Contemporary Themes

Treatment and Follow-up of Adolescents Addicted to Heroin

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Summary

A survey of the first year's referral of heroin-addicted adolescents was undertaken exactly two years after the opening of a special treatment unit. Out of 130 patients presenting 78 were selected for treatment and were followed up. The drug-taking pattern of this group is reported. At the time of the survey 27% were assessed as off all addictive drugs.

Introduction

Following the recommendation on heroin addiction in the *Second Report of the Interdepartmental Committee*¹ the Ministry of Health established special treatment centres in 1968 to deal with the serious epidemic that had arisen in the United Kingdom. The details of the system have been described and assessed elsewhere.²⁻⁵

The Home Office figures in 1968⁶ showed that about 27% (764) of addicts were teenagers. In view of this a small unit was opened in April of that year to treat addicts under the age of 18. The outpatient facility is for some 50 youngsters of both sexes, while that for inpatients provides accommodation for 10 boys. A fuller account of the policy and function of this unit has been published.⁷ The present paper describes certain aspects of all the patients seen in the first year, their treatment, and their state two years after the unit opened.

Patients

The survey included a total of 130 patients (116 males, 14 females), of whom 52 (46 males, 6 females) were not accepted for treatment for reasons of age, failure to attend, or because they were not really addicted.

Diagnosis of addiction must be a matter of careful judgement rather than proof. Venepuncture marks and clinical history help in what is essentially a clinical assessment. Urine analysis, though valuable, was not used as an absolute criterion because the technique is not always reliable in the modest dose range, and repeated positive urine tests are not themselves proof of dependence. In this age group withdrawal symptoms are not easy to identify. It is even more difficult to estimate the true quantity of the drug being taken. The need is carefully assessed initially and then subsequently measured by the response to dose reduction.

A total of 70 boys and 8 girls form the main group studied. Most came from a few focal points in the Greater London area. The initial age range was from 14 years 9 months to exactly 18 years (mean of 17.1 years). According to the Registrar General's social classification 69 patients (information on nine was not available) came from families belonging to the following social categories: I 1, II 2, III 49, IV 11, and V 6. None of the patients were married, and all were born in the United Kingdom or Eire. There was a history of severe emotional disturbance in one or other parent in 24 cases, in six of which one parent was absent through death, separation, or divorce. In a further 17 cases one or both parents were also absent from the family for the same reasons. In three cases the patient was an only child.

Altogether 70 patients had had court convictions—25 had had their first conviction before starting to take drugs and 32 afterwards; in 13 cases it was not possible to determine this time relationship. Of these 70 patients 37 had committed one or more drug offences.

The ages of the addicts when drugs were first tried are shown in Table I. Only three patients had tried heroin as their first drug experience, the rest had started on either amphetamines or cannabis or barbiturates (or other hypnotics) or amphetamine-barbiturate mixtures.

TABLE I—Ages of Addicts when Drugs were first used

Age in years:	11 –	12 –	13 –	14 –	15 –	16 –	17 and over
No. using non-opioid drugs	5	2	8	26	27	9	1
No. using heroin			1	6	24	34	13

No overtly psychotic patients presented, and the term "psychopath" was not appropriate to this group. Many neurotic features were, however, evident, especially obsessive-compulsive patterns and depressive moods. A form of chronic depression, expressed as apathy and boredom, seemed to underlie most cases. Under stress and without drugs these features became more pronounced. These youngsters tended to be highly suspicious, especially of adults in authority. Paradoxically they were also dependent on and demanding of adults. There was rivalry and resentment among each other and they remained isolated even within their own group. Many were emotionally immature and had failed in their social and educational environment. They were also sensitive to criticism, painfully aware of failure, and usually guilt-ridden. They showed low tolerance to anxiety and frustration, often responding to these by aggression and destructive outbursts or by illicit drug taking.

Treatment

The general policy was to provide overall psychiatric care and a programme of gradual drug withdrawal, substituting metha-

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done for heroin, either by injection or by mouth. Withdrawal was a joint enterprise between doctor and patient. An imposed programme of withdrawal in this setting is usually unsuccessful. Each outpatient was provided with weekly or fortnightly psychotherapy, and attendance though voluntary was ensured by the need for a prescription. A social worker was available to assess the family situation and to help by direct contact with parents and agencies.

The inpatient programme consisted of milieu therapy, group therapy, and individual psychotherapy, together with occupational, recreational, and educational activities similar to those of other adolescent units. The purpose was to help the adolescent to learn about himself and to make appropriate choices in a developing life situation. Enforced admission was not considered effective. Inpatient stay usually lasted many months, and in some cases readmission was necessary.

Results

Of the 78 patients in this study 37, all boys, were still attending at the time of follow-up. The remaining 41 (34 boys, 7 girls) terminated their treatment for various reasons. Fourteen were taken into custody—that is, remand centre, detention centre, approved school, or Borstal—10 were transferred to other clinics, 13 failed to continue their appointments but had not sought treatment elsewhere, and four were discharged as off drugs. None died.

It is difficult to judge precisely when a patient stops the use of drugs altogether. The current taking of opioids—that is, opiates and synthetic analogues such as methadone—was therefore assessed from the following sources of information: (1) the current prescribing of opioids; (2) urine testing where available; (3) the doctor's opinion on the use of illicit opioids; (4) the patient's statement about drug taking; (5) the patient's detention in custody; and (6) information from sources such as the Home Office, probation services, and other clinics. By using these criteria the patients were placed in the three groups shown in Table II.

TABLE II—Opiate usage by Patients at Time of Survey

Group		M	F
1—Apparently not taking opioids	(a) Consistent evidence from various sources and negative urine tests	2	
	(b) Consistent evidence from various sources without urine tests	3	
	(c) Assessed as probably off drugs	8	
	(d) Detained in custody	7	1
2—Apparently taking opioids	(a) On prescription at this clinic	28	
	(b) On prescription at other clinics	2	3
	(c) Assessed as probably on drugs illicitly	14	
3—Not assessable		6	4

Of the 78 patients studied 21 (27%) were assessed as off opioids (and other addictive drugs), of whom eight were in custody and withdrawn involuntarily. Of the remaining 57 patients 47 (60%) were still on opioids (33 on prescription and 14 illicitly) and 10 could not be traced. A comparison of the mean overall daily dose of opioid prescribed to the 37 patients still attending at the time of survey with that prescribed initially to these patients showed a reduction from 83 to 28 mg.

Discussion

It is difficult to get accurate information from drug-addicted adolescents or their relatives, and it has been impossible to gain co-operation of many parents. The facts presented offer at best a rough assessment. It is also premature to derive any firm conclusion about the programme. Many disturbed adolescents are unlikely to achieve stability, even with psychiatric

care, until they are through this stage of life, and the treatment of addiction is itself a long-term commitment.

A number of problems arise in a new pioneering project of this kind. Such factors as the inexperience of staff, the uncertain protocol of an adolescent unit, the lack of any previous therapeutic model, the lack of appropriate social agencies, and the moral, medical, and legal issues involved make decisions difficult. The combination of firmness and patience and consistent staff teamwork are not easily achieved in this setting, which lies outside the established pattern of psychiatry.

It has been shown that about half of the group studied abandoned the clinic in one way or another. Some found the commitment very demanding, others felt that they could obtain larger supplies of prescribed opioids elsewhere, and others were distressed by the pressure put on them to reduce their drug before they felt ready to do so. The need to obtain illicit supplies of drugs was the usual reason for those who were placed in custody.

At the end of the period surveyed, ranging from 12 to 24 months, about one in six had managed to withdraw voluntarily from the drug. The pattern may improve in the course of later surveys, as the policy has been to proceed cautiously.

A sharp reduction occurred in the mean dose of opioid in those still on prescription between that initially prescribed and that prescribed at the time of survey. It is evident that these youngsters have difficulty in abandoning the use of the needle and in withdrawing from the last small dose, usually about 20 mg of the drug.

There have been few comparable reports from other drug-dependence clinics in the United Kingdom. Gardner and Connell³ described the first year of operation of one clinic with particular regard to clinical groupings, management policy, dosage of drugs prescribed, and the use of urine analysis. Zacune *et al.*⁸ provided a survey on 37 heroin users treated in a provincial town. Six cases (16%) were thought not to be using heroin at the end of one year, but no indication was given of opioid or non-opioid drugs being used in substitution. Bewley *et al.*⁵ provided a full report on three clinics over the same period as the present study. They found that at the end of the second year fewer than 20% were off all drugs. Chapple and Gray⁹ reported on one year's work at a centre for the treatment of addicts; however, they made a discretionary allocation of patients to different treatment programmes and their figures are not comparable. Gardner¹⁰ reported that there were 58 deaths among United Kingdom opioid users in 1969.

Youngsters who have been in the care of the unit have profound personal problems, of which their drug taking is both a symptom and a deviant attempt at resolution. Much of the success of this type of unit will depend on additional factors, such as the policies of other treatment centres and the control of illicit supplies of drugs. There is still great need for both liaison between agencies and uniformity of policy.

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