportunity to benefit from intensive psychotherapeutic help. But the

permissive and non-authoritarian milieu of psychiatric hospitals today would not easily accommodate non-psychotic compulsory patients. unless a separate unit were set up.

Medical care of addicts deals only with one aspect of their problem: their social rehabilitation requires a network of supporting services. A number of difficulties were encountered here. The Advisory Committee[7] recommended that each Treatment Centre should have its own full-time social worker, who would be available to encourage motivation (however faint), contact families (where appropriate), arrange re-training (if acceptable), and effect liaison with outside agencies. Social workers at the Royal Edinburgh Hospital did what they could for individual cases, but none could take sole responsibility for the addict group. The Advisory Committee also recommended the provision of supervised hostels for addicts who had nowhere to stay. Edinburgh lacked accommodation of this type: the existing men's hostels are unsuitable for younger groups. Due to local conditions at the time of the survey, the likelihood of obtaining employment was almost nil (on a date in January, 1970, 5,962 men—5·1 per cent of the working male population in the Edinburgh area were totally unemployed). Handicapped as so many of the drug takers were by a criminal record, no skills, no references, and (often) their 'hippie' appearance, they stood little chance of a job other than casual labouring. Emigration was barred; they would not be acceptable to the Army; marriage and children on Social Security an unenviable prospect. In such circumstances, it is understandable that they sought pharmacological oblivion from their dimly realised despair.

The Edinburgh Centre, by its policy of withholding heroin, clearly had an effect in discouraging addicts from flocking to the city. Word would soon go round on the addict grapevine that no opiates were prescribed at the hospital. Since the end of the survey (May 1971) there has been a marked drop in the number of cases referred—17 only from then until March 1972. This no doubt reflects the vigilance of the Edinburgh Drugs Squad; increased security precautions taken by chemists; and a less lenient attitude towards drug offenders on the part of the Courts. It is also probable that the recent death in hospital of several well-known local addicts (4 in the space of 3 months) has caused others to stop and think.

In 1970, for the first time since 1958, Home Office statistics show a decrease in the number of known opiate addicts, from 2,881 in 1969 to 2,661 in 1970. Could this, and the decline in referrals to the Edinburgh Treatment Centre, be an indication that the epidemic tide is beginning to recede?

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