

Online archive 25b (vii)

Development of specialties – Substance misuse

In the 1800s psychiatrists thought excessive drinking was one of the causes of mental illness. They also were aware that people could become addicted to alcohol and to other drugs such as opium. This was considered to be due to depravity or weakness of will rather than to an illness that should be the concern of doctors. Those whose drinking had badly damaged their brains were cared for in asylums. During and after the First World War the amount of alcohol consumed was very considerably reduced following an increase in price and other controls brought in, in the UK by Lloyd George. After the Second World War there was a steady reduction in the real price of alcohol with increasing consumption and the many harms associated with this. There was also a steady increase in other drugs taken for social and recreational reasons. It became known that tobacco (nicotine), particularly when smoked as cigarettes, was one of the most powerfully addictive of all drugs. The medical profession accepted the idea that addiction (dependence) was an illness. The College developed a Faculty of Substance Misuse to train psychiatrists about these problems and illnesses.

The Royal College of Psychiatrists has a faculty of substance misuse which is a sub specialty. Trainee psychiatrists are expected to learn about the problems of dependence on alcohol, tobacco and other drugs (both those prescribed in medical treatment and those that are considered socially unacceptable). All of this has been a recent development, partly because there has been an increase in the availability of these substances, with an increase in the number of illnesses and harms caused by all of them.

In the early days of the Association, which preceded the College, awareness that it was possible to become physically dependent was hardly known. At that time doctors were aware that over consumption of alcohol could lead to harm and psychiatrists continually drew attention to ‘inebriety’ as a cause of mental illnesses. The causes of such inebriety however were thought to be due to weakness of will leading to pleasure seeking, bad character perhaps associated with a hereditary taint and evil behaviour that was the result of sin rather than illness.

The opiates were known to cause problems for some people. Tincture of laudanum (containing opium could be bought without any controls and made up in an alcohol base) was very widely prescribed for a plethora of conditions. These ranged also from physical pain to mental problems. It was known that people could become addicted, since they could find they had become ‘enslaved’ to the drug. This again could be seen as part of a moral weakness. In the second half of the nineteenth century there were growing fears about the recreational use of opiates among the working classes. In 1887 a Society for the Suppression of the Opium Trade was founded. There was a steady increase in the amount of alcohol drunk by the population as a whole and distilled spirits had become much more commonly used. There were concerns about increased levels of drunkenness and the response to this was to lead to the Temperance Movement with alcohol at times being treated as an evil itself. In the United States this ultimately led to Prohibition and in the UK to the changes brought in by Lloyd George who brought in licensing laws controlling the sale of alcohol and also increased its price.

Opium had been freely available until the middle of the nineteenth century but had moved to a more restricted situation by its end. In the first half of the century, the distinction between medical and non-medical use was difficult to make, and the drug was in widespread use for a variety of common ailments. The habit forming properties of opiates were recognised, but not dealt with specifically within a medical framework. The concept of ‘treatment’ for ‘addiction’ was absent, and those doctors who came into contact with regular opiate users did not automatically consider that treatment was appropriate. Opiate use was not defined as a problem requiring medical intervention.

Much began to change towards the end of the nineteenth century. The rise of medical specialisms brought with it a newly defined interest in the concept which was termed ‘inebriety’, encompassing both alcohol and drug use on a habitual basis. Doctors began to organise themselves round the study and management of the concept.

Before the First World War, management of addiction had to some degree been professionalised. Two strands marked pre-war control: management of supply through the pharmaceutical profession, and management of the user by means of the inebriates and lunacy legislation. Pharmaceutical control dated back to the mid-nineteenth century. Both the 1868 Pharmacy Act and the 1908 Poisons and Pharmacy Act reserved the sale of narcotics to the self-regulating monopoly of professionally qualified men. After 1908, opium, morphine, and cocaine were transferred to part one of the *Poisons Schedule*. Sale was intended to be to ‘known’ purchasers only, with the requirements of a signature in the pharmacy’s poisons book – a requirement which seems often to have been laxly enforced. During the First World War there was growing concern about possible use of cocaine by troops while on leave in London. In 1916 control measures were instituted under the Defence of the Realm Act. The first legislative control in the UK was by the passing of the Dangerous Drugs Act of 1920.

Other moves towards control encompassed the user as well as the use of narcotics. Addicts were occasionally admitted to lunatic asylums under the provisions of the Lunacy Acts, but their numbers appear to have been small. Sir Ronald Armstrong-Jones, superintendent of the Claybury Asylum and recognised as an authority on addiction, quoted 40 such cases admitted over an unspecified period, in an address

given to the Society for the Study of Inebriety in 1915. Bethlem Royal Hospital admitted only eight narcotic addicts between 1853 and 1892. There were also moves to bring narcotic users under the aegis of the Inebriates Acts, which provided both compulsory and voluntary treatment for those convicted of offences concerning drink. The Inebriates Committee of the British Medical Association, chaired by Dr Norman Kerr, President of the Society for the Study of Inebriety, pressed for the widening of the Acts of 1888 and 1898 to include all forms of drug addiction. But inebriates legislation remained limited so far as other forms of addiction was concerned. The definition of 'inebriate' ensured that only those consuming liquid forms of the drug could be admitted for treatment; morphine injectors were outside the competence of the Acts.

Powers of compulsory detention of non-criminal inebriates (which would have included drug addicts too) remained unenacted. The BMA had urged this course of action on the 1893 Departmental Committee on the Treatment of Inebriates. This was accepted by the 1908 Departmental Committee on the Inebriates' Acts, but the translation into practice never occurred. A series of abortive bills, introduced between 1912 and 1914, included a new definition of 'inebriate' which encompassed all forms of narcotic use. But these never became law and the old Inebriates Act itself fell into disuse. Other avenues of legal control were also limited. The BMA's proposal before the Royal Commission on the Care & Control of the Feeble Minded in 1908 – that both 'habitual inebriety' and 'drug habits' should be a matter for the Lunacy commissioners – was recognised in the 1913 Mental Deficiency Act only to the extent that 'mentally defective' habitual drunkards could be compulsorily admitted. Although the management of both supply and the user was recognised to be a professional medical and pharmaceutical matter,

systems were undeveloped prior to the war. Much treatment appears to have taken place in private nursing homes. Nor was medical expertise over addiction firmly located within one particular area of medical specialty. The Society for the Study of Inebriety founded in 1884, was the main specialist vehicle for the elaboration of disease views of addiction (this later became the Society for the Study of Addiction who publish the journal *Addiction*). Its members were a heterogeneous group, with Medical Officers of Health, temperance surgeons, general practitioners, asylum superintendents, and owners of nursing homes among its supporters, together with a wide variety of lay members, often with temperance connections. Addiction was not a specialist mental health matter, nor was its management located in any state-run system of treatment. However, a disease view of addiction (or inebriety), which had developed largely since the late nineteenth century, began to place the condition implicitly within the medical and psychiatric mould.

A significant event in these changes were the Rolleston Report which laid stress on the small dimensions of the problem of addiction and defined it as a disease. It condemned abrupt withdrawal, legitimised maintenance doses, and established a medical tribunal to deal with those cases and with medical addicts. Notification, a black list of over-prescribing doctors, and the compulsory declaration by addicts about previous medical treatment were omitted. Chlorodyne was the only preparation newly brought within the provisions of the Act.

From the start, the Rolleston Report was a potent force in defining policy. Symbolically also, the report assumed considerable importance. It has been widely credited with

establishing something called the ‘British system’ of drug control, which prevented Britain from experiencing the worst excesses of an American style ‘war on drugs’, with consequent criminalisation of both addicts and the doctors who prescribed to them. In the 1960s, Rolleston was a beacon for liberal reformers of the American drug control system. In the 1980s and 90s it retained its symbolic importance for those who wished to legitimate maintenance treatment and for advocates of harm-minimisation among them. The Rolleston report was the result, rather than the cause of the low numbers of British addicts and of a general *laissez faire* medicalised approach over the next 40 years. It was a system of masterly inactivity in the face of a non-existent problem. When the number of addicts increased in the 1960s and the type of addict changed, the Rolleston response was modified. But the deliberations of the committee also symbolised a closer relationship than before between doctors and the state in the area of drug addiction. Doctors moved from the sidelines, advising on policy, into a central position in its creation. Although the Home Office retained ultimate control, the mediating role of the newly established Ministry of Health and the role of its medical civil servants, was an important one. Rolleston was not a medical ‘victory’, for the proceedings of the committee show a process of accommodation between the Home Office and the profession – a balance of interests which could change as the pattern of addiction itself altered. Even before the Rolleston Committee Report there had been a gradual recognition by psychiatrists (for example by Thomas Clouston and going back to Thomas Trotter) that alcohol dependence was a disease of the mind.

Drug addiction, as the evidence to the committee demonstrates, was not an exclusively psychiatric preserve in the 1920s. It was still an area of medical heterogeneity, with

physicians, asylum doctors, and general practitioners all taking an interest. It was not until the 1960s when the 1965 Brain Report established a specialist clinic model, that psychiatry moved centrally and officially into the management of addiction. In the 1980s, that psychiatric hegemony was again challenged. But the alliance between doctors and the state over drug addiction, established by Rolleston, still remains as a fundamental basis of policy. There had been a significant change in the conceptualisation of alcohol and drug misuse over time. This had moved from the purely medical concern with phenomena such as delirium tremens and other ‘withdrawal symptoms’ towards viewing misuse and dependence as the outcome of psychological disturbance which require ‘psychological treatments’ from psychiatrists and at a later date from clinical psychologists. In the 1960s a sociological dimension entered the debate and the possible responses broadened significantly (for example by drawing attention to the relationships between the price of alcohol, the amount consumed by the population as a whole and the associated harm).

The conclusions of the Rolleston Committee’s report did much to shift the focus of British drug policy. A penal and prohibitive policy based on police control and government direction was subsumed into a more liberal form, where the medical profession and particularly psychiatrists played a significant role. The Home Office rather than the Ministry of Health remained in overall charge of policy, but doctors reclaimed the drug addict as their own. Partnership between that department and the profession replaced confrontation.

Concerns about the problems of alcoholism and addiction varied in different countries.

In the USA worries about over consumption of alcohol had led to Prohibition which was introduced at the end of the First World War and following this the USA had also introduced more controls over the use of other drugs. Their view was that this should be seen as a police rather than a medical problem. Most of the changes seen in the United Kingdom came about following the Second World War. The recommendations of the Rolleston Committee had ensured that responsibility remained with the medical profession. As well as this the price of alcohol was high between the wars and the slump meant that less people were in a position to drink heavily. There was little misuse or dependence on other drugs with the exception of tobacco, but at that time very few people were aware of its very strong addictive properties. Two thirds of the medical profession themselves were smokers.

Before the 1960s there were only two known types of drug dependence in Britain: dependence on alcohol and dependence on tobacco. There was little interest in dependence on alcohol, though there was an awareness that some people drank excessively and that this could be damaging. There was no real public awareness that tobacco (nicotine) caused dependence or addiction. Nor was there much accurate knowledge of the many harms to health caused by its consumption. At that time there was virtually no ‘non-therapeutic’ use of drugs of any sort, whether drugs had been obtained illicitly, or by diversion of some medications obtained on prescription. There was also very little awareness either by the public, or by the medical profession, that many drugs, both sedatives and stimulants, could lead to dependent use. The

commonsense view at that time was that there were only a handful of patients dependent on drugs, being those addicted to opiates initially prescribed for medical treatment.

All this changed markedly in the 1960s. Public concerns were raised by the knowledge that many young people had begun to experiment with drugs of different types such as cannabis, opiates, amphetamines and other stimulants as well as hallucinogens such as LSD. This led to the setting up of committees which reported and made recommendations. The Brain Committee reported on opiates (and cocaine) twice and the Wootton Committee reported on cannabis. These reports suggested guidelines to deal with what was perceived to be a new problem. They have been the basis for dealing with all such problems up to the present. This was also the decade when patterns of smoking began to change and over which consumption of alcohol continued to rise.

Following the end of the Second World War in 1945 there were changes in many countries with the start of increased affluence and increased travel between them. There was also much greater knowledge of what happened in other parts of the world. All of this made an increase in the use of psychoactive substances for recreational purposes inevitable. The speed of change varied from country to country and was clearly seen in the 1960s in the UK. Because there had been virtually no problems with drugs of any sort earlier, there was little guidance on the best methods of dealing with the problems. In the early 1960s there had been little evidence of smuggling of opiates and it would appear that most of the newly notified addicts had obtained their drugs initially from others, who had themselves had had drugs prescribed for them. With the benefit of hindsight it would appear that the level of prescribing made it possible for addicts to use

only some of the drugs prescribed for them for themselves. As well as this, they were able to give, lend, share or sell the remainder of the drugs prescribed for themselves to others.

A small number of addicts who had become dependent on heroin obtained illicitly were reported to the Home Office for the first time. The number of these non-therapeutic addicts rapidly increased. At this time also a small number of slightly older non-therapeutic heroin addicts arrived from Canada for private treatment. Some 80 came in the early 1960s but the numbers each year diminished rapidly. In 1964 Lady Frankau at an inquest stated that she had treated 70 Canadian addicts in the previous year. All this led to two reports from an Interdepartmental Committee which was chaired by Sir Russell (later Lord) Brain, the President of the Royal College of Physicians of London. The first report in effect decided that the guidelines laid down in the Rolleston Commission of 1926 were satisfactory and that there was no need to make any changes. Unfortunately the Committee had merely looked at the total numbers of opiate addicts known to the Home Office each year which had changed little. A closer look would have shown that while the number of therapeutic addicts was decreasing the number of non-therapeutic addicts was doubling every 18 months.

Table 1. Non-therapeutic heroin addicts 1960–1968.

Year	Number
1960	23
1961	54
1962	72
1963	90
1964	160
1965	258
1966	518

1967	745
1968	1304

Source: Home Office Annual Reports, 1960–1968.

At the time was the realisation that it was not always possible to ‘cure’ addiction and that there would be many chronic long-term problems in the future. This awareness led to harm reduction strategies such as advising addicts about how to clean and sterilise syringes and teaching about the dangers of sharing injecting equipment (the term ‘harm reduction’ only came in later). The development of the provision of clean syringes (to be followed later by syringe exchange schemes) was introduced in the context of prescribing injectable drugs. These strategies were introduced to prevent infective complications such as hepatitis (and later HIV/AIDS). Drug addiction was believed to be a new problem. Dependence on the socially acceptable drugs had not been recognised to be an identical one. This was the decade when clearer thinking about addiction began to emerge.

In the 1800s psychiatrists were aware that excessive drinking was one of the causes of mental illness, and could be associated with general paralysis of the insane. While they were aware that people could become addicted to alcohol and to other drugs such as opium this was considered to be due to depravity or weakness of will rather than illness as such. Those whose drinking had badly damaged their brains were cared for in asylums. Separate facilities for ‘inebriates’ were encouraged and developed in the early years of the 20th century. Social measures during and after the First World War such as control of licensing hours and premises and an increase in the price of alcohol were successful in considerably reducing consumption. After the Second World War there

was a steady reduction in the real price of alcohol with increasing of consumption and its associated harms. There was also a steady increase in the use of other drugs taken for social and recreational reasons. It was finally realised that tobacco (nicotine), particularly when smoked as cigarettes, was one of the most powerfully addictive of all drugs. The medical profession accepted the idea that addiction (dependence) was an illness. The College developed a Faculty of Substance Misuse to train psychiatrists about these problems and illnesses.

The Faculty of Substance Misuse started life as the Dependence/Addiction Group. The Author wrote to College members who were likely to be interested, inviting them to an initial meeting on 25 January 1978. Fifty-one members attended, and 32 others expressed support. The group was duly established, and Dr Brian Hore was elected *its* first Chairman, with Dr Robin Murray as secretary. Its aim was to promote knowledge and training in addiction, to disseminate relevant information through the College, and to provide members for relevant working groups and committees. Almost its first activity was to arrange a scientific session at the annual College meeting, at which Brian Hore presented a paper on detoxification units, and Martin Mitcheson on the treatment of opiate abuse. A working group on minor tranquillisers was established and Duncan Raistrick prepared a reading list for trainees. The group responded to national policy initiatives. In 1979 it engaged in discussions on the range of alcohol services, on drinking and driving, and whether barbiturates should become Schedule C controlled drugs. Members contributed to the College publication *Alcohol and Alcoholism*, edited by Griffith Edwards. An early concern of the committee was the recruitment and retention of addiction psychiatrists, which has remained as a problem for the Faculty. A

subcommittee relating to sick doctors was set up in 1982, an issue of importance for faculty members who were called on to examine and supervise the great majority of sick doctors referred to the General Medical Council.

In 1983 regional advisers in addiction were appointed. In 1986 the group played an active role in the successful banning of Skoal Bandits, a dangerous form of chewable nicotine aimed at young people. At first the focus of the group had been directed towards alcohol, but misuse of illicit drugs gradually attracted more attention during the 1980s, in response to the rapid increase in their use. In 1986 Dr Spencer Madden was elected chairman, and soon after the group changed its name to the Section of Substance Misuse. AIDS made its appearance in Britain, with a huge impact on substance misuse services. Government policy moved in the direction of ‘harm reduction’ and maintenance prescription of opiate substitutes such as methadone, which was supported by some faculty members and opposed by others. In 1990 Dr Hamid Ghodse was elected Chairman. The increase in illicit drug use made it important to engage GPs in treating users and so a joint working group was established with the College of General Practitioners. In 1994 Dr Bruce Ritson became Chairman. The Government established a task force on the effectiveness of drug misuse treatment, in which Prof John Strang and Dr Michael Farrell were actively involved. In 1997 the Section became a Faculty within the College, in anticipation of the acceptance by the Department of Health of Addiction Psychiatry as a separate specialty (which did not occur). This cause was a major focus of activity under the next Chair, Professor Ilana Crome, but the Faculty’s efforts were frustrated by the Department of Health’s opposition. She was more successful in promoting active co-operation with other Colleges, for example with the

Anaesthetists and with Public Health. The influential book ‘Drugs: Dilemmas and Choices’ was written in partnership with the Royal College of Physicians under the Chairmanship of Professor Robert Kendell, the then President of the College. In 2002 Dr Eilish Gilvarry succeeded to the Chair. The major preoccupations were not too different from those of the previous 25 years. These include the working relationship with GPs, the training, recruitment and retention of consultants, and campaigning to influence national policy. The development of the Specialist Clinical Addiction Network (SCAN), supported by the Department of Health and the National Treatment Agency, under the Directorship of Professor Colin Drummond worked closely with the Faculty to promote and support Addiction Psychiatrists and this period saw growth in the number of consultants and in the number of trainees. In 2006 Dr Michael Farrell succeeded to the Chair with the aim of continuing the constructive partnership with SCAN, promoting the training and recruitment of psychiatrists into addictions and also adapting the training to the new requirements of Modernising Medical Careers. The Department of Health and Chief Medical Officers initiatives on Sick Doctors became a topic of review also.

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