Written evidence from the Centre for History in Public Health

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The authors are two professional historians and a social policy specialist, all of whom have worked on the history of drug policy. The Centre for History in Public Health aims to bring insights from historical research into public health policy making.

Summary

- This memorandum argues that an evidence based response to drug policy must include context and an assessment of history.
- Such insights can tell us that people have used drugs for a long while, sometimes more extensively than at present.
- The idea of treatment arose only at the end of the 19th century and has passed through different versions since then, often with professional or political rationales to the fore.
- The international control of drugs has a long history dating back to the First World War and recently the system has come under strain. Its nature is unique and unusual.
- Model countries likewise have a long history with models chosen according to the direction of policy at the time or the impetus for reform.

We are commenting on 5 areas of the committee’s work:

1. What would an evidence based response look like? (Best Practice)
2. Why do people use drugs? (Prevention and Early Intervention)
3. Treatment and its history. (Treatment and Harm Reduction)
4. The role of international control and recent changes. (Best Practice)
5. Model countries and changes over time.(Best Practice)

1. What would an evidence based response look like?

The role of epidemiology, psychology and other disciplines is important. We would like to propose that an historical understanding of drug policy is also valuable. It is easy to consider only the present day, but history provides:

- context and a longer term perspective on current developments;
- evidence of what has been tried before and why;
- an understanding of the deep-rooted nature of many of the issues but also the way in which they have changed over time.

Instead of a hurried snapshot of the present, taking account of history allows the long view and a better assessment of current developments with a view to the future.

2. Why do people use drugs?

2.1 People have always used drugs. Back in the 19th century when drugs such as opium were widely available over the counter without any form of restriction, opiate use was widespread both as a cure-all in the absence of other effective drugs, but also shaded into recreational use and what would now be called addiction. Such use did cause concerns but these were founded on who was using drugs - was their use becoming embedded in the industrialised working class along with that of alcohol?"
2.2 The issue of out of control drug use has reappeared at other points in more recent history - for example in the 1960s when numbers of addicts were increasing and the older style middle class ‘medicalised ‘addict was giving way to a group using for more hedonistic reasons.

2.3. The 1980s was another period of concern. The number of known addicts rose from 2,666 in 1979 to 10,389 by 1987. Despite better reporting of addiction, these figures were thought to be a significant underestimate. Some commentators argued that it was quite possible that there were as many as 100,000 heroin addicts in Britain by the end of the 1980s. There was much discussion of the ‘normalisation’ of drug use, although it was pointed out that drug use had been more ‘normal’ in the population in the 19th century.

3. Treatment history

To understand where treatment is going, it is important to understand where it has come from and the tensions which shaped it.

3.1 Origins – C19th
Problematic drug and alcohol use had been characterised as ‘bad habits’ and ideas about disease and treatment only emerged in the 19th century. It was not until the late 19th century that treatment was considered appropriate. Opium use was widespread, but the idea of treatment was not automatic. More powerful opiate drugs, like morphine and heroin were developed. These were often administered to patients by doctors through the hypodermic syringe. This practice brought problem drug use to medical attention and indeed caused it as well. New labels and concepts began to develop. ‘Inebriety’ encompassed alcohol and drug use and had particular legal meaning whereby an ‘inebriate’ was offered treatment in a hospital or an inebriate asylum as an alternative to prison. By the 1880s, the term ‘alcoholism’ was coming into professional usage, and by 1900, ‘addiction’ was being used to describe problematic drug use. Accurate numbers are almost impossible to ascertain, but it is likely that the scale of drug use in the population as a whole was extensive. However, the main problem was seen to be alcohol and the attempts to widen the Inebriates Acts was intended to keep alcoholic inebriates out of the ‘revolving door’ of prison.

3.2 Rolleston era, 1920s
It was a sense of crisis during World War One that brought drug use and drug treatment to wider attention. Fears about cocaine use amongst troops on leave in London or billeted nearby resulted in an emergency piece of legislation: drugs like morphine and cocaine could still be obtained, but only on prescription. In 1920, these restrictions were made permanent for the general population under the Dangerous Drugs Act, in line with the newly established international control system. At the same time, members of the medical profession and government officials became concerned about the amounts of opiate drugs being prescribed to patients addicted to these, and whether or not continued prescription was a legitimate form of treatment. An Interdepartmental Committee chaired by Sir Humphrey Rolleston was convened to assess the situation. The Rolleston committee found that continued prescription of opiate drugs to addicts was an acceptable method of treatment if all attempts to withdraw the patient from the drug had failed. This practice, known as ‘maintenance’ was legitimated by the patient population, who were largely middle-aged, middle-class and had often become addicted as result of treatment for another condition, usually pain relief. This episode was also notable for the establishment of the relationship between the Home Office, with primary responsibility for policy, and the newly created Ministry of Health, a relationship which persists to the present.

3.3 Drug Dependence Units, 1960s
Treatment for drug addiction remained much the same until the mid-1960s. A small increase in the number of known addicts, and the fact that these new addicts were younger and more likely to be using drugs for recreational reasons, prompted a reassessment of addiction and its treatment. In 1965, the Departmental Committee on Heroin Addiction described addiction as a ‘socially infectious’ condition, and recommended the establishment of specialist treatment centres that would both treat addiction and prevent its spread. Initially, the Drug Dependence Units (DDUs) provided heroin maintenance treatment and some provided cocaine, but by the mid-1970s most had moved towards treating addicts with the opiate substitute methadone, first on an injectable basis and then orally. There was also a shift away from maintenance and towards withdrawal, encouraging addicts to come off drugs altogether.

3.4 Methadone, withdrawal and abstinence, 1970s-80s
The reasons for this treatment shift were multi-fold. There appeared to be some evidence to indicate that patients prescribed methadone rather than heroin were more likely to stop taking drugs, although methadone patients were also more likely than those on heroin to commit crime. Many doctors working in DDUs found heroin maintenance therapeutically frustrating: they wanted to do more to help their addict patients stop taking drugs. DDUs became more focused on ‘curing’ addicts of their addiction, and moved away from maintenance prescription (with either heroin or morphine) and towards a more confrontational response focused on withdrawal from drugs with abstinence as an end-goal.

This policy may have resulted in some addicts coming off drugs, but it drove others to seek out treatment, or drugs, elsewhere. Some users went to GPs who were thought to be easier to persuade to provide methadone on a maintenance basis. Others turned to the burgeoning black market in illicit drugs. Before the late 1970s, the illicit market in drugs had largely been confined to a ‘grey market’ in pharmaceutical heroin that had been diverted from legitimate sources, such as theft from pharmacists or over-prescription by doctors. But after 1979, there was a sharp increase in the amount of illicit heroin imported from places like Iran. This heroin was ‘brown’ and could be smoked rather than injected, something which was thought to be a factor in the rapid increase in the number of people using drugs.

3.5 HIV/AIDS, harm reduction and ‘treatment works’

In the early 1980s, Britain came under the influence of the US inspired ‘war on drugs’ and it seemed likely that the more restrictive and punitive view of treatment would prevail. The advent of HIV/AIDS and the fear that drug use might provide a conduit for the spread of HIV into the general population brought a significant change of stance, and there were moves towards the reinstatement of the response (now termed ‘harm reduction’) which had animated drug policy since at least the 1920s.

Initiated by the McClelland committee report in Scotland and in 1988 by the Part 1 report on AIDS and Drug Misuse of the ACMD (Advisory Council on the Misuse of Drugs) the new stance was informed by research evaluating needle exchanges and saw the legitimation of methadone prescribing as part of a ‘hierarchy of objectives’ leading to eventual abstinence.

A review of Treatment Effectiveness in the 1990s supported this approach, and its rationale changed with less focus on HIV prevention and greater emphasis on treatment as an alternative to prison. In this way the focus of treatment was changing back to the rationale of the 1890s.

3.6 The recovery agenda and recent developments

More recently, the Coalition Government brought further changes prioritising ‘recovery’ and abstinence and links to alcohol abuse, child protection, mental health, employment and housing. Experts agreed that more attention should be given to recovery – although drug treatment services were judged overall to be performing well. But there were challenges - especially multiple problems and needs and often the absence of support networks and ‘recovery capital’.

Several forces lay behind this shift. Among them the growth of the recovery movement; the example set by Scotland; reactions against what was seen as too liberal prescribing of methadone or people being ‘parked on methadone.’ Treatment services were said to be focusing too much on numbers in treatment and not enough on outcomes, an issue highlighted in a critical 2007 BBC report. Too rapid an expansion of services was thought to have increased the quantity but not the quality of services. And finally, the change was driven by promotion of new Conservative social policies, focusing on Broken Britain and the need for fundamental behavioural changes.

Instituting the goal of recovery involved re-arranging services. The National Treatment Agency (NTA) was abolished and its functions absorbed into a new public health service in 2012. Treatment funding moved into the public health budget. At local level, Directors of Public Health, jointly employed by Public Health England and the local authority, were given lead responsibility for drug and alcohol services. In competing for contracts, some DDUs lost out to large independent agencies who came to dominate provision. These institutional changes aimed at the long-desired goal of better joined up services. However, they also coincided with austere fiscal policies. While NHS expenditure was relatively protected, other budgets suffered cuts, so there were few funds for recovery-supporting action. And drugs and alcohol were lower priorities locally than the needs of children and old people. Even within public health, other concerns dominated, such as obesity and smoking.

3.7 To sum up: treatment policy has distinct themes which have remained constant over time.

- The tension between medical and criminal justice/punitive approaches
• Treatment policies driven by needs other than those of users, with the rationale often based on professional or political considerations.

4. The role of international control and its recent changes

4.1 Ideas about ‘model countries’ need to be set within the context of the history of international control, the global system. Key forces influencing the supply of drugs have been changes in patterns of trade – liberalisation and globalisation - and new technologies. In response, a system of global governance has evolved - international control mechanisms which date back to the early part of the twentieth century. The control system came into being as part of the peace settlement after World War One. The system in the interwar years was one of regulation of international trade, run by the old colonial powers. But during World War Two American influence entered the system in a major way and thereafter the focus was on control of supply.

UN Conventions of 1961, 1971 and 1988 constitute the main architecture of the multilateral system. Key institutions are the Commission on Narcotic Drugs (CND), the International Narcotic Control Board (INCB) and the United Nations Office on Drugs and Crime (UNODC) The World Health Organisation (WHO) schedules narcotic drugs and psychotropic substances and establishes international definitions.

4.2 Recent years have seen efforts to change the international drug conventions. Two polarities frame discussions: a drug free society versus harm reduction. Recognition has increased of the system’s unintended consequences: an expanding criminal market; policy displacement – from health to criminal justice; geographical displacement – as control was effective, production and distribution simply moved elsewhere; substance displacement – to more potent and unknown substances; and marginalisation of users.

Critics questioned the system’s effectiveness as it struggled to control increasing numbers of psychoactive substances.

4.3. The process of policy change has been one of ‘soft defection’ - low level deviance by states regarding adherence to the Conventions. Many countries moved towards less punitive and more health focused approaches, especially regarding harm reduction practices and changing attitudes to cannabis and coca. A ‘zone of pragmatism’ emerged in the EU.

4.4. Reformers proposed legally regulated markets. The establishment of licit markets for cannabis in Uruguay and Canada challenged the Conventions. The extension of marijuana reforms in US states has reduced that country’s leadership regarding strict interpretation of the Conventions. Countries now split between those who support the status quo (such as China, Russia, East Asia and the Middle East); radical reformers, such as some in Latin America; and moderate reformers, such as Europe. However, changes in the political complexion of a government can always change the stance of a particular country (as in Hungary or the Philippines).

4.5 To sum up: international narcotic control was from the outset a highly unusual international system with its own agencies within the League of Nations initially and then the United Nations. No other set of substances has a system remotely like this one, even with the advent of the Framework Convention on Tobacco Control (FCTC) in the early 21st century.

5. Model countries: changes over time

5.1. Ideas about ‘model countries’ have a long currency in debates with changes dependent on what are considered to be the main goals of drug policy world wide and at the national level.

5.2 Ideas about the ‘British system’ were influential for many years. The comparison often drawn was between ‘liberal’ Britain and the punitive stance of the United States. Then the focus changed in the early 1980s towards the US as a model. US Drug Courts were influential in the 1990s/2000s. Some now see their current opioid epidemic as a foretaste of what might happen here.

5.3 Today, the ‘Portuguese model’ is used to signify a more liberal approach. This was initially designed to address a heroin epidemic. The Netherlands previously was the source of new ideas. In the early 1970s, Amsterdam was a place where drugs were more freely available. Expert committees there advised cannabis
decriminalisation: they saw the risk factor for cannabis as rather low and argued for separating the subcultures and markets for ‘soft’ and ‘hard’ drugs.

5.4 In Europe, the choice was often posed between the Netherlands and Sweden. When drug use in Europe generally was expanding, Sweden was an exception. The explanation appeared to lie with the fact that the government made drug policy a high priority. As important was Sweden’s social context: low income inequality; low youth unemployment; high attention to health promotion generally; and high social expenditures. xxiv

5.5 In the late 1980s/early 1990s, those aiming to eliminate open drug scenes looked to Switzerland with its policy on heroin assisted treatment. Later others looked to innovations in Sydney and Vancouver, including medically assisted safe injecting facilities.

5.6 As the new synthetic psychoactive drugs appeared, New Zealand first provided a possible model to follow in regulation.xxv Its 2013 Psychoactive Substances Act appeared as ground breaking legislation where all NPS were illegal unless subsequently approved.

5.7 The above alternative models are largely to do with demand: Uruguay and Canada exemplify alternative approaches to supply. In December 2013, Uruguay became the first country to legalise recreational cannabis use. Canada legalised cannabis for adults in 2018. The increased availability of medical marijuana in US states was an important model on which later cannabis reforms built.

5.8 Finally, the EU model itself is distinctive internationally. The EU recognised in 2004 that harm reduction should play a central role in drug policy. It can be seen as a public health policy and harm reduction principles are now entrenched in most Europe level statements.

12 HMG (2010) Reducing demand, restricting supply, building recovery, supporting people to live a drug-free life