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Addiction research and the future of addiction psychiatry

Addiction research in the UK has a long and distinguished history. Over the past 25 years seminal contributions have been made. These include description of the dependence syndrome, an innovative range of psychometric instruments and radical re-thinking about treatment outcome of intensive interventions (Glass, 1989). Review of the past 5 years highlights continued developments in some areas, but significant gaps in others (Addiction Abstracts, 1994–1999). How will this impinge on the future policy and practice of addiction psychiatry in the UK?

Since the 1960s increased availability of drugs and alcohol has led to an escalation in use, harmful use and dependence (Royal College of Psychiatrists and Physicians, 2000). Research evidence is gathered from many different sources; from seizures of drugs, quantities of alcohol sold, offences, surveys and notifications of drug use to a variety of agencies. Sixty per cent of the population use alcohol and 5% are addicted to it (Raistrick *et al*, 1999). Approximately one-third of the population smoke cigarettes, 15% use cannabis, 5% use amphetamine and possibly 1–2% are using opiate drugs in a harmful manner or problematically. Moreover, there is considerable variation in the prevalence of type and route of substance use across the country. Epidemiological research indicates that there is a substantial problem in the young and in the older population. Young women especially are involved in the drug scene. There is an accumulating body of evidence that despite the revelations, and the widespread concern and consensus regarding extent of substance use in the young, for example, this has not been translated into the development and evaluation of good quality services. There are isolated pockets of committed provision, but this is patchy and underresearched.

Likewise, misuse in the older population, also increasing (17% of the adult population is now over 65 years of age), is neglected. On one hand this is not surprising, although on the other it is. Older people with the significant physical and psychological comorbidity that often accompanies ageing are non-compliant with prescribed drugs with misuse potential, which are supplemented by over the counter medications, alcohol and nicotine.

How does our research portfolio compare with the US? What are the similarities and differences? A major difference is the existence of national research policy and strategy. Over the years this has been underpinned by extensive resources for research, training and service provision. This is clearly evident in the research mapping exercise in which America dominates the rest of the world in producing two-thirds of published abstracts. The predominant area of interest for the States, as for the UK, is in the intervention domain. This includes both prevention and education, as well as treatment interventions. Wider policy issues related to advertising and cost of treatment are common to both countries.

In treatment intervention research, both the US and UK are interested in the 'new' range of pharmacological means of detoxification, e.g. lofexidine, naltrexone, levacetylmethadol hydrochloride and buprenorphine. 'Older' issues like methadone substitution, brief interventions, especially in relation to retention and relapse, and differing methods of service delivery are equally acknowledged. A major gap exists in terms of outcome of research for combination of pharmacological and/or psychological treatments administered for this group.

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Innovative interventions specifically for combined conditions appear to be a long way off.

Attention to psychological comorbidity has increased greatly. Evidence for prevalence of psychological symptoms in substance misusers and substance misuse in psychiatric patients is well researched in the clinical populations on both sides of the Atlantic. In the primary health care situation there is a dearth of published material although there is much written about the best models of service delivery in secondary care.

The UK has a relatively strong research profile on primary care, pathways to care, the prison setting and the implementation and evaluation of general practitioner training programmes. There is, on the contrary, limited training of other medical specialists – including general, child and adolescent and forensic psychiatrists – and, as a consequence, little appraisal. This is paradoxical in view of the presence of psychiatric and physical comorbidity.

The place of the user, patient and carer in assessment and control of care packages is well developed in America, and if this occurs in the UK, it is not reported to the same extent. North America demonstrates research activity in young people, gender, cultural, ethnic and racial issues and the workplace. Likewise, the US publishes work on 'predictors' in treatment outcome that includes pre-treatment and post treatment factors, 12 step facilitation and a limited interest in older people.

The focus on substances varies too: the UK devotes half published research to drugs, one-quarter to alcohol, one-tenth to nicotine and one-twentieth to polysubstance use. American research, however, reports less drugs related research (35%) and more on the more commonly prevalent substances, e.g. alcohol (27%), nicotine (22%) and polysubstance use (16%). The total output in publications in the UK and US on AIDS/HIV has diminished to some degree over the past few years. However, the UK research centres in Scotland and London have made a substantial contribution to work on prevalence and associated risks of HIV/AIDs.

Most telling is the lack of any significant neuroscience base, apart from a few notable exceptions. This is where the UK contrast with the US is most obvious. And it is not without its importance and potential impact. Technological advances in neuroimaging and genetic research may not be immediately translated into clinical situations, but the rapidly evolving knowledge base in the addiction field is ultimately likely to generate applications for assessment of treatment interventions. There are all kinds of possibilities, but we need to exploit our heritage, which is a sound one in all three fields: addiction, imaging and genetics.

In the UK four main centres produce approximately 50% of the published addiction research. However, the rest is diffusely dispersed and disconnected from a planned policy direction. Furthermore, there is evidence of regional and local variation not only in the pattern of use of individual substances, but also in the treatment facilities, consultant recruitment and models of service delivery, as well as the academic and educational opportunities. There are, for example, just four academic departments of addiction psychiatry. Given the ubiquity of the associated psychosocial problems – but the variability – in community, clinical and forensic settings, a national evidence-based research strategy that galvanises particular research issues where there is a consensus of national, regional or international importance, is urgently called for.

In this process it may be worthwhile for the UK to consider the development of a few specialist intra-disciplinary addiction research centres as part of a national priority to enhance the quality and maximise research output in a manner that is commensurate with investment. Collaborative scientific leadership that is inspiring; develops a career pathway for talented and motivated clinical academic psychiatrists and scientists; champions the need for resources; and thinks through the scope of any potential scientific contribution that is both of national and of international relevance, will sustain the key conceptual contributions of 'modern' UK addiction psychiatry some 25 years ago.

This editorial is based on a review of *Addiction Abstracts* (1994–1999), which will form part of a more extensive publication.

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