



Addiction and Lifestyles in Contemporary Europe: Reframing Addictions Project (ALICE RAP)

Addiction through the Ages: a review of the development of concepts and ideas about addiction in European countries since the nineteenth century and the role of international organisations in the process

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Abstract

The work on addiction through the ages proceeded through 4 interlinked studies:

- The emergence of concepts of addiction across Europe at the national level, 1860-1980
- The framing of the alcohol question at the international alcohol conferences
- The role of the World Health Organisation (WHO) and its expert committees in defining addiction from the 1940s to the early twenty first century
- The role of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in defining concepts of addiction

The long view of addiction concepts at the country level over time points to continuities and changes across countries. They have also played a significant role in international organisations, the pre World War Two alcohol conferences and the World Health Organisation (WHO) after that war. The European level through the European Monitoring Centre on Drugs and Drug Addiction has also come into the picture in more recent times with discussion of a different set of concepts. Although a degree of stability has been achieved around addiction concepts, these still encapsulate a variety of meanings which translate into different treatment and policy approaches and traditions within Europe. By understanding the history of such concepts and how and why they came in and out of use, we can better understand addiction terminology and substance use policy today.



1. Introduction

The work on addiction through the ages proceeded through 4 interlinked studies:

- The emergence of concepts of addiction across Europe at the national level, 1860-1980
- The framing of the alcohol question at the international alcohol conferences
- The role of the World Health Organisation (WHO) and its expert committees in defining addiction from the 1940s to the early twenty first century
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We therefore report on these individual components of the overall work package according to the standard format and draw our overall conclusions in the final section.



2. The Emergence of Concepts of Addiction Across Europe at the national level, 1860-1980

Abstract

This section of the report explores the changing concepts and terminology used to describe drug, alcohol and tobacco use in selected European countries from the 1860s to 1980s. Analysis centres on three periods: firstly, the 1860s-1930s; secondly, the 1950s-1960s; and finally, the 1970s-1980s. Focusing on Austria, Italy, Poland and the UK, and their historic national boundaries, the report sets terminological change in the context of long-running debates over how to describe substance use and its associated problems. Drawing on an analysis of medical journals, textbooks and policy documents (including laws, government reports and circulars) the report points to variations over time, between countries and across the substances. By the end of the period, however, there were some signs of greater homogeneity, partly as a result of international influences. Yet, national differences in concepts and terminology remain, suggesting that there is continuing uncertainty about how to describe and deal with substance use.

This section also reports on the unfunded Scandinavian (Nordic) study which did not work according to the model of the funded study. This case study shows that there were commonalities across the Nordic countries and with the other case study countries in Europe, but also distinct differences. We cannot easily speak of a regional response or conceptualisation.

2.1 Introduction

Throughout history, and across Europe, an assortment of different concepts and terms were employed to describe the long-term use of illicit drugs, alcohol and tobacco. Words such as 'inebriety', 'chronic alcohol poisoning', 'narcomania', 'dependence' and 'addiction' were used by a variety of actors in a range of contexts to describe the problems caused by psychoactive substances. The idea that excessive consumption of alcohol and drugs was a 'disease' to be managed by medical professionals and through treatment emerged in North America and Europe in the course of the nineteenth and early years of the twentieth century. The rise of disease theories in Britain and the United States has attracted particular study by historians and has been extensively analysed, using standard qualitative historical methodology (Levine, 1978; Berridge, 1999; Valverde, 1998). The terminology used to articulate such ideas was important both as a reflection of the emerging medical view of alcohol and drug use and as a way of shaping the response to these substances and the people that used them. Charting fluctuations in the language associated with drug and alcohol use is thus an important step in assessing the history of substance use. Moreover, as the terminology used also varied across national boundaries and within countries over time, examining the language of addiction is a useful tool for exploring temporal and spatial differences.

In this report we present an overview of some of the concepts in selected European countries (Austria, Italy, Poland and the UK and their historic boundaries and components) over the period from 1860 to 1980 and the work that these did. Following a description of our methodology and approach, in the main body of the report we summarise the key developments and concepts used in relation to alcohol, drugs and tobacco in Austria, Poland, Italy and the UK in three key phases: the 1860s-1930s, the 1950s-1960s, and the 1970s and 1980s. From these country studies a number of key themes are extracted for further analysis, such as the differences between countries and across the substances. Finally, we conclude by reflecting on what the long history of addiction concepts in Europe tells us and what it can contribute towards current debates.



2.2 Methods

To explore the history of addiction concepts across Europe, we decided to focus on Austria, Italy, Poland and the UK and their historic entities. This represented a good mixture of countries from different parts of Europe with varied drinking and drug taking cultures. We wanted to gain a 'long view' of 'Addiction through the ages', so we decided to centre on the period from the 1860s, when alcohol and drug problems first began to attract substantial interest, up until the 1980s, when drug use expanded exponentially in many countries. We subsequently broke this period into three phases: the 1860s-1930s; the 1950s-1960s; and finally the 1970s-1980s. We agreed that as far as possible all the partners would work in the same way, to make our results more comparable.

For our first period (1860-1930) we decided that we would focus on the medical approach to substance use, and thus decided to examine one general medical journal, one specialist addiction journal, and one medical textbook for each country. We developed a list of terms used to conceptualise addiction, and then aimed to analyse the content of the medical texts and journals that we had identified over the first period. Our initial assumption was that the advance of digitisation would enable such searches to be completed electronically and would produce swift results. However the hope for direct comparability proved too optimistic. Italy and Austria did not have electronic journals and those in Poland were only partly digitised; the situation changed in the course of the project. Even the British journals, which were digitised, presented problems. The main specialist journal for example, the *British Journal of Inebriety* (now *Addiction*) did not have its earliest volumes digitised and so these were less accessible. UK libraries including our own, had not paid for access to the earlier digitised volumes of some of our chosen medical journals and so these had to be accessed on site in the Wellcome Library.

Digital sources presented some additional problems during the searches. For example, the default search option with some sources included all a publisher's titles rather than allowing a search within a specific time frame and journal. Moreover, it was not always possible to alter the chronological ordering of search results, in order to view 'oldest first'. This posed a particular challenge for terms that produced a large amount of results. Key-word searches within electronic articles were also inconsistent, and sometimes failed to capture terms within the text, especially when the file resolution was poor. Nonetheless, through a combination of digital search methods and hand searching of paper copies of journals and textbooks we were able to generate useful results for all the study countries for the period 1860s-1930s. Detailed country case studies for this period can be found in a special issue of *Social History of Alcohol and Drugs* and are summarised below (Beccaria & Petrilli, 2014; Berridge, Walke & Mold, 2014; Eisenbach-Stangl, 2014; Moskalewick and Herczynska, 2014).

For the next period, the 1950s-1960s, we decided to alter our methodological approach. We agreed to move away from the focus on medical texts to look at how addiction concepts were utilised within policy documents produced in the 1950s and 1960s. The rationale for this change was in part practical. The 'medical' focus of the first period had proved difficult and lengthy to operationalise for the reasons given above. Our funding and reporting time frames did not allow for another extensive period of research. In addition there were conceptual reasons for the change, in that our supposition was that by the 1950s, the state might be playing a greater role in the promulgation of concepts than it had done in the late nineteenth century. Privileging the medical approach might give a skewed view of the differences between countries. The results of this work are presented in more detail in an article in *Contemporary Drug Problems* and summarised in the section on addiction concepts in Europe 1950s-1960s (Berridge et al, 2014).

For our third phase of research, (1970s-1980s) we decided to continue with our analysis of policy documents, as this had provided a rich corpus of material. 'Policy document' proved to be an Anglo-centric construct so this was broadened to encompass laws and regulations that were passed during



this period. Again there were differences from one country to another with varied national traditions of policy formation and elaboration. For example, British policy-making on alcohol in this period had relied on the issuing of circulars by the Ministry of Health and we found an extensive collection of these in the National Archives (TNA), but this was not a mode used in the other countries under investigation. Nevertheless, we were able to pursue some of the same techniques. All the research partners aimed to count the number of regulations, laws and circulars dealing with addiction and related concepts across the substances and also to see what language was in use. We summarise our findings below, and in more detail in a chapter in the edited volume by Matilda Hellman, Karen Duke, Virginia Berridge and Alex Mold, *Concepts of Addictive Substances and Behaviours across Time and Place* (Mold, Berridge, Beccaria, Eisenbach-Stangl, Herczynska, Moskalewicz, Petrilli and Taylor, forthcoming). We wanted to see if the use of terms was becoming more homogenous over time but also to identify local and national specificities.

2.3. Results

2.3.1. Addiction Concepts in Europe, 1860s-1930s

There is an extensive historiography on the development of addiction concepts, but as we point out elsewhere, the majority of this literature is confined to Britain and the United States. This has resulted in an Anglo-American interpretation of the rise of a disease-based view of drug and alcohol (and to a much lesser extent, tobacco) use since at least the late eighteenth century (Porter 1985; Levine 1978). Much of the literature points to a strengthening of such an approach in the nineteenth century, when medical and moral views of drug and alcohol use came together in the notion of addiction as a ‘disease of the will’ (Berridge 1979; Harding 1988; Valverde 1997). Yet, other terms were also in circulation. In the UK and the US, ‘inebriety’ was used to describe both drink and drug problems. Continental European concepts did enter this debate but through theorising about insanity, and were applied later in the nineteenth century to alcohol and to other drugs. Little attention, however, has been paid to the history of addiction concepts away from the US and the UK. Our research sought to bring a European perspective to bear on the Anglo-American narrative of addiction history. Based on our analysis of addiction terms in the medical literature, a brief survey of the changing language surrounding substance use in each of the four countries points out similarities and differences with the standard view of the rise of addiction.

In Austria, two distinct sets of terminology were used to describe alcohol and drug use. At this time Austria did not exist in its modern form, but rather was part of the Austro-Hungarian Empire which consisted of a number of countries that currently are sovereign states such as Austria, the Czech Republic, Hungary, Slovakia and Slovenia and even part of Ukraine. Language never coincided with country borders; German was the language of the Empire as well as that of the republic, but German was also spoken in neighbouring countries, where most medical associations were established and most journals published. Looking at two of the selected journals published in Austria, there were two sets of terminologies. The first terminology revolved around substances and their ‘isms’: ‘alcohol’ and ‘alcoholism’; ‘morphine’ and ‘morphinism’. A second set of terms concerned ‘drink’ and ‘drunkenness’. The first terminology was rooted in the language of natural science, or *Naturwissenschaft*. This concept identified one main cause – drinking alcohol – with harmful consequences, which, after the turn of the century, increasingly included hereditary degeneration. The second terminology was a domestic language that regarded *trunksucht* (ailing because of drinking) as an incurable secondary disease of a mental disorder and at the same time as the curable consequence of passion. Both concepts co-existed, and although the first type was becoming more common within scientific work, it could neither penetrate nor replace the local concept used by German speaking Austrians (Eisenbach-Stangl, 2014).

A variety of terms to describe alcohol and drug use could also be found in the Italian discourse around substance use in this period. ‘Alcoholic psychosis’ and ‘alcoholic paranoia’ were in



circulation, but the most commonly used concept was 'alcoholism'. Drug terms started to appear from the end of the nineteenth century, but their use was sporadic. For both drug and alcohol words, there was a divide between those concepts that emphasised the physiological, with a focus on 'poisoning', and those that centred on the pathological, such as 'morphinism', 'cocainism' and 'morphinomania'. At this time alcohol was 'owned' by positivist criminology and forensic science, and alcohol problems were often seen in eugenic terms (Beccaria and Petrilli 2014).

During the period 1860 to 1930, the primary concern in Poland was with alcohol, rather than drugs or tobacco. Like Austria, throughout most of this period Poland did not exist as a sovereign state. From the fifteenth to the eighteenth centuries the Polish-Lithuanian Kingdom was comprised of a number of different nations states including Poland itself and some of the Baltic States such as Belarus, Lithuania, and the eastern part of Ukraine. Poland regained its independence just after World War One: before that time the country was partitioned by neighbouring Russia, Germany and the Austro-Hungarian Empire. In the Polish region a range of concepts was used to describe alcohol use throughout this period, such as 'alcoholism', 'drunkenness', 'poisoning', (including chronic and acute) and 'inebriety'. 'Alcoholism' gradually became the key term at the expense of others, but it meant different things at different times. 'Alcoholism' was initially conceived of as an artificially induced madness of both an acute and chronic nature. By the middle of the period, the concept of alcoholism developed to include both the medical and social consequences of drinking, and later still it was seen as a mental illness in and of itself. Another term, '*natóg*', which linguistically could be a concept close to inebriety and/or addiction, was very rare indeed (Moskalewicz and Herczyńska 2014). Unlike Italy, the eugenic perspective did not enter the Polish debate on alcoholism until the 1920s and 1930s.

In the UK, during the first part of the period from the 1870s to the outbreak of World War I, the term 'inebriety' appeared to dominate. Encompassing alcohol and other drugs, 'inebriety' later fell out of favour to be replaced with substance specific terms, such as 'alcoholism'. 'Alcoholism' was present in the medical discourse since the late nineteenth century, but its use declined during the inter-war years when alcohol was regarded as less of a social issue. 'Addiction', in relation to drugs but not alcohol or tobacco, was ascendant from 1918, but a range of other terms also continued to be used, especially those which were substance specific, such as 'morphinism' (Berridge, Mold, and Walke 2014).

The period 1860-1930 was one of great flux across Europe with respect to the concepts used to describe drug and alcohol use. No single concept or concepts appeared to dominate, and though 'alcoholism' was used in all of the countries studied it did not necessarily mean the same thing. Local discourses, such as that around drink and the drinker in Austria, still had a role to play. After World War Two, we begin to see more homogeneity around addiction terminology across Europe. For this phase of our work we analysed the operationalization of addiction concepts in policy documents, laws and regulations in our four countries.

2.3.2. Addiction Concepts in Europe, 1950s-1960s

In Austria, the domestic terminology around drink and the drinker gave way to a more international understanding of habitual drinking. In part, this was a reflection of Austria's occupation by the Allies until 1955, meaning that the country followed America's lead, as seen in the introduction of strict laws on drugs. Addictive poisons were separated out from other poisons in law, and the possession of such substances was criminalized. The actual drug problem at this time was, however, small: alcohol was a much bigger issue. This is reflected in the fact that there were more laws made at this time on alcohol (nine) than on drugs (six). Drink driving attracted legislative notice and alcohol use was established as an aggravating rather than mitigating circumstance in court cases. There was also interest in treatment, and a special system for the treatment of alcoholics was established.



In Poland too alcohol remained the dominant concern. Of 20 laws issued on substance use in the period 15 were concerned with alcohol, two dealt with illicit drugs and three with tobacco. Early on there was some interest in drunkenness as a social problem, but when this persisted, despite the ideological presumptions of the new socialist society, the disease concept of alcoholism began to gain purchase. The notion of alcoholism reduced the problem to an individual disorder thus shifting blame from the structural to the individual level (Moskalewicz, 1985). The first law on 'fighting alcoholism', which was passed in 1956, contained a mixture of regulatory measures, such as those relating to the availability of alcoholic beverages, alongside those aimed more at helping the user, including 'sobering up stations' and the decriminalization of public drunkenness. Alcohol at this time was regarded as being both a medical and a social problem, approaches which were combined in the introduction of compulsory treatment. Little attention was paid to drugs, apart from restrictions on access to certain substances and the registration of drug 'abusers'. Interest in tobacco was confined to the prohibition of smoking in some public places such as buses and sporting events.

In contrast, in Italy during the period from the 1950s to the 1960s, there was much more emphasis on drugs rather than alcohol. Although Italy also established specialized treatment centres for 'social diseases', of which 'toxicosis' from narcotics was one, Italian substance use policy at this time concentrated on drugs and associated crime. This is reflected in the laws that were passed: there were nine laws on drugs, eight on alcohol and three on tobacco. The laws on alcohol and tobacco were concerned predominately with production, taxation and trade – there were no references to abuse or addiction. In terms of problems relating to substance use, the focus was very much on drugs. In the first part of the period, the primary concern was the new synthetic analgesics such as Dolantin. Later in the 1950s, there was more interest in Italy's role in the international drug trade, especially in relation to corruption and the country's apparent slowness to deal with traffickers.

Policy in the UK was also especially concerned with drugs, although there was emphasis on drug treatment as well as drug related crime. In the period studied the majority of laws passed were on drugs (39), compared to tobacco (eight) and alcohol (six). Other kinds of policy documents, such as Ministry of Health circulars, also tended to centre on drugs, with 38 being issued on drugs, compared to 26 on tobacco and five on alcohol. Not all of these related to 'addiction' though, and some laws, such as the Dangerous Drugs Act of 1951 were framed by international commitments. An attempt to define 'addiction' was made by the Interdepartmental Committee on Heroin Addiction in 1961, a definition that was subsequently used in legislation. Other measures included the establishment of treatment centres for heroin addicts. A treatment system also developed for alcoholics. Tobacco was not seen in terms of addiction at this time, with policy instead emphasizing public education about the health dangers of smoking rather than the disease of addiction.

Looking across the different countries, we can see a coming together of concepts around 'alcoholism' and 'addiction', although other terms were still in circulation. International influences were also becoming more apparent, but at the same time national differences remained. There was, for instance, a differing emphasis on drugs and alcohol between countries. Moreover, not all of the laws and policy documents produced in this period focused on the 'addictive' nature of substances. Tobacco was of relatively little interest, except in terms of trade, and in the UK, in relation to other health risks. To what extent did such patterns continue into the 1970s and 1980s?

2.3.3. Addiction Concepts in Europe, 1970s-1980s

In Austria, alcohol was a minor policy issue during the 1970s and 1980s. There were no laws made specifically on alcohol at this time, although alcohol did appear in other pieces of legislation. Conversely, the law around drugs was much more focused on addiction and its effects. In the period 1970-1980, seven laws were passed that concerned 'Suchgift' or 'addictive poisons'. Legislation dealt with both drug treatment and drug control. In the 1970s, drug treatment was mostly abstinence orientated, but by the 1980s more emphasis was placed on harm reduction, especially after the



appearance of AIDS (Eisenbach-Stangl, 2014b). On the other hand, police powers increased and convicted drug dealers met with large sentences. Such a dichotomy in policy was not only about domestic politics, but it also had an international dimension. The location of the UN Office on Drugs and Crime in Vienna from 1980, and the city's hosting of the meetings of the International Narcotics Board, made legislators keen to ensure that Austria abided by all international treaties on drugs. By the end of the 1980s, the picture across the substances was diverse: alcohol legislation tended to focus on the effects of drinking rather than alcoholism; drug policy was divided between treatment and control approaches and tobacco smoking was not seen as an addiction.

Italian alcohol policy in this period, like that of Austria, was primarily concerned with the regulation of production and trade rather than the effects of alcohol consumption. Laws on alcohol passed between 1970 and the end of the 1980s dealt with the taxation of alcoholic beverages and the wine market, and the Parliament was critical of European policies that would have had a negative impact on the Italian wine trade. Drug policy in the 1970s and 1980s was characterised by heterogeneous discourses: prevention, care, public order, social concern and international relationships all played a part. Like many other European countries, Italy experienced a boom in cannabis use from the mid-1960s and an increase in opiate use from the early 1970s. Towards the end of the 1980s, legislation on drug taking and driving came into force, and there was a decree that made provisions aimed at reducing the risk of HIV infection. But, as in the earlier period, more attention was devoted to control of the drug trade rather than the consequences of drug use. Trade also figured in attempts to deal with tobacco, and though the Italian legislature was content to follow all international requirements with respect to illicit drugs, they were less keen on enacting rules on alcohol or tobacco, which were important to the Italian economy.

A different approach to addiction can be found in Poland during the 1970s and 1980s. Here, the focus was very much on alcohol, with regulation spanning a variety of topics, including treatment; drink driving; and drinking in the workplace. A major piece of legislation was the 'Law on upbringing in sobriety and counteracting alcoholism', passed in 1982. The text of the law used a variety of terms to describe alcohol problems, including 'alcoholism', 'alcohol abuse' and 'alcohol dependence'. Beneath the legislative changes, important conceptual shifts were also taking place. These can be detected in the language used in the laws to describe alcohol problems. A militaristic rhetoric of 'fighting alcoholism' was gradually replaced with more moderate terms such as 'counteracting' alcoholism. The terms used to describe individuals with alcohol problems also changed, as 'alcoholics' became 'alcohol dependents' a development that underscored the supposed medical sources of the problem. A similar approach can be found in Polish drug policy in this period. The language used in the legislation appeared to reflect a non-punitive approach to drug using individuals, who were referred to as 'drug dependent persons'. Treatment, however, was not an issue referred to in relation to tobacco. Indeed, smoking appeared to be of little concern to Polish legislators. Once again, tobacco seemed to encounter a different response than either alcohol or drugs in this period.

The relative neglect of tobacco in Poland, Italy and Austria during the 1970s and 1980s was not a pattern replicated in the UK. Of the 34 major policy documents (including government reports and circulars, as well as laws) 14 were concerned with tobacco, nine with alcohol and eleven with drugs. Such a move was rooted in a policy context that not only emphasised the harm smoking posed to health, but was also concerned with the 'dependence-producing' properties of tobacco itself. 'Dependence' was a term still seen occasionally in alcohol policy documents in the 1970s and 1980s, but a variety of other concepts were also in play. Alcohol 'misuse', 'abuse', 'alcoholism' and 'alcohol related harm' were all present and a new term, 'problem drinker', came on the scene. Some of the same concepts used in alcohol policy in this period also appeared in drug policy in the UK. Drug 'dependence' was a term still in operation, and a key piece of legislation, which brought in the contemporary classification of illegal drugs into three categories, Class A, B and C, with differing legal



penalties attached, was concerned with drug 'misuse'. Unlike alcohol, however, there was no concept of 'sensible' drug taking, although there were efforts to attempt to reduce the harm that drug users could cause both to themselves and to society, an approach that strengthened in the wake of HIV/AIDS. This did not necessarily result in a more liberal drug policy, and whilst drug treatment became somewhat more flexible, from 1985 onwards government strategy documents tended to emphasise control of the drugs trade rather than the regulation of drug treatment.

2.3.4. The Scandinavian (Nordic) countries

A separate and unfunded group looked at a regional bloc, the Nordic countries of Denmark, Sweden and Finland, focussing on the period after World War Two and on drugs. These countries are often identified as a regional entity but analysis of the history of concepts and of policy for drugs in each of them showed divergences over time, but also a coming together in terms of policy more recently. Again, theories of disease and addiction in the nineteenth century owed little to the Anglo American tradition of inebriety. The language of 'morphinism' and 'morphinomania' was again stimulated by German scientific thought. 'Narcomania' was a concept employed well into the twentieth century and the term 'euphomania' was also put forward because of the use of different drugs, the amphetamines. But medical influence died away after World War Two when a more social approach in policy was established. Sweden and Finland operated in this period with a more collective approach in policy making, while Denmark focussed more on the needs of the individual. In more recent times boundaries have shifted and there is greater similarity in policy across the three countries, although distinctive approaches have still been maintained. But this case study shows that there were commonalities across the Nordic countries and with the other case study countries in Europe, but also distinct differences. We cannot easily speak of a regional response or conceptualisation (Bjerge, B. Houborg, E., Edman, J Perälä, R - forthcoming).

2.4. Discussion

2.4.1 Expertise, science and addiction concepts

Taking the long view over the period 1860-1980, and looking across our different study countries, we would seem to have moved away from a situation where medicine was the dominant form of expertise in relation to addiction and towards a more diverse 'policy community' made up of a range of professional actors. As drug, alcohol and tobacco use increased, and spread throughout the population, substance use appeared to present different problems that could no longer be dealt with by individual medical treatment alone. Stronger measures of control were introduced, and this brought other kinds of expertise to bear on drug and alcohol use. Such a shift is reflected in the language used to describe drug, alcohol and tobacco use. Although there had long been a plethora of terms in existence relating to habitual substance use, from the middle of the twentieth century, a terminology began to develop that emphasised the social impact of long-term substance use as well as the danger to individual health. Of course, the wider (especially moral) implications of substance use had been of concern since the nineteenth century, but the growing involvement of the law and other kinds of policy makers in regulating drugs and their users was indicative of an approach that emphasised a need to keep social order as well as provide treatment.

We should, however, be cautious about broad generalisations. Different kinds of expertise in dealing with addiction can be found in different places and at different times. For instance, in the nineteenth century in Italy forensic science and criminology were the dominant disciplines dealing with addiction, whereas in Britain it was the preserve of general physicians, and later specialist psychiatrists. Just as there was no single terminology to describe addiction, there was no single addiction science.



2.4.2 Differences between the substances

Plurality in addiction is further underscored if we look across the substances. A variety of approaches to drugs, alcohol and tobacco can be found over time and place. All the countries we studied faced problems with these substances, but the nations dealt with them in a myriad of ways and accorded drugs, alcohol and tobacco varied levels of priority. In the first period (1860-1930) alcohol was the prime concern throughout the study countries, but by the middle of the twentieth century we start to see differences emerge. In the second and third periods (1950-1960 and 1970-1980), in Italy and Austria, drugs were of more legislative interest than alcohol, perhaps partly because of the significant domestic production and trade in wine. In Poland, alcohol was the main concern, with drugs and tobacco attracting much less attention. In the UK, all three substances prompted policy initiatives, and tobacco was of much greater concern there than in any of the other countries studied. The different substances also prompted different kinds of approaches. Alcohol was more likely to be seen as a medical problem with social aspects, and drugs as a social or criminal problem with a medical dimension. But, this was not the case at all times and in all places.

2.4.3 Local/national/international variations

Indeed, there was considerable heterogeneity in approaches to addiction at the national and local level. The differences between countries and their substance use policies were a reflection of the different problems that they faced, but such contrasts also pointed to specificities in national politics and the policy making process. For instance, in the 1970s and 1980s Polish alcohol policy was a reflection not only of the need to deal with alcohol, but was also rooted in conflict between the state and the unions. In the same period in Austria, broader changes in the nature of politics during this period also influenced the direction of drug policy. A move away from a strict, hierarchical, patriarchal structure and towards a more egalitarian mode with greater rights for women and children resulted in more tolerance of the 'socially deviant'. As a result, drug laws became more liberal, with greater emphasis on treatment rather than punishment. In Italy, concern about corruption, the mafia and the international drug trade meant that policy was outward as well as inward facing. British substance use policy was a reflection of the country's pragmatic system of government, where policy tended to be made less through laws and more through expert reports and government departmental circulars. National differences in policy were thus the result of national circumstances as well as other influences.

At the same time, by the end of the period studied some degree of homogeneity appeared to have been achieved. The roles played by the World Health Organisation (WHO) expert committees on drugs, alcohol and tobacco are discussed in more detail elsewhere in this report, but there are signs that the work of such bodies influenced the domestic framing of substance use. In the UK, for instance, the definition of alcoholism used in a Department of Health circular on the provision of services for alcoholics in 1973 drew explicitly on that provided by the WHO. The global framework designed to regulate illegal drugs, alcohol and tobacco had other effects too. In Austria, the location of the UNODC in Vienna not only ensured that the country abided by all the international regulations on narcotics control, but also added impetus to the efforts of those who wanted to introduce stricter measures to domestic policy. Elsewhere, however, international pressures could be resisted. Italy, for instance, was reluctant to accept global regulation of alcohol and tobacco as both substances were important to the national economy. Yet, at the same time, international concerns were at the heart of Italy's drug policy. Not only did Italy sign up (as did all of the countries under investigation) to the United Nations Single Convention on Narcotic Drugs in 1961, but the country's role in the transnational illegal drug trade was also a major political and policy issue.



2.5. Conclusions and recommendations

Taking the long view, we can observe the rise of a plethora of terms to describe alcohol and drug problems in the nineteenth and early twentieth century. Many of these fell away by the second half of the twentieth century, with some coherence forming around key terms such as ‘dependence’ and ‘addiction’. Yet other terms continued to exist, and some new concepts also came on the scene. To some extent these were country and time specific, as with the brief career of ‘problem drinker/drug taker’ in the UK. Whatever the word used, however, there seemed to be a dual dimension to substance use terminology. On the one hand, there was a concept that emphasised the disease-based nature of substance use, whereas on the other hand, there were terms that stressed the social effects of drinking or drug taking. Sometimes these elements were encapsulated in separate words like ‘drug misuse’ versus ‘drug addiction’, but sometimes the term meant both a disease that needed to be treated and a social problem that required control. Such a dichotomy is also reflected in substance use policies which have tended to have the twin aims of both helping those with drug and alcohol and problems and mitigating the effect that these have on wider society. Once more, the emphasis between these different elements changes over time and place, but both can usually be found.

The long view of addiction concepts in Austria, Italy, Poland and the UK therefore has much to add to current debates. By pointing out the continuities and changes between countries and at different times, we can tease out more general trends. Although a degree of stability has been achieved around addiction concepts, these still encapsulate a variety of meanings that translate into different treatment and policy approaches. By understanding the history of such concepts, and how and why they came into and out of use, we can better understand the changes in addiction terminology and substance use policy today.

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3. From self-control to medicalization: the framing of the alcohol question at the international alcohol conferences

Abstract

The aim of this sub-project was to analyse the alcohol question and its responses through a series of international anti-alcohol conferences from 1885 onwards. How did they view the alcohol problem and its causes; what were the consequences for the individual and the society as a whole; and which solutions merited discussion?

The conferences before the First World War can be seen as an arrangement for the modern state where the temperance movement placed itself in the service of the state and at the same time demanded that it be given some responsibility for the future development of society. These were years when the nation acted as a point of reference in several questions that were chafing within the modern project: population qualities and the condition of future generations, the notion of citizenship, industrial strength and competitiveness, the role and the strength of the state.

The first inter-war conferences enjoyed an optimistic and internationalist atmosphere, added to by American prohibition, which had given the temperance movement plenty to be hopeful about. But when the 1920s turned to the 1930s, the conferences were transformed into arenas for national solutions and into outright propaganda pieces. The responses to the alcohol problem debated in the inter-war conferences built on a combination of scientifically masked ideological conviction and ideologically inspired passion for science.

Several themes from the early part of the twentieth century also dominated the post-war conferences: much of the presented research could easily fall into categories such as control, treatment and prevention; women and youth (who still hold positions as extraordinary but frequently discussed problem groups); and traffic and working life. All these themes are recurrent arenas for the formulation of alcohol and drug problems. But sociological and psychological perspectives are more common now, epidemiological research has grown steadily, the drug problem is ever present and a comprehensive addiction concept has opened up for topics beyond substance misuse.

3.1. Introduction

The aim of the project was to analyse the alcohol question and its responses through a series of international anti-alcohol conferences from 1885 onwards. How did they view the alcohol problem and its causes; what were the consequences for the individual and the society as a whole; and which solutions merited discussion?

The investigated conferences have been important in several respects. Meetings of this magnitude demonstrated that the alcohol question had become an important social political question. They have functioned as key sites for international knowledge and policy dissemination in the alcohol field and they were the first institutionalised and frequently held meetings for researchers, government officials and NGO representatives to focus on a topic which has often been described as one of the most critical issues for modern society.

This section of the report briefly comments on the source material and method, before turning to the results from two studies: one on the international conferences during the years 1885–1913



(Edman 2015a) and one on the conferences during the years 1920–1939 (Edman 2015b). The report concludes with a presentation of the post-war developments and a discussion of the results.

3.2. Methods

The primary source materials were the conference proceedings from the international alcohol conferences (see table 1).¹ From the beginning there was no permanent organisation behind the conferences, but this changed when the International Temperance Bureau (ITB) was founded in 1907. The ITB was tasked with collecting literature and informing writers, authorities and the public about the temperance cause in order to battle disinformation and myths and to strengthen the overall mission of the temperance movement. Together with a permanent organisational committee, the ITB continued to arrange the international temperance or anti-alcohol conferences. In 1923, the ITB changed its name to the International Bureau Against Alcoholism (IBAA) and was again renamed in 1964 as the International Council on Alcohol and Alcoholism (ICAA). Even though the ICAA is still in operation, there seems to be very little going on at the present time and some of the planned conferences during recent years have been cancelled. After the 1995 conference in San Diego, there are also no accessible conference proceedings.

Table 1: Conference Proceedings

<i>Year</i>	<i>Title</i>	<i>City</i>
1885	Meeting international d’Anvers contre l’abus des boissons alcooliques (CP 1885)	Antwerp
1887	Verhandlungen der II. Internationalen Versammlung gegen den Missbrauch geistiger Getränke (CP 1887)	Zurich
1890	Bericht des III. Internationalen Congresses gegen den Missbrauch geistiger Getränke (CP 1890)	Christiania
1893	Compte-rendu du 4me Congrès international contre l’abus des boissons alcooliques (CP 1893)	The Hague
1895	Bericht über den V. Internationalen Kongress zur Bekämpfung des Missbrauchs geistiger Getränke (CP 1895)	Basel
1897	6me congrès international contre l’abus des boissons alcooliques (CP 1897)	Brussels
1899	Vlle congrès international contre l’abus des boissons alcooliques (CP 1899)	Paris
1901	Bericht über den VIII. Internationalen Congress gegen den Alkoholismus (CP 1901)	Vienna
1903	Bericht über den IX. Internationalen Kongress gegen den Alkoholismus (CP 1903)	Bremen
1905	Xème congrès international contre l’alcoolisme (CP 1905)	Budapest
1907	Den XI internationella antialkoholkongressen (CP 1907a) + Bericht über den XI. Internationalen Congress gegen den Alkoholismus (CP 1907b)	Stockholm
1909	The proceedings of the twelfth international congress on alcoholism (CP 1909)	London
1911	Bericht über den XIII. Internationalen Kongress gegen den Alkoholismus (CP 1911)	The Hague
1913	Compte-rendu du XIV congrès international contre l’alcoolisme (CP 1913)	Milan
1920	Proceedings of The Fifteenth International Congress Against Alcoholism (CP 1920)	Washington

¹ All conference volumes barring two have been accessible at The Swedish Council for Information on Alcohol and Other Drugs (CAN). Despite all efforts, it has not been possible to trace the report of the 1937 conference in Warsaw or the report of the 1952 conference in Paris



1921	Compte-rendu du XVI congrès international contre l'alcoolisme (CP 1921)	Lausanne
1923	Compte-rendu du XVIIe congrès international contre l'alcoolisme (CP 1923)	Copenhagen
1925	Proceedings of the International Congress Against Alcoholism (CP 1925)	Geneva
1928	Compte-rendu du XIXe congrès international contre l'alcoolisme (CP 1928)	Antwerp
1934	Proceedings of the Twentieth International Congress on Alcoholism (CP 1934)	London
1937	---	Warsaw
1939	Proceedings of the Twenty-Second International Congress Against Alcoholism (CP 1939)	Helsinki
1948	Compte rendu du 23e congrès international contre l'alcoolisme à Lucerne (CP 1948)	Lucerne
1952	---	Paris
1956	25e congrès international contre l'alcoolisme (CP 1956)	Istanbul
1960	Proceedings of the 26 th international congress on alcohol and alcoholism (CP 1960)	Stockholm
1964	27. Internationaler Kongress: Alkohol und Alkoholismus (CP 1964)	Frankfurt-am-Main
1968	28 th international congress on alcohol and alcoholism (CP 1968)	Washington
1970	29 th international congress on alcoholism and drug dependence (CP 1970)	Sydney
1972	30 th international congress on alcoholism and drug dependence (CP 1972)	Amsterdam
1975	Proceedings of the 31 st international congress on alcoholism & drug dependence (CP 1975)	Bangkok
1978	32 nd international congress on alcoholism and drug dependence (CP 1978)	Warsaw
1982	Proceedings of the 33 rd international congress on alcoholism and drug dependence (CP 1982)	Tangier
1985	Proceedings of the 34 th international congress on alcoholism and drug dependence (CP 1985)	Calgary
1988	Proceedings of the 35 th international congress on alcoholism and drug dependence (CP 1988)	Oslo
1992	36 th international congress on alcohol and drug dependence (CP 1992)	Glasgow
1995	37 th international congress on alcohol and drug dependence (CP 1995)	San Diego
1999	The 38 th international congress on alcohol, drugs and other dependencies (GR 1999)	Vienna

The proceedings – with contributions written in French, German, English, Swedish and Hungarian – tell us who the participants were and which organisations were present. The reports give us access to formal speeches and other expressions of conference etiquette, to minuted discussions and – what is clearly most important in terms of this study – to the participants' papers which had been dispatched and were read aloud in the conference. The agenda listed such items as a temperance organisation's work, legislation intended to curb the misuse of alcohol, the degenerating impact of alcohol on the next generation, the most appropriate way of providing treatment to alcoholics, the significance of female citizenship on the alcohol question, and sterilisation as a means of solving the alcohol problem. The account here builds on the common and recurring topics and themes in these conferences.

The project answers questions about how the alcohol problem was depicted in terms of consequences, causes and potential solutions. The main research interest was how the alcohol problem was framed in terms of current discussions on general themes such as the individual's role in society, the challenges of modernity and the contribution of science in solving a problem traditionally seen as a moral issue?



3.3. Results

3.3.1. Alcohol Consumption as a Collective Problem, 1885–1913

The first of the examined anti-alcohol conferences took place in the autumn of 1885 in Antwerp, with more than 500 delegates coming together around the alcohol question. The alcohol question called for transnational collaboration, especially since ever more people were being incorporated into an international world. The transnational context and the very use of an international discourse also provided a resource for political struggle and debate.

The conferences offered an arena for friends of temperance and prohibition to exchange information and experiences. The mood of the temperance movement can be gleaned from the fact that the conferences did not really talk *about* the alcohol problem. Rather, from the very first meeting in Antwerp in 1885 until the 1956 congress in Istanbul, these were conferences *against* alcohol misuse or alcoholism. But the conferences kept growing, with more delegates from more countries, more interest groups from different professions and more wide-ranging topics. The presentations and discussions focused on alcohol from a great many different perspectives: alcohol was the framework for debates ranging from the condition of women to the state's role in modern society.

3.3.1.1. Solving the problem

The alcohol problem was of the most serious kind; this the conferences never contested. The answers were necessarily comprehensive and drastic and entailed variations of still recognisable alcohol policies: prevention, treatment and restricted consumption. The conferences stressed moral, educational and individually-minded approaches during this period. Self-control and temperance were also dealt with together at the conferences. The concept itself is ambiguous: while temperance denotes abstinence from alcohol, it may also refer to moderation in consumption. Self-control is therefore both a cause and an effect: it is what one needs to abstain from alcohol and what one loses by virtue of drinking.

In the fight for temperance, many conference contributions talked about the role of the press, and showed confidence in non-governmental action and freedom of the press in general. But often the temperance movement also allied itself with other progressive causes in order to influence government and legislation. The alliance with the women's rights movement was to an extent linked with an image of women as particularly adept temperance workers. This partly justified their political rights and partly gave them a special role in pro-temperance work: it was heard on repeated occasions at the conferences that the fight against drunkenness hinged on women's ability to organise around the problem. Women were role models, mothers and housekeepers – albeit not yet partners in legislative work.

The moral uplift that some in the temperance movement advocated can mostly be likened to some of today's efforts in preventive measures in the alcohol and drug abuse fields. But we also find that the treatment of individual misusers was given increasing attention during the years that the first anti-alcohol conferences were held. Different treatment possibilities had been on the conference agenda ever since the first congress in 1885, but when it came to poor drinkers, coercive measures were rather more prominent on the wish list. Coercion was advanced as a protection against contagion, as a means of controlling the misusers' bad influence on the environment but also as an opportunity to keep them from procreating. This aspect became more important once the racial hygienic arguments spread in the early part of the twentieth century (see below). In some cases coercive care was also justified as a paternalistic measure against misuse, to "protect the enslaved inebriate against himself" (Kerr 1890, p. 154).



The treatment of alcohol misusers touched on the larger question of the government's right and duty to solve the alcohol problem. Alcohol functioned, as criminologist Nils Christie (1981, p. xiii) has put it, "as a sort of trigger for state action". With reference to the liberal British politician William Gladstone, the 1895 conference aired the view that the primary duty of the state "should be so to legislate as to make it easy to do right and difficult to do wrong" (Leigh 1895, p. 428). The question of a total ban of alcohol remained relatively abstract for a long while, as no country had even tested this measure until prohibition was introduced in Russia in 1914 as part of the war mobilisation campaign. At the end of the nineteenth century countries preferred to pursue the question of sales restrictions, in many cases as a conscious strategy to counter demands for a total ban, which was advocated by some factions of the temperance movement. Reference was made on many occasions to the Gothenburg system, which had been introduced in Sweden in 1865 and aimed to remove the interest of profit from the alcohol trade.

3.3.1.2. A collective problem

Whether one championed sales restrictions or total prohibition, moral education or treatment, the alcohol problem was part of a bigger picture. Causes were sought, for example, in regularities and principles of a medical or social nature. The answers were often a match for the causes, also when they were brought from the general to the individual level, while the objectives would aim at a collectively binding solidarity. Alcohol misuse was part of a complicated social problem, a formidable catalogue of all sorts of evils which in the social historical studies on the turn of the nineteenth and twentieth century have been called the labour question, the poverty question, pauperism or the social question depending on what was to be examined and for which ends. Modern social policies were to a great extent shaped by the educated middle class, whereas the alcohol problem was archetypically embodied by working-class men. Examples of copious alcohol consumption among the upper classes further helped to carve out the source of modern social policies as devout, orderly, entrepreneurial and middle class.

The predominant problem formulation was future-oriented and occupied itself with such entities as people, culture and nation. To solve the alcohol problem was to safeguard a better future. The concern about troublesome youth was evident in both contemporary debates and crime statistics, and the anti-alcohol conferences frequently addressed the importance of children's and young people's temperance education. It was an important subject, for the youth was the future: "the well of youth from which our tribe shall one day draw its vitality", as one German presentation stated (Gonser 1907, p. 84). Young people were also a resource in temperance work, partly because they were attracted by the patriotic significance of the temperance question and partly because they were fascinated by a battle of this kind.

The fight for the welfare of youth was thus manifestly bound up with the nationalistic character of the temperance question. "Nation" held that force which could take the anti-alcohol battle beyond individual inebriation. The temperance movement regularly found allies in other progressive causes, and as part of this partnership intoxicants came to be identified as a threat to the nation just when the nation was a crucial tenet in the identity of the modern states' growth. The educated middle class of the temperance movement made use of nationalism, as it gave them more widespread popular support and confirmed their self-image as the leading force of modern society.

The home, the people and the nation were woven into a normative ideal, as a contrast to the abuse of alcohol but also as its potential casualty. A contemporary movement – hygienism – brought the essentials of this thinking together. There was widespread concern at the turn of the nineteenth and twentieth century over the degenerating impact of modern society on the population. Public health, in a wide sense, emerged as an answer to this problem, and physicians were the guarantors of its maintenance. As the consequences on future generations became a key issue, the alcohol problem,



too, was placed in this larger context. The anti-alcohol conferences made it clear on repeated occasions that the human race was growing weaker because of alcohol: it was worse-equipped in many respects, because the sins of one generation impaired the chances of the generation to come.

Hygienism was a conceptual construct which could mean many things. Somewhat simplistically, it aimed to improve the population quality, while the means consisted of a host of measures, from improved sanitary conditions and more modern housing to spiritual education and racial biological selection. The hygienic movement made bold claims, and its' thought structures were used, in the words of the sociologist Eva Palmblad (1990, p. 13), "to naturalise, rationalise the existence of a given order and to make certain social circumstances appear as natural". Hygienism became both an explanatory and legitimating ideology and it accommodated public health objectives of conventional medicine as well as health ideas of alternative movements such as the German *gesünder leben* movement.

One can to a certain extent understand the success of medico-hygienic thinking as a consequence of increased medical knowledge, but the perspective shift also needs to be seen against the backdrop of more overall societal processes where, for instance, the efforts of the temperance movement to ground its battle in scientific thought were one of the reasons why these ideas came to occupy a more prominent place in the hygienic movement at large. The notion of the people and the nation as a – scientifically explained – social organism made the collective into a morally compelling entity which mattered more than an individual's welfare. This manifested itself especially clearly in the most radical variety of hygienic thought, racial hygiene. In many countries in Europe, as also in the United States, sections of the temperance movement therefore found an ally in the eugenic movement. The German *gesünder leben* movement was, for example, clearly compatible with ideas of selective breeding.

However, contemporary eugenic thought had not yet been put to the test; it was relatively inquiring. This is especially true if one compares it to the eugenic thinking of the inter-war years. Some kind of loosely knitted theory of heredity was on the agenda when the causes and consequences of alcohol misuse were to be explained in terms of degeneration. These thoughts lent scientific legitimacy in the battle against drinking but also more gravity when an individual's alcohol consumption could be linked with the welfare of future generations and national well-being. But this focus on heredity also challenged an older temperance paradigm which had rather departed from the significance of the social circumstances in the emergence of misuse. In the conferences, and depending on the speakers, one could hear very different stresses being laid on the root causes of misuse, and there were also attempts to mediate between heredity and environment as well as a kind of Michurian theory of heredity which claimed that heredity could be influenced by such things as bad housing and poor diet.

Several presentations highlighted the view that alcohol destroyed not only the drinkers themselves but also their offspring. This is how alcohol use ceased to be an individual concern: alcohol could kill the individual but also destroy the race. Alcohol would lead to degeneration and in the end become "a racial illness which is antisocial as it brings down the morals of a nation, encourages impure pleasures and is the enemy of pure enjoyment" (Legrain 1907, p. 70). This image of an impending racial war, if not literally then through evolutionary contest, intensified the fateful gravity of the question.

The first National Conference on Race Betterment, held in Michigan in 1914, had an entire session to discuss the alcohol and tobacco problem. There were thus manifest links between the anti-alcohol movement and the eugenic movement, but the anti-alcohol conferences did not at the time debate sterilisation as a plausible response to the alcohol problem. Extremely long periods at alcoholism



treatment institutions could stop unwanted procreation, but it was also deemed to be a costly alternative.

3.3.1.3. Modernity and science

The alcohol problem that was formulated during the nineteenth century emerged at the intersection of recognisably increased drinking and new expectations being placed on the citizens of the modern society. The latter factor was in all probability decisive: the fight against alcohol took place (and to an increasing degree at the time examined) as part of a fight for the modern society – and starting from the premises of what this society demanded from its citizens in the name of progress and efficiency.

Industrialisation made alcohol misuse more visible in the poorer urban areas, and temperance work consisted in great part of disciplining the working class. The link between drinking and disorderly conduct raised among the propertied classes the worst-case scenario of a revolution. If nothing else, hedonistic drinking habits were a direct opposite to orderly and entrepreneurial life. One can therefore argue as Weber did that the more ascetic ideal of the temperance movement acted as a means of spreading the spirit of capitalism. Alcohol habits need to be reinterpreted in light of these new working life demands and against the fact that alcohol use obstructed industrial and economic efficiency.

Concerns were expressed most clearly in the debate on the place of alcohol in the state's core functions. The importance of sobriety on the railway was a recurring theme, but the foremost of the state's jobs was war. Here, the alcohol problem could partly be seen as a problem of degeneration when alcohol-damaged offspring were not good enough to fight, partly as a problem when the drunken soldiers could not do battle particularly effectively.

The conferences examined in this study were also frequently concerned about the increased alcohol trade in Africa as a result of colonialism. The 1887 conference in Zurich linked the battle against alcohol with the white man's burden: how could one civilise the natives if one at the same time provided them with copious amounts of alcohol and guns? We may glimpse an underlying critique of a more general nature as regards the colonisation of Africa, but the situation now called for beneficial measures in order to improve the condition of these countries.

The period examined here covers the breakthrough to modernity when new communications, popular movements, industrialisation, urbanisation and democratisation left their mark on western societies. The anti-alcohol conferences articulated the alcohol problem as part of this change whether the problem entailed the importance of a sober railway personnel or women's new citizenship. At the same time, however, modernity carried a kind of critique which did not see alcohol in terms of a hindrance to progress but rather viewed the problem as a consequence of modern progress. The causes for the misuse of alcohol were found, for example, in the rapid scientific progress and in the ubiquitous industrial machines. The battle against alcohol misuse then came to resemble general social policy, turning into a battle for shorter working hours and improved housing conditions. However, it was pointed out on repeated occasions in the conferences that alcohol could be both the cause and consequence of poor social circumstances.

The anti-alcohol battle around the turn of the nineteenth and twentieth century was a moral battle, often with Christian overtones, but it would be a mistake to picture this as clearly opposed to a more scientific view of the alcohol problem. For example, if the late nineteenth-century theories on degeneration appear as imbued with a moral tone, one should perhaps rather understand that they were so popular at this time precisely because they appeared secular and scientific. And the American Anti-Saloon League, a union which rather resembled morally and politically active



transnational advocacy networks, operated purposely – by collaborating with the Scientific Temperance Federation, for example – in order to be seen as objective and scientific. The powerful Woman’s Christian Temperance Union, too, sought to influence already at the end of the 1800s by educational materials where the alcohol question was illustrated with scientific arguments.

The prestigious position of science and medicine obviously came to have an impact on the work around the temperance question – linguistically, strategically and methodologically. A specific aspect in the scientific nature of the alcohol question was the medical interpretation of copious alcohol consumption as an illness. The official history of the International Council on Alcohol and Alcoholism (ICAA) describes this as a shift of perspective in conjunction with the first conference after the Second World War, in 1948. But the question of the pathological status of alcohol misuse is far older than this and can be traced back to such influences as the late eighteenth-century studies by the American physician Benjamin Rush; the early nineteenth-century British physician Thomas Trotter; and the accounts of the Swedish doctor Magnus Huss in the mid-1800s. The anti-alcohol conferences of 1885–1913 also discussed alcohol misuse as an illness, a notion that correlated with the idea that big problems must be grounded in substantial causes. The link to a human being’s physical constitution satisfied this need for a deeper and uniform cause. However, the description of alcohol misuse as an illness was not an empirical given, but an agreement with its own therapeutic and administrative consequences.

3.3.2. Nationalism and Radicalisation, 1920–1939

By comparison with the period around the turn of the century, the alcohol problem was rather played down as a political question in the inter-war years. A great many countries introduced some form of retail control on alcohol in the course of the 1910s, and this trend was further boosted by the move towards national efficiency and sober warfare during the First World War. When several countries (Russia, Iceland, Norway, Finland and the United States) also introduced their own versions of prohibition during or soon after the war, the future looked bright for one of the key objectives of the radical temperance movement. But this, paradoxically, also contributed to a relative weakening or at the very least to a more passive role for the temperance movement which had left such a clear mark on the anti-alcohol conferences of the first decades. However, the temperance movement was still influential in the conferences and the meetings remained articulated anti-alcohol venues.

3.3.2.1. Solving the problem

Abstinence and religiosity shared several points of contact, which is also evident in the conference delegates’ background organisations, including the Anti-Saloon League and Woman’s Christian Temperance Union (WCTU). It was also made clear that religion could become a useful resource in the temperance work. The prohibition in the United States was interpreted as a manifestation of religious inspiration, and in the 1920 conference in Washington Christian citizens were encouraged to involve themselves in society and politics to solve the problem of drunkenness.

Youth and women were still perfect representatives of the alcohol question, both as its tender victims and as its would-be solution. Female qualities and duties were regularly extolled as promoting temperance: women were exemplary builders of character and now that more countries had granted them political citizenship, they were able to drive these questions as voters and legislating politicians. Women’s responsibility for home and children were in the end the arguments that sealed their role in temperance work. Home and nation were part of a larger context in which women were tasked with nurturing both their own children and the characteristics of the population as a whole; women were “the guardians of the race”, ultimately responsible for any “influence upon race deterioration” (McIlroy 1934, p. 92).



There were far fewer conference presentations on alcohol treatment in the inter-war years than there had been before the First World War. This may be because remarkably few treatment institutions had survived the war, in the English-speaking world at least, and there were therefore fewer treatment units to provide treatment experiences. Conference presentations on institutional treatment often came from countries such as Sweden and Finland, which had defined the alcohol problem in social terms and relied on social retraining. Some presentations also came from the Soviet Union, where it became possible in 1927 to commit alcohol misusers into coercive treatment on social grounds.

Most participating countries had by this stage introduced some kind of alcohol controls. The war experiences helped to shift the focus from individual alcohol misuse to collective alcohol control and the conferences debated large-scale consumption studies as points of departure for various alcohol-political initiatives. The Gothenburg system had been frequently debated at pre-war conferences, but prohibition started to dominate the discussions once it had been introduced in several countries.

The Lamarckian theory of inheritance – that acquired characteristics could be passed on to offspring – was admittedly being questioned at the time. But as far as some conference delegates were concerned, it was still held to be true that the alcohol misuser “belongs to an inferior stock”, that his “tendency to drink is based on an inborn inferiority”, and that his alcohol consumption in turn led to inferior offspring (Gachot 1934, p. 212). In the conferences before the First World War, such thoughts had not led to any consensus about suitable measures. In the inter-war period, turn-of-the-century hygienic movements turned to a state-sanctioned agenda, which then appeared in many different guises depending on the ideological setting of the state. Comprehensive public health measures against sanitary problems and unhealthy environments shared the platform with measures of a more race-biological nature. It is therefore not particularly helpful to make a distinction between inter-war eugenics and public health measures: the primacy of the collective was a common feature in both.

But proposals for practical measures during this time show a radicalisation of the racial hygiene which had served as a frame of thought in the temperance work ever since the late 1800s. The war gave a boost to ideas of national efficiency in several fields and this was linked with population qualities and racial hygienic care of future generations. Racial hygiene did however not necessarily result in sterilisations: the goal of promoting good qualities (positive eugenics) and obstructing bad qualities (negative eugenics) could also appear as birth control advice. The way the causal relation worked was central: should poverty and social problems be explained by poor inheritance or should social problems and poverty be understood as concurrent and socially dependent forces? The former was the predominant notion during the inter-war period, which explained the interest to limit the procreation of socially troublesome groups. This is where sterilisation – forced or otherwise – became one of the means in, for example, Germany where heavy alcohol misuse was seen a manifestation of social or psychopathic damage.

Inheritance and environment were debated as competing and complementary factors during the entire inter-war period when an individual’s behaviour was to be made sense of. The usual conclusion was that biological inheritance was the stronger of the two and that alcohol misusers therefore should be prevented from parenthood. As internment was deemed to be complicated, ineffectual and costly and as a marriage ban was seen as similarly ineffective, sterilisation appeared to be the most promising means. One of the few dissenting voices came from the Catholic church, which held that sterilised drinkers would suffer from much eroded sexual control, that sterilisation would be an encroachment on a person’s free will and – with the backing of a papal announcement – that such measures were against nature.



3.3.2.2. Modernity, state ideology and science

In comparison with pre-war conferences, the alcohol problem was debated in much more concrete terms in the inter-war years. This was in all likelihood due to war experiences, the aim to achieve both military and civic efficiency. Many delegates advocated practical responses which were depicted as ethically neutral. This is where sterilisations appeared as a technical solution to a practical problem, an approach that permeated several aspects of the alcohol problem.

As before the First World War, the demands of modern society helped to define the alcohol problem. The ever-expanding mechanisation and Taylorism left their mark on the working environment where sobriety and efficiency were demanded from the workers. Alcohol had had its place in working life – at times even sanctioned by the employer – and it was not without friction that people now adjusted to the demands of the new era. Leisure was another dilemma, and all the more so with increasingly shorter working hours. Leisure pursuits could come in all kinds of unwanted guises, such as the much debated dancing nuisance, with concomitant drinking and immorality. To remedy this, one needed new leisure interests, such as sports.

Modernity demanded its dues but also met its critics. The destructive but logical function of alcohol in the industrial society had been addressed since Friedrich Engels' studies on the condition of the English working class and the nature of alcohol as an escapist comforter. At times the conferences would raise these perspectives again, but preferably with the caveat that increased welfare, improved working conditions, better education and training, and a more varied leisure time had by now decreased the need for alcohol as a social anaesthetic.

The First World War had remodelled the very structures of the warring nations and in many cases also the make-up of nations which managed to stay outside the war. Warfare, military preparedness, trade embargos and rationing meant that the modern states had to assume new duties. The politically and administratively revitalised states therefore addressed the alcohol problem with new conviction during the inter-war period. The clearest indications of views on state control were seen when the conferences debated the liberal dilemma of collective rule for the benefit of the individual. This was not a major problem in the authoritarian states of the inter-war period but not a matter of principle for the democracies, either, when it came to dissecting their undemocratic ways of governing colonial populations. The colonial powers could without problem make decisions on sales restrictions and prohibition; indeed, the question of alcohol consumption among "the Native Races" was "a subject which *par excellence* is suitable for discussion at an International Conference" (Harford 1920, p. 291).

The First World War fed on and reproduced nationalistic frames of understanding which survived the peace and continued to organise political thinking also during the inter-war period. In the conferences, this mindset could argue that alcohol use was a foreign custom or that solutions to the alcohol question were intended to preserve the national community, "die Volksgemeinschaft" (Paulstich & Gabriel 1939, p. 37). During the politically turbulent inter-war period the nationalistic take on the alcohol question went hand in hand with increasingly obvious political positioning, especially in the 1930s when Nazi Germany was seeking to sell its ideological framing by the side of liberal and social democratic democracies and the communist Soviet Union. One obvious change during this period is therefore the decline of internationalism and the onslaught of nationalistic propaganda manoeuvres. The less important role of the transnational temperance movement and the rise of totalitarian regimes most likely contributed to this. The totalitarian regimes also used the conferences as propaganda platforms on several occasions.

The Nazi German and the Soviet communist notions were explained in explicitly ideological terms, but the problem was constructed as an individual's conflict with the collective in many countries.



Problems conceived in such terms guarantee ideological solutions which will partly debate the legitimacy of the morally binding collective and partly anchor the solutions in this very legitimacy. And it is here that the scientific argument often stood the debate in good stead. Then as now, the positivist ideal of science strengthened time- and culture-bound notions on the society and the individuals, endowing them with traces of eternal truths. Conference delegates toned down their emotional aversion to alcohol, and when the repeal of the American prohibition was being debated, it was made clear that the decision could not be based on “a wave of sentiment” but that the matter should rest on “sound evidence” (Lyman Fisk 1920, p. 39). This also applied to temperance education: to be successful, such education should abstain from “moral exhortation against drinking” in favour of “scientific facts” (Stoddard 1920, p. 312). And when one discussed suitable methods of alcoholism treatment, the debate was able to draw on what was regarded as modern scientific conceptions. Sterilising alcohol misusers was not an issue, either, that could be discussed “from an ethical or humanitarian standpoint”; it could only be seen “on a scientific basis” (Stockard 1920, p. 375). Also, a shift from the medical aspects toward considering the social factors was motivated as being influenced by “a more scientific outlook on social phenomena in general” (Kinberg 1939, p. 307).

But there was no shared point of departure and strategy built on scientific ground. It was not even certain that the conference delegates were speaking about the same question. There was tremendous breadth in the conceptual understanding of the alcohol problem. Turn-of-the-century attempts to describe alcohol misuse as a disease had made few converts, and the problem formulation was also relatively disparate in the inter-war years.

3.3.3. Continuity and Change during the Post-War Years

In their official historiography, ICAA argues that the post-war conferences have represented something qualitatively new, possibly a more scientific approach to alcohol problems because of the recognition of alcohol as a disease in the first post-war conference in 1948 in Lucerne. In light of the investigated pre- and inter-war conferences, it is however difficult to see this as a particularly clear break with previous themes and approaches (Edman 2015a). Substance misuse problems have also, during the post-war period, been made intelligible as aspects of the wider society and any new themes that can be observed in the second half of the twentieth century were mainly associated with this. But even if the disease model was not necessarily new, this perspective now became part of an ever more influential biochemical research field – especially from the late 1970s onwards. This bio-reductionist approach had, however, earlier been widely represented by different types of heredity research.

A clear post-war trend is the growth of the ICAA conferences, at least if one can judge by the number of presentations and the thickness of the conference proceedings. To some extent this reflects an expansion of the topics discussed, primarily due to drugs now taking a more prominent place at the conferences from the 1968 conference in Washington onwards. Starting with the 1982 conference in Tangier there are also more presentations on tobacco and later on concepts such as misuse, dependence and addiction, which have come to cover a variety of human conditions and behaviours previously not discussed at the conferences. The 1999 conference in Vienna was explicitly a conference “on alcohol, drugs and other dependencies” (GR 1999).

But much is recognisable from the first half of the twentieth century. For instance, the first post-war conference discussed, just as the first inter-war conference did, the role of alcohol in the latest war. Since then, the armed forces have vanished as an exponent for alcohol problems but other important societal core functions – such as traffic and working life – have remained dominant themes. Alcohol and drug control, treatment measures and the ever-present education and information activities – now usually described as part of a more comprehensive prevention – are



other common and familiar themes. Prevention work has sought scientific legitimacy in the post-war period and in the conflict between idealism and a more scientific approach, which appeared during the former half of the twentieth century, the morally justified and religiously tinged temperance movement has been set aside. A certain planning and steering optimism came to characterize the first post-war decades and prevention work was now woven into general programs aiming to influence large parts of society. Religion did however recur as a theme at several post-war conferences, mainly as a possible community of values for treatment work.

Concerns for vulnerable youths remain a strong theme all throughout the post-war period and even more so when the drug issue was formulated as a youth problem. Female drinkers were rediscovered as a problem with unique causes and solutions during the 1970s, a problem construction that can be linked to the pre-war discussions on the same theme. The family, as a breeding ground for problems but even more as a therapeutic tool, occupies an equally strong position in the 1978 conference in Warsaw as when this theme was discussed around the turn of the nineteenth century. But the problem construction widened, the world grew and to some degree the conferences abandoned their Western-oriented focus. The 1975 conference was arranged in Bangkok, the 1982 conference in Tangier. Post-war decolonization helped to replace former colonial perspectives with the research conducted by the former colonies' own research institutions. An older problem description is nevertheless also recognizable when developed nations are set against developing countries and a certain criticism of modernity, partly portrayed as a continued interest in the drug consumption of indigenous peoples and ethnic minorities, is noticeable both in the 1970s and 1990s.

From the early 1960s onwards, sociological alcohol and drug research appear as a more coherent research perspective, although part of its approach can be traced to the early 1900s' more impressionistic symptoms and theoretical speculations. Psychological research was also more frequently heard at the conferences. Epidemiological research showed strong and growing popularity from the 1972 conference in Amsterdam and beyond. Some cultural and social anthropological relativism can be traced to the older conferences but a more explicit questioning of the factuality of alcohol and drug problems is visible only from the late 1960s onwards (Edman 2009). Since then, the investigated conferences have been an arena for the strange duality that characterizes the alcohol and drug research field where the majority of researchers study alleged real problems, while some other researchers question the philosophical, ideological and conceptual foundations of the same problem description.

3.4. Discussion

The alcohol question, such as it was discussed in the anti-alcohol conferences during the years 1885–1913, was both homogeneous and disparate. The conference delegates agreed on and departed from the premise that alcohol was destructive; they sought to tackle this serious question in different ways; and successfully discussed a great many subjects. If one were to pick an overarching theme for this period, one could describe it as an arrangement for the modern state where the temperance movement placed itself in the service of the state and at the same time demanded that it be given some responsibility for the future development of society.

However, these temperance advocates were not content with trying to make the old authoritarian state see things more soberly. The temperance movement was in great part a radical force with liberal and socialist overtones. But the situation looked very different from one country to the other: for example the temperance movement retained strong links to the progressive forces in the Nordic countries, while in the United States it rather allied itself with conservative forces towards the end of



the nineteenth century (and was something of a spent force in Great Britain). At the anti-alcohol conferences it was however evident that the temperance question was discussed with political overtones.

The decades before the First World War have been described as the heyday of confident internationalism, a period when knowledge, capital and political interest formations found allies across borders and hope was found in the collective rather than the narrow nation-state. It was in this spirit that the temperance movement took up its project. At the same time, these were years when the nation acted as a point of reference in several questions that were chafing within the modern project: population qualities and the condition of future generations, the notion of citizenship, industrial strength and competitiveness, the role and the strength of the state. Given the historical context of the alcohol question, it is interesting that the responses seem to centre on the very themes that appear entirely modern even more than a century later: treatment, prevention and restriction. The states' willingness, ability and legitimacy to force certain measures on the citizens in order to solve the problem points to vitalised governmental social political ambitions. The alcohol problem was now bound up with a kind of core in the self-image and purpose of the western nation. Alcohol was depicted as one of the great epidemics and hence also as a fundamental threat to the potential strength of the modern nation.

The transnational context of the conferences did not necessarily entail an internationally-minded community. Quite the opposite, this context was at least as frequently an arena for national examination and self-assertion. Obviously, as much then as it is now, it was also a manifestation of national limitations in politics. It was the population of one's own nation, their education, hygiene, working and housing conditions that could be set against the demands of and on the state. That nation which desired industrial competitiveness, an efficient infrastructure and a strong military institution also did well to ally itself with those temperance advocates who met at the transnational anti-alcohol conferences. The nation which had such objectives and wanted to see sober and strong citizens was encouraged also by the progressive forces in the temperance movement to take up a whole host of issues from women's political status to an individual's sex life. The fact that the alcohol question was made into a question for science was in this context a delicate resource: the problem could be defined according to its political formulation, while the notion of an illness and the state's alliance with physicians allowed different responses in the different countries.

The First World War tested the internationalist ambitions of popular movements but the first post-war conferences nevertheless enjoyed an optimistic atmosphere – and American prohibition had obviously given the temperance movement something to be hopeful about. But when the 1920s turned to the 1930s, it became increasingly evident that the conferences were being made into arenas for various national agendas. Such shared problems as criminality, population characteristics, core functions of the state and industrial efficiency were now given a national stamp. And when the enthusiasm of the early years over the desirable prohibition had waned, it was possible to see how the common endeavour to solve a common problem through a common agenda was exchanged for national solutions and outright propaganda pieces, where one's own responses were marketed as a logical outcome of state ideological aspirations.

This was a transition period in a temperance movement which was driven by a relatively vague religious yet still idealistic power on the one hand and which, on the other hand, was for both strategic and epistemological reasons influenced by scientific thought. The division was apparent over the whole field, from inspired Presbyterian ministers and Nazi philosophers of a mysterious bent to science-prone Baptists and sociologically-oriented communists. The radical race hygienic responses made room for ideological convictions of varying colours, but they shared a common faith in ethically neutral science. Sterilisation was propagated and practised as a response to individuals'



alcohol consumption in such democratic countries as Sweden, the United States and Weimar Germany. The national socialist takeover in Germany extended the eugenic arsenal to include murder.

The responses to the alcohol problem debated in the inter-war conferences built on a combination of scientifically masked ideological conviction and ideologically inspired passion for science. The apparently neutral ethics that we can detect in such thinking was manifested in its most extreme forms in the horrors of the Second World War. The more brutal varieties of race biology were discredited in the racist genocide committed by the Nazis, but the scientification of the alcohol problem had only been hinted at during the inter-war period. While the rise of the influential alcoholism movement after the Second World War was equally grounded in social, economic and ideological currents, it was often portrayed as a triumph of science. Now that various means of collective alcohol restrictions had been found wanting, the alcohol problem needed new solutions. After the Second World War, the relationship would yet again be shaken between the alcohol misusing individual and a new kind of society.

3.5. Conclusion and recommendations

The conferences provide a 'pre-history' for the development of an international movement and institutions after the Second World War, highlighted in sections 4 and 5 of this report which deal with WHO and EMCDDA. The confident internationalism of the pre-World War One years and also of the 1920s show responses centring on the very themes that appear entirely modern even more than a century later: treatment, prevention and restriction. Alcohol was depicted as one of the great epidemics and hence also as a fundamental threat to the potential strength of the modern nation. Science was fundamental to the international enterprise and in the 1930s, as eugenics, this became allied to ideas about the 'underclass', race hygiene and sterilisation in many countries, not only Germany. The history of the international alcohol conferences thus provides both positive and negative agendas for understanding the history of international endeavour for alcohol.

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4. The role of the WHO and its expert committees in defining addiction from the 1940s to the early 21st Century

Abstract

This section of the report examines the role of the World Health Organization (WHO) and its expert committees in disseminating concepts around addiction in relation to illicit drugs, alcohol and tobacco from 1949 to 2013. Three time periods are surveyed: 1949-1963 when intense discussion of concepts and terminology in relation to drugs and alcohol occurred and the substances were discussed as separate issues; 1964-1989 when the concept of dependence emerged ushering in the potential for a combined approach to the substances and when discussion of tobacco arose; and the 1990s onwards, when a more sustained combined approach to the substances developed and the WHO exercised its constitutional powers to establish an international convention on tobacco control. Review of the WHO expert committees demonstrates considerable engagement with concepts and terminology and the importance of the role of the WHO in establishing and shifting the conceptual boundaries between these substances. This highlights increasing linkages between the three substances under consideration, a more combined approach to research and treatment but differences in control. Early involvement with the problems of substance use and earlier discussion of tobacco than has generally been indicated in the existing literature is revealed. It is apparent that attempts at the harmonisation of concepts of addiction at the international level are by no means straightforward.

4.1 Introduction

This section of the report provides an international perspective by examining the role of the World Health Organization (WHO) and its expert committees in disseminating concepts around addiction in relation to drugs, alcohol and tobacco from 1949 to 2013. Three time periods were surveyed: 1949-1963 when intense discussion of concepts and terminology in relation to drugs and alcohol occurred and the substances were discussed as separate issues; 1964-1989 when the concept of dependence emerged ushering in the potential for a combined approach to the substances and when discussion of tobacco arose; and the 1990s onwards, when a more sustained combined approach to the substances developed and the WHO exercised its constitutional powers to establish an international convention on tobacco. Major objectives of our research were:

- To discover what were the concepts discussed in relation to illicit drugs, alcohol and tobacco.
- To analyse what terms were used and how were they defined.
- To investigate what were the similarities and differences in terminology across the substances.
- To establish how the expert committees were situated within the WHO and where responsibility lay for each substance.
- To analyse the impact of the professional composition of committees.



- To consider how terminology used in expert committee reports compared to that of the International Classification of Diseases (ICD), the standard diagnostic tool for epidemiology, health management and clinical purposes and conventions.

After discussion of our methodology in this report we present an overview of the WHO expert committees and show how they demonstrate considerable engagement with concepts and terminology and the importance of the role of the WHO in establishing and shifting the conceptual boundaries between these substances. We highlight increasing linkages between the three substances under consideration, and a more combined approach to research and treatment but differences in control measures. The research shows early involvement with the problems of substance use and earlier discussion of tobacco than has generally been indicated in the existing literature and in particular we highlight the problems involved in the creation of standardized definitions at the international level.

4.2 Methods

To explore the role of international agencies in the history of addiction concepts we decided to review the role of the WHO viewed through the work of its expert committees dating from 1949 to 2013. A literature review was carried out on secondary material on the WHO and illicit drugs, alcohol and tobacco. This included topics on the history of the WHO, the development of international control mechanisms, WHO expert committees, and other relevant mechanisms such as the ICD and UN Conventions.¹ We then went on to examine original printed material focusing upon the *Technical Report Series*, which publishes findings of the expert committees. Other primary material included WHO Conventions, texts of which we surveyed for pertinent terms. Terms used in the ICD in relation to drugs, alcohol and tobacco were also reviewed. WHO archival material on this topic has rarely been utilised and we surveyed material held in the WHO Archives, Geneva. Unfortunately, the archive does not hold minutes of meetings but it does hold other relevant documentation such as correspondence with committee members.

The existing literature has demonstrated the importance of expert committees but it has largely reviewed the substances individually and tends to concentrate on drugs and alcohol, not tobacco. Tobacco has been studied but with a greater focus on the development of the Framework Convention on Tobacco Control rather than its longer history within WHO. The extant literature has largely been written by those with connections to WHO rather than by historians. Overall, we aimed to establish the role of the WHO expert committees in defining addiction and we consider the three substances together under the umbrella of ‘concepts of addiction’ and examine the relationship between concepts and terminology across these three substances.

We summarize our findings below and in Taylor, S., Berridge, V. and Mold, A, WHO expert committees and key concepts for drugs, alcohol and tobacco 1949-2013, (forthcoming).

¹ Catalogues and databases searched included: the Wellcome Library, British Library, Senate House, Pubmed, Historical Abstracts and JASTOR. Further material was garnered from bibliographies and by word-of-mouth.



4.3 Results

4.3.1 WHO expert committees on illicit drugs, alcohol and the early development of terminology, 1949-1963

Much literature on the WHO has concentrated on its role in combatting infectious diseases. Health promotion and public health has also been discussed; since the 1970s there has been interest in international substance control, both illicit drugs and alcohol.^{2, 3} Within this the mechanism of the expert committee has been examined demonstrating its importance in the development of concepts, terminology and definitions. WHO Expert Committees are the highest official advisory bodies to the Director-General of WHO and Member States. They are established by the WHO World Health Assembly (WHA) and each committee makes recommendations on a subject of interest to the WHO. Members are chosen from WHO Expert Advisory Panels, temporary advisers, representatives from international organizations, nongovernmental organizations and professional associations. The WHO Expert Committee on Drug Dependence has been one of the most active committees, meeting every two years since it was established in 1949 (undergoing various title alterations) and it has played a central role in the international drug control system, making recommendations to the United Nations Commission on Narcotic Drugs on control measures. In contrast, alcohol and tobacco committees, not needing to make scheduling decisions in relation to international conventions, have met less frequently, often in response to a WHA resolution calling for research on a particular area of emerging interest. Bruun *et al* have examined expert committees on drugs and alcohol and highlighted their significance in the development of key concepts; the importance of a committee's composition, policy imperatives and outputs.⁴ Room has written extensively on this topic focussing on alcohol and drugs.⁵ His analysis demonstrated the fluctuating focus of committees and major turning points such as the 1992 Expert Committee on Drug Dependence (ECDD).⁶ Room uncovered significant shifts in terminology, for example, the transition from 'habit' and 'addiction' to 'dependence' or from 'alcoholism' to 'alcohol-related problems'.⁷

This report splits the expert committee discussions into three time periods; 1949-1963 when intense discussion of concepts and terminology in relation to drugs and alcohol occurred and the substances were discussed as separate issues; 1964-1989 when the concept of 'dependence' emerged and

² McCarthy M, A brief history of the World Health Organization. *Lancet*. 2002; 360. (9340): 1111 – 1112.; WHO, *History of international public health*, Geneva: World Health Organization, 1975.; Cueto TM and Fee E, The World Health Organization and the transition from "international" to "global" public health. *Am J Public Health*. 2006; 96: 62-72; Yach D and Bettcher D, 'The globalization of public health. *Am J Public Health*. 1998; 88: 735-74.

³ McAllister W, *Drug diplomacy in the twentieth century: An international history*, London: Routledge;

⁴ Bruun K, Pan L and Rexed I, *The gentlemen's club: International control of drugs and alcohol*, Chicago and London: University of Chicago Press; 1975.

⁵ Room R, A farewell to alcoholism? A commentary on the WHO 1980 expert committee report. *Brit. J. Addiction*. 1981; 76: 115-123.

⁶ Room R, Harm reduction, human rights and the WHO expert committee on drug dependence. In: Erickson P and Riley D and Cheung Y and O'Hare P, eds. *Harm reduction: A new direction for drug policies and programs*. Toronto: University of Toronto Press; 1997:119-130.

⁷ Room R and Babor T, World Health Organization's global action on alcohol: resources required to match the rhetoric. *Addiction*. 2005; 100 (5): 579-580.; Room R, Alcohol and the World Health Organization: The ups and downs of two decades. *Nordisk Alkohol and Narkotikatidskrift*, 2005. 22; Selvaggio K, World Health Organization bottles up alcohol study. *Int J Health Serv*. 1984; 14 (2): 303-388.



ushered in the potential for a combined approach to the substances, and when discussion of tobacco arose; and the 1990s onwards when a more sustained combined approach to the substances developed and the WHO exercised its constitutional powers to establish an international convention on tobacco.

Drug committees, in comparison to alcohol and tobacco committees, were the most active (see table 1, in the appendix). Between 1949-63 terminology was a crucial factor in discussions. In relation to illicit drugs, the main term used was 'habit-forming' and the first committee established in 1949 was termed the Expert Committee on Habit-Forming Drugs. Members were pharmacologists/chemists and discussions centred on the status of various substances in relation to the Conventions on controlled drugs.⁸ But attention turned to a new term 'addiction' and in 1950, the committee became the Expert Committee on Drugs Liable to Produce Addiction (ECDLPA). Attempts were made to differentiate between the two terms.⁹ A 'habit-forming' drug was described as:

'one which is, or may be, taken repeatedly without the production of all of the characteristics outlined in the definition of addiction and which is not generally considered to be detrimental to the individual and to society.'

The term referred mainly to 'psychic dependence', whereas 'drug addiction' which implied both 'psychic' and 'physical' dependence was preferred by the committee and was defined as:

'a state of periodic or chronic intoxication, detrimental to the individual and the society, produced by the repeated consumption of a drug (natural or synthetic).....A psychic (psychological) and sometimes a physical dependence on the effects of the drug...'

'Dependence,' a term that would become prominent in the 1960s, was mentioned but not defined. The committee decided that 'habit-forming' should be eliminated from all texts and urged governments to consider medical research on 'drug addiction'.

The distinction between the two was important because attempts were made to link these concepts to control measures. A 1952 committee acknowledged that the term 'addiction' implied a serious state, one which '*must be rigidly controlled.*' In contrast, drugs resulting in 'habituation' were thought more innocuous as they, '*cause no sociological damage and do not need rigid control.*'¹⁰ This split proved problematic because some 'borderline' drugs such as alcohol fell into an intermediate position and were outside international control.

Discussion of alcohol focused more on the condition, 'alcoholism' with a more medical approach. The first expert committee, the WHO Expert Committee on Mental Health's Alcoholism Subcommittee of 1951, focused on conceptual discussion of 'alcoholism'.¹¹ Its membership was mainly psychiatrists and it was chaired by Dr G.A.R. Lundquist, Assistant Professor of Psychiatry at

⁸ World Health Organization, *Expert committee on habit-forming drugs*. Geneva: WHO, 1949.

⁹ World Health Organization, *Expert committee on drugs liable to produce addiction, second report*. WHO Technical Report Series, 21. Geneva: WHO, 1950.

¹⁰ World Health Organization, *Expert committee on drugs liable to produce addiction, third report*, WHO Technical Report Series, 5. Geneva: WHO, 1952.

¹¹ World Health Organization, *Alcoholism subcommittee, first report*, Technical Report Series, 42. Geneva: World Health Organization, 1951.



Langbro Hospital, Stockholm. The secretariat included Professor EM Jellinek, a WHO consultant on alcohol and Dean of the Yale Institute of Alcohol Studies; much of the historical literature has focused on his work on alcoholism. The subcommittee made clear that 'alcoholism' was a disease and a social problem in which public health services should play a significant role in prevention and treatment.

Terminology occupied a large part of the committee's report. The initial term used was 'chronic alcoholism' but this was quickly discredited due to cross-cultural misunderstandings, an important consideration for the WHO working in a global environment. 'Alcoholism' defined as *'any form of drinking which in its extent goes beyond the traditional and customary dietary use or the ordinary compliance with social drinking customs,'* was seen to have a more consistent meaning and became the preferred term. 'Alcoholism' was refined into stages which were important for their clinical significance and potential treatment regimes. In referring to 'addictive drinking', the subcommittee noted the work of the 1950 Expert Committee on Drugs Liable to Produce Addiction (ECDLPA) on definitions for 'addiction'. The subcommittee acknowledged similarities to drugs of addiction but maintained a distinction in that it was *'uncertain whether or not the pharmacological concomitants of drug addiction exist creating a physical dependence on the drug.'* This led to pressure for a new subcommittee under the ECDLPA to examine the potential 'drug of addiction' alcohol, rather than the 'disease' of 'alcoholism'.

The subcommittee on Alcoholism met again in 1951. Chaired by Dr M Schmidt, Chief Psychiatrist, Department of Police, Denmark, it concentrated on practical and specific aspects of 'alcoholism'. The previous subcommittee's provisional definition of 'alcoholism' was adopted for 'excessive drinkers' while alcoholics were defined as:

*'excessive drinkers whose dependence upon alcohol ... shows a noticeable mental disturbance or an interference with their bodily and mental health, their inter-personal relations and their smooth social and economic functions....They therefore require treatment.'*¹²

The position of alcohol in relation to other drugs became increasingly important especially as the term 'addiction' became dominant in relation to illicit drugs. An Expert Committee on Alcohol was created and reported in 1954.¹³ The composition of the alcohol committee differed from that of the previous committees on 'alcoholism', and it comprised mainly pharmacologists, and physiologists. Later committees also had a wider range of disciplines. This committee was chaired by Dr Lundsgaard, Professor of Physiology at the University of Copenhagen and included Professors of Pharmacology, such as Dr L Goldberg from Stockholm, and Dr J Mardones from Santiago, Chile, an Associate Professor of Medicine from Stanford University, and LD MacLeod from the Burden Neurological Institute, Bristol. They discussed broader ramifications -the etiological, epidemiological, sociological and anthropological issues, as opposed to purely pharmacological or clinical concerns. The committee drew on the work of the 1950 ECDLPA which added to the confusion because alcohol and 'alcoholism' could not easily be fitted into the definition of 'drug addiction'. Alcohol was placed

¹² World Health Organization, *Alcoholism subcommittee: second report, Technical Report Series 48*. Geneva: World Health Organization, 1952.

¹³ World Health Organization, *Expert committee on alcohol: first report*. Geneva: World Health Organization, 1954.



in a category of its own, one intermediate between ‘addiction-producing’ and ‘habit-forming’. Concepts pertaining to the pharmacological position of alcohol remained unclear, for instance, the term ‘tolerance to alcohol’ was seen as causing misunderstandings. A distinction was deemed necessary between ‘tolerance’ related to addiction-producing drugs of the morphine type and that associated with alcohol. ‘Withdrawal symptoms’ also proved contentious as in the alcohol field the term ‘withdrawal symptoms’ was used whereas the term ‘abstinence syndrome’ was used in the case of drug addiction of the morphine type. Thus, the committee was unable to match the definitions between alcohol and illicit drug terminology. The separate category for alcohol was necessitated by the difficulty of drawing a line between the presence and absence of addiction-producing properties.¹⁴ The subcommittee pressed for a further meeting incorporating both clinicians and experimental workers to attempt further clarification.

This borderline position of alcohol remained important for the Expert Committee on Alcohol and Alcoholism which met in 1955.¹⁵ Jellinek and Wolff had left and a changing membership drew together pharmacologists, physiologists as well as psychiatrists and members from both the Expert Advisory Panel on Mental Health and that of Drugs Liable to Produce Addiction. Its mandate was to clarify basic concepts related to alcohol and the features of the problem in different countries. The committee re-iterated the importance of ‘alcoholism’ as a medical problem in order to involve public health services. However, this was proving difficult due to inadequately defined terminology.

The introduction of the concept of ‘problems of alcohol’ or ‘problem use’ forced a broader consideration of the problem. This shift away from ‘alcoholism’ was important because it was ‘excessive drinking’ rather than ‘alcoholism’ which was a major problem for most countries. One approach was to cease the use of the term ‘craving’ and adopt ‘physical dependence’. Though the 1955 committee acknowledged recent evidence which indicated a closer resemblance between responses to the withdrawal of alcohol and that of opiates, it remained of the opinion that there was no justification for a change in the position of alcohol. Instead the preferred concept became the ‘problems of alcohol’ of which ‘alcoholism’ was just one aspect.

‘Addiction’ continued to pose problems for illicit drugs and the renamed Expert Committee on Addiction-Producing Drugs (ECAPD) revisited the issue in 1957.¹⁶ Its membership began to broaden and significantly included Dr Goldberg who had sat on the 1953 Expert Committee on Alcohol and for the first time included a psychiatrist, Dr Pernambuco Filho, Professor of Psychiatry, Faculty of Medicine, University of Rio, Brazil. The distinction between ‘addiction’ and ‘habit-forming’ remained problematic and the committee was forced to refine the previous definitions.

Drug addiction: *‘Its characteristics include: 1) an overpowering desire or need or compulsion to continue to take the drug ... 2) a tendency to increase the dose; 3) a psychic (psychological) and generally a physical dependence on the effects of the drug; 4) detrimental effects on the individual and on society.’*

¹⁴ World Health Organization, *Expert committee on alcohol: first report*. Geneva: World Health Organization, 1954.

¹⁵ World Health Organization, *Alcohol and alcoholism: report of an expert committee, Technical Report Series, 94*. Geneva: World Health Organization, 1955.

¹⁶ World Health Organization, *Expert committee on addiction-producing drugs, seventh report, Technical Report Series 116*. Geneva: WHO, 1957.



Drug habitation (habit) 1) *a desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders; 2) little or no tendency to increase the dose; 3) some degree of psychic dependence on the effect of the drug but absence of physical dependence and hence of an abstinence.*

These new definitions were to find some acceptance by the time of the 1960 committee but they were far from perfect. The committee complained that they had included heterogeneous criteria to meet the requirements of international control but this made definitions difficult to interpret. Hence they reiterated the basis of control, which was related to risk to the community, the *'fundamental criterion for control is the extent to which these drugs induce behaviour disturbance and risk to the community.'*¹⁷

A significant shift appeared when interest expanded to the user and the methods of prevention and treatment as opposed to the pharmacological action of drugs. The issue of the 'addict' and 'treatment' appeared in the 1958 expert committee after pressure by the UN Economic and Social Council.¹⁸ It became significant as the committee pressed for an opportunity to comment on drafts for the 1961 UN Single Convention on Narcotic Drugs. The Convention enshrined the term 'addiction', a term the expert committees would later try to replace. In 1959 the committee had raised disquiet over the schedules for the Convention, the scope of control, and the treatment of drug addicts.¹⁹ Attitudes toward drug addicts and their treatment came more to the fore in 1961 when the committee discussed the medical control of addicts. Though proposals for civil commitment of an addict (in the case of mental patients) to a medical panel were approved, they were not deemed a replacement for legal penalties.²⁰ The 1962 committee pointed out that whilst 'withdrawal' must be the first step in treatment, for a 'cure' to be successful, 'rehabilitation' was necessary, and hence an immediate need for treatment and rehabilitation facilities.

In sum, during this period both drug and alcohol committees were active. Tobacco was not considered at this point. Drugs and alcohol were considered by separate committees but concepts and terms were important areas of discussion for both committees. Drug committees were initially largely composed of pharmacologists, but slightly widened to include other disciplines, notably the occasional inclusion of a psychiatrist, and the presence of one member who had also sat on the alcohol committee. This period saw a shift from the term 'habit forming' to 'addiction' though the term remained problematic. Drug committees had been established to provide advice in relation to pre-existing international drug control treaties so the focus was on the substance though there was a slight shift to consider the problems of use, for example, consideration of the 'addict' by the end of this period. In contrast there were no international treaties for alcohol control hence the WHO began with health concerns over the condition, not the 'drug'. Committees on alcoholism began as largely psychiatric-based and focused on the condition 'chronic drinking' and later 'alcoholism'. Later committees developed to include pharmacologists, physiologists and a psychiatrist and turned to

¹⁷ World Health Organization, *Expert committee on addiction-producing drugs, tenth report, Technical Report Series, 188*. Geneva: WHO, 1960.

¹⁸ World Health Organization, *Expert committee on addiction-producing drugs, eighth report, Technical Report Series, 142*. Geneva: WHO, 1958.

¹⁹ World Health Organization, *Expert committee on addiction-producing drugs, ninth report, Technical Report Series, 160*. Geneva: WHO, 1959.

²⁰ World Health Organization, *Expert committee on addiction-producing drugs, eleventh report, Technical Report Series 211*. Geneva: WHO, 1961.



consider 'alcohol' and the 'problems of alcohol use' and 'excessive drinking' rather than just 'alcoholism'. Whilst some similarities were drawn with illicit drugs, significantly, alcohol was deemed to occupy an intermediate position. Furthermore, in contrast with drug committees, alcohol committees began with an interest in prevention and rehabilitation and an acknowledgement of the significance of cultural differences in alcohol use.

4.3.2: The rise of 'dependence', tobacco, and the prevention of problems associated with substance use, 1964-1989

During the period 1964-1989, the concept of 'dependence' developed and opened the way for a combined approach to the substances (see Table 2 in the appendix). Though the 1971 UN Psychotropic Drugs Convention led to a focus on scheduling requirements rather than drug terminology and interest in alcohol declined by the 1980s, some influential reports emerged emphasising the concept of a medical rather than penal approach, the threat to the community as well as the individual and the need for prevention of both drug and alcohol 'related problems' rather than a narrow focus on supply. Additionally, tobacco entered the WHO's consciousness as a serious global public health threat.

A significant moment was the adoption of the term 'dependence' by the 1964 Expert Committee on Addiction-Producing Drugs, chaired by Dr NB Eddy, a pharmacologist and Consultant on Narcotics, National Institutes of Health, USA. The committee largely consisted of pharmacologists but it did include one psychiatrist, Dr P Kielholz, Professor of Psychiatry University of Basel, Switzerland and it had a different emphasis. It welcomed the fact that other agencies, such as the Commission on Narcotic Drugs, were pushing for an increased emphasis on the sociological and economic aspects of 'drug abuse'. With the increasing number of drugs available and continuing confusion over 'addiction' and 'habituation', it had proved difficult to find a term that could be applied generally to 'drug abuse'. The concept of 'dependence' was seen as a common factor between the huge varieties of drugs. Though the term had been loosely used previously, it became the preferred term defined as,

'a state arising from repeated administration of a drug on a periodic or continuous basis. Its characteristics will vary with the agent involved and this must be made clear by designating a particular type of drug dependence in each specific case.'²¹

Specific types of drug dependence were elucidated, for example, drug dependence of the morphine type. Crucially, 'dependence' was not linked to any type of control. The 1965 committee was renamed the Expert Committee on Dependence-Producing Drugs (ECDPD).²² But 'dependence' had flaws. Criticisms were made of the vagueness of the term, cross-cultural applicability and cross-drug applicability.²³ Furthermore, it created conflicts with the ICD. Room has considered the development of alcohol and drug categories in instruments such the International Classification of Disease (ICD), revealing its relationship with the WHO, problems of cross-cultural applicability of terms, such as 'dependence', differentials between lay and technical understandings, and cross-drug applicability of

World Health Organization, *Expert committee on addiction-producing drugs, twelfth report, Technical Report Series*, 273. Geneva: WHO, 1964.

²² World Health Organization, *Expert committee on dependence-producing drugs, fourteenth report, Technical Report Series*, 312. Geneva: WHO, 1965.

²³



terms.^{24, 25} The section which covered drug addiction in the ICD contained a diverse list of terms which the committee argued were not necessarily addiction-producing drugs in a pharmacological or legal sense. The report therefore recommended 'drug dependence' be taken into account by the ICD.

There was added pressure for clarity when the committee's mandate was broadened in 1966 and 1969 from the determination of the control status of drugs to other aspects of 'drug dependence' and 'abuse'.²⁶ The committee's name was also altered to the Expert Committee on Drug Dependence (ECDD) in 1969. In addition to the pharmacologists, membership of the ECDD was widened to include Dr A Wikler, Professor of Psychiatry and Pharmacology University of Kentucky, and Dr PH Connell, a psychiatrist at the Bethlem and Maudsley Hospital, London. This shifting membership resulted in a shift towards the condition rather than a strict focus on the drug. 'Drug abuse' was defined as '*persistent or sporadic excessive drug use inconsistent with ... acceptable medical practice.*' 'Drug abuse' was deemed convenient on the grounds that there was no universally accepted term but 'abuse' would be dropped by the WHO by 1975 due to its stigmatizing connotations, though it would remain in the ICD until 1992.²⁷

These developments meant that the split between alcohol and illicit drugs was harder to sustain. The WHO wanted to encourage authorities to look at 'alcohol and alcoholism and use and abuse of drugs together'. A more combined approach had been sought by the Expert Committee on Mental health but more in relation to research, and to a lesser extent with treatment and education, as opposed to control measures.²⁸ The increasingly combined approach to drugs and alcohol was reflected in the 1967 WHO Expert Committee on Mental Health Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs.²⁹ This committee was chaired by Dr K Evang, Director-General Health Services of Norway and consisted of sociologists, psychiatrists, neuro-psychiatrists and a pharmacologist. It also included representatives from the UN narcotic drug organizations such as Mr A Lande, Secretary to the Permanent Central Narcotics Board as well as those from the alcohol field including Mr HD Archibald, Director of Alcoholism and Drug Addiction Research Foundation, Toronto, Canada. The broader disciplinary backgrounds reflected the committee's mandate which was to consider the establishment of services for the prevention and treatment of 'dependence' on both alcohol and other drugs. The rationale to combine the approaches was persuasive. This concept of 'dependence' brought the concepts around the differing substances closer together with the committee taking note of the similarities in causation and treatment and the fact that drugs were themselves often used in combination. Research from the alcoholism field was also viewed as

²⁴ Room R, Alcohol and drug disorders in the International Classification of Diseases: a shifting kaleidoscope. *Drug Alcohol Rev.* 1998; 17: 305-317.

²⁵ Room R, Harm reduction, human rights and the WHO expert committee on drug dependence'; pp. 119-130. Room R., The World Health Organization and alcohol control. *Br J Addict.* 1984; 79: 85-92.

²⁶ World Health Organization, *Expert committee on drug dependence, sixteenth report, Technical Report Series* 407. Geneva: WHO, 1969.

²⁷ Kramer JF and Cameron DC. *A Manual on Drug Dependence.* Geneva: WHO, 1975.

²⁸ World Health Organization, *Expert committee on mental health, Technical Report Series 367.* Geneva: World Health Organization, 1967.

²⁹ World Health Organization, *Expert committee on mental health services for the prevention and treatment of dependence on alcohol and other drugs, Technical Report Series 363.* Geneva: World Health Organization, 1967.



relevant to controlled drugs and it was accepted that, whilst attitudes towards ‘alcoholism’ had shifted towards the therapeutic, this had not happened, to the same extent, with controlled drugs.

Tobacco has not been considered in relation to drugs and alcohol. Little has been said about expert committee discussion of tobacco despite its inclusion in WHO discussions from 1970. Tobacco, when it surfaced as an issue for the WHO, did so within the different framework of public health. A 1970 Report of the Director-General, (DG), based on the work of Charles Fletcher and Daniel Horn, leading anti-smoking campaigners, sought to establish the problem as worthy of consideration by the WHO by referring to the links to diseases such as lung cancer, and the increasing uptake of smoking especially by women.³⁰ The report led the WHO to affirm the hazards of smoking and to ban smoking in its own meetings. The concept of ‘less hazardous smoking’ arose focusing on the development of ‘less hazardous’ cigarettes and methods of smoking. Other methods such as filters were also considered, and the report called for research on the effects on health of modifications in the constituents of cigarettes. A follow-up report in 1971 focussed on potential methods of control.³¹ Legislation was considered important, for example, in enacting measures to encourage smokers to stop smoking. The ‘less hazardous cigarette’ remained an option and differential taxation favouring the use of ‘less harmful cigarettes’ was discussed. Any economic losses from reduced tobacco revenue were expected to be offset by a healthier population. By the early 1970s tobacco would enter discussions of the drug committees.

Psychotropic drugs became the major focus in 1971 with the creation of the UN Convention on Psychotropic Substances. This became a priority for the committee in 1970, when draft protocols of the convention were sent to the ECDD. At this time the committee mainly consisted of pharmacologists, although there were also two psychiatrists one being Dr M Shepherd, Professor of Psychiatry, the Institute of Psychiatry, London. The Convention necessitated refinement of the terminology. A link to ‘dependence’ was one criterion for control. The term ‘psychotropic’ applied only to substances specifically listed in one of the first four schedules and the committee accepted that many psychotropic substances used in medicine did not produce ‘dependence’ and therefore, to avoid confusion, a qualifying term, ‘dependence-producing’ was introduced to be added when speaking of psychotropic substances to be controlled in the draft protocol. This committee also broached the concept of a medical rather than penal approach emphasising treatment and rehabilitation within public health services.

The 1973 committee reflected the rise of the public health population approach and it was comprised of a wider spread of disciplines with epidemiologists and sociologists joining the pharmacologists and psychiatrists. This led to further refinements around the concept of ‘dependence’ with a focus upon ‘dependence-producing drugs and more interest in the problems surrounding the use of such drugs.’³² ‘Dependence’ in itself was not necessarily considered harmful for in a broad sense it could include tea and coffee, while drugs, such as alcohol, cannabis and opiates, resulted in individual, public health and social problems. Thus by 1974 there was a shift in

³⁰ CM Fletcher and D Horn, smoking and health report to the twenty-third World Health Assembly, *WHO Chronicle* 24. 1970; 345-370.

³¹ The limitation of smoking, Report submitted by the Director-General of WHO to the Twenty-Fourth World Health Assembly. *WHO Chronicle*, 25, 1971; 452-257,

³² WHO Expert Committee on Drug Dependence, *Expert committee on drug dependence, nineteenth report, Technical Report Series 526*. Geneva: World Health Organization, 1973.



focus to prevention of the problems associated with drug use. The committee was chaired by Dr B.S. Brown, Director of the National Institute of Mental Health, Department of Health, Education and Welfare, USA, and included several members of the UN Division on Narcotic Drugs such as Dr O.J. Braenden, and members of the International Council on Alcohol and Addiction. Dr H. Halbach, a Professor of Pharmacology at the University of Munich, was invited to consider what was known about preventing problems associated with the use of psychoactive dependence-producing drugs. This shift meant that alcohol gained a higher profile because it was deemed more of a problem than many illicit drugs. Tobacco, as the most widespread form of drug-dependence was also drawn into discussion though it was excluded from pre-review (the preliminary stage to decide whether a substance should undergo a fully documented or critical review which might lead to the scheduling of a psychoactive substance) on the grounds that its psychotoxic effects were slight compared to other drugs.³³

Yet tobacco warranted its own expert committee.³⁴ Following a 1974 resolution requesting that an expert group be convened, the *Expert Committee on Smoking and its Effects on Health* was created and met in 1975 to summarize evidence on the harmful effects of smoking and to propose actions to discourage smoking. Hence, tobacco was isolated from illicit drug committees and smoking entered the expert committee's realm from a public health perspective. This was reflected in its membership which consisted mainly of social medicine and public health experts, cardiologists and policy makers.³⁵ It was chaired by Sir George Godber the UK Chief Medical Officer with Dr Sujoy B Roy, Professor and Head of Department of Cardiology, at the All-India Institute of Medical Sciences, New Delhi acting as the Rapporteur. Its members included Dr F Beske Professor of Social Medicine and Public Health, Secretary of State, Ministry of Social Affairs, Kiel, Germany. Charles Fletcher acted as a temporary adviser. This committee reviewed the state of knowledge since Fletcher's 1970 report and reviewed the gamut of potential control measures including: warning notices, prohibition in certain public places, and protection of the rights of 'non-smokers', as well as quality control and education. Some terms used were similar to those adopted for alcohol and drugs, including 'psychic dependence' and 'withdrawal'. Whilst drug terminology had moved away from 'habit' or 'habitation' early on, the phrase 'smoking habit' was widely used in reports. Few terms were defined. 'Dependence' was adopted in relation to nicotine,

'chronic use of nicotine produced dependence and that for some people the disturbing nicotine withdrawal syndrome...contributes to the difficulty of giving up.'

The issue of 'withdrawal', developed in drug and alcohol committees, was picked up for tobacco but differences were also identified in the sense that social reinforcement and 'dependence' were thought to develop faster than with other drugs such as alcohol.

At the same time, the effects of smoking were accepted as extending beyond the individual user. What would become known later as 'passive smoking' was discussed as 'involuntary exposure to smoke.' The report noted potential damage to non-smokers.

³³ World Health Organization, *Expert committee on drug dependence, nineteenth report, Technical Report Series 551* Geneva: World Health Organization, 1974.

³⁴ WHO Resolution WHA23.32 *Health Consequences of Smoking*, 1970.

³⁵ World Health Organization, *Smoking and its effects on Health: Report of a WHO Expert Committee* (Geneva: WHO, 1975).



‘the non-smoker exposed to the side stream and mainstream of smokers in enclosed, ill-ventilated spaces such as cars and small offices may be exposed to harmful concentrations of smoke.’

This threat to the wider community boosted the need for stricter control measures and by protecting the non-smoker it was hoped to reduce opportunities for smoking.

Threat to the wider community was an important concept for all these substances. This was especially true with alcohol. As discussed by Room, work during this time focused on alcohol’s impact on the wider community rather than the individual drinker.³⁶ The question of ‘alcohol disabilities’ was discussed by a WHO Steering Group between 1973-1975 resulting in a broader focus than the ‘alcoholic.’ ‘Alcohol-related disabilities’ and later ‘alcohol-related problems’ became the focus at the WHO. Griffith Edwards, in reviewing the WHO’s 1977 report on alcohol-related disabilities, highlighted the lack of commonly accepted terminology as an obstacle to research and policy. His work emphasized the shift to ‘disability’ as the preferred term to describe the social burden resulting from disease.³⁷ This emphasis on ‘disability’, rather than the disease was intended to draw attention to the need to reduce the consequences on the family and society as well as the individual. Whilst concrete definitions were not deemed possible a loose definition was:

‘Alcohol-Related Disability is deemed to exist when there is impairment in the physical, mental or social functioning of an individual of some nature that it may be reasonably inferred that it is part of the causal nexus determining that disability.’³⁸

By 1976 ‘dependence’ was adopted by the alcohol field. Alcohol-Dependence Syndrome was seen as one variety of alcohol-related disability (ARD) and was adopted by the 1980 committee. Not all those with ARD were seen as alcohol-dependent but were at more risk of becoming so. ‘Alcohol dependence’ entered the 9th revision of the ICD.

Whilst with alcohol attempts were made to ‘manage’ associated problems, with tobacco the goal was elimination, and tighter control of the smoking epidemic was the primary focus of the 1979 tobacco expert committee. Membership was weighted to anti-smoking advocates. The committee was chaired by Sir George Godber, with Dr Nigel Grey, of the Anti-Cancer Council of Victoria, Australia as Rapporteur. Others included Dr K Bjartviet, Chairman of the National Council on Smoking and Health, Oslo and Dr L Ramstrom, Director-General of the National Smoking and Health Association, Stockholm. Significantly, the aim was elimination, ‘removal of the hazard not marginal reduction’.³⁹ This meant that the concept of the ‘safe cigarette’ was rejected. Instead, potential methods of control leading to elimination were promoted including: control of sales promotion; health warnings; taxation; restrictions on smoking in public places; and evaluation of legislation. Crucially, this report marked the first calls for the use of WHO’s constitutional powers to develop an international treaty.

³⁶ Room R, The World Health Organization and alcohol control. *British Journal of Addiction*. 1984; 79; 85–92.

³⁷ Edwards G, How the 1977 World Health Organization report on alcohol-related disabilities came to be written: a provisional analysis. *Addiction*. 2007; 102 (11): 1711-1721.

³⁸ Edwards G, et al, *Alcohol-Related Disabilities*, Geneva: WHO, 1977.

³⁹ WHO Expert Committee on Smoking Control, *Controlling the Smoking Epidemic: Report of the WHO Expert Committee on Smoking Control* (Geneva: WHO, 1979).



To summarize, although the 1971 Psychotropic Convention came into force during this period and there was less discussion of concepts around illicit drugs as the committees became more involved in technical discussion over scheduling, there were significant developments. There were major changes to the drug committees' composition with the pharmacologists being joined by epidemiologists and sociologists and the involvement of those working in the alcohol field. There was also a shift in how the problems were conceptualised. 'Addiction' was replaced by the concept of 'dependence' and a focus on 'dependence-producing drugs', a move which brought potential for a more combined approach to the substances. As such alcohol became an issue as it could be seen as a 'dependence-producing drug'. Major changes saw a shift in interest to, not only prevention of drug use but, the limitation of problems once drug use had occurred. There were limited reports on alcohol but significantly, concepts developed around 'alcohol-related disabilities' and 'alcohol-related harm'. Importantly, smoking emerged as a public health problem and warranted the establishment of its own expert committee. Membership of the committee was broad both in terms of geographical location and disciplines but with a medical/public health emphasis. The focus was on the elimination of smoking, though the idea of the 'less hazardous cigarette' emerged, and calls began for WHO to exercise its constitutional powers for an international legal approach to tobacco control.

4.3.3: A combined approach?: The Programme on Substance Abuse and the Framework Convention on Tobacco Control, 1990-2013

The period from the 1990s to 2013 is characterised by a more sustained combined approach to substance use reflected in changes to the WHO structure with the creation of the Division of Mental Health and Prevention of Substance Abuse's Programme on Substance Abuse (PSA) and by the development of global strategies for tobacco control, most notably with the Framework Convention on Tobacco Control representing the first time the WHO had exercised its constitutional powers and the origin of the Framework Convention on Tobacco Control (FCTC) in 2005 has been a prominent feature of research (see Table 3, in the appendix). Taylor and Bettecher analyzed the development of international health law.⁴⁰ Collin *et al* discussed the FCTC in the context of accelerating globalization. Civil society contributions to the negotiation process proved important for tobacco, and Yach, and Bettcher demonstrated that the tobacco industry increasingly attempted to influence agencies such as the WHO.^{41, 42} Likewise Weishaar, *et al* have pointed to the transnational tobacco corporations' efforts to undermine the FCTC.⁴³ The applicability of the Framework to other substances has been the focus of a number of works.⁴⁴ A final aspect of the literature is that it is

⁴⁰ Taylor A and Bettecher D, WHO Framework Convention on Tobacco Control: a global "good" for public health. *Bull World Health Organ.* 2000; 78: 920-9.

⁴¹ Collin J, Lee K, and Bissell K, The Framework Convention on Tobacco Control: the politics of global health governance. *Third World Q.* 2002; 23: 265-282; Mamudu HM, and Glant SA, Civil Society and the negotiation of the Framework Convention on Tobacco Control. *Glob Public Health.* 2009; 4: 150-168.

⁴² Yach D and Bettcher D, Globalisation of tobacco industry influence and new global responses. 2000; 9: 206-216.

⁴³ Weishaar H, *et al*, Global health governance and the commercial sector: A documentary analysis of tobacco company strategies to influence the WHO Framework Convention on Tobacco Control. *PLOS Medicine.* 2012; 9 (6):

⁴⁴ Lien G, and Deland K, Translating the WHO Framework Convention on Tobacco Control. Can we use tobacco control as a model for other non-communicable diseases? *Public Health.* 2011; 125 (12): 847-853. Jernigan H *et al*, Towards a global alcohol policy: Alcohol, public health and the role of the WHO. *Bull World Health Organ.*



generally written by non-historians, many employed or connected to the WHO and whilst this has the advantage of insider knowledge, it tends to lack context and be allied to an activist perspective.⁴⁵

Mounting pressure for a combined approach to drugs and alcohol was built into the structure of the WHO in the 1990s. The WHO's Global Strategy for Health for All By The Year 2000 led in 1990 to the creation of a new programme, the Programme on Substance Abuse designed to prevent and control alcohol and drug abuse.⁴⁶ This resulted in alcohol and drugs being briefly separated from the Mental Health Division. Expert committees began to review the substances together. *Health Promotion in the Workplace* reviewed approaches to health promotion as a means of preventing both alcohol and drug problems. Alcohol and drug-related problems were defined as being applicable to any of the adverse accompaniments of drinking or drug-taking and they could be related to either an individual drinker or to society.⁴⁷

The 1993 ECDD also considered alcohol and although it was initially outside of the PSA's remit, tobacco was also included in discussions. Membership was broad, including psychopharmacologists, addiction psychiatrists, epidemiologists and policy makers. The Director-General of the WHO had requested the committee look at strategies for reducing substance use and its harmful consequences. Crucially, the tenth edition of the ICD (ICD-10) included alcohol and tobacco in the list of psychoactive drugs with potential to cause mental and behavioural disorders including 'dependence'. The committee discussed the concept of drawing together illicit and licit substances and co-ordination of their control mechanisms. In terms of tobacco the committee argued that the 'dependence-producing' properties of nicotine and the severe health consequence of tobacco and nicotine warranted its inclusion in discussions of the committee thereby further expanding the committee's mandate.

In re-defining the role of the committee, concepts and terminology occupied an important place in the report. Many of the terms from the previous reports remained valid but with new research findings there were important subtle shifts. 'Harmful use', (*a pattern of psychoactive drug use that causes damage to health, either mental or physical....harmful use of drugs by an individual often has adverse effects on the drug user's family, the community and society*) replaced the term 'abuse' which was deemed ambiguous.⁴⁸ However, it was recognized that the term 'drug abuse' had entered numerous national laws and international conventions and so 'abuse' remained in operation.

2000; 78 (4):491-499.; Room R, and Babor T, World Health Organization's global action on alcohol: resources required to match the rhetoric. *Addiction*. 2005; 100 (5):579-580.

⁴⁵ Yach, D, Monteiro MG, The Road to a World Health Organization global strategy for reducing the harmful use of alcohol. *Alcohol research & health*. 2011; 34 (2):257-260. Moser J, *Prevention of alcohol-related problems: An international review of preventive measures, policies and programmes*, Toronto: Addiction Research Foundation; 1980. Conversation with Judith Mackay Interview 107 *Addiction* 108, 1897-1904. 2013; Conversation with Joy Moser, Interview 7 *British Journal of Addiction* 79 (1984) 355-363; Conversation with Robin Room, Journal Interview 100 *Addiction* 107 493-500.

⁴⁶ Babor TF, *Alcohol: no ordinary commodity: research and policy*, Oxford: Oxford University Press; 2003.; Grant M, The role of the World Health Organization in alcohol research. *Alcohol, Health and Research World*. 1993; 17 (3): 187.

⁴⁷ WHO Expert Committee on Health Promotion in the Workplace: Alcohol and Drug Abuse, Technical Report Series, 833 (Geneva: WHO, 1993).

⁴⁸ WHO Expert on Drug Dependence, WHO Technical Report Series No. 833 (Geneva: WHO, 1993), p 6.



'Dependence' remained dominant. The committee decided to follow the ICD-10 diagnostic guidelines and not make a distinction between 'physical dependence' and 'psychic dependence' in order to avoid clinical misunderstandings.⁴⁹ However, there was a shift towards 'problems' or 'disabilities related to drug use' of which 'dependence' was just one factor. Further review of the term 'dependence-producing drug' drew nicotine and tobacco into consideration. The level of dosage of a drug now came into prominence.

'...a state of dependence is not necessarily harmful in itself, but it may lead to self-administration of the drug at dosage levels that produce deleterious physical or behavioural changes constituting public health and social problems.'⁵⁰

Research had led to a reconceptualization of alcohol consumption levels as a continuum and that alcohol-related problems were related to alcohol consumption patterns. This was seen as applicable to all substances. This resulted in a change in focus to those with 'less heavy patterns of use'.⁵¹ Thus concepts and terminology around levels of consumption were becoming important.

Discussion of 'Harm minimization' or 'harm reduction' or the '*preventing of problems associated with the use of psychoactive dependence-producing drugs*' now explicitly appeared in texts and the committee highlighted the value of 'harm reduction as opposed to its potential for encouraging drug use.'⁵²

Common approaches were brought together when another re-organization took place in 1995 when the Programme on Substance Abuse was amalgamated with the WHO Division of Mental Health to create the Division of Mental Health and Prevention of Substance Abuse.⁵³ Significantly, this Division was involved with all psychoactive substances whether licit or illicit including amongst others, tobacco, alcohol, and illicit drugs.

The 1995 ECDD reflected these changes and acknowledged that whilst different legal approaches existed for drugs, alcohol and tobacco, there were significant similarities in treatment options and consequently the committee sought treatments that could be used across the three substances. Treatment and rehabilitation were meant to include 'comprehensive identification, assistance, health care and social integration.' In-line with growing interest in 'human rights' in relation to controlled drugs, inherent in the definition was the idea that all users should be 'treated with humanity and respect.'⁵⁴

In 2000, the Department of Substance Abuse was merged with the Department of Mental Health to create the Department of Mental Health and Substance Abuse, under the Non-Communicable Disease and Mental Health cluster, to bring together common approaches to the management of mental health and substance use disorders. For example, a more sympathetic approach to illicit drug patients developed as similarities in treatment options developed. This process continued with the 2003 ECDD which sought to achieve greater consistency on terminology used in reporting abuse-

⁴⁹ WHO Expert on Drug Dependence, WHO Technical Report Series No. 833 (Geneva: WHO, 1993), p 5.

⁵⁰ WHO Expert on Drug Dependence, WHO Technical Report Series No. 833 (Geneva: WHO, 1993), p 6.

⁵¹ World Health Organization, WHO Technical Report Series No. 833 (Geneva: WHO, 1993), p 4.

⁵² WHO Expert on Drug Dependence, WHO Technical Report Series No. 833 (Geneva: WHO, 1993), p3.

⁵³ http://apps.who.int/iris/bitstream/10665/63317/1/WHO_MSA_PSA_97.2.pdf?ua=1

⁵⁴ WHO Expert Committee on Drug Dependence, *WHO Expert Committee on Drug Dependence Twenty-ninth Report*, WHO Technical Report Series No. 856 (Geneva: World Health Organization, 1995)



related adverse drug reactions and consistency with the ICD.⁵⁵ Amendments were seen as essential given the adverse attitudes towards drug users and the committee pressed for an update to the WHO lexicon of alcohol, tobacco, and drug terms, a tool for clinicians, administrators and researchers, which had been established in 1994.

Tobacco had proved awkward for the ECDD. Whilst approaches to research and treatment had drawn substances closer together, approaches to control took a different track. The existing conventions were not deemed appropriate for regulating tobacco, because the only option would be prohibition, which was not viable. The idea of an alternative global mechanism for tobacco control was formalized in 1995 at the World Health Assembly.⁵⁶ By 1997 the PSA had a section specifically for tobacco: Tobacco or Health for which the development of an international framework was an important element of its strategy. It published *Guidelines for controlling and monitoring the tobacco epidemic* advocating long-term, comprehensive tobacco control policies.⁵⁷ In 1998 after Gro Harlem Brundtland, a physician herself, became Director-General of the WHO, tobacco control activities were set within a new structure for the WHO the Tobacco Free Initiative (TFI) run by Dr Derek Yach, to raise the profile of tobacco control. Its role was to initiate a process to develop a framework convention that would permit member states to adopt a comprehensive tobacco control policy dealing with aspects of tobacco control that transcended national boundaries.⁵⁸ While tobacco had been rejected for pre-review in 1996 by the ECDD, by 1999 this decision was reversed because of new evidence of a greater liability for abuse.⁵⁹ In 2000, the WHO Framework Convention on Tobacco Control (WHO FCTC) was adopted by the WHA becoming the first international treaty negotiated under the auspices of WHO and coming into force in 2005.⁶⁰

Terms such as ‘addiction’, ‘nicotine addiction’, ‘addictive nature’, and ‘tobacco dependence’ and ‘cessation’, were used but they were not defined in the Treaty. ‘Habit’, while frequently adopted in discussions, did not appear in the Treaty text. Definitions related more to the needs of the Treaty and so were focused more on issues of control, trade and products, rather than usage. The definition of tobacco control included supply, demand and ‘harm reduction’ strategies. ‘Harm reduction’ itself was not defined and the emphasis remained on achieving elimination.

Engagement with definitions emerged via a new body, the Scientific Advisory Committee on Tobacco Product Regulation (SACTob) established in 2000 with the objective to advise WHO on the most effective evidence-based means to fill regulatory gaps in tobacco control and achieve a coordinated regulatory framework. In 2003 the WHO Study Group on Tobacco Product Legislation SACTob was made into a scientific advisory committee to the study group and it became known as the WHO Study Group on Tobacco Product Regulation (TobReg). Its report of 2006-8 considered product

⁵⁵ World Health Organization, *WHO Expert Committee on Drug Dependence Thirty-Third Report, Technical Report Series 915* (Geneva: World Health Organization, 2003)

⁵⁶ WHO Resolution WHA.48.11 An international strategy for tobacco control, 1995. WHO Resolution WHA49.17 *International Framework Convention for Tobacco Control*, 1996. Working Group on the WHO Framework Convention on Tobacco Control, WHO Framework Convention on Tobacco Control: Report of the First Meeting of the Working Group (Geneva: WHO, 1999).

⁵⁷ World Health Organization, *Guidelines for Controlling and Monitoring the Smoking Epidemic* (Geneva: WHO, 1998).

⁵⁸ WHO resolution: WHA49.17

⁵⁹ World Health Organization, *WHO Expert Committee on Drug Dependence Thirty-First Report* (Geneva: World Health Organization, 1999).

⁶⁰ WHO Framework Convention on Tobacco Control, (Geneva: WHO, 2003).



regulation, for example, cigarette contents. 'Dependence' was used as a synonym for 'addiction' which was replaced in the 2012 report. Reflecting a focus on the consumer, the term 'attractiveness' crept in, a phrase that did not appear for drugs or alcohol. Reports noted that cigarettes were exempt from health and safety standards and the aim of the WHO FCTC was to lay the ground for future regulation of contents. Whereas the concept of a 'safe cigarette' had earlier been rejected 'harm reduction' methods were again a feature. A detailed explanation of 'harm reduction' based on other organizations' definitions was provided but the Committee pointed out that any such action *'must not undermine prevention, cessation and reduction of exposure to second-hand smoke and, ideally, should support them.'*⁶¹

Alcohol moved to follow the approach taken for tobacco, rather than 'illicit' drugs. The co-ordinated global public health approach became a feature of alcohol policy, which focused on reducing the problems of alcohol consumption. In 2001 Gro Harlem Brundtland, spoke on alcohol issues for the first time and a WHO Alcohol Policy Strategic Advisory Committee was established. In 2005 a WHO resolution called for evidence- based strategies and interventions to reduce alcohol-related harm.⁶² The 2007 WHO Expert Committee on Problems Related to Alcohol Consumption pressed the WHO to develop a global action plan to reduce the harmful effects of alcohol consumption. The committee argued for clear definitions of alcohol-related terms, particularly in the area of alcohol policy. Definitions reflected this altered focus, for example 'alcohol-related harm' and 'problems related to alcohol consumption' were seen as equivalent terms encompassing a wide variety of health and social problems at the individual and societal level.⁶³ Whilst 'harmful use' was in the ICD-10, the WHO expert committee argued for a broader understanding, one related to the public health aims of the WHO, in which the 'risk of harm' now appeared as a part of 'alcohol-related harm'. Distinctions, however, were drawn and the problems with the term 'harm-reduction' in relation to alcohol noted.⁶⁴

The term 'intoxication' was introduced and defined as *'a predictable consequence of the ingestion of substantial quantities of alcoholic beverages in a limited period of time.'* Whilst it was noted that 'intoxication' was part of the ICD the committee pointed out a number of different factors that impacted on intoxication including cultural differences, and the amount consumed. It was seen as leading to 'risk taking behaviours' such as unprotected sexual activity which could lead to 'disabilities' and impose burdens to health services and third parties.

'Dependence' was accepted for alcohol. Significantly, the committee reiterated that if alcohol had been considered under the 1971 Convention it would have qualified for scheduling as it constituted a public health and social problem.⁶⁵ However, like tobacco, it was not considered practical to include it in current conventions. Instead by 2008 the WHO had drafted a global strategy which included national actions such as policies for drink driving, while at the international level, priority

⁶¹ WHO Study Group on Tobacco Product Regulation, *Report on the Scientific Basis of Tobacco Product Regulation Technical Report Series 945* (Geneva, WHO, 2007)

⁶² WHA58.26: Public health problems caused by harmful use of alcohol

⁶³ WHO Expert Committee on Problems Related to Alcohol Consumption. Second report (Geneva: WHO, 2007).

⁶⁴ WHO Expert Committee on Problems Related to Alcohol Consumption. Second report (Geneva: WHO, 2007).

⁶⁵ WHO Expert Committee on Problems Related to Alcohol Consumption. Second report (Geneva: WHO, 2007).



areas included public health advocacy and partnership; and the production and dissemination of knowledge.⁶⁶

In sum this period is characterised by a more sustained combined approach to substance use and its related problems. With drugs, in particular, prevention of drug use related problems of which 'dependence' was just one aspect became important. In so doing concepts of 'harm reduction/minimization' entered discussions. Common approaches, especially for treatment and rehabilitation, were examined but differences in control policy remained. This is highlighted by the major development in the tobacco field with the creation of the FCTC. Alcohol policy was reinvigorated with a focus on 'alcohol-related harm' and pressure mounted for a global policy in the light of developments in tobacco control.

4.4 Discussion

4.4.1 Changing addiction concepts and terminology across the substances

WHO expert committees were active in changing concepts and definitions around 'addiction'. The term 'habit-forming' and its replacement 'addiction' quickly proved unsatisfactory, especially, in light of addiction's link to control measures and the creation of 'borderline' substances which could not be defined by either term. 'Addiction' was replaced by the concept of 'dependence' and a focus on 'dependence-producing drugs'. This shift highlighted similarities between the illicit and licit substances, for example, alcohol became an issue as it could be seen as a 'dependence-producing drug'. This opened the door to a more combined approach to the substances, at least in relation to research and treatment, less so control. Major changes saw a shift in interest to, not only prevention of substance use but, the limitation of problems or 'disabilities' once such use had occurred. Further refinement led to concepts around levels of consumption, for example an increasing concern with 'excessive drinking' rather than a focus on 'alcoholism'. A term that appeared in discussions for all these substances although it proved contentious was 'harm reduction'. This was interesting in the case of tobacco for which there was emphasis on the concept of 'elimination'. However, whilst elimination was impractical, concern remained for those unwilling or unable to quit thus the concept of 'harm reduction' had to be considered. The balance between 'harm reduction' and 'elimination' proved difficult as evidenced by the issue of 'less hazardous' or 'safer cigarettes'. Recently, it has led to heated debate over the development of E-cigarettes. As a final point whilst tobacco discussions largely drew on terms already established for alcohol and drugs it also brought new terms such as 'consumer attractiveness'.

4.4.2 The role of expertise and different scientific disciplines

Changing scientific disciplines within the committee system have played an important role in the development of these concepts and terms. For example, the early drug committees dominated by pharmacologists focused on the substance, in comparison, alcohol committees initially dominated by psychiatrists concentrated on the medical condition. Broadening of the professional disciplinary base to include, pharmacologists, psychiatrists, sociologists and clinicians and cross fertilization between the committees led to greater interest in treatment and rehabilitation and eventually combined approaches to these needs. Tobacco committees began with a medical/public health

⁶⁶ WHA63.13



composition and focus from the start. This is one reason for the contrast in policy approaches to illicit drugs and tobacco, a point reflected in the associated conventions.

4.4.3. Placement of drugs, alcohol and tobacco within WHO

The position of these substances within the structure of WHO has been important. Alcohol and drugs were both placed under mental health but were initially considered by separate committees, though increasingly linkages brought consideration of research and potential treatment options closer together. However, approaches to control have differed. Control was a given for illicit drugs with international mechanisms and conventions established within a penal framework developed prior to the creation of the WHO. But this was not the case for alcohol and tobacco. Alcohol committees increasingly sought to emphasise the medical aspects of the problem to ensure a public health oriented approach. In contrast, tobacco, seen as an epidemic, even pandemic, entered WHO's consciousness as a public health issue, and one with added impetus due to the threat to the non-smoker. Its position in relation to the other substances is an interesting one. Initially considered separately, it was later incorporated into the PSA but it began to follow its own track leading to the formation of the FCTC whereby the WHO set the precedent for a convention under its own auspices. This left alcohol the only one of the three substances without some form of international control mechanism. As a result the WHO began to press for alcohol to be dealt with as a global public health issue in a similar vein to tobacco.

4.4.4. Relationships between committees, diagnostic tools and external agencies

WHO committees did not operate in isolation. Differences existed between committees, conventions, diagnostic tools, and common usage of terms. In addition there were time-lags between committee discussions and changes to diagnostic mechanisms such as the ICD. For example, the WHO committees pressed the ICD to include 'dependence' in its classification. At times the committees have been at odds with other tools such as the American Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) which wanted to reinstate 'addiction' in 2006 and to replace the broad meaning of 'dependence' with 'substance use disorder' while the ICD-11 has retained 'dependence.' Further comparisons can be drawn with other international agencies such as the EMCDDA which focused on different terminology such as 'addictive behaviours'. (See the EMCDDA section of the report). These differences all contribute to uncertainty and lead to the question of who has overall control of terminology.

4.5 Conclusion and recommendations

This review of the WHO expert committees on illicit drugs, alcohol and tobacco reveals the wide range of concepts and terms employed in relation to 'addiction'. In the early days at the WHO 'habit-forming' was rapidly replaced by the concept of 'addiction'. Addiction however was seen as having too many variations and had connotations to control measures. WHO began the job of standardizing terms at both the conceptual and practical level and the concept of 'dependence' appeared to offer a way forward for all substances.

Development in concepts and terminology were important, not only at the conceptual level, but for practical reasons. WHO in particular has pushed the medical dimension of substance use and the subsequent impact on the community pressing for a public health rather than punitive agenda.



Despite some differences in expert committee discussions of the different substances there has been enough common ground to allow for cross fertilisation of ideas. This has led to an increasingly combined approach at least in terms of treatment if not control. Furthermore, moves to bring tobacco and alcohol into a public health agenda over which the WHO has control has highlighted the difficulty of maintaining the distinction between licit and illicit drugs.

Yet there remain problems even with the more generally accepted terms, such as dependence. Indeed, concepts and terminology around 'addiction' are not fixed, for with changing scientific understanding, cultural differences, evolving drugs and delivery methods, as well as policy imperatives, they are in constant flux. On-going debates both within the WHO and other bodies highlight this, for example, over the little discussed term 'intoxication' and the current debate found outside the WHO over consumption levels and terms such as 'heavy use over time'.⁶⁷ Whilst the WHO has moved away from the term addiction the EMCDDA has retained it and has attempted to refine its usage, moving on to consider the concept of 'addictive behaviours'.

Finally, other sections of this report demonstrate how national differences in concepts and terminology remain and that uncertainty continues over how to deal with substance use. International agencies have attempted to standardize discussions but the review of international committees highlight the difficulties of achieving such harmonization. This is especially necessary, yet difficult to achieve, in a global situation in which substance use is increasingly drawn into international policy framed as a public health imperative. Understanding the development and use of concepts and terms by these agencies is therefore important in understanding current substance use policy and for its future formation.

⁶⁷ Rehm J. Defining Substance Use Disorders: Do We Really Need More Than Heavy Use? *Alcohol and Alcoholism*. 2013; 46 (8) 633-40.



4.6 Appendix

Table. 1 Major WHO expert committee reports 1949-1963

Date	Committee	Output	Substance	Major shifts in terminology
1949	Expert Committee on Habit-Forming Drugs	World Health Organization, <i>Expert committee on habit-forming drugs</i> . Geneva: WHO, 1949.	Drugs	Habit-forming/habituation
1950	Expert Committee on Drugs Liable to Produce Addiction	World Health Organization, <i>Expert committee on drugs liable to produce addiction, second report. WHO Technical Report Series, 21</i> . Geneva: WHO, 1950.	Drugs	Addiction
1951	Expert Committee on Mental Health: Alcoholism Sub Committee	World Health Organization, <i>Alcoholism subcommittee, first report, Technical Report Series, 42</i> . Geneva: World Health Organization, 1951.	Alcohol	Alcoholism; chronic alcoholism, addictive drinking.
1952	Expert Committee on Drugs Liable to Produce Addiction	Expert Committee on Drugs Liable to Produce Addiction, <i>Expert Committee on Drugs Liable to Produce Addiction third report, WHO Technical Report Series 57, (Geneva: WHO, 1952)</i> .	Drugs	
1952	Expert Committee on Mental Health: Alcoholism Sub Committee	World Health Organization, Alcoholism subcommittee: second report, Technical Report Series 48. Geneva: World Health Organization, 1952.	Alcohol	Alcoholism, excessive drinkers
1954	Expert Committee on Alcohol	World Health Organization, <i>Expert Committee on Alcohol: first report</i> . Geneva: World Health Organization, 1954.	Alcohol	Alcohol: Alcohol intermediate between habit-forming and addiction-producing.
1954	Expert Committee on Drugs Liable to Produce Addiction	Expert Committee on Drugs Liable to Produce Addiction, <i>Expert Committee on Drugs Liable to Produce Addiction fourth report, WHO Technical Report Series No. 76, (Geneva: WHO, 1954)</i> .	Drugs	
1955	Expert Committee on Drugs Liable to Produce Addiction	Expert Committee on Drugs Liable to Produce Addiction, <i>Expert Committee on Drugs Liable to Produce Addiction fifth report, WHO Technical Report Series No. 95, (Geneva: WHO, 1955)</i> .	Drugs	



Date	Committee	Output	Substance	Major shifts in terminology
1955	Expert Committee on Alcohol and Alcoholism	World Health Organization, <i>Alcohol and alcoholism: report of an expert committee, Technical Report Series, 94</i> . Geneva: World Health Organization, 1955.	Alcohol	Excessive drinking rather than alcoholism: Problems of alcohol use or problem use of which alcoholism is one aspect.
1956	Expert Committee on Drugs Liable to Produce Addiction	Expert Committee on Drugs Liable to Produce Addiction, <i>Expert Committee on Drugs Liable to Produce Addiction sixth report [of a meeting held in Geneva from 24 to 29 October 1955] Technical Report Series, No. 102</i> , (Geneva: WHO, 1956).	Drugs	
1957	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs Seventh Report, WHO Technical Report Series No. 116</i> , (Geneva: WHO, 1957).	Drugs	Addiction-producing drugs
1958	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs, Eight Report, WHO Technical Report Series, 142</i> , (Geneva: WHO, 1958).	Drugs	Interest in the 'addict'/treatment emerges.
1959	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs, Ninth Report, WHO Technical Report Series, NO. 160</i> , (Geneva: WHO, 1959).	Drugs	
1960	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs, Tenth Report, WHO Technical Report Series, No. 188</i> , (Geneva: WHO, 1960).	Drugs	



Date	Committee	Output	Substance	Major shifts in terminology
1961	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs, Eleventh Report, WHO Technical Report Series No. 211, (Geneva: WHO, 1961).</i>	Drugs	Medical control of addicts.
1961	Convention	UN Single Convention on Narcotic Drugs	Drugs	
1962	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs, Twelfth Report, WHO Technical Report Series No. 229, (Geneva: WHO, 1962).</i>	Drugs	



Table 2. Major WHO expert committees report, 1964-1989

Date	Committee	Output	Substance	Major shifts in terminology
1964	Expert Committee on Addiction-Producing Drugs	Expert Committee on Addiction-Producing Drugs, <i>Expert Committee on Addiction-Producing Drugs, Twelfth Report, WHO Technical Report Series No.273, (Geneva: WHO, 1964).</i>	Drugs	Dependence; drug abuse.
1965	Expert Committee on Dependence-Producing Drugs	WHO Expert Committee on Dependence-Producing Drugs, <i>Expert Committee on Dependence-Producing Drugs, Fourteenth Report, WHO Technical Report Series No. 312 (Geneva: WHO, 1965).</i>	Drugs	Dependence-producing drugs.
1966	Expert Committee on Dependence-Producing Drugs	WHO Expert Committee on Dependence-Producing Drugs, <i>Expert Committee on Dependence-Producing Drugs, Fifteenth Report, WHO Technical Report Series No. 343 (Geneva: WHO, 1966).</i>	Drugs	
1967	Expert Committee on Mental Health	WHO Expert Committee on Mental Health Services for the prevention and treatment of dependence on alcohol and other drugs: <i>Fourteenth Report on the WHO Expert Committee on Mental Health [meeting held in Geneva from 4 to 10 October 1966] (Geneva, World Health Organization, 1967).</i>	Alcohol and Drugs	
1968	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>Expert Committee on Dependence-Producing Drugs [meeting held in Geneva from 1 to 7 October 1968]</i>	Drugs	
1969	Expert Committee on Drug Dependence	WHO Expert Committee on Dependence-Producing Drugs, <i>Expert Committee on Dependence-Producing Drugs, Sixteenth Report, WHO Technical Report Series No. 407 (Geneva: WHO, 1969).</i>	Drugs	



Date	Committee	Output	Substance	Major shifts in terminology
1970	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Seventeenth Dependence, WHO Technical Report Series, 437</i> (Geneva: World Health Organization, 1970).	Drugs	
1970	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Eighteenth Report, WHO Technical Report Series 460</i> (Geneva: World Health Organization, 1970).	Drugs	Psychotropic drugs and the qualifying term 'dependence-producing'.
1970		CM Fletcher and D Horn, smoking and health report to the twenty-third World Health Assembly, <i>WHO Chronicle 24</i> . 1970; 345-370	Tobacco	Less hazardous smoking/cigarette.
1971	Convention	UN Psychotropic Drugs Convention	Drugs	
1973	Expert Committee on Drug Dependence		Drugs	
1974	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twentieth Report, WHO Technical Report Series 551</i> (Geneva: World Health Organization, 1974).	Drugs, Alcohol and Tobacco	Problems associated with the use of psychoactive, dependence-producing drugs. Includes alcohol and tobacco but tobacco excluded from pre-review.
1975	Expert Committee on Smoking Control	WHO Expert Committee on Smoking Control, <i>Controlling the Smoking Epidemic, Meeting: Report</i>	Tobacco	Psychic dependence and withdrawal; smoking habit; dependence adopted in relation to nicotine; involuntary exposure to smoke.



Date	Committee	Output	Substance	Major shifts in terminology
1978	Expert Committee on Smoking and Its Effects on Health	WHO Expert Committee, <i>Smoking and its effects on Health: Report of a WHO Expert Committee</i> (Geneva: WHO, 1975).	Tobacco	
1978	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-First Report, WHO Technical Report Series 618</i> (Geneva: World Health Organization, 1978)	Drugs	
1979	Expert Committee on Smoking Control	WHO Expert Committee on Smoking Control, <i>Controlling the smoking epidemic: report of the WHO Expert Committee on Smoking Control</i> (Geneva: WHO, 1979).	Tobacco	Elimination. Rejection of the safe cigarette.
1979	Expert Committee on Problems Related to Alcohol Consumption	Problems related to alcohol consumption: report of a WHO Expert Committee [meeting held in Geneva from 20 to 26 November 1979].	Alcohol	Problems related to alcohol consumption.
1980	Expert Committee on Problems Related to Alcohol Consumption.	WHO Expert Committee on Problems Related to Alcohol Consumption. Meeting (1979: Geneva, Switzerland) 1980.	Alcohol	Alcohol-related disabilities, alcohol dependence syndrome.
1983	Expert Committee, Smoking Control Strategies in Developing Countries	WHO Expert Committee, <i>Smoking control strategies in developing countries: report of a WHO Expert Committee</i>	Tobacco	
1985	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-Second Report, WHO Technical Report Series No. 729</i> (Geneva: World Health Organization, 1985)	Drugs	



Date	Committee	Output	Substance	Major shifts in terminology
1987	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence 23rd Report</i> (Geneva: World Health Organization, 1987)	Drugs	
1988	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-Fourth Report, Technical Report Series 761</i> (Geneva: World Health Organization, 1988)	Drugs	
1989	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-Fifth Report, WHO Technical Report Series 775</i> (Geneva: World Health Organization, 1989)	Drugs	
1989	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence 26th Report</i> (Geneva: World Health Organization, 1989)	Drugs	



Table 3. Major WHO expert committee reports 1990-2013

Date	Committee	Output	Substance	Major shifts in terminology/focus
1991	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-Seventh Report, WHO Technical Report Series No. 808</i> (Geneva: World Health Organization, 1991)	Drugs	
1993	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-Eighth Report, WHO Technical Report Series 836</i> (Geneva: World Health Organization, 1993)	Drugs	Harmful use to replace abuse; dependence; disabilities or problems related to drug use of which 'dependence' was just one factor; alcohol consumption and levels of use eg less heavy patterns of use; harm minimization
1993	Expert Committee on Health Promotion in the Workplace	WHO Expert Committee on Health Promotion in the Workplace, <i>Health Promotion in the Workplace: Alcohol and Drug Abuse, WHO Technical Report Series No. 833</i> (Geneva: WHO, 1993).	Drugs and Alcohol	
1995	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Twenty-ninth Report, WHO Technical Report Series No. 856</i> (Geneva: World Health Organization, 1995)	Drugs	Different legal approaches to control but similarities of treatment options for drugs, alcohol and tobacco.
1998	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence 30th Report</i> (Geneva: World Health Organization, 1998)	Drugs	



Date	Committee	Output	Substance	Major shifts in terminology/focus
1999	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Thirty-First Report</i> (Geneva: World Health Organization, 1999)	Drugs	Tobacco included for pre-review.
2000	Expert Committee on Drug Dependence		Drugs	
2000		Framework Convention on Tobacco Control adopted	Tobacco	
2001	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence: thirty-second report, WHO Expert Committee on Drug Dependence, Technical Report Series 903 (Geneva, WHO, 2001).		
2003	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Thirty-Third Report, Technical Report Series 915</i> (Geneva: World Health Organization, 2003)	Drugs	
2005	Convention	Framework Convention on Tobacco Control	Tobacco	Nicotine addiction', 'addictive nature', and 'tobacco dependence' and 'cessation'
2006	Expert Committee on Drug Dependence	WHO Expert Committee on Drug Dependence, <i>WHO Expert Committee on Drug Dependence Thirty-Fourth Report, WHO Technical Report Series No. 942</i> (Geneva: World Health Organization, 2006)	Drugs	
2006	Study Group on Tobacco Product Regulation	Meeting Kobe Japan 28-30th June	Tobacco	Attractiveness; harm reduction; dependence used as a synonym for addiction
2006	Expert Committee on Problems Related to Alcohol Consumption	WHO Expert Committee on Problems Related to Alcohol Consumption.	Alcohol	



2007	Expert Committee on Problems Related to Alcohol Consumption	WHO Expert Committee on Problems Related to Alcohol Consumption. Second Report (Geneva: World Health Organization, 2007).	Alcohol	'Alcohol-related harm' and 'problems related to alcohol consumption'; risk of harm; intoxication
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5. The Role of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Defining Concepts of Addiction

Abstract

This section of the report explores the role of a European agency, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in defining concepts and terminology around addiction, in particular, related to the use of drugs, alcohol and tobacco. The report covers the period from the establishment of the EMCDDA in 1995 to 2014. Drawing on the examination of annual reports, reports on activities, and glossary, the report reveals an expanding and evolving institution facing an increasingly complex situation. This report notes the sheer variety of terms used and the evolution of new terminology to cope with the increasingly complex substance use culture. Recognition of poly-drug use and the difficulty of maintaining the distinction between licit and illicit substances has led to the emergence of new terms such as 'addictive behaviours' designed to apply across the different substances. Finally, variations in focus and terminology with other international agencies, such as the WHO, are noted reflecting the continuing uncertainty over terminology around addiction.

5.1 Introduction

WP1 'addiction through the ages' considers the emergence of the concept of addiction in different European countries. One objective is to consider the interface between the local, national, international and global. In order to achieve a global perspective part of the research was the role of international agencies in defining addiction. One facet of the research, reviewed in the previous section, concentrated on the role of the World Health Organisation and its expert committees from the late 1940s to the early twenty first century. This section of the report concentrates on the more recent European history and is focused on the role of a European agency, the EMCDDA, in defining concepts around addiction. The EMCDDA had its origins in December 1989 when a European Committee to Combat Drugs (CELAD) was set up. In June 1990 the Dublin European Council approved a study on the "need and possible scope of a European Drugs Monitoring Centre", and in 1991 the European Council agreed that such a Centre should be created. The result was the adoption in 1993 of a European Council Regulation setting up the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The regulation stated: *'objective, reliable and comparable information concerning drugs, drug addiction and their consequences is required at Community level to help provide the Community and the Member States with an overall view and thus give them added value when, in their respective areas of competence, they take measures or decide on action to combat drugs.'* The EMCDDA's mandate was to observe, collate and disseminate. It was inaugurated in Lisbon in 1995.¹ It is a decentralized agency of the EU which provides member states with an overview of European drug problems and an evidence-base for policies and strategies. It aims to:

- Provide the Community and EU member states with: 'factual, objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences'
- Collect, register and analyse information on 'emerging trends', particularly in poly-drug use, and the combined use of licit and illicit psychoactive substances
- Offer information on best practice in the EU Member States and facilitate exchange of such practice between them.²

¹ <http://www.publications.parliament.uk/pa/ld201012/ldselect/ldcom/270/27005.htm#a4>

² <http://www.emcdda.europa.eu/about/mission> accessed 02/march/2015



The EMCDDA developed the infrastructure and tools to collect country data in a harmonised way, for example, 30 national drug monitoring centres (Reitox network) were established and these fed data to the EMCDDA in Lisbon for analysis. The EMCDDA also works with partners from outside the EU, such as potential EU candidates and international organizations, such as WHO. The EMCDDA consists of a Directorate to manage the Centre, two statutory bodies to advise and assist in the decision-making process, as well as various working units. It receives stable funding under the European Commission budget line B3-441 of the general budget of the European Union.

In this section we provide a recent history of the role of this European agency's influence on concepts and terminology around addiction from 1995 to 2014. Following discussion of our methodology, in the main body of the report we summarise the development of the EMCDDA, and key developments in concepts and terminology discussed by the Centre in relation to alcohol, drugs and tobacco. From this review we drew out important themes such as the development of concepts across the substance such as 'addictive behaviours' and differences with other international bodies such as WHO. Finally we reflect on the role of international agencies in the history of addiction concepts.

5.2. Methods

Initially a literature review was carried out. Catalogues and databases searched included: the Wellcome Library, British Library, Senate House, Pubmed, Historical Abstracts and JSTOR. Further material was sought from bibliographies and by word-of-mouth. However, given its recent establishment it emerged that there is very limited secondary literature on the EMCDDA. It became clear that research needed to focus on primary material.

A review of published material by the EMCDDA was carried out. Publications include: annual reports; general reports on activities; special issue reports; technical reports; literature reviews; and technical data sheets as well as a glossary of terms and information provided on their website.

In light of the dearth of secondary literature, in-depth interviews could be a useful addition to this review of the published literature. In carrying out the research potential interviewees were identified, and interviews will be carried out at a later stage.

In reviewing these sources we aimed to analyse the focus of discussions, the utilisation and emergence of concepts and terms and how these changed over time, as well as any similarities or differences with other agencies such as WHO. We summarise our findings below.

5.3 Results

5.3.1. Literature review

A literature review was carried out to locate any secondary literature on the EMCDDA. However, this quickly demonstrated the dearth of research and published material on the EMCDDA. The only notable discussion was in a House of Lords Report 2012 on the European Drug Strategy. This provided a section on the background to the establishment of the EMCDDA and an evaluation of its work. It noted, that after a shaky start, it had since 2000, played an effective and a valuable role. It recommended that the Centre continue to work towards common definitions and common data collection practice. Additionally, the House of Lords recommended that the Centre could do more to indicate when evidence pointed to a particularly successful policy and that its resource levels should be maintained.³

³ House of Lords, *European Union Committee - Twenty-Sixth Report The EU Drugs Strategy*, House of Lords 2012.



5.3.2 On-line Glossary

The EMCDDA has published an online glossary of terms related to developed methodological tools and usual practice. Relevant terms that are included are:

Detoxification

Detoxification is a medically supervised intervention to resolve withdrawal symptoms. Usually it is combined with some psychosocial interventions for continued care. Detoxification could be provided as an inpatient as well as in a community-based outpatient programme.

Harm reduction

The aims of a harm reduction approach are to reduce the incidence of drug use-related infections and overdose, and encourage active drug users to contact health and social services.

Problem drug use

Injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines.

Many terms used in EMCDDA literature are not found in this glossary, for example, dependence, or poly-drug use or addictive behaviours, but there is no general glossary of terms in relation to substance use.

5.3.3 Major Published EMCDDA Reports

1995

The first annual report was published in 1995. It presented a yearly overview of the drug phenomenon in the European Union. The report was aimed at policy-makers, specialists and practitioners in the drugs field. It concentrated on the extent and nature of the demand for drugs and the measures in place to reduce that demand. Topics covered in the report included: anti-drug strategies; actions by the EU; epidemiology; information sources; exchanges between national and international levels; and information structures. Demand reduction was the dominant feature of the report and the lack of consensus on what 'demand' reduction' entailed was deemed an obstacle to policy. In particular, the boundaries between primary and secondary prevention, and treatment were seen as unclear. Resolution of this problem was set as priority task for the Monitoring Centre. The report revealed the necessity to establish an improved information infrastructure.⁴

1997

1997 saw a new design and change in content for the report. New topic sections now included: prevalence and patterns of use; demand reduction; new trends in synthetic drugs; national strategies; and the international environment. Demand reduction occupied a significant part of the report. But new areas of unease surfaced, for example, trends in synthetic drugs became a major issue. In relation to 'problem drug use' the spread of infectious diseases such as hepatitis caused by injecting drugs was of note. Terms used but not defined included: drug problems, drug users, demand reduction, synthetic drug use, abuse of drugs, and dependent patterns of use.⁵

⁴ 1995 Annual report on the state of the drugs problem in the European Union
EMCDDA, Lisbon, August 1996.

⁵ 1997 Annual report on the state of the drugs problem in the European Union
*EMCDDA, Lisbon, November 1997; General report of activities 1997
EMCDDA, Lisbon, January 1998.*



1998

By 1998 the EMCDDA had expanded to 40 full-time members. Important structural changes had also taken place with the creation of a new section to coordinate the Centre's work relating to joint action on new synthetic drugs as adopted in 1997 in Brussels by the Council of the European Union. Reitox was strengthened by the appointment of a Head of Department and the aim was to develop closer relationships with central and east European countries. Information sharing was to be improved through the development of a website providing services such as document-sharing and newsgroups.⁶

The 1998-2000 work programme focused on demand reduction and two priority areas were 'to enhance the Centre's achievements in the field of demand for drugs and the reduction of that demand'; and 'to develop its activities in the field of national and Community strategies and policies'. The 1998 annual report made further distinctions between trends and directions and epidemiological indicators in which 'a new distinction is made between current trends and directions (based on a combination of informal and less systematic sources) and key epidemiological indicators (structured around agreed definitions where these are available).'⁷ Financial aspects of the drug problem were examined with an analysis of public spending on drugs. Individual drugs were discussed in depth, most notably cannabis. Having noted the problem of drug use on infectious disease, methods of prevention were discussed. Problems emanating from Eastern Europe now warranted a section in its own right.

Demand reduction was defined for the first time. It was viewed as:

'encompassing all activities within the health, social, educational and criminal justice system that aim to prevent drug use, to assist and treat drug users, to reduce the harmful consequences of drug use and to promote the social (Re) integration of former users. Demand reduction targets individuals, families, groups and communities as the basis for a broader social approach to substance misuse, in which cooperation between statutory bodies, individuals, and community groups is a fundamental prerequisite'.

Other terms used but not defined included: social re-integration; drug use and abuse; problematic patterns of use; multiple drug use; addiction problems; and prevention of drug dependence.

1999

Evaluation was the watchword for 1999. The Centre became the first decentralised EU agency to undergo an external evaluation of its activities by private consultants. The Centre contributed to the development of the European Union's Drug Strategy 2000-2004, especially pressing for the concept of evaluation, specifically the evaluation of drug prevention programmes.⁸

The Reitox network was seen to play a crucial role. The report noted the 'importance of reliable and comparable information on drugs as a basis for sound political decision-making.' Within this, core tasks included: promoting the five key epidemiological indicators at national level; providing essential input to the EMCDDA's Annual report; promoting mechanisms at national level under the joint action on new synthetic drugs; and actively publicising the Centre's demand-reduction database, EDDRA (Exchange on Drug Demand Reduction Action).

⁶ General report of activities 1998 EMCDDA, Lisbon, January 1999

⁷ 1998 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, December 1998

⁸ General report of activities 1999 EMCDDA, Lisbon, January 2000



Topics which would become standard reporting features of the annual report were: developments in drug use; problems and responses; prevalence patterns and consequences of drug use; and established responses to drug misuse in the EU. Other areas of focus included synthetic drugs eg ecstasy; demand reduction activities; treatment responses; early intervention; community responses; statistical and mathematical models; challenges for healthcare systems; drug users and the criminal justice system. In relation to individual drugs cannabis remained an important issue.⁹

Terminology remained largely similar but a few crucial developments were taking place. Multiple drug use entered the discussion and a new term, poly-drug use appeared (not defined) and became increasingly important for subsequent reports.

Another significant discussion was centred around licit and illicit drugs and it was noted that the distinctions between the two were blurring.

Debates centre on the extent to which it is useful to maintain the traditional distinctions between illicit drug and licit recreational substances (alcohol and tobacco) and licit psychoactive medicines (tranquilisers). The status of other substances (solvents/steroids) adds a further dimension. Illicit drug use patterns frequently also involve licit substance notably alcohol tobacco and tranquilisers. More problematic patterns of drug use are characterised by multiple use of licit and illicit substances while treatment centres are reporting more poly-drug use. Prevention initiatives are generally geared to preventing the use of any drug, illicit or licit. Increasingly this trend is also being recognised in the treatment field with the tendency forwards merging care for those with drug, alcohol or prescription drug problems.

It was notable that the type of drug use was changing and it became necessary to define synthetic drugs:

The term synthetic drug strictly refers to psychoactive substances manufactured in a laboratory rather than derived from natural sources and thus included tranquilisers, methadone, amphetamines, ecstasy and LSD. The term is also used for new substances that have appeared on the ecstasy market that fall outside existing legal controls-some deliberately manufactured to do so. This use of the term thus indicates a preoccupation with the particular problems of controlling the producing and distribution of synthetic drugs rather than reflecting the patterns of their use.

2000

By 2000 changes in the work of the EMCDDA were taking place. Indeed, the House of Lords reflected on changes to the direction of the EMCDDA:

*'The EMCDDA got off to a somewhat shaky start. In its early years it was, in the view of the Home Office, "by no means as effective as it is today." An external evaluation of the first five years of the agency noted in 2000 that the EMCDDA needed to define a more focused work programme based on a limited number of priorities.'*¹⁰

In 2000 the EU Action Plan on Drugs was endorsed raising the profile of information and evaluation. This resulted in some reforms for the EMCDDA including its target audience and working methods.

⁹ 1999 Annual report on the state of the drugs problem in the European Union
EMCDDA, Lisbon, November 1999

¹⁰ <http://www.publications.parliament.uk/pa/ld201012/ldselect/ldcom/270/27009.htm>



Changes including a switch to project-based planning and activity-based budgeting and management, and an improved approach to quality management. Again evaluation was a vital feature. Indeed policy-makers were now designated as the primary audience and the goal was to provide policy-makers with instruments to measure the impact of actions thereby providing a solid knowledge base for drug-policy planning. This resulted in a new communication and dissemination strategy.¹¹

Significant changes took place to the report's format.¹² Trends in drug use and its consequences were broken down into more detailed and specific sections, for example, on specific drugs such as cannabis, amphetamines, multiple drug use, and drug-related infectious diseases. Trends in response to drug use became a separate section introducing policy and strategy developments, prevention, reducing the harmful consequences of drug use, and treatment. Selected issues saw in-depth discussion, for example, substitution treatment, prosecution of drug-related offences, problems facing female drug users and their children, and the drug problem in central and eastern Europe.

A raft of additional terms appeared including: multiple drug use; successfully treated addicts; drug prevention; reduction of drug-related harm; crime deterrence; risk behaviours; prevention of synthetic drug use; and harmful consequences of drug use. There remained a mixture of terms such as dependence and addiction. The phrase 'problem drug use' remained in common usage but now discussion arose on a 'drug career' and potential 'reintegration'.

Some operational definitions were proffered. eg problem drug use was defined as:

'intravenous or long-duration/regular use of opiates, cocaine and/or amphetamines'. This operational definition excludes ecstasy and cannabis and irregular use of any drug.

There was also growing recognition that 'problem drug users' were also multi-drug users. Multi-drug use for example the use of amphetamines, ecstasy, medicines and cannabis would prove problematic for analysis and definitions.

Risk behaviours were discussed and high risk groups were identified as: ethnic minorities, socially deprived and/or homeless young people, institutionalised youths and young offenders, and sex workers.

2001

The work of the EMCDDA was now seen as concentrating on four areas: monitoring the drug situation; monitoring responses to the drug problem; implementing the 1997 joint action on new synthetic drugs; and monitoring national and community strategies and policies and their impact on the drug situation.¹³

Selected issues for the annual report included: cocaine and 'base/crack' cocaine, infectious diseases, synthetic drugs, and the drug problem in central and east European countries.¹⁴

¹¹ General report of activities 2000, EMCDDA, Lisbon, January 2001

¹² 2000 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, October 2000

¹³ General report of activities 2001 EMCDDA, Lisbon, January 2002

¹⁴ 2001 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, November 2001



Synthetic or 'designer drugs' were gaining prominence and a detailed explanation was proffered.

The term 'synthetic drug' strictly refers to psychoactive substances that are manufactured through a chemical process in which the essential psychoactive constituents are not derived from naturally occurring substances. The term 'synthetic drug' began to be used synonymously with dance or recreational drugs following the emergence of the synthetic drug ecstasy (MDMA) and other ring-substituted amphetamines in the recreational dance drug scene, although non-synthetic drugs, such as cannabis, cocaine and magic mushrooms, are also consumed in these settings. Synthetic drugs with long histories of illicit use include amphetamines and lysergic acid diethylamide (LSD), while ecstasy (MDMA) and other drugs listed in Alexander Shulgin's Pihkal list (1) have much shorter histories of illicit use. There is growing global concern about the potential manufacture of other and newer synthetic drugs sold as an alternative to MDMA, or added to MDMA tablets. The ease with which many 'synthetic drugs' can be manufactured constitutes a challenge to efforts to control supply,

New terminology based on the level of usage emerged around MDMA,

Heavy users: 'a minority of users show a compulsive pattern of use — more than once a week, more than one pill at a time, use of multiple other substances, intensive party activity throughout the weekend and a lack of sleep. They are frequently part of a network where drug use is very common'.

Cautious users: 'with a less extensive pattern of use'.

Occasional users: 'with less knowledge and awareness of possible risks.'

2003

By 2003 interest was falling on target populations, in this case, young people and drug and alcohol use. Relatedly methodological developments continued with new indicators and information collection and analysis strategies in the relevant policy areas of drug crime, and in drug use among young people. Investment was made in the Epidemiological Information System on Drug Data (EISDD)¹⁵

As well as the usual reviews the annual report included new topics such as,

- Drug and alcohol use among young people
- Social exclusion and reintegration
- Public expenditure in the area of drug-demand reduction

Terms used though not defined included: 'hard drugs', drug abuse, drug addicts, drug-related health damage, harm-reduction, dependency, drunkenness, 'binge' use of alcohol for recreational purposes, stabilisation, recreational consumption, and the 'gateway effect'.¹⁶

2004

In 2004 the EMCDDA was trying to deal with issues raised by the expansion of the EU with the ten new member states.¹⁷

¹⁵ General report of activities 2003 EMCDDA, Lisbon, January 2004

¹⁶ 2003 Annual report on the state of the drugs problem in the European Union and Norway EMCDDA, Lisbon, March 2003

¹⁷ General report of activities 2004 EMCDDA, Lisbon, January 2005



New areas of focus included drug prevention specifically working with communities and targeting high risks groups; treatment; and crime and prison issues, as well as in-depth selections on cannabis problems and the increase in European treatment demands and co-morbidity.

By this time a driving force behind the report was the goal of achieving a balanced approach between demand and supply reduction with the report stating:

'there shall be a balanced approach between demand reduction and supply reduction, each reinforcing the other, in an integrated approach to solving the drug problem'.¹⁸

2005

In 2005 there was a change in leadership, as Wolfgang Götz became Director. He had previously worked at the EMCDDA as Head of the Information Department and latterly as Coordinator of the Reitox network. High on the agenda was continued assistance to the newer members of the EU, and the strengthening of the Reitox network.¹⁹

Discussion of poly-drug use, that is, the interrelated consumption of psychoactive substances, which include both alcohol and tobacco remained important.

There was a move to focus on a community-based approach on the grounds that *'in many European countries, there is a growing concern about the wider impact of drug use on the communities in which it occurs. Issues related to public safety and the exposure of young people to drugs are among the more commonly cited concerns that can be grouped under the title of 'drug-related public nuisance'.²⁰*

2006

A wider perspective was introduced in 2006 when a public health perspective was given more emphasis and some drug-related projects gained funding with the aim of *'promoting health and preventing disease through addressing health determinants across all policies and activities'.²¹*

Gender issues, specifically, the use of drugs by women, entered into discussions as an important area for attention.

Poly-drug use remained an area of interest, especially as it was suggested that nearly all drug users could be considered poly-drug users. However, definition of the concept remained elusive. Poly-drug use was deemed a challenge not only to public health but to the monitoring systems of the EMCDDA and the report noted:

'There is therefore a critical need to develop a better conceptual framework for describing different types of polydrug use as a first step to understanding the implications of this behaviour'.²²

¹⁸ 2004 Annual report on the state of the drugs problem in the European Union and Norway EMCDDA, Lisbon, March 2004

¹⁹ General report of activities 2005 EMCDDA, Lisbon, January 2006

²⁰ 2005 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2005

²¹ General report of activities 2006 EMCDDA, Lisbon, January 2007

²² 2006 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2006



The report on to describe a further category that of chaotic poly-drug use:

'Within the general concept of multiple drug use, several specific meanings of the term must be considered. At one extreme, there is the use of several substances in an intensive and chaotic way, simultaneously or consecutively, in many cases each drug substituting for another according to availability. For instance, this is the case with problem users who use different opioids, as well as pharmaceuticals, cocaine, amphetamines and alcohol. This pattern of use seems to exist among some chronic users, possibly among marginalised groups, possibly among people with psychiatric conditions. In many recording systems in Europe, these cases will be attributed to opioids. As such, these individuals will fall within the definition and monitoring of problem drug users. However, there remains a further question of whether this intensive, chaotic poly-drug use is enough of an entity in itself — a drug non-specific addiction therefore requiring targeted epidemiological measurements and treatment, support or harm reduction in a particularly difficult situation. Under these circumstances, any monitoring of the component parts of problem drug use would need to include poly-drug use as one of these separately measured components.'

An operational definition was attempted:

'Poly-drug use could be usefully defined operationally as the frequent use of more than one substance over a minimum specified time period, for example one month. This does not distinguish the various types of use described above, but gives an overall picture of what might be a high-risk group. The exception to discarding lifetime use in characterising poly-drug behaviour is when dealing with the very young — pupils or students — in which case lifetime multiple use may more strongly reflect current use. The evidence, for example from ESPAD surveys, suggests that the more deviant/low prevalence patterns of drug use among students (ecstasy, amphetamine, hallucinogens, cocaine, heroin) cluster among a few individuals.'

The distinction between licit and illicit drugs continued to be debated with the division becoming increasingly difficult to maintain. A switch to the concept of 'addictive behaviours' rather than a focus on a specific substance was taking place across Europe. The report stated,

'The scope of drug policies is beginning to stretch beyond illicit drugs and to encompass other addictive substances or even types of behaviour. This is found in the drug policies of some Member States and in EU drug strategies. Increasingly, research is addressing the issue of addiction or addictive behaviours irrespective of the substances concerned. The selected issue on the increasing attention being given in national illicit drugs strategies or policy documents to licit substances or to addiction per se aims at presenting a first insight into this emerging phenomenon in the European Union. Although drug strategies do not always refer to licit drugs or addictions, the selected issue finds that prevention programmes and, in some countries, treatment measures apply to both licit and illicit drugs, targeting as a priority children and young people. A slow integration, strategically or institutionally, of licit drugs into policy and measures against illicit drugs appears to be more and more common.'

2007

By 2007 activities were streamlined to cope with budgetary constraints yet still meet the priorities defined in the EU strategy and action plan on drugs.²³

²³ General report of activities 2007 EMCDDA, Lisbon, June 2008



Harm reduction was now considered to be an explicit component of the European approach. It was defined as:

*'There are still considerable differences between European countries in the nature and scale of their national drug problems and also in the range and configuration of response. Despite this, there is considerable agreement on more general fundamentals: that drug policies should be balanced, comprehensive and evidence-based. In the area of demand reduction, the need for prevention, treatment and social rehabilitation activities is accepted by all. But, historically, the topic of harm reduction has been more controversial. This is changing, and harm reduction as part of a comprehensive package of demand reduction measures now appears to have become a more explicit part of the European approach. This is evident in the fact that both opioid substitution treatment and needle and syringe exchange programmes are now found in virtually all EU Member States, although the level of service provision varies considerably. It is also evident in a recent report from the European Commission, which found that the Council recommendation of 18 June 2003 had played a role in encouraging Member States to develop and expand harm-reduction activities.'*²⁴

Environmental strategies including increasing the age of access and the creation of alcohol free zones, were developed to combat the uptake of licit substances.

By 2007 an external evaluation of the EMCDDA noted that the annual report was well received by target groups.

2009

This time the EMCDDA mission was refined to focus upon: better implementation of the key indicators; understanding poly-drug problems; the establishment of more timely information systems; and the dissemination of good practices.²⁵

Central approaches included treatment and health interventions and a shift from 'one fits all' approach towards a range of targeted measures. New definitions included:

Selective prevention: 'Both selective and indicated prevention acknowledge that problem drug use is concentrated in vulnerable groups or individuals with limited social and personal opportunities (EMCDDA, 2008c). Selective prevention intervenes with specific groups, families or communities, where people, due to their scarce social ties and resources, may be more likely to develop drug use or progress into dependency.'²⁶

Social reintegration: 'is recognised as an essential component of comprehensive drug strategies. It can be implemented at any stage of drug use and in different settings, and includes capacity building, improvement of social skills, measures to facilitate and promote employment and to obtain or improve housing.'

Changes in the drug use within Europe were highlighted and included: new evidence that Europe was moving into a period of declining levels of cannabis use but instead poly-drug use and alcohol

²⁴ 2007 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2007

²⁵ General report of activities 2009, EMCDDA, Lisbon, June 2010

²⁶ 2009 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2009



problems were becoming defining elements of the European drug problem. In the same year, this led to the EMCDDA publishing a specific report on polydrug use.²⁷

New forms of drug use, and sources of supply were emerging such as internet sales of 'spice', and this was starting to cause alarm.

'Products marketed on the Internet and in some specialised shops under the name 'spice' have been available since at least 2006. Although 'spice' may be advertised as incense, when smoked the effects are described by some users as similar to those of cannabis. Following a report from Sweden, the early-warning system has been monitoring 'spice' products since the beginning of 2008.'

Spice continued to be of concern in 2010 when the report explained that it was not a 'harmless herbal mixture':

'Spice' is sold on the Internet and in specialised shops as a smoking mixture. In 2008, forensic chemists discovered that it is not the harmless herbal product that it claims to be. The real psychoactive constituents of 'Spice' were identified as synthetic additives.'

'Legal highs' were therefore becoming problematic and were explained and defined as:

'a wide range of products, from herbal mixtures to synthetic or 'designer' drugs and 'party pills', which are used in different ways (smoked, snorted, ingested). In addition, these products can be marketed as room odourisers, herbal incenses or bath salts, though they are intended for a different use.'

It was this diversity that made it difficult methodologically for the Centre to collect and interpret data related to 'legal highs.

2010

In 2010 the EMCDDA published its 10th scientific monograph aimed at policy makers and health care professionals, entitled *Harm reduction: evidence, impacts and challenges*. This reviewed the emergence of harm reduction approaches, considered the evidence and impacts of harm reduction and its current challenge. It noted the mainstreaming of harm reduction in Europe and transferability across substances especially to alcohol and tobacco.²⁸

2011

Significant themes for the EMCDDA were the consolidation of core data, investment in more complex and policy-relevant analysis, and the development of a small number of new areas of strategic importance.²⁹

Of note were the differences between types of prevention under discussion, eg universal, selective and indicative, and these were defined as:

²⁷ EMCDDA, Polydrug use: patterns and responses, EMCDDA, Lisbon, November 2009.

²⁸ Harm reduction: evidence, impacts and challenges
EMCDDA, Lisbon, April 2010

²⁹ General report of activities 2011 EMCDDA, Lisbon, June 2011



Universal prevention: addresses entire populations, predominantly at school and community levels. It aims to deter or delay the onset of drug use and drug-related problems by providing young people with the necessary competences to avoid initiation into substance use³⁰.

Selective prevention: intervenes with specific groups, families or communities who, due to their reduced social ties and resources, may be more likely to develop drug use or progress into dependency.

Indicated prevention: aims to identify individuals with behavioural or psychological problems that may be predictive for developing substance use problems later in life, and to target them individually with special interventions.

2012

The spotlight fell on specific populations of drug users, especially, the family and drug-using prisoners, both of which were deemed vulnerable populations. New products such as bath salts and plant food were recognised as new challenges.

Reference continued to be made to licit and illicit drugs and addictive behaviour, though definitions were not proffered. Instead problem drug use was further refined as:

*‘injecting drug use or long duration or regular use of opioids, cocaine or amphetamines’. Injecting drug use and the use of opioids form the greater part of problem drug use in Europe although, in a few countries, users of amphetamines or cocaine are important components. Problem drug users are mostly poly-drug users, and prevalence figures are much higher in urban areas and among marginalised groups. Given the relatively low prevalence and the hidden nature of problem drug use, statistical extrapolations are required to obtain prevalence estimates from the available data sources (mainly drug treatment data and law enforcement data)’.*³¹

In 2012 a House of Lords report made recommendations to the EMCDDA in relation to the European Drug Strategy. It noted the high esteem in which the Centre was held, agreed that it should play no part in grading the success or failure of policies in the different Member States but recommended it could indicate where evidence pointed to a specific policy as being successful and that the government should ensure that the EMCDDA’s resources were retained at their current level.³²

2013

2013 marked the start of a new work programme reflecting the evolving European drug situation.³³ It appeared that the situation was relatively stable with some positive changes eg. improved levels of treatment and reduction in new heroin use. But the EMCDDA argued that new problems were emerging and that the situation was increasingly complex eg. with the rise of new synthetic drugs and new patterns of use for both controlled and non-controlled substances.³⁴

³⁰ 2011 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2011

³¹ 2012 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2012

³² <http://www.publications.parliament.uk/pa/ld201012/ldselect/ldcom/270/27002.htm>

³³ General report of activities 2013, EMCDDA, Lisbon, June 2013

³⁴ 2013 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2013



In 2013 the EMCDDA published on models of addiction³⁵. The report aimed to provide a better understanding of the science of ‘addiction’ and it contained a critical review of existing addiction theories and importantly reviewed how these could be used to inform the assessment, prevention and treatment of ‘addictive behaviours’. As such the concept of addiction was expanded well beyond illicit drug use. Instead it was deemed appropriate to a variety of substances such as alcohol and tobacco, and ‘behaviours’ such as gambling or compulsive use of the Internet. The report used the term ‘addiction’ in preference to ‘dependence but incorporated definitions of dependence into its understanding of addiction.

2014

The preface to the latest report reviewed symbolizes the complexity of the situation. It noted changes to the face of the European drug problem with the breaking down of the dichotomy between ‘small numbers of highly problematic drug users, and a larger number of recreational and experimental users’. It highlights instead the development of a ‘more graduated and complex situation.’ This situation was one in which stimulants, synthetic drugs and cannabis were becoming more important while drugs like heroin were of less importance. The term ‘drug use’ was similarly broadened to reflect this increasingly complex picture, and was defined in the report as:

‘covers many different patterns of consumption that range across a continuum from one-off experimental use to habitual and dependent use. Different consumption patterns are associated with different levels of risk and harm. Overall, the risks that an individual will be exposed to through their use of drugs will be influenced by factors including the context in which drugs are used, the dose consumed, route of administration, co-consumption of other substances, number and length of drug consumption episodes and individual vulnerability.’³⁶

5.4 Discussion

5.4.1 The EMCDDA

Initially the EMCDDA focused on providing an overview of the drug phenomenon in the EU, namely the state and nature of the demand, and the measures in place to reduce that demand. But over the period studied the EMCDDA’s role and structure expanded, with the addition of staff members, and new sections, for example, to deal with emergent synthetic drugs use, as well expansion into central and eastern Europe. Areas of specific interest to the Centre also broadened shifting from individual drugs like cannabis to synthetic drugs and later a major focus on poly-drug use. Other areas of interest that expanded include, drug related infectious disease, targeted prevention, at risk populations such as prisoners, young people or female drug users and their children. Operating in a time of an increasingly complicated drug situation required constant development of its methodologies for its monitoring role, for example, with the further development of the Reitox network and statistical and mathematical models. The Centre underwent its own external evaluation process in 1999 and it went on to call for evaluation of programmes in the EU drug strategy. Overtime its audience became more focused, shifting from policy-makers, specialists, and practitioners in the drugs field to a specific focus on policy-makers and new goals to provide them with instruments to measure the impact of actions and provide the evidence-base for drug policy planning.

³⁵ Models of addiction? <http://www.emcdda.europa.eu/publications/insights/models-addiction>

³⁶ 2014 Annual report on the state of the drugs problem in the European Union EMCDDA, Lisbon, March 2014



5.4.2 Addition concepts and terminology across substances

A review of the EMCDDA published material demonstrates the wide variety of terms utilised in relation to substance use such as problem drug use, misuse, dependence, abuse of drugs, risk behaviours, multi-drug use, drug prevention, reduction of drug related harm, harmful consequence of drug use, dependent patterns of use and drug career. Terms such as dependence which had earlier been extensively debated by the WHO were used without discussion but EMCDDA debated a number of additional concepts and terms which are discussed below:

5.4.2.1 Demand reduction

Demand reduction was the cornerstone, but this was problematic because the term was inadequately defined, particularly, in relation to the boundaries between primary and secondary prevention and treatment. Demand reduction was defined for the first time in EMCDDA literature in 1998 and this definition highlighted a focus upon a broad social approach to substance misuse and greater co-operation between statutory bodies, individuals and the community as well as re-integration of users. A change was discernible by 2004 when a more integrated approach was advocated aiming at achieving a balance between demand and supply reduction. Difficulties in achieving demand and supply reduction meant that the sometimes controversial concept of harm reduction, became an explicit part of the European approach to demand reduction across the substances.

5.4.2.2 Designer drugs and level of use

The EMCDDA had been initiated at a time when synthetic drugs were the up and coming threat. In particular, concern grew over 'Designer drugs' such as MDMA which became a key stumbling block to efforts to control production and distribution. The uptake of these drugs, particularly in the 'dance scene', opened up the concept around behaviours in relation to 'usage levels' with new terminology around, heavy users, cautious users and occasional users.

5.4.2.3 Poly-drug use

Whilst initial emphasis was given to in-depth studies of individual drugs, such as cannabis or MDMA, by 1999 the increasing complexity of the problem was highlighted by engagement with the concept of multi-drug use and the emergence of the new term *poly-drug use*. Poly-drug use drew attention to the combined use of controlled and non-controlled substances such as tobacco and alcohol. The term 'chaotic poly-drug use' further demonstrates the complexity of the drug use picture and the inter-relationship between substances, and magnifying health problems. It was particularly problematic conceptually and practically. For example, it posed difficulties methodologically for monitoring, which tended to be substance specific. Its variations over populations, patterns of use and substances made standardized definition near impossible.

5.3.2.4 Models of Addiction and Addictive behaviours

The term addiction was abandoned by the WHO and it was not found in the ICD-10. The EMCDDA continued to use the term and refined the concept finding a common thread between substances and actions, through the concept of 'addictive behaviours'. Analysis of the EMCDDA reports has demonstrated how borderline substances continued to undermine the distinction between illicit and licit drug use (controlled and non-controlled substances). This difficulty has driven a major shift away from a focus on individual substances to the concept of 'addictive behaviours' irrespective of the substance consumed or behaviour practiced.



5.4.2.5 Drug Use

Most interesting is the 2014 definition of drug use:

'covers many different patterns of consumption that range across a continuum from one-off experimental use to habitual and dependent use. Different consumption patterns are associated with different levels of risk and harm. Overall, the risks that an individual will be exposed to through their use of drugs will be influenced by factors including the context in which drugs are used, the dose consumed, route of administration, co-consumption of other substances, number and length of drug consumption episodes and individual vulnerability.'

A definition that encompasses numerous concepts and terms ranging from habitual use to dependence to consumption patterns, risk and harm, poly-drug use, to administration routes to individual vulnerability, highlighting the complexity of the substance use and the terms used to describe it.

5.4. Conclusion and recommendations

The review of the EMCDDA provides an insight into recent developments in concepts, not just of addiction, since 1997. The EMCDDA has played an important role in monitoring the European situation and has significantly improved the information infrastructure around substance use. It has also collated information on national and Community strategies and policies and evaluated their effectiveness especially in relation to drug prevention programmes. As a main goal was the establishment of comparable and reliable information on drugs for sound political decision-making, harmonized concepts and terminology were essential when collating information from numerous nation states and as a result the EMCDDA has been valuable in the development of concepts and terminology.

As with research on the WHO, this review of the EMCDDA published reports demonstrates the wide variety of terms in use. Many such as misuse, drug problem and dependence stem from work carried out earlier at the WHO. Slight differences in focus are notable, possibly due to the timing of EMCDDA's creation. For example, the EMCDDA has been especially concerned with the use of synthetic drugs.

Towards the end of the period studied the EMCDDA was highlighting significant changes in the pattern of drug use, for example, a decline in concerns over heroin but a rise in multi-drug use and alcohol problems, a shift which resulted in new terms such as poly-drug use. Distinctions between licit and illicit drugs became harder to maintain. As new drugs and patterns of use emerged, concepts and terminology struggled to keep up. For example in 2009 'spice' and 'legal highs' became an area of increasing unease, especially in the light of new sources of supply, such as via the internet. These changes created difficulties methodologically for the Centre. The evolving terminology around drugs, licit and illicit reflects this greater complexity and the difficulties of finding universally acceptable terminology within one agency let alone nationally or globally.

In reviewing the development of concepts and terminology at the EMCDDA differences may be discerned with other agencies like the WHO which had abandoned the term addiction in favour of dependence. In searching for a better conceptual framework and concepts transferable across substances the EMCDDA attempted to refine 'models of addiction' and introduced the concept of 'addictive behaviours' bringing in not only multiple different drugs but also activities such as gambling.



Finally, understanding the development and use of concepts and terms adopted by these agencies is important for our understanding of current substance use policy and for its future formation.



6. Final discussion, conclusion and recommendations

This final section considers the results of sections 2-5 of the report considered against the objectives for the work package.

6.1. Concepts of addiction in different European countries over time

Here our country based researches challenged the dominance in the historiography of the Anglo American concept of 'inebriety' for the initial period from the 1860s. They showed the variety of concepts which operated in different European countries at the end of the nineteenth century and in the early years of the twentieth century, many deriving from theories of insanity. Although greater homogeneity was visible as time went on in the later periods we studied, the 1950s and 60s and the 1970s and 80s, there was still considerable national variation in the ways in which concepts were promoted and operationalised within policy and indeed in which substance was a primary focus of policy attention.

6.2. The role of expertise

Here there were also traditions which operated at the country level. In Britain the role of public health doctors with temperance interests had characterised the late nineteenth century. But other countries had different professional groupings, for example the role of forensic science in Italy.

The role of temperance was also of importance internationally as research on the international alcohol conferences from the late nineteenth century demonstrates. Those who were delegates at the conferences came from a variety of backgrounds, with temperance enthusiasm as a unifying strand at least until the 1930s.

In the post-World War Two period the role of the WHO in developing concepts for alcohol and for drugs initially brought a much greater role for scientific expertise. Initially disciplines such as pharmacology dominated the field, subsequently expanding to encompass psychiatry. From the 1970s onward the range of expertise on WHO expert committees widened still further to include sociologists and psychologists. Tobacco/smoking had its own expert committee from that decade but expertise came from within public health disciplines rather than exclusively medicine.

6.3. The interface between local/ national and global/ international

Our studies illustrated the importance of national variation in concepts in this field but some degree of homogeneity was achieved over time. International conferences, for example those on alcohol studied in this work package, began a process of internationalisation of the issue but this influence declined as national differences became sharper in the 1930s. The role of international agencies, in particular WHO and its expert committees after World War Two, re-started a process of standardisation and dissemination of new concepts such as that of 'dependence' and of disability, also which potentially brought together drugs, alcohol and tobacco.

The EMCDDA has played less of a role in disseminating concepts like 'addiction' and has been more concerned with standardising approaches to the range of substances in Europe. Nevertheless, in its



reports and with its glossary of terms it has also brought a new dimension to discussion of the terminology in use in this area.

6.4. Theories

Theories about addiction have been widely discussed in the historiography, which we have surveyed. Theories from different professional fields have marked this area. The research on the international alcohol conferences shows how alcohol was of major concern in eugenic theories which stressed degeneration of 'the race' in the early twentieth century. These theories developed at the international level into the 'racial hygiene' approach later displayed in Nazi Germany and this marked some of the conferences in the 1930s.

In the post war world, different theoretical and scientific influences came to bear through WHO. The language around drugs and alcohol, initially operating separately, developed a differentiation between 'addiction' and 'habit' and 'alcoholism', with attempts to develop a 'combined approach' to concepts and to treatment in the 1970s. The concept of 'dependence' that was discussed initially for drugs in the 1960s and then for alcohol later on provided a unifying focus which also began to be applied to tobacco. Tobacco had largely fallen outside any of these discussions and was rarely considered in European countries. Even in the initial UK policy document in 1962, 'habit' was the focus. Later on, there were attempts to apply 'dependence' to tobacco and this would have brought all three sets of substances - drugs, alcohol and tobacco - together.

6.5. The role of science

Science has played an important role in this area, and the language of science was used almost from the outset of the period studied. Morality and science have always been entwined and the development of theories of degeneration tied to alcohol was stressed in the first decades of the twentieth century and in the inter war focus on eugenics. In more recent times a widening range of scientific approaches has developed in this area and our work on WHO showed how the role of science expanded through the expert committees. The work of EMCDDA has extended scientific involvement.

6.6. Comparisons across the substances

Our work illustrated clear differences across the substances- drugs, alcohol and tobacco – but also commonalities which have developed over time. Different countries focussed on different substances at the national level. Alcohol for example, was more important in Poland while Britain began to focus on tobacco much earlier than other European countries.

At the international level, drugs were constrained by the international conventions after World War One, while the other substances were not. Nevertheless, alcohol retained a significant presence internationally through the international conferences and inspired by temperance and prohibition.

Within WHO drugs and alcohol initially operated separately but came together from the late 1960s. There were also attempts to bring tobacco into the picture too but tobacco went ultimately down a different route with the Framework Convention. This had much less discussion of definitions than the earlier drug and alcohol committees. But tobacco operated within a different framework - that



of public health. Ideas about addiction arrived later and the policy route through the Framework Convention on Tobacco Control (FCTC) was different. The professionals who promoted the concepts, as at the national level, were different too - pharmacologists and psychiatrists on some of the drugs and alcohol committees and public health professionals for tobacco.

6.7. Recommendations

The recommendations we draw from this range of research are for recognition of the importance of the history of addiction concepts within Europe and their variation.

The international level of expertise has also been important for the elaboration of concepts and in recent times a European dimension has been added through the EMCDDA to the longer role of WHO.

The multiplicity of historical influences on these concepts and their fluidity needs recognition. They are rooted in history, in changing national international and European contexts. Policies to address issues concerning drugs, alcohol and tobacco at those different levels needs to recognise that historical complexity, which underpins the present.



Appendix

Publications

Berridge, V., Mold, A. and Walke, J., 'From Inebriety to Addiction: Terminology and Concepts in the UK, 1860-1930', *Social History of Alcohol and Drugs*, 28 (2014), 88–106.

Berridge, V., Mold, A., Beccaria, F., Eisenbach-Stangl, I., Herczynska, G., Moskalewicz, J., Petrilli, E., and Taylor, S., 'Addiction in Europe, 1860s-1960s: Concepts and Responses in Italy, Poland, Austria and the United Kingdom', *Contemporary Drug Problems* 41:1 (2014) pp. 551-566

Bjerge, B. Houborg, E Edman, J Perälä, R (forthcoming) in Matilda Hellman, Virginia Berridge, Alex Mold and Karen Duke (eds.) *Concepts of Addictive Substances Across Time and Place* (Oxford: Oxford University Press, forthcoming)

Beccaria F. and Petrilli, E., 'The Complexity of Addiction: Different Conceptualizations of Alcohol and Drug Addiction(s) among Italian Scholars in the Late 19th and Early 20th Century', *Social History of Alcohol and Drugs*, 28 (2014), 34–56.

Edman, J. (2015a). "Temperance and modernity: alcohol consumption as a collective problem 1885–1913", *Journal of Social History*, doi: 10.1093/jsh/shv029.

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Mold, A., Berridge, V., Beccaria, F., Eisenbach-Stangl, I., Herczynska, G., Moskalewicz, J., Petrilli E., and Taylor, S., 'Concepts of addiction in Europe in the 1970s and 1980s: what does a long view tell us about drugs, alcohol and tobacco?' in Matilda Hellman, Virginia Berridge, Alex Mold and Karen Duke (eds.) *Concepts of Addictive Substances Across Time and Place* (Oxford: Oxford University Press, forthcoming)

Moskalewicz J., and Herczyńska, G., 'The Changing Meaning of Addiction in Polish Medical Literature of the Late Nineteenth Century and Early Twentieth Century', *Social History of Alcohol and Drugs*, 28 (2014), 57–87.

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