Contents

List of Figure and Tables viii
Abbreviations ix
Glossary x
Acknowledgements xii

Introduction 1

1 1965–2010: A Background Sketch 6

2 Prescribing and Proscribing: The Treatment and Rehabilitation Report 26

3 Defining ‘Good Clinical Practice’ 44

4 Ambiguous Justice: The General Medical Council and Dr Ann Dally 65

5 ‘Friendly’ Visits and ‘Evil Men’: The Home Office Drugs Inspectorate 89

6 Unifying Hierarchs and Fragmenting Individualists: Three Professional Groups 117

7 Guidelines and the Licensing Question 147

Conclusion 167

Appendix: Interviewed Doctors’ Professional Roles 181

Notes 183

Bibliography 223

Index 244
1

1965–2010: A Background Sketch

Introduction

From the 1930s through the 1950s, while England faced and fought fascism in Europe and rebuilt in its aftermath, the country's drug scene was relatively peaceful. The rest of the 20th century, however, saw a dramatic transformation in the ways drugs were obtained and used, stimulating growing public and professional interest. Between 1970 and 1999 there was a massive increase in the availability of illicit drugs in England, and a corresponding rise in the numbers of drug users both outside and seeking treatment. From the 1980s there was a new disease that could be transmitted through injecting drug use: AIDS. These three developments were central to the policy changes during this period.

In 1970, 2657 addicts were notified to the Home Office, while in 1992, after a long rise, 24,703 addicts were notified. Estimates vary as to whether these figures represent half, one-fifth or one-tenth of the overall addict population. The impact of HIV/AIDS, once its transmission through injecting drug use became clear, was major. HIV was known to have infected drug users in New York by 1984–85 and a few deaths had occurred in Britain. In 1985, concern significantly permeated the drugs ‘policy community’ – the network of civil servants and experts involved in making and advising on policy in and around government. The reality of HIV’s arrival became clear when an epidemic among injecting drug users in Edinburgh was made public in 1986. Complex political manoeuvring preceded the official permission for syringe provision to drug users and the subsequent allocation of specific funding to HIV prevention.

A fragile national consensus emerged which emphasised a pre-existing and more accepting approach to drug use, while attempting to reduce
the harm it caused to the user and others, becoming known as 'harm minimisation' or 'harm reduction'. Prescribing was used to attract patients into treatment services, with the Department of Health promoting a return to the prescription of oral methadone on a maintenance basis to discourage injecting at a time when long-term prescribing was discouraged. Needle exchanges, which had sprung up through grassroots activism, were introduced officially, albeit on a ‘pilot’ basis. The drugs field, long divided between those advocating abstinence as the goal of treatment and those more sympathetic towards maintenance prescribing, saw a shift towards greater consensus after HIV and in 1988 the harm-reduction approach received official policy approval.

1965–1970: The second Brain Committee

The committee responsible for a new age in drug treatment services, the Interdepartmental Committee on Drug Addiction, was chaired by Lord Brain, a former president of the Royal College of Physicians (1950–57). It published its slim report to government, the second Brain Report, in 1965. Its membership and the almost wholesale implementation of its recommendations by government reflected the dominance of the medical profession in the formulation of drug treatment policy in the first three-quarters of the 20th century. In 1961 the same committee’s first report had advocated a medical rather than a criminal justice approach to drug users, recommending treatment in the psychiatric ward of a general hospital because ‘addiction should be regarded as an expression of mental disorder rather than a form of criminal behaviour’. This medical approach was reinforced in the 1965 report with its statement that ‘the addict should be regarded as a sick person [and] should be treated as such and not as a criminal, provided that he does not resort to criminal acts’.

As a response to the growing number of drug users of a noticeably different social and age demographic, the committee reconvened in 1964. Since the 1920s there had been very little opiate addiction. What there was had tended to be concentrated among ‘therapeutic addicts’ who had acquired their dependence inadvertently through medical treatment, and among professionals involved in medicine whose proximity to medicines had facilitated their dependence. They were a diminishing, ageing population who received prescribed drugs and were not generally seen as a cause of social disturbance. Fears were raised by the press and parliament, however, in response to the new type of
young, usually male, drug users, mainly congregating in London from the late 1950s. Between 1960 and 1964, the number of heroin addicts known to the Home Office rose from 94 to 342. The number of cocaine addicts also increased from 52 in 1960 to 211 in 1964. Today, these figures seem startlingly tiny but the increases warned of things to come.

The 1965 Brain Report, reconsidering its earlier findings, resulted in wide ranging legislative and policy changes. The committee’s medical membership interpreted its terms of reference ‘as meaning that we were not being invited to survey the subject of drug addiction as a whole, but rather to pay particular attention to the part played by medical practitioners in the supply of these drugs’. The report concluded that the major source of the new addicts’ heroin and cocaine was not trafficked drugs but ‘the activity of a very few doctors who have prescribed excessively for addicts’. Greater treatment provision and tighter control of supply within a medical framework were the report’s recommendations, implemented in the 1967 Dangerous Drugs Act and the Dangerous Drugs (Supply to Addicts) Regulations, 1968, which introduced special licences, to be granted by the Home Office to doctors wishing to prescribe heroin or cocaine.

Between 1968 and 1970, specialist hospital-based drug dependency units (DDUs) were set up, mostly led by consultant psychiatrists and generally in London where the problem was particularly concentrated. In practice, the Home Office almost exclusively limited heroin and cocaine licences to doctors working in the DDUs or the ‘Clinics’, as they became known, and in hospital departments. Until this point, many addicts were known by the Home Office through doctors’ voluntary reports, inspections of pharmacy registers and inspectors’ face-to-face contacts with users. From 1968, formal notification became a statutory requirement modelled on infectious disease notification.

The problem of drug use was defined as that of addiction, maintaining the disease model. The second Brain Report described addiction as ‘a socially infectious condition’. It has been argued that prior to the 1960s the medical model was only pursued in terms of individual treatment but that the second Brain Report formulated the disease model to emphasise control within a public health approach. These developments drew drug users into specialist medical treatment and discouraged GPs from involvement, moves not forcefully opposed by the latter. They also established the DDUs in a dual role of treating drug users and controlling the wider drugs supply to addicts. This control system saw the Clinics as near monopoly suppliers of drugs, which not
only prescribed free drugs but also checked a government register to see whether a patient was already receiving a supply from another doctor.\

1970–1984

The Misuse of Drugs Act, 1971, was a substantial piece of legislation, consolidating previous Dangerous Drugs Acts, renaming them ‘controlled drugs’ and incorporating heavy criminal penalties. It created an important policy mechanism in the Advisory Council on the Misuse of Drugs (ACMD), taking over from the earlier Advisory Committee on Drug Dependence established in 1967, to advise on future policy responses to the evolving drug scene. It brought back the Home Office’s Drug Tribunals, which were designed to regulate doctors’ prescribing of controlled drugs behind closed doors.

In the early years of the DDUs, the numbers of addicts were very small with only 2240 registered heroin addicts in 1968, and the Clinics seemed able to meet patient demand. They were initially liberal in their prescribing, but policy began to change in the mid-1970s when they started offering only short-term detoxification to new patients, while private doctors picked up patients’ unmet demand for long-term prescribing. Major changes also took place in England’s illicit drug supply: until 1979, prescribing had remained the main source of opiates and other drugs both legitimately and on the illicit market, with patients selling or sharing the excess from their prescriptions. H. B. ‘Bing’ Spear, Chief Inspector at the Home Office between 1977 and 1986, recalled that some expensive smuggled Chinese heroin could be found but relatively small quantities of trafficked drugs were entering the country. However, from 1978 to 1979, the quantity of trafficked heroin in England increased, as did the number of heroin users both outside and seeking treatment.

Until the 1980s, most of England’s heroin use and its treatment provision had been concentrated in London, but where heroin spread across the country, drug services were slow to follow. What Clinics there were had insufficient treatment places and found that drug users were increasingly looking elsewhere for treatment. The Home Office Addicts Index showed that during the 1970s the proportion of patients seeing both private and NHS GPs grew in both absolute terms and as a proportion of all those seen by doctors. After the establishment of the Clinics, NHS doctors in general practice had had little involvement in the treatment of addiction and minimal training. In 1970, GPs only notified 15 per cent (111) of all addicted patients to the Addicts Index in 1970. This rose to 29 per cent (264) of notifications in 1975 and 53 per cent (1191) in 1981.
Outside the NHS

While government and the medical profession chiefly shaped services within the NHS, the voluntary and private sectors tended to play the role of meeting unmet demand. The term ‘voluntary sector’ has been used here to encompass charities and other non-statutory, non-profit organisations. Voluntary bodies set up to help drug users with social and health problems were numerous in the drugs field. The late 1960s saw a growth in street services and day centres providing social care and counselling in London and other cities, some church based, usually following a social rather than medical model but often with close links to treatment services.

The UK’s first Narcotics Anonymous (NA) began in 1979, modelled on Alcoholics Anonymous, a ‘12-step’ or ‘Minnesota Model’ fellowship. These meetings aimed at maintaining daily abstinence from all mood-altering drugs, with attendance and ‘recovery’ going long beyond initial detoxification. Psychiatrist Brian Wells, a 12-stepper himself, described a common cynicism both among users and professionals regarding NA in the early 1980s. Despite this the movement continued to grow.\textsuperscript{31} Voluntary services were represented by the umbrella organisation, the Standing Conference on Drug Abuse (SCODA), set up in 1973.

Those working within the NHS were also involved in voluntary sector projects and their approaches had mutual influence. Griffith Edwards, an NHS psychiatrist who had started and run the Institute of Psychiatry’s Addiction Research Unit, was instrumental in establishing Phoenix House, an abstinence-based therapeutic community modelled on its original in New York. Fellow NHS psychiatrist John Strang has suggested that these and other similar abstinence rehabilitation houses in the UK influenced the move against maintenance prescribing in the late 1970s and early 1980s.\textsuperscript{32}

A system under strain

Despite the expansion of specialist care from London to the provinces (by 1975 there were 15 outpatient DDUs in London and 21 in the rest of the country), the continuing increase in the number of drug users put pressure on their ability to meet demand,\textsuperscript{33} and Clinic staff felt a sense of therapeutic disillusionment. In the country at large, optimistic expectations about future investment in the health service had been ended by the impact of the 1973 oil crisis on the British economy. Historian Charles Webster explained, ‘Until that time, it was confidently
anticipated that the economic system was capable of achieving a rate of growth sufficient to meet rising social expectations.34 Optimism did not return swiftly as from 1974 to 1979 four factors created a state of crisis and demoralisation in the health service: cuts in public expenditure; Sir Keith Joseph’s reorganisation; resentment from vulnerable groups about the failure to improve services; and the failure in leadership of health ministers.35 From 1974 the hospital service lost its protection from spending cuts, and health spending plans became subject to stricter financial disciplines.36

The second Brain Report had anticipated that controls on the prescription of heroin and cocaine would be sufficient to deal with demand, but, once the prescription of those drugs was under tighter control, there seems to have been a move among patients to obtain other drugs from doctors outside the Clinics. The Iranian Revolution with its resultant emigration helped to establish a new heroin route into Britain from the Gulf, meeting demand of existing addicts who were no longer supplied by the DDUs, and spreading use across the country on a previously unimagined scale. This source was then superseded by Turkish heroin in 1980 and then the following year’s major supplier became Pakistan.37

Yet it is perhaps unsurprising that a medical committee which had restricted its remit to the role of medical practitioners in the supply of drugs, rather than ‘drug addiction as a whole’,38 did not consider or anticipate the subsequent changes in the international drugs trade. As the DDUs had been set up with the aim not only of treating but of controlling the spread of addiction, the penetration of trafficked heroin into new areas of the country in the 1970s, and most dramatically from 1979, provided a basis for the criticism that the Clinics had failed. In some circles, this was presented as a failure of the ‘medical model’.39 Others responded by criticising maintenance prescribing, about which they had long felt uncomfortable.40

The reluctant return of general practice

In 1968, GPs had lost the authority to prescribe heroin and cocaine to their addict patients, although they could still prescribe them for the treatment of pain and some other indications. Other opiates, like methadone, could be prescribed by any doctor for the treatment of drug dependence. Until the 1980s, most general practices in England and Wales had had little to do with the management of drug misuse. The opposite was the case in Scotland, where there was minimal specialist involvement.41 Due to the relatively small numbers of drug users in the
1970s, few GPs in England were affected by the problem, but by the early 1980s the situation had changed and heroin addicts sought help from their GPs, bringing them into the picture in an unplanned way. The ACMD addressed this state of affairs in 1982 and recommended that renewed GP involvement become official policy alongside the Clinics. The government responded to these recommendations and an ongoing battle began between forces encouraging GP involvement (emanating from both specialists and generalists, the drug policy community and central government) and the many reluctant GPs, supported in the 1990s by their trade union, the General Medical Services Committee of the British Medical Association. GP reluctance was largely due to the unpopularity of drug addicts as patients and uncertainty over whether drug problems constituted an appropriate sphere for medical intervention, even among those who treated them as patients. Similar attitudes have been noted in doctors’ attitudes towards alcoholic patients, described in sociologist Philip Strong’s study of doctors and ‘dirty work’.

**Polydrug use and the Clinics**

In the 1970s a pattern of use distinctive to Britain emerged, with drug users injecting barbiturates often in combination with other drugs. The hypnotic and tranquiliser drugs used became seen as a major problem for accident and emergency departments, particularly in London, due to frequent overdosing and aggression towards casualty staff. Through the 1970s, barbiturates were the drugs most commonly involved in overdose deaths among addicts. After experimentation, it was concluded that barbiturates were not a suitable drug for maintenance therapy through the Clinics, which were later criticised for their apparent inability to respond to polydrug use and, in particular, barbiturate use. Whether, in fact, polydrug use was a new phenomenon in the 1970s or had always been part of the non-therapeutic drug use addressed by the second Brain Committee was unclear. Gerry Stimson and Edna Oppenheimer noted that in 1964 virtually all the cocaine users known to the Home Office were also addicted to heroin.

In 1975 the ACMD launched the Campaign on the Use and Restriction of Barbiturates (CURB) to reduce barbiturate prescribing by doctors. According to Bing Spear, ‘As an effective response to the barbiturate-injecting problem, CURB was a singularly futile exercise, which merely postponed the day when realistic controls would have to be imposed.’ Barbiturates eventually became controlled drugs in 1984, but by this
time the problem had already diminished, possibly because of the increasing availability of trafficked heroin in the 1980s.\textsuperscript{51}

As barbiturates fell from favour, benzodiazepines were mistaken for a non-addictive substitute\textsuperscript{52} and, with widespread prescribing, their use by addicts followed suit. By 1986–87, benzodiazepines were commonly available from GPs and on the streets.\textsuperscript{53} In Scotland in particular, a ‘non-injectable’ gel-filled oral temazepam capsule was formulated to prevent this use but persistent injectors suffered horrific injuries and disease during the 1980s and 1990s. In 1992 the ACMD called for restrictions on the prescription of temazepam but legislative change did not follow until three years later. An alternative and, in the eyes of the BMA, very effective approach to restricting the black market in temazepam gel-filled capsules was pursued by banning the formulation from NHS prescription.\textsuperscript{54}

\textbf{1982 onwards: political interest grows}

Under the Conservative government, drugs became a highly political issue with substantial resources allocated to services, high-profile media campaigns and the first comprehensive government strategy document for drugs policy in 1985. Responding favourably to the recommendations of the Advisory Council on the Misuse of Drugs,\textsuperscript{55} the Department of Health and Social Security (DHSS) prepared a large new source of funding to cover start-up costs for new services. This Central Funding Initiative (CFI) consisted of £17.5 million distributed in 188 grants from 1983 to 1989.\textsuperscript{56} It aimed at funding local initiatives, such as the development of cross-agency problem drug teams, the development of community-based responses across the country, and integration of drug services into mainstream health services. On the quiet it was also intended to shift the concentration of services and power away from the London psychiatric Clinic consultants.\textsuperscript{57}

The voluntary sector gained new status and recognition in the mid-1980s.\textsuperscript{58} Although acknowledging the importance of the CFI, David Turner, who represented voluntary drug services from 1975 to 1994 as co-ordinator of SCODA, considered that the sector’s strong influence and growth pre-dated the flow of money from the CFI by a couple of years.\textsuperscript{59} However, it may be that he preferred to see voluntary services as responding sensitively to local demand rather than following central edict. This initiative and the return of GPs have also been linked to a ‘normalisation’ of drug services in first half of the 1980s, as drug use and drug dependence became more common and drug services were integrated into mainstream healthcare.\textsuperscript{60,61}
1985–1999

British drug policy during the 1980s has received academic interest from sociologists, anthropologists and historians. Agreement has emerged over a number of the themes of this period: that community drug services, both voluntary and statutory, expanded during the 1980s; that the professional groups involved in drug treatment and policy increased and diversified; that GPs re-entered the picture after more than a decade’s absence; and that in response to HIV/AIDS, drug and treatment policies were liberalised in the late 1980s, with ‘harm reduction’ becoming official policy in 1988. Later observations by Gerry Stimson, a sociologist and activist in the harm-reduction movement, defined 1997 as the beginning of yet another new phase, with the election of Blair’s New Labour government. This, he claimed, brought an end to the ‘public health approach’, dating from 1987, where ‘the aim was to help problem drug users to lead healthier lives, and to limit the damage they might cause themselves or others’, and introduced an ‘unhealthy’ ‘punitive and coercive ethos’ for dealing with dependent drug users.

Behind these policies, drug use continued to rise, to spread to new parts of the country and diversify. New drugs and new formulations joined the existing array of substances, while others dropped from availability or favour. Heroin use climbed through the 1980s and 1990s, joined by ‘crack’, a new smokeable form of cocaine, which came from the USA in the mid-1980s and grew to considerable popularity. Ecstasy (the street name for 3,4-methylene-dioxymethamphetamine), a stimulant with empathy-inducing properties, became popular as a ‘dance drug’ at parties and clubs, usually taken as an oral tablet, along with other stimulants and psychedelic drugs. Amid great public and media concern over a small number of sudden deaths associated with the drug, educational responses were launched but no individual treatment was provided. Meanwhile, cannabis remained the most popular drug in England throughout this period, with demands for reduced penalties or legalisation becoming increasingly common and less controversial.

**GPs and community-based services**

From the beginning of their re-involvement, with the exception of a small number of enthusiasts, and despite concerns over HIV/AIDS in the later 1980s and 1990s, GPs remained reluctant to prescribe substitute drugs to addicts. In 1990, GP Tom Waller, prominent for his encouragement of his peers, proposed additional payments to GPs as an
Although criticised as expensive, possibly unethical and probably ineffective,\textsuperscript{68} the idea was taken up by GP negotiators in 1996, who declared that treatment of drug misuse was no longer to be considered part of their contract to provide general medical services but required an additional fee.\textsuperscript{69} While there were a few local arrangements paying extra, the Department of Health did not move on the issue.

Despite GPs’ wariness of addicts, commentators noted a shift from specialist to generalist services during the 1980s. The 1984 clinical guidelines and subsequent DHSS circulars reinforced this, making drug services more like other areas of the NHS, where it was unusual for any condition to be addressed solely by specialists. Criminologist Alan Glanz has linked the revival of GPs’ involvement in drugs and the emphasis on ‘community’, rather than specialist or institutional care, to their rising status as a group. GP leaders had been working to establish general practice as a ‘speciality’ with academic departments and compulsory vocational training. Improved terms and conditions had followed and by 1984 it had changed from being an unpopular career choice for medical students to the most desirable.\textsuperscript{70}

Political encouragement of private medicine, which strengthened through the 1980s and 1990s, related mainly to services reimbursed by health insurance rather than direct payment by the patient and did not concern private prescribers. Early after achieving power, the Conservatives abolished the Health Services Board, established by Labour to supervise the private hospital sector and phase out private beds from the NHS,\textsuperscript{71} but private prescribing was almost overwhelmingly on an outpatient basis.

**AIDS and official harm reduction**

Once those in the drugs field had started to see HIV/AIDS as an important threat, a number of policy options were available. Hard-line campaigns against drug use had issued from the Conservative government in 1985–86 and at the same time a penal approach, at both a political rhetorical and a policy level, pressed through legislation to freeze, trace and confiscate money from drug dealing and to increase penalties for trafficking.\textsuperscript{72} Virginia Berridge’s research has shown that while a continuation of this penal and stigmatising approach might have been expected from the New Right, in the event it was a non-coercive public health approach that won out. The struggle behind this owed much to medical bureaucrats in the Department of Health in alliance with outside pressure groups in the voluntary sector. As a result,
AIDS brought together politicians and ‘experts’ in an alliance based on minimising the harm from drug use, rather than eradicating or curing it, using needle exchange as the means to achieve this.\textsuperscript{73}

Although given the new name of ‘harm reduction’, this approach had a long history, with antecedents in the 1880s and 1960s.\textsuperscript{74} Rather than the drugs policy community switching wholesale from one approach to another, controversy over different methods of dealing with drug use had existed since at least the 1960s, with different groups gaining ascendance at particular moments. ‘Fixing rooms’, for instance, where injectors could take their prescribed drugs, had existed in the early 1970s, but along with the provision of injecting equipment, these had been phased out by 1975 as the Clinics moved to providing oral drugs.\textsuperscript{75} The voluntary sector had always pursued a more ‘harm reductionist’ approach but advocated it more openly after 1986.\textsuperscript{76}

The significant policy event of that year was the McClelland Report, from a committee set up by John Mackay at the Scottish Home and Health Department under the chairmanship of Dr D. B. L. McClelland. From a committee membership not derived from the drugs field, it was this document which first officially championed a harm-reduction approach in relation to AIDS, including the establishment of needle exchanges. This position has often erroneously been given to the ACMD, whose report \textit{AIDS and Drug Misuse} did not come out until 1988.\textsuperscript{77,78} Scotland had taken the lead on this approach as the problem of HIV among injecting drug users had been effectively publicised by Dr Roy Robertson, a GP practising in the deprived Muirhouse area of Edinburgh. In 1985 he had found levels of HIV among his injecting patients of around 50 per cent.\textsuperscript{79}

Harm reduction, which became official British policy in 1988, changed prescribing once again. AIDS made long-term prescribing a legitimate option once more and appeared to resolve ‘the prescribing question that had bedevilled drug policy in the 1970s and 1980s’.\textsuperscript{80} The 1960s and 1970s policy of ‘competitive prescribing’ was revived to attract drug users into treatment, albeit with oral methadone rather than injectable heroin. Just as proponents of harm reduction did not appear overnight in 1988, neither were its earlier opponents complete converts under the new ‘consensus’. Furthermore, ‘harm reduction’ meant different things to different professional groups.\textsuperscript{81} Political scientist Hervé Hudebine noted that the 1991 edition of the clinical guidelines,\textsuperscript{82} chaired by John Strang, emphasised the importance of harm reduction but reasserted abstinence as a primary goal, and advised GPs against undertaking methadone maintenance without specialist
advice. Through this the specialists, who had had to face competition from other sectors in both financial and policy terms since the first half of the 1980s, reaffirmed their primacy.

Part of the government’s strategy against HIV/AIDS involved funding research not just on epidemiology and biology but also on the intimate behaviour of drug users, including their injecting and sexual practices. Government research grants went from a total of £2.5 million in 1986/7 to around £23 million in 1992/3. By 1995–96, however, Hudebine noted that harm reduction, still pursued at local level, had almost disappeared from the national policy agenda and that earmarked funds for Health Authorities to prevent AIDS also ceased after 1993. This was then followed by harm reduction becoming more contentious once again in the political rhetoric, and it had fallen to the lowest ranking policy goal of the White Paper Tackling Drugs Together by 1995. Sociologist Nigel South has observed, however, that harm reduction continued as a policy priority in Scotland.

**Drugs and crime**

While possession and distribution of drugs controlled under the Misuse of Drugs Act, 1971, were usually crimes in themselves, public and policy concern over drug-related crime during this period tended to translate as acquisitive crime perpetrated to obtain the means to buy addictive drugs, and sometimes violent crime resulting from intoxication. Estimates varied as to what proportion of crime was committed by drug users in pursuit of their substances. In the mid-1990s, politicians and drugs policy researchers produced contradictory estimates, with researchers emphasising the range of income sources available to dependent heroin users other than acquisitive crime. In the late 1990s, however, there seemed to be emerging consensus in the drug policy field, as well as among politicians, on the importance of links between dependent drug use and acquisitive crime. A literature review showed that dependent heroin users, disproportionately likely to be poor people in deprived communities, were very likely to resort to burglary, shoplifting, fraud and theft to pay for drugs. Stimson observed with dismay the changes he observed in treatment services that flowed from making this connection. Focusing treatment on reducing drug use in order to curb drug-related crime broke the post-AIDS public health consensus, which had prioritised the prevention of bloodborne disease and pursued harm reduction as a humanitarian goal.

While some of Stimson’s concerns related to anticipation of the future direction of such policies, policy initiatives were already in place by
the end of the century. Drug treatment and testing orders (DTTOs), influenced by American ‘drug courts’, could ‘sentence’ a drug user to treatment rather than prison, with freedom dependent on monitored results, and these were piloted by the Criminal Justice Act, 1998. Without waiting for the pilot study’s conclusions, the Home Secretary extended DTTOs across the country. Until this point there had been little coercive treatment in England, although it had been discussed since the 1880s and was recommended by the second Brain Committee. Another linking mechanism used in the 1990s was arrest referral schemes, where drugs workers sought out drug users in the criminal justice system, often in police cells, and referred them to treatment. Here, though, involvement with the schemes was voluntary and not an alternative to prosecution. Although these multiplied from 1999 onwards, they had been in existence before this, and some have seen arrest referral as part of a liberal rather than a penal approach.

So has Stimson overemphasised the starkness of policy change from public health to crime prevention in the pre- and post-Blair era to make a political point? Berridge took the view that penal policy persisted during the era of harm reduction, albeit in a modified form, and that coercive approaches to drug and alcohol treatment had their roots as far back as late nineteenth-century inebriates legislation. Between 1987 and 1997, Britain did not depart from the international or European systems of drug control and, at a local level, police were involved in drug advisory committees, co-operating in the establishment of needle exchanges. Furthermore, the option of diverting drug users into treatment rather than prison had become government policy as long ago as 1990 in the White Paper *Crime, Justice and Protecting the Public*. Berridge, writing in the early 1990s, considered the balance of power between penal and medical approaches post-AIDS to be too complex to be ‘adequately subsumed under rhetorical barriers, such as the “public health” approach of drug policy’. Furthermore, Stimson overlooked the potentially coercive role of public health, which has used powers of compulsory quarantine and notification.

**Voluntary services**

Voluntary services became critical to the direction of policy and service provision post-HIV, although initially divided over the issue of needle exchanges. The distinction between ‘voluntary’ and ‘statutory’ had become somewhat blurred in the last quarter of the 20th century by government funding of voluntary sector organisations. This trend strengthened in the 1980s when the Conservative government
started to contract out many statutory services to the voluntary sector. SCODA's David Turner claimed that the establishment of voluntary services had not diminished their role as advocates of drug users and agitators for change. And, although government funding could be seen as a way of controlling these organisations, and reining in their radicalism, Berridge, in her work on the anti-tobacco pressure group Action on Smoking and Health, has shown how state support for a radical group outside government could serve to lobby for change desired by, but unvoiceable from, government. Turner, writing after needle exchange had become orthodoxy, explained voluntary drug services' fears over endorsing harm reduction as a result of threats to funding when they were perceived ‘as having gone too far’, suggesting that control was still an element in state funding.

Professionalisation was a feature of the 1980s, and continuing in the 1990s, in the voluntary sector, including greater requirement for formal qualifications among staff, management standards, performance measures and other bureaucratic features demanded by those contracting its services. Also emerging in the 1990s was drug user activism, agitating for changes to services and legislation. As well as providing statutory services, the voluntary sector saw the growth of self-help groups in the 1980s and 1990s. NA continued to spread across the country with 223 weekly meetings by 1991. There were also residential 12-step treatment centres in the private and voluntary sectors, with ‘a diluted version’ sometimes found in NHS addiction units. By 1991 there were 30 treatment centres in the UK and Ireland providing Minnesota Model drug-free-style treatment.

Local arrangements
In the 1990s, central government encouraged treatment services to make arrangements locally, and chief among these exhortations was ‘shared care’, which involved a formal division of a patient’s workload between specialist psychiatrists and GPs. Local inter-agency cooperation had been encouraged for many years but from 1995 there was a radical departure from the established arrangements, with the setting up of Drug Action Teams in every health district. Their memberships comprised a small number of budget holders ideally representing key local authorities, services and criminal justice agencies. Their aim was to reduce drug-related harm in accordance with the targets set by the Conservative government’s White Paper Tackling Drugs Together. These goals were aimed at reducing both drug supplies and demand for drugs, and they encompassed both penal and harm-reduction approaches.
Each Drug Action Team was advised by a Drug Reference Group made up of local people with expertise in the various services, and these arrangements persisted through to the end of the century with minor modification. Similar but separate arrangements were set up following strategies for Wales, Scotland and Northern Ireland. Later, under Labour, Drug Action Teams became responsible for commissioning and evaluating drug services.

**Wider changes in health services, public and private**

If drug treatment services had joined the mainstream in the 1980s, what was happening in the rest of the health service? A major theme of the 1980s and 1990s in the rest of the NHS was the changing relationship between the centre and the periphery, with management becoming increasingly important. Before the 1974 reorganisation of the NHS, ‘management was conspicuous by its absence’. Administrators and treasurers did not take a proactive line in developing services, which was left to the medical profession. This was followed by a period of ‘consensus management’ that tended to reinforce the strong position of the medical profession, but all this changed with the election of the Conservative government in 1979. From then on the NHS underwent ‘continuous revolution’. The medical profession’s assumed right to consultation over NHS changes was not honoured by Margaret Thatcher and even employment terms and conditions were imposed without mutual agreement.

General management was introduced in 1984–85, providing for the first time, according to Stimson and Lart, an effective central mechanism for controlling peripheral activity beyond budgetary control. However, this central control paradoxically encouraged devolved decision-making, which in turn led to a huge increase in guidelines, directives and circulars from the centre, advising the periphery on how it was to carry out these devolved responsibilities. The CFI could be seen as part of this pattern, encouraging the development of locally autonomous services while orchestrating them from the centre. Throughout the 1990s, management of the NHS was led by the NHS Executive, with centralisation becoming stronger in the second half of the decade.

Most controversial was the introduction of market reforms and a split between ‘purchasers’ of healthcare, GPs and Health Authorities, and providers, hospitals and community services, following 1989’s White Paper *Working for Patients*. With providers’ budgets dependent on the success of their services in attracting patients, the idea was that both consumer choice and efficiency would improve. From this major change
arose a pressure to quantify the outcomes of treatment for comparison and to standardise treatment through the use of clinical guidelines, coinciding with the emerging ‘evidence-based medicine’ movement in the medical profession, which favoured guidelines as a distilled, applied source of research findings. The market endured under John Major’s premiership but was partially dismantled by Tony Blair, reflecting its unpopularity with the public.

One of the themes of John Major’s period of office noted by Rudolf Klein was the transformation of NHS patients into ‘consumers’. The Patient’s Charter (1991) outlined patients’ consumer rights for the first time, although it was more symbolic and rhetorical in significance than in actually producing change. The extent to which NHS patients were able to exercise effective choice as consumers has been questioned. Consumerism was also a popular theme with New Labour, appealing as it did across employees and employers, the constituents of ‘old’ Labour and the New Right.

With the rejection of competition as the spur of change in the NHS, the managerialism of the early and mid-1980s was revived in the late 1990s. The new National Institute for Clinical Excellence (NICE) was set up to assemble and disseminate evidence in good practice guidelines and policy advice.

Against this background of new and growing state controls over the medical profession, there came to light the case of two heart surgeons working at Bristol Infirmary. Found guilty of serious professional misconduct in 1997 after the deaths of 15 small children, the government capitalised on the case to increase scrutiny in the NHS without medical opposition. On top of the huge media attention, the government launched a public inquiry into the case, creating an atmosphere in which the medical profession were pushed into accepting a much higher degree of government control than ever before in the NHS. Clinical audit, where the outcomes of treatment were monitored, was made compulsory. In 1999, trust in the profession was further shaken when GP Harold Shipman was accused of mass-murdering his patients over a long period.

Although government attention fell directly on the public sector, the increased pressure on the General Medical Council (GMC) also increased surveillance of all doctors. By the end of the 20th century, medical regulation looked quite different from how it had 30 years earlier: the president of the GMC himself was calling for a more active approach to self-regulation and the medical Royal Colleges had accepted regular competence testing of consultants. Klein concluded: ‘collegial control
over the performance of doctors had largely been maintained but at the cost of sacrificing the autonomy of individual doctors’.

**Wider drug policies**

In 1985 the first comprehensive drug strategy, *Tackling Drug Misuse*, had been published by the Conservative government. 112 This new development signalled increased political interest, and Stimson has claimed that this act politicised drug strategy in a new way, 113 but when the subsequent Labour government published its ten-year drug strategy, *Tackling Drugs Together to Build a Better Britain*, it demonstrated continuity with the Conservatives’ earlier *Tackling Drugs Together*, 114 and cross-party consensus. The appointment to the newly created post of ‘Drug Czar’ of the former chief constable of West Yorkshire, Keith Hellawell, was seen as part of the penal approach to drug policy dating from 1997. 115 However, his deputy, Mike Trace, had extensive experience in drug treatment services. The 1998 drugs strategy departed from its predecessors by concentrating policy on heroin and cocaine as the drugs causing the greatest harm, and by hailing health interventions as the most effective way of reducing offending behaviour over and above penal solutions. Hellawell put forward performance targets for the next decade – for instance, the reduction of the number of people under 25 using heroin and crack cocaine by a quarter within five years and by a half within ten years. Such targets drew criticisms from a number of sources as unmeasurable by existing mechanisms. 116 They were later quietly abandoned, as was, less quietly, the Drug Czar himself.

Those who have passed judgement on the 1990s have tended to emphasise continuity over change. 117, 118 Perhaps because they have considered drug policy as a whole, rather than focusing on treatment services, any move away from harm-reduction rhetoric and greater use of coercion in treatment were marked as less significant than in the work of Stimson. 119 Though Nigel South acknowledged a punitive approach in both rhetoric and legislation, he saw inconsistency in policies across Britain. Labour’s concerns about the role of ‘social exclusion’ as a factor in drug use were seen by both Rowdy Yates, a harm-reduction activist, and Geoffrey Pearson, a criminologist and sociologist, as a significant change during the late 1990s, 120, 121 but what impact this had in practical policy terms was unclear. Both authors also considered the emergence of ecstasy and the widespread dance drug phenomenon of the late 1980s and 1990s as a major development, which Yates claimed had ‘made existing drug treatment services almost irrelevant’.
How treatment policy was formulated, 1970–1999

The drug policy community and the policy-making process have been considered primarily by Stimson and Lart, Berridge, Smart, Duke and MacGregor. Stimson and Lart noted the traditions of British policy-making which continued into the 1970s, reached through committees where debate was characterised by politeness and an absence of politics. Policy was made in private through accommodation between experts and civil servants, as exemplified by the ACMD, set up in 1971. Berridge’s account of the development of AIDS policy during the 1980s, although involving much more media attention and a greater variety of outside groups, had similar components being privately formulated between bureaucrats and outside interests and experts. While doctors were not the chief architects of policy, as they were with the second Brain Report, key members of the profession, particularly medical civil servants like Dorothy Black, and psychiatrists like John Strang, held great influence. The growth of new drug agencies following the Central Funding Initiative drew many new occupational groups into working with drug users, diversifying the policy community in the 1980s, and displacing the purely medical perspective on drug use and users. Responses to drugs in the late 1980s included a more prominent place for government, the criminal justice system, and the community, with medicine taking an important but less central role.

In a departure from the earlier ‘gentlemanly’ period of policy-making, Stimson saw the late 1980s as a time of politicisation. The establishment of the Ministerial Group on the Misuse of Drugs, for instance, showed that drugs were moving out of professional and advisory committees and that debate was becoming more public. Linked to this politicisation was a huge rift between the ‘political’ and ‘policy’ community view of drugs, exemplified by the controversy over the Conservative government’s mass media anti-heroin campaign in 1985–86. Going against ‘expert’ advice from the drugs policy field, including that of the ACMD, which opposed widespread publicity not part of an overall educational approach, the advertisement told people that ‘Heroin Screws You Up’, with the aim of eradicating rather than reducing the harm from use. The government commissioned its own evaluation of the campaign, which gave it positive results, but the methodology was also criticised by the policy community. Undeterred, in 1987 the government launched another campaign with the message ‘Don’t Inject AIDS’. These events corresponded with anthropologist Susanne MacGregor’s picture of a
British approach to policy developing from debate among a limited range of ‘well-informed interest groups’ which shared a basic consensus. This process would occasionally be interrupted by intervention from politicians seeking to gain political capital from taking up drug issues.\textsuperscript{133}

Examining both national policies and local drug services in London in the last 15 years of the century, Hudebine described the policy process as existing at a number of levels simultaneously, with gaps between the levels of national political rhetoric, policy resulting from civil servants and from local agencies. A complex process appeared to be at work in the drug policy community, involving various understandings, tolerance and flexibility, and acceptable degrees of confrontation and challenge born of mutual dependence between government and the various agencies. This allowed some degree of coexistence within the apparent policy contradictions of the different levels.\textsuperscript{134}

2000–2010

The first decade of the 21st century did not see the astonishing rises in drug use witnessed in the 1980s or 1990s. Drug use levelled out or fell among 16–59-year-olds asked about their consumption during the previous year (with the exception of crack and powder cocaine).\textsuperscript{135} Services for drug users continued to evolve, with some particularly noteworthy trends. The voluntary sector grew to make up 35 per cent of the total costs of treatment, often involving collaborative arrangements with the private sector and the NHS. The Labour government’s aim of shifting drug treatment into the voluntary and community sector resulted in the proportion of NHS treatment places falling from 80 per cent in 2001 to 65 per cent in 2005.

In the 20th century, prescribing policy had largely been left to medical leadership. However, in 2001, Labour politicians started to express views about the value of injectable heroin and other opiates for the treatment of addiction, which were then included in the 2008 government Drug Strategy.

Overall, drug policy continued to focus particularly on users of opiates and crack, which were designated the most problematic drugs.\textsuperscript{136}

Conclusion

This background sketch of the last five decades has shown a period of turbulent change in both drug use and the policy responses to it. An increasing number and widening range of people have become...
involved in taking illicit drugs, in commenting upon drug use and in providing services. The policy process has moved from being conducted mainly in private to an often public and more overtly political undertaking, and while there was no disagreement about the ubiquity of drugs in the early 21st century, the extent to which their use has become ‘normal’ remains contentious.
abstinence
  Minnesota Model, 10, 19, 152
  -oriented treatment, 2, 35, 39, 53, 56, 59, 71, 147, 149, 168, 169–70
Phoenix House/rehabilitation centres, 10
ACMD, see Advisory Council on the Misuse of Drugs (ACMD)
acquisitive crime, 17, 147, 169
Action on Smoking and Health, 19, 173
activism, drug user, 7, 14, 19, 22, 93, 122
see also drug user groups
addiction
  definition, 8
  disease debate, 1–2
  disease model, 8, 34, 113
drug, 1, 7, 8, 11, 12–13, 27, 29, 33, 37, 40, 50, 85, 103, 109, 113, 130, 132, 144, 161
as mental disorder, 7, 66
research, 10, 17, 127, 137, 156
and 1926 Rolleston Report, 101
spread of, 3, 11, 14, 30–1, 47, 74, 168, 169, 177
statistics, 6, 8
treatment, 24, 28, 30, 34, 47–8, 54, 61, 65, 67, 75, 76, 88, 106, 109, 113, 121, 151, 158
Addiction (journal), 130
Addiction Research Unit, 10, 127, 137
addicts
cravings, 57, 100
statistics, 6, 8
treatment, 2, 5, 9, 11, 15, 24, 26, 27, 28, 34, 39, 42, 47–8, 50, 54, 56, 63, 68, 75, 76, 85, 86, 87, 88, 106, 107–8, 113, 121, 122, 130, 134, 148, 150, 152, 155, 159, 170
T&R redefinition, 33–4
  as ‘victims’ of drug control system, 71, 80
  welfare of, 92, 99, 164
Addicts Index (Home Office), 9, 31, 73, 93, 95, 103–4, 113, 114, 115, 137, 139, 184, 185
Advisory Committee on Alcoholism, 33
Advisory Committee on Drug Dependence, 9
Amphetamines Sub-committee, 101
Advisory Council on the Misuse of Drugs (ACMD), 9, 13, 29, 45, 70, 103, 131, 146, 150, 167–8, 175
AIDS and Drug Misuse, 16
  report, 16
  launch of CURB, 12–13
  policy-making process, 29
  and T&R, 29–42, 52, 55, 58, 70, 73, 134–5, 156
Ahmad, W. I. U., 59
AIDA, see Association of Independent Doctors in Addiction (AIDA)
AIDS, see HIV/AIDS
AIDS and Drug Misuse, 16
AIP, see Association of Independent Practitioners (AIP)
Alba Association, 178
Alcoholics Anonymous (AA), 10, 152
  alcoholism, 12, 18, 33–4, 49, 52, 80, 90, 164
  regulatory guidelines, 53
alternative care, 2
amphetamines, 2, 35, 45, 61, 62, 67, 124, 155, 166, 175
Anderson, A. J., 204
anti-heroin campaign, 23
anti-nausea drug, 190, 199
anti-psychiatry movement, 66
Armstrong, David, 112–13, 172
arrest referral schemes, 18
Ashton, Mike, 85
Association of Independent Doctors in Addiction (AIDA)
aims, 122–3
and AIP/LCG, relations between, 136–7
Dally's leadership/criticisms against the Clinics, 38, 57, 65–88, 121
draft guidelines, 38, 47, 49–51, 57, 72, 129, 131, 136–7, 139, 140, 144
and the GMC, 65–88
internal/external influence, 131–6
Medical Working Group, 50
membership/policies, 49–51, 128–9
organisational structure, 125–6
regulating role, 137–9
relations with the state, 139–41
Spear, Bing and, 72, 74, 97–8, 121, 128, 139–40, 173
see also Dally, Ann
unifying and divisive forces, 141–5
Association of Independent Practitioners (AIP) (also known as The Association of Independent Practitioners in the Treatment of Substance Misuse)
and AIDA/LCG, relations between, 136–7
Cultural Theory, classification system, 117–20
and the 1999 Guidelines, 152
internal/external influence, 131–6
licensing concerns, 162
membership/policies, 128–31
name change in 1998, 122
organisational structure, 125–8
origins and aims, 121–2, 124–5
regulating role, 137–9
relations with the state, 139–41
unifying and divisive forces, 141–5
Association of Independent Prescribers (AIP), see Association of Independent Practitioners (AIP)
audit, clinical, 21, 149
Audreson, Michael, 122, 126
Baker, Alex, 86, 120, 127
Banks, Arthur, 49, 50, 57, 143
barbiturates, 2, 12–13, 31, 53, 54, 124
BBC (British Broadcasting Corporation), 126, 178
Beckett, H. Dale, 50, 61, 124, 125, 132, 133, 141, 144–5
benzodiazepines, 13, 53, 54
Berridge, Virginia, 15, 18, 19, 23, 90–1, 173
Bethlem Royal Hospital, see Maudsley Hospital
Better Services for the Mentally Ill, 33
Bewley, Thomas
anti-maintenance approach, 35–8, 45, 46, 50, 56
and Connell, Philip, 35–6, 38, 45, 50, 56, 58, 74, 78, 84, 127, 130–1, 133, 134–5, 136, 144, 146, 176
and Dally case, 36, 73, 74, 76, 78, 80, 84, 85, 127, 130–1, 133, 136, 142, 176
and final version of the Guidelines, 56–8, 60
and Ghodse, Hamid, 73, 74, 85
and the LCG, 123–4, 127–8, 130–1, 142, 144, 146
as member of the GMC, 130, 135, 142
published attacks in the medical press, 28, 36, 61, 73, 176
and role in T&R Working Group, 35–8, 40, 43, 134–5
and Tarnesby case, 81, 83, 84–5
blackcurrant syrup, methadone formulation, 123
Black, Dorothy, 23, 38, 51–2, 58, 72, 128, 140, 144, 164
black market, see illicit market
Blair, Tony, 14, 18, 21
blood tests, 106
‘Blue Book’, GMC’s, 83
Blunkett, David, 168
Brahams, Diana, 82
Brain, Lord, 7
Brain Committee (Interdepartmental Committee on Heroin Addiction)
first committee (1958–1961), 7, 8
second committee (1964–1965), 7–9, 11, 12, 18, 23, 31, 33, 39, 42, 43, 74, 113, 134, 146, 155
Brewer, Colin, 80, 125, 126, 133–4, 152, 175
Bristol Royal Infirmary, 21, 70
British economy, 1973 oil crisis and, 10–11
British Hospital for Functional Nervous Disorders, 81
British Medical Association (BMA), 12, 13, 42, 49, 51, 66, 86, 102, 154
General Medical Services Committee, 12, 42, 154
Working Party on Drug Misuse, 154
British medical ethics, 86, 87–8
British Medical Journal (BMJ), 28, 50, 73, 74, 83, 84, 85, 135, 136
British National Formulary, 59, 75, 77, 150
British System, the, 1–2, 53, 90, 99
bureaucracy
accusation against NHS, 3
and the AIP, 126
approach to HIV/AIDS and harm reduction, 15–16, 23
and civil servants, 52, 167
and the Clinics, 61, 62, 63
in the voluntary sector, 19
Weberian, 98, 112, 173
Burr, Angela, 62
Bury, Judy, 157, 158
Campaign on the Use and Restriction of Barbiturates (CURB), 12–13
Cane Hill Hospital, 50, 61
cannabis, 14
Carne, Stuart, 109
case law’, 86
Central Drugs Coordination Unit, 154
Central Funding Initiative (CFI), 13, 20, 23, 33, 129, 149
‘Certificate in the Management of Drug Misuse’ 2000, 100
Chemist Inspecting Officers (CIOs), 48, 89–90, 91, 93–4, 94, 95, 104, 205
Chief Medical Officer (CMO), 36, 49, 52, 130–1, 158
Chinese heroin trafficking, 9
Chorlton, Penny, 85
civil rights movements, 66
civil servants
administrative, 51, 52, 126, 204
alliances, 15–16, 29, 44, 53, 63, 98, 99, 100, 115–16, 140, 168, 170–1, 172
medical, 23, 35, 49, 51, 52, 120–1
role in policy-making, 6, 23, 24, 40, 43, 48, 49, 51–2, 72, 84, 92, 97, 119–21, 124, 136, 140, 163, 165–6, 167–8, 171–3
role of key, 23, 51–2, 92, 93, 171–3
Clarke, Kenneth, 40
class system, 130–1
Clee, William, 157, 158
clinical audit, 21, 149
clinical guidelines
1984, 15, 44, 46, 59–60, 80, 81, 83, 85, 123, 133, 135, 136, 137–8, 149–50, 154, 156, 159, 178
1991, 16, 108, 135, 150, 151, 155, 159, 161
1999, 54, 59, 114, 133–5, 141, 148, 150–9, 162, 163, 164, 166, 169, 170, 172, 177, 178
2007, 59, 134, 135, 150, 152–3, 178
see also guidelines, clinical practice
Clinical Guidelines Working Group
1984, 49–51, 52, 55, 63, 85, 106, 133, 147–8, 154, 157, 160, 175, 178
1991, 151, 155
1999, 100, 133, 134, 147, 150, 151–2, 153, 154, 156–7, 159, 161–2, 163, 165, 172, 178;
sub-group, private prescribing, 154, 163
2007, 134, 150, 152–3, 178
‘Clinics, the’
Dally’s attacks on, 38, 57, 65, 71–81, 84, 87, 121, 126, 136–7
early years, 9–13, 26–9
establishment/aims, 2
licensing, 8, 54–6, 160–4
prescribing changes, 44–64, 138, 139, 144
prescribing policies, 58–62
and T&R report, findings/significance, 31–42
see also Drug Dependency Units (DDUs)
clonidine, 131
cocaine
addicts, statistics, 8
1998 drugs strategy, 22
licensing, 32–3, 36, 156, 160, 162, 163, 189
powder vs. crack, 14, 22, 24
prescribing, 2, 11, 26, 47, 50, 51, 54–5, 61, 91
in First World War, 90
Cohen, John, 109
Cohen, Lord, 67, 70
compliance, monitoring, 3, 91, 104
compulsory treatment, 21, 26
see also Drug Treatment and Testing Orders
Connell, Philip
attacks on Sathananthan, Kanagaratnam, 139, 140–1
and Bewley, Thomas, 35–6, 38, 45, 50, 56, 58, 74, 78, 84, 127, 130–1, 133, 134–5, 136, 144, 146, 176
and Dally case, 78, 84, 127, 136
and Edward, Griffith, 127
as GMC member, 36, 76, 130–1, 135
and the LCG, 130–1, 135–6, 142, 144, 146
role in formulation of the Guidelines, 49–50
and role in T&R Working Group, 35–8, 43, 49–50, 134–5
and Strang, John, 152, 161
Conservative governments and drug policy, 13, 14
AIDS/harm reduction strategies, 15–17
anti-heroin campaigns, 23–4
comprehensive drug strategies, 22
drugs and crime, 17–18
GPs and community-based services, 14–15
health services, public/private sector, reforms, 20–2
local initiatives, 19–20
1979 manifesto, 40, 48
voluntary services, funding, 18–19
consultants, (medical)
and AIP/AIDA, relations between, 136–7
Cultural Theory, classification system, 117–20
and ‘diverted’ pharmaceuticals, 62
and the Inspectorate, 48–9
internal/external influence, 131–6
and media, 84–5
membership and policies, 49–51, 128–31
organisational structure, 125–8
origins and aims, 120–5
regulating role, 137–9
regulation by the state, 52–8, 139–41
and the secretariat, 51–2
and the T&R, 29–43
terminological significance, 3–4
and treatment model, imposition of, 58–62
unifying and divisive forces, 141–5
consumer choice, 20–1, 61, 69
consumerism, 21, 69, 87, 150, 151
consumerist model, 46
consumer rights, 21, 50, 87, 153
consumption, supervised, 148, 153, 155, 159, 162, 177
controlled drugs
Dally case, 71–81
Inspectorate, role of, 70, 104–8
licence, 70, 74, 148, 163
‘non-bona fide prescribing’ of, 86, 104
prescription, 28, 32, 48, 57, 66, 68, 70, 73, 74, 76, 77, 78, 93–6, 98, 103, 104, 106, 148, 151, 163, 172, 179
registers, 9, 55–6, 103
terminology, 77, 89, 189
see also individual drugs
Cooter, Roger, 69
counselling, 2, 10, 163
crack cocaine, 14, 22, 24
crime, 17–18, 177
see also acquisitive crime
Crime, Justice and Protecting the Public, 18
criminal justice
approach, 7
system, 18, 23
Criminal Justice Act (1998), 18
Croydon Drug Dependency Unit, 99, 145
Cultural Theory, 117–20, 125, 135, 136, 173
see also Douglas, Mary
Curson, David, 134, 152–3
cyclizine, 190, 199

Daily Mail (newspaper), 73
Daily Mirror (newspaper), 82, 84–5, 111, 112
Daily Telegraph (newspaper), 84
Dally, Ann, 36, 38, 49, 50
and AIDA, establishment of, 38, 49, 50, 65, 71–81, 121–46
and Alba Association, establishment of, 178
appeal, 75, 76
autobiography, 57–8, 142
and Banks, Arthur, 50, 143–4
and Bewley, Thomas and Connell, Philip, 36, 73, 74, 76, 78, 80, 84, 85, 127, 130–1, 133, 136, 142, 176
and Brahams, Diana, 82
and Brewer, Colin, 80–1, 126
and the GMC, 36, 65–88, 97, 107–11, 135, 142, 170, 176, 177
and Home Office inspectors, 71, 74, 75–9, 80, 87, 92, 105–6, 128
and Home Office Tribunal, 71, 75–6, 78, 79, 81, 83, 98, 102, 105–6, 109
inspected on ‘friendly basis’, 92
and Johnson, Matthew, 132, 144
and the London consultants, 84, 135–7, 142, 146, 177, 178
and McIntosh, Donald, 79, 80, 92, 97–8, 105–6, 107, 110–11, 115
and the media, 72–4, 82, 84–5, 87, 125–6, 132, 133, 136–7, 175–6
and the 1984 Guidelines, 49, 80, 83, 85, 123, 133, 135–6
and O’Donnell, Michael, 79, 85
opposition against licensing, 50
and the Social Services Committee, 68, 79–80, 83, 133
and Spear, Bing, 49, 72, 76, 78, 87, 92, 105, 108, 121, 137, 139–40
and Thatcher, Margaret, 72, 76, 125–6, 132–3
Dally, Peter, 71
Dalmation (flurazepam), 77
‘dance drug’, see ecstasy
dangerous drugs, see controlled drugs
Dangerous Drugs Act 1920, 48, 91, 94, 204
1926, 207
1967, 8, 124
Dangerous Drugs (Supply to Addicts) Regulations (1968), 8
‘dedicated practitioners’, 108
Deedes, William, 84
Defence of the Realm Act, Regulation 40B (1916), 90–1, 94
Departmental Committee on Morphine and Heroin Addiction, see Rolleston Committee/Report
Department of Health and Social Security (DHSS)
Better Services for the Mentally Ill, 33
1984 clinical guidelines, 15, 44–64, 133
funding arrangements, 29
dependence
and acquisitive crime, 169
benzodiazepine, 13, 53, 54
and 1984 clinical guidelines, 53–4
and illegal market, 32
terminology, 33–4
unwillingness to break, 27
see also addiction
detoxification
abstinence-oriented, 4, 35, 39, 149
clonidine, 131
drug-free, Priory Clinics, 134
failure in, 57
home, 152
lofexidine, 131
methadone, 27, 45, 46, 53–4, 59, 60, 107
under sedation/anaesthesia, 152
short-term, 9, 45, 59, 60, 129
dexamphetamine, 45, 155
DF118s (dihydrocodeine), 55, 77
DHSS, see Department of Health and Social Security
diamorphine, see heroin
Diconal (dipipanone), 190, 199
AIDA and, 72, 78, 123, 129, 135
Bewley and Ghodse's article against, 73, 74, 85
Brennan and, 96
British National Formulary and, 75
Dally and, 75, 78, 82, 85, 123, 129, 135
GMC and, 72, 74, 75, 78, 82, 83, 96, 123, 135
and Home Office licensing, 32–3, 34, 42, 47, 74, 83, 96, 108, 123, 163
prescribing outside London, 142
Rai and, 72, 123
Tarnesby and, 83, 108
Dispensary, Armstrong, 112–13
diversion, of pharmaceuticals
AIP and, 121–2, 129
and Burr, Angela, 62
and the GMC, 87–8, 101, 104–5, 111, 177, 179
and Gruer, Laurence, 153
and the Inspectorate, 54, 87–8, 90, 97, 99, 101, 104–5, 108, 111
and Macfarlane, Alan, 99, 161, 164
and Misuse of Drugs Act, 1971, 101
and the 1999 Guidelines, 155, 162
prevention of/concern about, 18, 50, 54, 57, 62, 90, 97, 99, 104–5, 108, 111, 153, 155, 162, 164
and Strang, John, 161, 162
Dole, Vincent, 50
‘Don’t Inject AIDS’ campaign, 23
‘double scripting’, 103
Douglas, Mary, 117, 174
Drug Action Teams, 19–20, 119, 122
‘drug cocktails’, 26, 161
Drug Czar, 22
Drug Dependency Units (DDUs)
aims of, 11, 27, 122
Brighton, 80
Croydon, 99, 145
establishment/early years, 2–3, 8–9
Hackney Hospital, 77, 127
Liverpool, 139
St Bernard’s Unit, 143–4
St Thomas and Tooting Bec Hospitals, 28
University College Hospital, 133, 160
see also ‘Clinics, the’
Drug Licensing and Compliance Unit, 104
Druglink (journal), 85, 157, 158
Drug Reference Group, 20
drugs
prescribed, 3, 4, 7, 16, 29, 32, 35, 50, 53, 54, 60, 81–2, 87–8, 100–1, 108, 111, 129, 153, 177, 178
trafficked, 8, 9, 11, 13, 15, 27, 62, 74, 104, 169
Drug treatment and testing orders (DTTOs), 18
drug user groups, 33, 150, 161, 171, 178
see also activism, drug user
Duke, Karen, 23
Dzjkovsky, Dr, 122
estasy, 14, 22
Edinburgh, 6, 16
Edwards, Griffith, 10, 127
‘Effectiveness Review’, see Task Force to Review Services for Drug Misusers
Ellis, R., 118
epidemiology, 17, 63
ethics, medical, 32, 69–70, 79, 86, 87–8, 92, 132, 140
evidence-based medicine, 21, 41, 59, 148, 149–50, 165, 168
Farrell, Michael, 152, 158, 164
Fazey, Cindy, 140–1
feuding societies, 146
Ford, Chris(tine), 153, 157, 158–9
Foucault, Michel, 112–13, 116, 172
Foucauldian surveillance model, 116, 172
Fowler, Norman, 29, 33, 40, 41, 42, 52
free market, 69

Garfoot, Adrian, 93, 99, 102, 103, 104, 108, 109, 114, 156–7
General Medical Council (GMC)
activities and failures, 67–8
Bewley, Thomas, 130, 135, 142
‘Blue Book’, 83
Connell, Philip, 36, 76, 130–1, 135
Dally case, 36, 65–88, 97, 107–11, 135, 142, 170, 176, 177
defining terms, 82–4
and Diconal prescribing, 72, 74, 75, 78, 82, 83, 96, 123, 135
diversion of pharmaceuticals, 87–8, 101, 104–5, 111, 177, 179
and the Inspectorate, relationship with, 95, 96, 97, 101, 102, 103, 104, 105, 110, 112, 114, 115
media, 84–5, 115, 170
Spear, Bing, 70
and the state, relationship between, 68–71
Tarnsby case, 65, 71, 80, 81–5, 87–8, 108, 110–12, 177
General Medical Services Committee (GMSC), 12, 15, 42, 154
General Practitioners (GPs)
additional payments to, 14–15
and committee membership, 7–9, 16, 49–58, 128–31, 141–5
exclusion from treating addiction, 28, 31, 42, 162, 172
fundholding, 150
and licensing, 8, 28, 36–7, 42, 47, 50, 51, 54–6, 98–100, 148, 156, 158–9, 160–6, 189
NHS, 1–5, 6–9, 11–12, 14–15, 31, 32, 63, 117, 121, 122, 128, 141, 143, 144, 148, 153, 171, 173, 180; as proxy for private prescribers, 166, 172
NHS/private GPs, both, 28, 35, 61, 71, 73–4, 84, 121, 122, 139, 150, 158, 179
private, 2–3, 4, 15, 26–7, 28, 29, 32, 37, 42, 43, 44, 45, 47, 54, 58–9, 63, 65, 67, 68, 71, 72, 73, 74, 80, 81, 83, 84, 87, 88, 93, 97–8, 99, 102, 103, 111, 113, 114, 117, 121, 122, 125, 126, 129, 134, 136–7, 139, 141, 142, 144, 145, 147, 148, 152, 153, 161, 163, 166, 167, 169, 170, 171–2, 173, 174, 175, 176, 177, 180
reluctance to treat addicts, 11–12, 14–15, 100, 163
return to treating addiction, 11–12, 13, 14–15, 34, 42–3, 171–2
Royal College of General Practitioners, 42, 49, 100, 163, 164
as specialists, 4, 12, 15, 150, 162, 166, 171, 172
and T&R, 26–43
training, additional, 9, 15, 28, 42, 109, 112, 135, 148, 155, 156, 161, 164, 166, 172, 173, 205
see also
primary care
Gerada, Clare, 152, 158
Ghodse, A. Hamid, 73, 74, 85, 138, 139, 142
Glanz, Alan, 15
Gluckman, Max, 146
GMC, see General Medical Council (GMC)
‘Good Practice’ Guidelines, see clinical guidelines
Greater Glasgow Health Board, 153
Gruer, Laurence, 153
Guardian, The, 85
guidelines, clinical
AIDA, 38, 47, 49–51, 57, 72, 129, 131, 136–7, 139, 140, 144
Inspectorate, 48–9, 56, 57, 64, 99–100, 105–14
1984, 15, 44, 46, 59–60, 80, 81, 83, 85, 123, 133, 135, 136, 137–8, 149–50, 154, 156, 159, 178
1991, 16, 108, 135, 150, 151, 155, 159, 161
1999, 54, 59, 114, 133–5, 141, 148, 150–9, 162, 163, 164, 166, 169, 170, 172, 177, 178
2007, 59, 134, 135, 150, 152–3, 178
Gulf, drug trafficking, 11
Hackney Hospital, 77, 127
Hague Conventions, 90
Hanway Clinic, 122, 126, 141
Hare, Tessa, 132
Hargreaves, Sally, 122, 141
Harley Street, 44, 58–9, 81, 152
harm minimisation, see harm reduction
harm reduction
government campaigns/strategies, 15–17; drugs and crime, 17–18; local inter-agency, 19–20; 1988 official policy, 7, 14, 16, 147, 170, 171; 2010 shift in policy, 168; and voluntary services, 18–19
and the Inspectorate, 107–8, 115
Northern Ireland and, 158
and Stimson, Gerry, 14, 17, 18, 187
and Turner, David, 19
and Yates, Rowdy, 22
Harrison, S., 59
Harrison Act, 1914, 67
Hartnoll, Richard, 45, 59, 64, 124
Hartnoll-Mitcheson Trial, 45, 59, 64, 124
Hayward, Siwan Lloyd, 122
Health Authorities, 30, 69, 89, 121, 137, 141
Heaton, Ian, 75, 128
Hellawell, Keith, 22
hepatitis B, 63
heroin
injectable, 2, 16, 24, 45, 46–7, 59, 60, 124
1968 licensing system, 156
1998 drugs strategy, 22
prescribing, 27, 35, 45–7, 50, 61, 98–9, 127, 134, 139–40, 155, 165, 168, 175
statistics, 7
trafficking, 2, 27–8
Heroin Addiction Care and Control, 92
‘Heroin Screws You Up’ (advert), 23
Hillier, Ted, 137
HIV/AIDS
emergence/impact of, 6, 148, 170 and harm reduction strategies, 15–17, 107, 115
needle exchange schemes, 16, 18, 75, 147, 179
policy issue, 115
prevention, 6, 17, 75, 85, 147
spread of, 147
Home Office
Addicts Index, 9, 31, 73, 93, 95, 103–4, 113, 114, 115, 137, 139, 185
Home Office – continued
Home Secretary, 18, 42, 48, 67, 68, 91, 99, 101, 168, 204 hospital-based services, 8, 31–2, 34–5, 41, 54, 162 see also Drug Dependency Units (DDUs)
London, 4, 8, 9, 10–11, 12, 24, 30, 32, 35, 47, 58–9, 62
devolved pharmaceuticals in, 62
patterns of drug use, 8, 9, 32, 142
voluntary sector, 10, 122
London Consultants Group (LCG)
and AIDA/AIC, relations between, 136–7
Cultural Theory, classification system, 117–20
internal/external influence, 131–6
membership and policies, 128–31
organisational structure, 125–8
origins and aims, 120–5
regulating role, 137–9
relations with the state, 139–41
unifying and divisive forces, 141–5
Macfarlane, Alan, 93, 99–100, 114, 148, 151, 154, 161, 164
MacGregor, Susanne, 23–4
Mackay, John, 16
maintenance therapy
and ACMD, 39, 55, 156
and AIDA, 122, 141–2
and AIP, 129, 134, 141–2
the Clinics, 11, 12, 26, 27, 28, 36, 46
Conservative Government’s 2010 policy, 168
criticisms against, 10, 11, 16–17, 28, 35, 37–8, 45, 48, 50, 54, 61
debates in the US, 2, 67
licensing, 54–5, 160
methadone, 7, 16–17, 26, 27, 28, 45, 108, 147, 148, 153, 155, 157, 158, 165–6, 179
the 1999 Guidelines, 54, 56, 59, 80, 155, 165–6
opiates, 35, 67, 160
and polydrug use, 12
and Spear, Bing, 49, 139
and Spurgeon, Peter, 107
and T&R, 37, 55, 59
US ban on, 2, 67
Major, John, 9, 21
managerialism, 21, 149
Marks, John, 139–40, 141, 175
Maudsley Hospital, 35, 81, 127, 135, 151, 161
McClelland, D. B. L., 16
McClelland Report, 16
McIntosh, Donald, 79, 80, 92, 93, 97, 98, 105, 107, 110, 115
media
and the AIP, 134, 142
anti-drug campaigns, 13, 21, 23
d and Dally, Ann, 72–4, 82, 84–5, 87, 125–6, 132, 133, 136–7, 175–6
drug policy debates, 166, 169
and the GMC, 115, 170
Medical Act, 1858/1969, 66, 67, 86
medical marketplace, 61
‘medical model’, 8, 10, 11, 34, 40, 43
Medical Register, 3, 66, 68, 70, 80–1, 86, 102, 144, 152, 170, 179
Medical Working Group, 32, 34, 37–8, 49–50, 51, 52, 54, 55, 57, 63, 85, 106, 143
Medicines Control Agency, 89, 93
Mellor, David, 55, 56
Merrison Committee, 66
Merrison Inquiry, 68, 86
methadone
detoxification, 2, 4, 27, 45, 46, 54, 59, 60, 107
dosage, 54, 132
formulation, 27, 29, 45, 124
injectable, 2, 26, 27, 28, 45, 123, 129, 130, 135, 144, 155, 161, 162
maintenance, 7, 16–17, 28, 45, 108, 129, 147, 148, 153, 155, 157, 158, 165, 166, 179
oral, 2, 7, 16, 27, 28, 38, 45–6, 60, 74, 108, 124, 130, 147, 160, 163
protocol (Ireland), 164–5
supervised consumption, 153, 155, 159, 162
suppositories, 81
withdrawal, 53–4
Methedrine, 62, 67
3,4-methylenedioxymethamphetamine, see ecstasy
Middlesex Hospital Medical School, 109
Ministerial Group on the Misuse of Drugs, 23
Ministry of Health, 27, 91, 120, 121, 126, 146
Minnesota Model, 10, 19, 152
Ministry of Health, 27, 91, 120, 121, 126, 146
Ministry of Health, 27, 91, 120, 121, 126, 146
Ministerial Group on the Misuse of Drugs, 23
Ministry of Health, 27, 91, 120, 121, 126, 146
Minnesota Model, 10, 19, 152
see also Narcotics Anonymous (NA);
12-step programmes
Misuse of Drugs Act, 1971, 9, 17, 36, 68, 82, 86, 94, 96, 101–2
Misuse of Drugs Bill, 67
Misuse of Drugs Regulations, 1985, 77, 94
Mitcheson, Martin, 45, 46, 59, 64, 124, 127, 133, 137, 142, 160
mood-altering drugs, see psychoactive substances
morphine, 1, 90
‘muddling through’, 172
‘multi-disciplinary’ approach, 29, 30, 33, 34–5, 39, 42, 54, 122
Munro, Ian, 132
Narcotics Anonymous (NA), 10, 152
National Addiction Centre, Maudsley Hospital, 151
National Health Service (NHS)
and AIDA, 128–9, 131, 139–40, 141–2, 143, 144, 145
ban of temazepam, 13
‘continuous revolution’, 20
and the GMC, 68–71
and the Guidelines, 134–5, 150, 153, 158–9, 163, 165, 166
licensing, 47, 98–9, 133, 139, 140–1
management/reorganization of, 20–2, 149
market reforms, 20–1, 44, 63, 149
origin, 2
and private practitioners, relationship between (phases), 3, 98, 169–70, 171–3, 175, 179–80
T&R, 31, 32, 35, 37, 38, 40
treatment of addiction, 9, 24, 28, 34, 47–8, 75, 76, 88, 106, 113, 121, 170
and voluntary sector, 10, 19, 24, 122
National Institute for Clinical Excellence, 21
National Treatment Agency for Substance Misuse (NTA), 150, 178
needle exchange(s), 7, 16, 18–19, 75, 147, 158, 179
New Labour, 14, 21, 69
New Right, 15, 21
News of the World, The (newspaper), 122, 176
New York, 6, 10
NHS, see National Health Service
non-bona fide prescribing, 86, 104
non-profit organisations, see voluntary sector
Northern Ireland Committee on Drug Misuse, 153
notification (to the Addicts Index), 8, 9, 103, 113, 139
NTA, see National Treatment Agency For Substance Misuse (NTA)
obligatory therapy sessions, 45, 154
O’Donnell, Michael, 79, 85
Official Secrets Act, 169
oil crisis, 1973, 10–11
Oldroyd, David, 117
Openshaw, Susan, 125, 144
opiates
availability, early days, 1–2
detoxification under sedation/anaesthesia, 152
injectable, 24, 99, 133, 152, 159, 160, 166
maintenance, 35, 67, 160
regulatory guidelines, 53
opioids, 28, 32, 36, 38, 42, 50, 54, 55, 57, 58, 68, 79, 80, 86, 99, 148, 170
opium, 90
Opium Advisory Committee, 103
Oppenheimer, Edna, 12, 58
‘Orange Book’, 147
overdose, 3, 4, 12, 32, 60, 82, 83, 177
Oxford University, 125
Paddington Hospital, 81
paediatric cardiac surgery, death rates, 69–70
pain, 11, 75, 96
Pakistan, heroin trafficking, 11
Palfium (dextromoramide), 55
Panopticism, 172

Patient’s Charter (1991), 21

Patten, John, 55

Patterson, Diane, 153, 158

Pearson, Geoffrey, 22

peer pressure, 14, 46, 47, 62, 63–4, 66, 68, 82, 101, 105, 130, 142, 145, 175, 176

penalties, 9, 14, 15, 77, 101

Petro, John, 67, 73

pharmacies, 8, 71, 90, 91, 94, 95, 162

pharmacists, 56, 69, 90–1, 94, 104, 126, 151, 153, 167, 177

Pharmacy Act, 1868, 90

Phoenix House, 10

physical examination, 76, 106, 111–12

police

arrest referral, 18

accusation against Dally, Ann, 76–7, 78

Chemist Inspecting Officers (CIOs), 89–90, 93–4, 96, 104

and the GMC, 67–8, 115, 177

and the Inspectorate, 4, 48, 53, 67–8, 88–91, 93–6, 104–5, 110, 122

involvement in drug advisory committees, 18

policy community

AIDA, 147

civil servants, 84, 136, 145, 171, 172

expansion of, 43

formulation of treatment policy, 23–4

the GMC, 65, 72, 115

GPs, 172, 178

and HIV/AIDS, emergence of, 6–7, 115, 170, 171

the Inspectorate, 53, 98, 100, 107, 114–15, 170–1, 179

methadone maintenance, 153

and Tory politicians, 13, 14, 40, 48, 168

voluntary sector, 10, 13, 14, 15–16, 18–19, 151

policy-making

AIDA, 133, 136, 147

AIP, 133

media, 84, 136, 175–6

1999 Guidelines, 150, 155, 165–6

London’s dominance over, 168, 175–6

process formulation, 23–4, 165–6

the Secretariat, 51

T&R Working Group, 29–31

Polkinghorne, Rev. John, 161

Poncia, John, 131

prescribing

amphetamines, 2, 61, 124, 175

barbiturates, 2, 12–13, 31, 124

benzodiazepines, 13, 53, 54

cocaine: Beckett, Dale, 61; the Clinics, 26; the Inspectorate, 90, 91, 103, 163, 184, 185, 189, 190, 204; licences, 8, 11–12, 32–3, 36, 47, 50, 51, 54–6, 156, 160, 162, 163, 189; 1998 drugs strategy, 22; private prescribers, 2, 8, 11–12; second Brain Report, 11

competitive, 16, 125, 127

conformity in, 47, 53, 64, 172, 175

controlled drugs: Addicts Index, 103–4; AIDA, 57; barbiturates, 12–13; Bewley on, 28, 43, 73, 74; British Medical Journal, 74; British National Formulary, 77; Dally’s suspension, 77, 78, 83; the GMC, 66–8, 70, 89, 104, 115; guidelines, 148, 151, 163, 172, 177; Inspectorate, 48, 54, 70, 98, 103–5, 106–7, 110; mechanisms of state control, 93–6; Medical Act, 1858, 66; Misuse of Drugs Act, 1971, 9, 189; registers, 56; in return for fees, 76; T&R, 32, 43

‘double scripting’, 103

eXperimental, 2

heroin, 27, 35, 45–7, 50, 61, 98–9, 127, 134, 139–40, 155, 165, 168, 175

injectable: barbiturates, 12–13;

Diconal misuse, 72, 75, 78, 108, 123; heroine, 2, 16, 24, 26, 27, 45, 46–7, 59–60, 123–4, 130, 131, 140, 144, 175; methadone, 2, 16, 26, 28, 45, 59, 81, 123–4,
prescribing – continued
129–30, 135, 144, 155–6, 161, 162; opiates, 99, 133, 159, 160, 166; opioids, 148
‘in return for fees’, 76, 83
‘irresponsible’, 33, 48, 49, 52, 68, 76, 77, 81, 82, 86, 87, 94, 96, 98, 101–2, 104, 105, 109, 114, 159, 177
liberal, 2, 32, 47, 60, 102, 115, 171
long-term, 1, 2, 7, 9, 16, 50, 60, 71, 75, 76, 77, 80, 107–8, 129, 163
maintenance: licensing, 54–5, 160; methadone, 7, 16–17, 26, 27, 28, 45, 108, 147, 148, 153, 155, 157, 158, 165–6, 179; opiates, 35, 67, 160; US ban on, 2, 67; see also maintenance therapy
methadone, injectable, 2, 26, 27, 28, 45, 123, 129, 130, 135, 144, 155, 161, 162
methadone, oral, 2, 7, 16, 27, 28, 38, 45–6, 60, 74, 108, 124, 130, 147, 160, 163
morphine, 1, 90
‘non bona fide’, 86, 104
opiate: availability in 18th century England, 1; the Clinics, 27, 45; guidelines, 53–4; illicit, 27–8; injectable, 99, 133, 159, 160, 166; Pharmacy Act, 1868, 90
oral, 2, 7, 16, 27, 28, 31, 38, 41, 45, 53, 60, 72, 74, 75, 108, 109, 120, 124, 130, 133, 147, 160, 163
regional variations in, 4, 96, 144, 158, 165, 166, 168
short-term, 2, 9, 45, 59, 60, 119, 129, 175
substitute, 1, 3, 4, 13, 14, 30, 45, 50, 53–4, 57, 67, 74, 107, 148, 152, 155, 158, 165, 175
Prescription Pricing Authority, 56
prescriptions
controlled drug, 28, 32, 48, 57, 66, 68, 70, 73, 74, 76, 77, 78, 93–6, 98, 103, 104, 106, 148, 151, 163, 172, 179
handwriting requirements, 77
NHS, 13, 98, 139, 163, 169
private: illicit sale, 28, 29, 74, 135, 177–8; opiate, 53–4; opioids, 55; patients selling, 3, 9, 28–9, 32, 60, 74, 76–7, 78, 82, 177; pressure from patients, 32; registers, 56; second Brain Report, 11; terminology, 3–4
primary care, 148, 150, 153, 154, 155, 157, 162, 164, 166, 168, 172
Priory Clinics, 134, 152
‘problem drug taker’/‘problem drinker’, 33–4
Professional Conduct and Fitness to Practice, 68
Professional Conduct Committee (PCC), 68, 75, 77, 79, 80, 82, 103
professional misconduct, 3, 21, 66, 75, 76, 77, 81, 87
Dally case, 71–81
Tarnesby case, 81–2
psychedelic drugs, 14
psychiatrists, 2
heroin prescribing licences, 47
psychiatrists
Addiction Research Unit, Institute of Psychiatry, 10, 127, 137
anti-maintenance prescribing, 37–8, 45, 50, 139–40, 158, 175; disagreement with, 46–7, 48, 53, 92
and civil servants, 23, 26–7, 29, 40, 43, 48, 51–2, 84, 93, 97, 136, 145, 163–4, 168–74
conformist pressures, 46–7
and drug dependency units (DDUs), 8, 80, 99, 123, 139–40
generational and regional gap, 39–40
the GMC, 65, 67, 69, 71, 76, 78, 80, 81, 83, 105
and the Inspectorate, 53, 92, 97, 98–9, 105, 109
leadership, 2, 65, 107, 109
licensing, 46–7, 51, 54–6, 98–9, 160–6
1984 Guidelines, 49–50, 53, 55–62, 156
1999 Guidelines Working Group, 152, 155
Royal College of Psychiatrists, 36, 49, 76, 130–1, 135, 146, 175
and second Brain Report, 7, 8, 134
the secretariat, 51–2
and Social Services Committee, 133
T&R Working Group, 31, 34, 35, 37–8, 39–40, 49–50, 63, 121, 134–5
training opportunities, 109
see also individual psychiatrists
psychiatry
anti-psychiatry movement, 66
government alliances, 100
Institute of Psychiatry, 10, 127, 137, 151
legal powers, 61
new approaches for, 34
professional prestige/status, 60, 63–4, 123–4, 127, 145
public health system, 8, 14, 15–18, 27, 57, 61, 113, 122, 141, 151–2, 153, 155, 162, 164, 165, 171, 177
Radio Four, BBC, 134
Rai, D. D. P., 72
Raistrick, Duncan, 154
referrals, 4, 18, 76–7, 95, 110, 111, 112, 122, 173
Regional Drug Misuse Databases, 103
Regional Health Authority, 121, 137
regionalisation, Home Office, 96–7
Regional Medical Officers (RMOs), 31, 91, 96, 104
Regional Medical Service, 89, 93, 96
Regulation 40B, Defence of the Realm Act, (1916), 90–1, 94
‘regulatory capture’, 179
rehabilitation houses, 10
rehabilitation services, 33
re-registrations, of doctors, 70
research
approaches to prescribing, 44–8, 58–62
evidence, 3, 29, 41, 45, 59, 63, 83, 149, 153, 156, 173
HIV/AIDS, 17, 41
lack of, 41, 58, 167
on treatment effectiveness, 64, 167, 168
Rhodes, Gerald, 112, 172, 204
Riddell, J. A., 51, 57
Ritalin (methylphenidate), 74, 75, 199
Robertson, A. B., 16
Rohypnol (flunitrazepam), 77
Rolleston Committee/Report, 91, 101
Royal College of General Practitioners, 42, 100, 163, 164
Royal College of Physicians, 7
Royal Colleges of Psychiatrists and General Practitioners, 49
Royal Pharmaceutical Society (RPS), 89–90, 92, 94–5, 104
Royal Postgraduate Medical School, 109
Samways, Diana, 141, 143
Sathananthan, Kanagaratnam, 99, 139, 140–1, 145
SCODA, see Standing Conference on Drug Abuse
Scotland
AIDS/harm reduction approach, 16–17, 20
1999 Guidelines Working Group, representation in, 151
prescribing traditions, 165
Scottish Home and Health Department, 16
script, see prescription
‘script doctors’, 28, 82, 103, 108
Secretariat
Department of Health, 51–2, 57–8, 128
Home Office, 29, 51
sedation/anaesthesia, 152
self-administration of drugs, 106
self-help groups, 19
self-regulation, 65, 91, 100
AIDA, 125–45
AIP, 125–45
attempts, successful, 35, 113, 130
attempts, unsuccessful, 99, 129, 133, 134, 159, 164, 170
self-regulation – continued
the Clinics, 44–64
formal, 8, 51, 67, 135, 173, 174, 175
informal, 41, 48, 70–1, 96, 97, 135,
139, 146, 167, 173, 175
under State pressure, 3, 52–8, 66,
68–71, 139–45, 171–2, 173, 174,
175
shared care, 19, 150, 156, 162, 163,
172, 218–19
Sheridan, Janie, 162
Sherland Road, 129
Shipman, Harold, 21, 115
Shipman Inquiry, 115
Shortell, Stephen, 60
Sigsworth, Brian, 75
Sippert, A., 35
Smart, Carol, 23
‘social exclusion’, 22
Somerville College, 72, 132–3
South, Nigel, 17, 22
Spear, Bing (H. B.)
accusation against the Clinics, 28,
92–3, 107, 114, 135
and AIDA, 72, 74, 97–8, 121, 128,
139–40, 173
comments on British Medical
Journal’s article, 74, 135
‘compassionate approach’ towards
drug users/doctors’ clinical
autonomy, 48, 49, 92, 93, 99,
139, 164, 172
concern for overflow of drugs onto
black market, 9, 28, 53, 107,
108–9, 110
consideration of the treatment
model, 58
criticism against the
enforcement-dominated US
approach, 93
and Dally, Ann, 49, 72, 76, 78, 87,
92, 105, 108, 121, 137, 139–40,
53, 97–8
and the GMC, 70
vs. Macfarlane’s leadership, 93, 99,
164
and maintenance therapy, 49, 139
vs. McIntosh’s leadership, 79, 92,
98, 107
recommendation to reintroduce the
Tribunal system, 70, 96, 98, 101
role in the Inspectorate, 9, 12, 28,
33, 48–9, 53, 70, 72, 76, 78–9,
90, 91–3, 96, 97–9, 105, 107,
108, 109, 111, 114, 120, 121,
128, 137, 139, 140, 164, 207
and Sathananthan, Kanagaratnam,
99, 140–1
‘script doctors’/‘dedicated
practitioners’, distinctive view
of, 108–9
vs. Spurgeon’s leadership, 79, 92–3,
98, 107, 111
strong belief in the ‘British System’,
53, 90, 99
suspicion on role of private
prescribers, 28
and T&R, 28, 33, 34–5
and Tarnesby, Herman Peter, 110
view on CURB, 12
‘specialised generalist’, 154, 166
Spurgeon, Peter, 79, 92–3, 97, 98, 107,
111
Stacey, M., 87
Standing Conference on Drug Abuse
(SCODA), 10, 13, 19, 30, 31, 151
Stanton, Jennifer, 63
Stapleford Clinic, 152
state
funding, 13–22, 19, 26, 69, 160–1
regulation, 52–8, 68–71, 93–6,
139–45, 166, 173
statutory services, 8, 14, 18–19, 38, 69,
122, 141, 159, 171, 184
St Bartholomew’s Hospital, 120, 131
St Botolph’s, Aldgate, 92
St George’s Hospital, 138
Stigler, George, 179
Stimson, Gerry, 12, 14, 17–18, 20, 22,
23, 39, 58
stimulants, 2, 14, 26, 45, 53, 131, 157,
199
see also individual drugs
Strang, John, 10, 16, 23, 46, 99–100,
134, 135, 136–7, 138, 141, 145,
148, 151–2, 154, 157, 161, 162
Strong, Philip, 12
St Thomas Hospital, 28
substitution therapy see prescribing, substitute
Sun, The (newspaper), 73
surveillance, 21, 35, 101, 112–13, 116, 172
suspension, of doctors, 70, 75, 76, 77, 87, 101, 132
Sutton, Gary, 122, 126
Switzerland, heroin prescribing, 155

Tackling Drug Misuse (1985), 22
Tackling Drugs Together (1995), 17, 19–20, 22
Tackling Drugs Together to Build a Better Britain (1998), 22
Tarnesby, Peter Herman, 65, 71, 80, 81–5, 87, 88, 108, 110, 111–12, 177
Task Force to Review Services for Drug Misusers (Effectiveness Review), 151, 156, 161
Tavistock Centre, 81
temazepam, 13
terminal disease, 75
Thames Television, 85
Thatcher, Margaret, 20, 69, 72, 76, 125, 132–3
‘therapeutic addicts’, 7
‘therapeutic apartheid’, 46
Thom, Betsy, 34
Thompson, M., 118
Thorley, Anthony, 34, 35, 36, 39–40, 56, 99, 141, 151, 152, 161, 162–4
Times, The (newspaper), 176
tobacco, 19, 33
Tooting Bec Hospital, 28
T&R, see Treatment and Rehabilitation
Trace, Mike, 22
trade union, 12, 154
tranquillisers, 12, 31
treatment
compulsory, 2, 15, 18, 21, 26, 113; see also Drug Treatment and Testing Orders (DTTOs)
NHS, 23–4, 29–42, 58–62, 129
private, 28, 47, 126, 129, 131, 158
Treatment and Rehabilitation (T&R)
‘drug addict’/’alcoholic’, definition of, 33–4
emergence of, 29
expansion of treatment services, 29–31
extensive curbs on prescribing, 32–3
good practice guidelines, 37–9
‘interim report’, 29–30, 33
1983 medical conference on proposals, 41–2
multi-disciplinary approach, 39–40
prescribing policy, 34–7; private prescribers, 28–9, 32, 36–8, 42
re-involvement of GPs, 31–2, 34–5
research evidence, lack of, 41
Trebach, Arnold, 125–6
Tribunals, see Home Office, Drugs Tribunals
tuberculosis, 112–13
Turkey, drug trafficking, 11
Turner, David, 13, 19, 30, 36, 37, 38, 43
12-step programmes, 10, 19, 152
see also Narcotics Anonymous (NA)
Tylden, Elizabeth, 49

UK
divergent prescribing traditions, 165
1988 ‘harm reduction’ policy, 147
international narcotics control system, 90
Minnesota Model treatment centres, 19
trafficking, 27–8, 62
UK Anti-Drugs Coordination Unit, see Central Drugs Coordination Unit
UK Harm Reduction Alliance, 187
undercover reporters, 81–2, 84, 85, 176
United States of America
crack cocaine use spread to UK, 14
debates on addiction as illness, 2
‘drug courts’, 18
1914 Harrison Act, substitute drug restriction, 67
influence in the pre-First World War Hague Conventions, 90
maintenance prescribing outlawed (1919), 2, 67
methadone substitution therapy, 50
United States of America – continued
restrictive legislation and decline in
drug use, 91
Supreme Court, 2, 67
University College Hospital, 46, 133, 160
urine tests, 75, 106, 124, 131, 143
Valium (diazepam), 77
veterinary surgeons, prescribing
rights, 90
voluntary sector
AIDS/’harm reductionist’ approach, 15–17
funding for private prescribers
policy role, 29–42, 173
social care and counselling, 10
state funding of, 18–19
Wales
general practices, 11
1999 Guidelines Working Group,
representation in, 151, 152
regional Home Office, 96
Waller, Tom, 14
Weber, Max, 98, 206
Webster, Charles, 10–11, 40
Wellcome Library for the History and
Understanding of Medicine, 120
Wells, Brian, 10
Westminster Drug Action Team, 122
White papers
Better Services for the Mentally Ill, 33
Crime, Justice and Protecting the
Public, 18
Tackling Drugs Together, 17, 19
Working for Patients, 20
Whitney, Ray, 55–6
Wildavsky, A., 118
Willis, James, 61, 145
withdrawal
licences, 67, 91, 99, 100, 124, 157
symptoms, 1, 2, 53–4, 57, 106, 158
Wittenberg, R., 51–2
Working for Patients, 20
World Medicine, 85
World War I, 48, 90
World War II, 86
Yates, Rowdy, 22