Another explanation is that failure to respond to treatment was due to continuation of illness behaviour (Parsons, 1951). Different patterns of abnormal illness behaviour have been described by Pilowsky (1978), and his description of "illness affirming psychologically focused abnormal illness behaviour" could be considered in these two cases. Since both women believed that 'curses' remained on them in London, relinquishing the sick role could only occur with repatriation, when these curses would be removed. Similarly, unexplained episodes of unconsciousness and hypotension may be viewed as responses to the failure to remove the perceived threats. An analogy may be found in Australian aborigine culture, where a witch-doctor can place a curse on another in the ceremony of 'pointing the bone' (Elkin, 1964). If the curse is not removed within three days, the unfortunate victim is certain to die, with no apparent physical cause of death.

Whether any of the above explanations is correct remains unclear. Fortunately, both cases had a satisfactory outcome, despite a stormy passage, and it was only after detailed ethnic enquiry that the clinical team was able to assist in their recovery and facilitate repatriation. Since we all work as clinicians in a multicultural society, it behoves us all not to disregard the meaning of 'maggots in the salt', and we ignore the relevance of the 'snake factor' at our (patients') peril.

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British Opiate Addicts: An 11-Year Follow-up

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Summary: A cohort of 83 British addicts from one clinic was followed-up after 11 years; Home Office records and medical notes were personally searched to trace current status. Twenty-nine were still using drugs, 37 were not known to be using drugs, and 17 had died. The group still using drugs had become markedly more stable on parameters of drug use, criminality, and social stability over the follow-up period.

In 1968, a number of NHS Drug Dependency Clinics (DDC) were set up following the 1967 Dangerous Drugs Act, and as a response to the rise in drug abuse during the early 1960's. The Act also provided for notification of opiate and cocaine addicts to the Home Office, thus facilitating the follow-up of opiate addicts. The original policy of DDCs was that after an initial maintenance period, the majority of addicts would be weaned completely off drugs (Edwards, 1979), the intention being to practice an energetic and comprehensive approach to the problem, and not just to provide

prescriptions, (Lancet, 1968). The DDCs have been criticised from many sources, and their efficacy in dealing with the problems of drug dependence questioned, but despite problems in defining what constitutes a good outcome for drug dependence, the report of the Advisory Council on the Misuse of Drugs (DHSS, 1982) suggests that the British system does show significantly better recovery rates than European and United States figures. As little is known of what happens to drug addicts over time, follow-up studies are important in increasing our understanding of the natural history of drug dependence and of the impact of the DDCs. This is particularly pertinent at a time when Government policy is to encourage the development of regional drug dependence services. The following study is the longest follow-up report yet published for British addicts (11 years), and uses information taken over a six-month period, rather than at a single point in time. Details presented here of the cohort and of their current status.

Method

The cohort was made up of all 83 patients attending a London DDC for treatment in July, 1971. Their case notes were studied, and data for the six-month period prior to that month extracted in a standardised and pre-arranged fashion. With due regard for confidentiality, Home Office records were then searched to reveal the names of those addicts still receiving prescriptions in 1982, or the date of the last contract for those not known to be using drugs. Data were then extracted from case notes for a six-month period in 1982 for those still receiving drugs, or for the six-month period prior to the last known date of contact. In 1982, two of the group known to be receiving drugs were doing so from a private doctor, who would not provide data for the follow-up period.

Results

The cohort consisted of 60 men and 23 women. The mean age of onset of drug use was 17.1 years, the mean number of years on drugs before 1971 was 7.1, and the mean number of months on injectable drugs before 1971 was 39.7. There were no significant differences between the sexes for these figures. In July 1982, 29 of the cohort were known to be using drugs, 17 were dead, and 37 were not known to be using drugs. These different outcome groups were then examined in more detail.

Those known to be using drugs

The drugs prescribed to this group are set out in the Table. Although there had been few changes overall, the prescription of heroin had ceased altogether by 1982. In 1971, 14 of the group had complications directly attributable to drug use, (accidental overdoses, abscesses, withdrawal fits, jaundice, etc.), whereas in 1982 only five were suffering from these complications. Criminality was assessed by counting the number of references to prosecutions in the case notes during each six-month period. The results indicate a substantial fall in criminality. Data for various social parameters are also given in the Table. A stable relationship included those who were cohabiting and had a regular partner, as well as those who were married. Permanent accommodation refers to accommodation where regular weekly or monthly payments for it had to be made.

TABLE

Drug use, criminalty and social stability of those who continued to use drugs

Parameters	*1971*	*1982*
Drug use		
Number receiving heroin + methadone	3	0
Number receiving methadone alone	26	27
Number receiving injectable drugs	29	26
Number with complications of use	14	5
Criminality		
Number prosecuted for drug related offences	8	1
Number prosecuted for all offences	10	1
Social stability		
Number with stable relationship	14	20
Number in permanent accommodation	21	21
Number in regular work	6	10

Those who were dead

The mean age at death was 29.9 years. The deaths were spread evenly over the eleven-year period and yielded a mortality rate of 18.6 per 1,000 addicts yearly; all those who died were known to be using drugs at the time of death. The cause of death was ascertained from the DDC notes but was not always available. Drug overdose was the commonest cause of death, and drug abuse appeared to be linked with the cause of death in all cases.

Those not known to be using drugs

It was unfortunately beyond the scope of this study to interview members of this group personally, but a record was made of their status at last contact with the clinic. Thirteen were stated to be off all drugs at last contact. Thirteen were in prison, though these are not necessarily still in prison, and indeed, most should have finished their sentences by now. They were, however, not known to have used drugs at any time between release and July 1982. Four had gone abroad permanently, two were hospital in-patients and definitely not using drugs, and for five no information was available.

Discussion

This is a retrospective case note study and has all the disadvantages of such an investigation. However, the data were initially recorded in the notes in a semi-structured manner, with future research in mind. Despite this, it is likely that there will have been an under-reporting of prosecutions in the criminality figures, but no reason to assume that this would occur more often in one year than another.

Though drawn from one DDC, the cohort was similar with regard to mean age, lenth of time using drugs, and male:female ratio to the sample of people approaching DDCs described by Blumberg

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et al (1974). Two other long-term studies of British addicts have been published (Wille, 1981; Gordon, 1983), and the overall outcome of our cohort, with 29 still receiving drugs, 37 not known to be taking drugs and 17 dead, approximated closely to the outcomes that they describe.

In the group still using drugs, there has been a definite move towards stability, viz—a marked fall in those having complications of drug use and in those involved in criminal proceedings. There has also been a slight increase in the attainment of a stable relationship and of regular employment; the latter is perhaps particularly surprising given the current economic climate. It is of interest that despite the official clinic policy of weaning addicts from injectable drugs, 26 were still on these at follow-up. This is testimony to the stability of this group over the 11 years, since a chaotic lifestyle (abuse of other drugs, excess side-effects, etc.) would have led to cessation of prescription. Mitcheson & Hartnoll (1980) showed that there was no difference in social adjustment or illicit drug use between two groups, when one received oral methadone and the other injectable heroin, which would suggest that continuation on injectable drugs reflects stability rather than causes it. Whether the changes in criminality and social parameters are a result of continuation on drugs (oral or injectable) or a cause of continuing prescription, remains to be shown, but the changes are marked. This group may well be similar to the 'stable' sub-group described by Willie (1981), which was more likely than any other to contain continuous heroin users (by injection).

The 20% mortality is slightly higher than that of other studies, but this study covers a longer period; the mortality rate of 18.6/1,000 addicts yearly is comparable with other studies (Ghodse *et al*, 1978).

Little can be said about those not known to be using drugs. Edwards (1979) and Johnson (1975 a; 1975 b) have shown that Home Office records are generally valid and internally consistent. The category 'not known to be using drugs' should not be confused for 'known not to be using drugs', but Stimson *et al* (1978) personally followed-up a group who stopped attending clinics, and 80% were shown to be abstinent.

Thus, the outcome for opiate dependence within the British system is not as gloomy as is often thought. Those still receiving drugs after 11 years have become more stable on a number of parameters, and it has been suggested that up to 80% of the non-attending group are abstinent, (Stimson *et al*, 1978). However, the role of the clinic in bringing about such changes has not been fully evaluated (Edwards, 1979). Further long-term studies of addict careers, both in and out of the clinic system, are essential if any such assessment is to be made (DHSS, 1982).

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