

DYNAMIC DUALITIES: THE 'BRITISH SYSTEM' OF HEROIN ADDICTION
TREATMENT, 1965-1987

by

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Abstract

This thesis is concerned with the treatment of heroin addiction between 1965 and 1987. It examines a series of conflicts between seemingly opposed forces: between the medical and the social, the specialist and the generalist, the public and the private provision of healthcare, and the short-term and the long-term prescription of drugs to addicts. The establishment of specialised Drug Dependence Units (DDUs) in 1968 demonstrated that addiction was seen as both a disease to be treated and a social problem to be controlled. It is argued that the effects of this dynamic duality can be observed in the subsequent response to heroin addiction. Tension existed between specialist consultant psychiatrists who treated addicts at hospital based DDUs and community based private and general practitioners involved in the treatment of addiction. This was the result of contrasting approaches to addiction and its treatment. Conflict between these groups was particularly evident in the General Medical Council's (GMC) cases for serious professional misconduct in 1983 and again in 1986-1987 against Dr Ann Dally, a leading private practitioner involved in the treatment of addiction. These cases highlighted the continuing differences between medical and social approaches to addiction but also demonstrated how these elements were inseparable and equally crucial to the formulation of drug treatment policy in this period.

Dedication

To my family and in memory of my Grandfather, Peter Mold

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Abbreviations Used

ACDD – Advisory Committee on Drug Dependence

ACMD – Advisory Council on the Misuse of Drugs

ACPO – Association of Chief Police Officers

AIDA – Association of Independent Doctors in Addiction

AIDS – Acquired Immune Deficiency Syndrome

ARU – Addiction Research Unit

BMA – British Medical Association

BMJ – British Medical Journal

CFI – Central Funding Initiative

CMAC – Contemporary Medical Archives Centre

DDU – Drug Dependence Unit

DHSS – Department of Health and Social Security

GMC – General Medical Council

GP – General Practitioner

ISDD – Institute for the Study of Drug Dependence

HIV – Human Immunodeficiency Virus

LMA – London Metropolitan Archive

MDU – Medical Defence Union

MRC – Medical Research Council

NHS – National Health Service

NTA – National Treatment Agency

NTORS – National Treatment Outcome Research Study

PCC – Professional Conduct Committee

PPC – Preliminary Proceedings Committee

PRO – Public Record Office

RCP – Royal College of Physicians

RCPsych – Royal College of Psychiatrists

WHO – World Health Organisation

Introduction

Addiction, Drugs and History

In order to examine the treatment of heroin addiction between 1965 and 1987 this thesis will consider a series of conflicts between seemingly diametrically opposed forces: between the medical and the social, the specialist and the generalist, the public and the private provision of healthcare, the short-term and the long-term prescription of drugs to addicts. It will argue that though these conflicts were differentiated by content, form and tone they were all rooted in two aspects of addiction, a complex duality in which the condition was both a medical disease and a social problem. To explore these two apparently separate, yet forever intertwined, aspects this thesis examines tensions between contrasting ways of responding to addiction through different kinds of treatment offered by different kinds of medical practitioners for different reasons. Central to these practices was the relationship between the medical and the social. Indeed, the very history of addiction cannot be understood outside of the changing politics of medical and social authority which perennially shaped the nature of the discussion.

In 1968, at the behest of the Ministry of Health, a number of London teaching hospitals established Drug Dependence Units (DDUs) to both control the social problem of heroin addiction and provide treatment for the addict. Initially, there was a distinct lack of knowledge about addiction and psychiatry came to fill a vacuum by claiming to offer a treatment-based solution to the problem of addiction. Psychiatrists ran the DDUs and addiction rapidly became an area of psychiatric expertise. Through these specialist clinics a particular view of addiction came to dominate, one that placed a premium on curing the addict of their disease. This was in line with the principles of clinical medicine practised in the hospitals where the DDUs were

located. However, in the 1980s a series of challenges were presented to the expert status of the DDU psychiatrist and the treatment they offered. DDUs were increasingly unable or unwilling to handle rapidly rising numbers of heroin addicts. At the same time, some addicts grew dissatisfied with the treatment on offer at clinics, claiming that it did not meet their needs. They began to seek out alternatives, by either buying drugs on the burgeoning black market or turning to other medical practitioners for help. This period saw a dramatic increase in the involvement of the General Practitioner (GP) in the treatment of addiction. This undermined the specialist nature of the treatment provided by the DDUs as it implied that a generalist could also provide adequate care.

A simultaneous but different kind of threat to the expert status of the DDU psychiatrist was posed by the growing interest of private practitioners in the treatment of heroin addiction. Many of these doctors were also psychiatrists, so the challenge they presented centred on the type of treatment on offer rather than on the authority of the psychiatrist as the principal expert on drug addiction. Debates about the most appropriate way to treat heroin addiction came to dominate the field, as supporters of the rapid withdrawal of drugs from addicts sought to prevent the continued long-term prescription of drugs to addict patients, a practice that was often found in the treatment of addiction in private and general practice. These doctors were more amenable to the long-term prescription of drugs to addicts (a practice termed 'maintenance') than clinic-based psychiatrists because this method reflected their understanding of the treatment of disease. Community based doctors tended to concentrate more on the needs of the patient rather than purely on the cure of disease, and this philosophy can be seen in their support for maintenance. Maintenance

prescription seemed to benefit addicts by providing them with a fixed amount of the drug they claimed they needed in order to allow them to rebuild a stable life.

Maintenance was also characterised as being more ‘social’; not only did it consider the needs of the patient, it also considered the needs of society: a stable addict with a regular supply of drugs was less of a problem to the community. In contrast, DDU psychiatrists usually presented a more ‘medical’ view of addiction and its treatment by emphasising the rapid withdrawal of drugs from addict patients. This practice was grounded in a hospital-based clinical conception of disease and its treatment that placed greater emphasis on curing the disease rather than on the patient as an individual. Such a view is evident in the short-term prescription policies pursued by most clinics, which emphasised rapid withdrawal of drugs from the addict resulting in ‘cure’ – the patient being drug free.

This method was dominant throughout the early to mid 1980s. Short-term withdrawal held on to this position because it was practiced by DDU psychiatrists trying to preserve their status as the leading experts on the treatment of addiction by removing the non-DDU doctor (NHS and private, generalist and specialist) and maintenance treatment from the field. By the end of the decade, however, clinical psychiatric opinion appeared to be changing; there was a growing acceptance that there was a place for both the non-clinic doctor and maintenance in the treatment of addiction. This shift was provoked (in part) by concerns about incidences of HIV and AIDS amongst intravenous drug users and the desire to make treatment more ‘attractive’ to addicts, so that the further spread of these conditions could be prevented, but was also motivated by the wider realisation that heroin addiction had important social dimensions which could not be ignored by medical practitioners offering treatment. For the clinical psychiatrist to retain a role in the expanding drug

‘policy community’ he or she needed to demonstrate that they could combine the ‘medical’ with the ‘social.’¹

To an extent, this combination of medical and social existed in all attempts to deal with addiction: ‘social’ elements could be discerned in ‘medical’ practices and vice-versa. Indeed, the notion that addiction was a problem requiring both medical and social approaches was by no means specific to the period under consideration. Both these elements can be discerned in responses to substances described as ‘addictive’ throughout the twentieth century. This does not, however, suggest that addiction was, or is, an invariant reality. Indeed, a wider consideration of the history of addiction indicates that this is a malleable term moulded by a range of powerful forces. Regardless of arguments about the ultimate flexibility of all concepts and language, the meaning of addiction has been more contested than other more stable terms. Notions of addiction have changed over time, place and context: addiction is a construction that reflects the values, ideas and fears of the society in which it is, or was, created. To demonstrate this, it is necessary to analyse the history and historiography of addiction. This Introduction will consider historical approaches to addiction and relate these to theoretical understandings of some of the key issues involved, such as the role of expert knowledge in the creation of labels such as ‘the addict.’ From theory it will turn back to historiography to argue that though the current literature on the history of addictive substances is expanding, two areas have yet to be sufficiently developed: firstly, most historical analyses of drugs and British drug policy end in the mid-twentieth century, and secondly, much of the existing

¹ The expansion in the range of groups and individuals involved in the development of drug policy in the 1980s has been described as the ‘policy community’ by Virginia Berridge in *Opium and the People: Opiate Drug Use and Drug Control Policy in Nineteenth and Early Twentieth Century Britain*, (Revised edn., London: Free Association Books, 1999) and V. Berridge, ‘AIDS and British drug policy: continuity or change?’, in V. Berridge & P. Strong, *AIDS and Contemporary History* (Cambridge: Cambridge University Press, 1993) 135-152, p. 141.

literature on this area lacks the insight that an engagement with theoretical approaches to addiction provides. This thesis attempts (at least partially) to rectify this imbalance.

1. What was addiction? The historiography of addiction

According to Jessica Warner the ‘modern conception of alcohol addiction’ emerged during the seventeenth century.² Contemporaries were aware that the regular consumption of alcoholic beverages could result in habitual drunkenness, a state, Warner argues, Stuart clergymen often described in terms of addiction. She found that seventeenth-century sermons and religious writings on drunkenness asserted that drinkers could lose control of their behaviour, resulting in a compulsion to drink. Preachers referred to parishioners ‘addicted to drunkennese’ whose drinking had turned from ‘delight into necessitie.’³ There was, Warner argues, also a related tendency to describe habitual drunkenness as a disease and even as an epidemic. This description emanated not from physicians, but from the clergy. The disease concept of addiction was thus a moral rather than medical construction, created through clerical appeal to inner-discipline as a means of social control.⁴ In this, Warner may well be correct, but there are some problems with her analysis in other areas. Crucially, the contemporary understanding of what the term ‘addiction’ meant did not necessarily reflect the meaning Warner ascribes to it. According to the Oxford English Dictionary, seventeenth-century usage of the word meant inclination, bent,

² J. Warner, ‘“Resolv’d to drink no more”: addiction as a pre-industrial construct’, *Journal of Studies on Alcohol*, 55, (1994) 685-691, p. 685.

³ J. Downname, ‘A disswasion from the sin of drunkenness foure treatises tending to diswade all Christians from foure no lesse heinous then common sinnes: namely, the abuses of swearing, drunkennesse, whoredome and briberie’, 1609, quoted in *Ibid.* p. 687.

⁴ *Ibid.* p. 690.

leaning, or penchant towards something, often a habit or a pursuit.⁵ Moreover, the illustrative quotations provided from this period suggest something rather more benign than Warner's choice of examples indicate. A work on Shakespeare, published in 1675, remarked on 'His own proper Industry and Addiction to books.'⁶ Although Warner does note the wide usage of the term, observing that during the seventeenth and eighteenth century addiction 'did not necessarily imply a loss of control over one's drinking behaviour,' the tenor of her article suggests otherwise.⁷ She appears eager to relate early modern usage of 'addiction' to more recent understandings of the term, and is quick to describe seventeenth century drinkers in terms they may not have understood or used themselves. For example, Warner states that drunks referred to in a sermon 'are in fact addicts' and contemporaries were not 'blinded to the addicts in their midst.'⁸ Despite referring to addiction as a 'construct' in the title of her paper Warner has a fixed idea of what addiction is, and therefore what it was; she does not appear to be sensitive to different understandings of addiction across time and space.

This is not a criticism that can be levelled at Harry Gene Levine whose article on the 'discovery' of addiction in America has set the tone for a number of critical considerations of the condition.⁹ Levine argues that the modern concept of alcoholism as a progressive disease dates from the end of the eighteenth century. Prior to this, the assumption was that people drank because they wanted to, not because they were compelled to. Levine asserts that doctors associated with the temperance movement created the addiction paradigm in order to explain the

⁵ Oxford English Dictionary Online, <http://dictionary.oed.com>.

⁶ *Ibid.*

⁷ Warner, "'Resolv'd to drink no more'", p. 686.

⁸ *Ibid.* p. 687, p. 688.

⁹ Warner's article is, in part, a response to this: H.G. Levine, 'The discovery of addiction: changing conceptions of habitual drunkenness in America', *Journal of Studies on Alcohol*, 39, (1978), 143-174.

overwhelming desire for drink amongst their patients. These doctors thought that inebriety or habitual drunkenness was a disease derived from the consumption of alcoholic drinks. Addiction was thus located in the drug as alcohol itself was held to be inherently addictive. After the prohibition era, Levine notes a change in the addiction paradigm. He argues that addiction was no longer located in alcohol, but in the alcoholic. Levine considers this change to be ‘intraparadigmatic,’ as both notions of addiction held that the only cure was abstinence.¹⁰

To explain the emergence of the concept of addiction Levine utilises a ‘sociology of knowledge’ approach. He uses Foucault and Weber to argue that the concept of addiction developed not just because it made sense to drunkards, but because it also made sense to large numbers of the middle classes who were trying to keep their own desires in check. Thus:

The invention of the concept of addiction, or the discovery of the phenomenon of addiction, at the end of the eighteenth and the beginning of the nineteenth century, can be understood not as an independent medical or scientific discovery, but as part of the transformation in social thought grounded in fundamental changes in social life – in the structure of society.¹¹

Addiction was, therefore, a social construction; one that Levine feels is still relevant today, or at least at the time of the publication of his article in 1978, since he argues that the conditions which made addiction a reasonable way of interpreting behaviour in the eighteenth and nineteenth century did not disappear in the twentieth. What was different, however, is what Levine calls ‘the degree of human interdependence’ which made it ‘possible to see the “social” nature of what had formerly been viewed as “individual” problems.’¹² There are some difficulties with Levine’s equation of the disease concept of habitual drug and alcohol use with addiction. Warner’s work, no matter how flawed in other areas, does indicate that the description of habitual

¹⁰ *Ibid.* pp. 143-145.

¹¹ *Ibid.* p. 166.

¹² *Ibid.* p. 166.

drunkenness as a disease predates the notion of addiction (disease based or otherwise). This does not, however, detract from Levine's insight on the development of a social dimension to addiction, a premise that will be expanded on in more detail below.

Disease was also an essential element in the emergence of the concept of addiction in Britain. Most historians date the 'birth' of addiction in the nineteenth century and whilst there is some disagreement about the precise point at which this occurred, all point to both moral and medical influences, bound together through the notion of disease. The most thorough exploration of this theme is found in Geoffrey Harding's *Opiate Addiction, Morality and Medicine: From Moral Illness to Pathological Disease*.¹³ Harding argues that addiction was initially constructed as a moral failing by organisations such as the Society for the Suppression of the Opium Trade (SSOT). However, morality was connected to disease through the idea that the addict suffered from a 'pathologically impaired moral faculty'; that the use of opium resulted in physical damage to the will. Harding asserts that this made sense to the largely Quaker membership of the SSOT who believed that the moral faculty physically existed and could, therefore, be harmed by the use of 'stimulants' such as opium.¹⁴ Yet the SSOT were not the only body to describe compulsive opium use in terms of pathology and morality; this view also gained credence within the medical profession during the nineteenth century. Doctors too began to refer to addiction as a 'moral pathological phenomenon,' such that 'by the late nineteenth century the effects of opium could be commonly understood, either directly or by implication, in terms of a pathologically debilitated moral faculty.'¹⁵ Harding notes that even those physicians

¹³ G. Harding, *Opiate Addiction, Morality and Medicine: From Moral Illness to Pathological Disease* (Basingstoke: Macmillan, 1988)

¹⁴ *Ibid.* pp. 33-34.

¹⁵ *Ibid.* pp. 54-55.

who believed that there was a physiological basis to addiction and continued to search (unsuccessfully) for this retained the notion that addiction was a disease of the will.¹⁶

This combination of medical and moral approaches to addiction expressed through ‘disease’ has been emphasised by other commentators on the period. Terry Parssinen and Karen Kerner argue that there was a broad consensus on the disease theory of addiction encompassing a range of voices and authorities. Some referred to addiction as a ‘moral insanity,’ others to a ‘disease of the will,’ yet, ‘these definitions did not reflect fundamental disagreements...but rather differing emphases on parts of the same problem.’¹⁷ Virginia Berridge reaches a similar conclusion. She asserts that ‘medical as well as moral perceptions defined disease theory’; that ‘addiction was disease and vice.’¹⁸ Berridge addresses the question of how it was that medicine came to see addiction as a disease, as do Parssinen and Kerner. They all point to the advent of the hypodermic syringe in 1856 as a significant moment, as the possibility of subcutaneous injection of large doses of morphia helped to bring the use of opiates to the attention of the medical profession.¹⁹ Parssinen and Kerner maintain the greater quantity of drug administered through injection resulted in the intensification of the physiological complaints associated with opiate use and that physicians felt guilty about creating addiction in their patients through incautious use of morphia.²⁰

Hypodermic use involved doctors in addiction to a greater extent than previously and

¹⁶ *Ibid.* pp. 63-64.

¹⁷ T. Parssinen & K. Kerner, ‘Development of the disease model of drug addiction in Britain, 1870-1926’, *Medical History*, 24, (1980) 275-296.

¹⁸ V. Berridge, ‘Morality and medical science: concepts of narcotic addiction in Britain, 1820-1926’, *Annals of Science*, 36, (1979), 67-85, p. 72, p. 74. See also Berridge, *Opium and the People*, pp. 150-151; V. Berridge, ‘Morbid cravings: the emergence of addiction’, *British Journal of Addiction*, 80, (1985) 233-243; V. Berridge, ‘Opium and the doctors: disease theory and policy’ in R.M. Murray & T.H. Turner (eds.), *Lectures in the History of Psychiatry: The Squibb Series* (London: Royal College of Psychiatrists, 1990) 101-114.

¹⁹ Berridge, ‘Morality and medical science’, p. 73; Parssinen & Kerner, ‘Development of the disease model of addiction in Britain’, p. 275, pp. 290-291. Berridge also discusses the impact of hypodermic syringes on the use of morphine in more detail in *Opium and the People*, pp. 135-149.

²⁰ Parssinen & Kerner, ‘Development of the disease model of addiction in Britain’, p. 291.

once doctors intervened, as Berridge points out, ‘medical involvement itself helped to define the problem and its contribution to disease views.’²¹

Parssinen and Kerner also suggest a deeper cause to the development of the disease model of drug addiction. They note that medical men during the nineteenth century appropriated certain functions previously exercised by priests:

Physicians, the new guardians of morality, simply substituted new names for ancient evils: madness became mental illness; drunkenness became alcoholism; and the sin of Onan became masturbation. The old sins to be confronted and overcome were, by the late nineteenth century, diseases to be cured.²²

Unfortunately, Parssinen and Kerner do not sufficiently develop this intriguing line of analysis. This is, perhaps, unsurprising as they were writing at a time when the history of medicine was just beginning to move away from its positivist origins through its interaction with the sociology of medicine. The suggestion that medical knowledge was not objective opened up disease categories for closer scrutiny. Here, the work of French philosopher Michel Foucault has been particularly influential.²³ In *The Birth of the Clinic* Foucault developed the concept of the anatomico-clinical ‘gaze,’ which created the body and placed disease within this.²⁴ He argued that nineteenth and twentieth century anatomico-clinical medicine was based around what could be seen, about what was visible. Doctors pointed to visible lesions within the body of the patient as the source of disease. They were, however, only able to ‘see’

²¹ Berridge, ‘Morality and medical science’, p. 73.

²² Parssinen & Kerner, ‘Development of the disease model of addiction in Britain’, p. 292.

²³ The influence of Foucault on the history of medicine is dealt with in C. Jones & R. Porter (eds.), *Reassessing Foucault: Power Medicine and the Body* (London: Routledge, 1994) and in A. Petersen & R. Bunton, *Foucault, Health and Medicine* (London: Routledge, 1997). More general accounts of the influence of medical sociology on the history of medicine encompassing the work of Foucault to a greater or lesser degree can be found in articles contained in D. Porter (ed.), *Social Medicine and Medical Sociology in the Twentieth Century* (Amsterdam: Rodopi, 1997). Dorothy Porter also considers changes in the approach to the history of medicine when discussing public health in the introduction to her work *Health, Civilisation and the State: A History of Public Health From Ancient to Modern Times* (London: Routledge, 1999).

²⁴ M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock Publications, 1973).

certain things, an alliance being ‘forged between words and things, enabling one *to see* [his italics] and *to say*.’²⁵ The body and the disease within it, therefore, were a construction; a combination of what could be seen and what could be expressed. The conventional understanding of the history of medicine as a quest to find pre-existing diseases was, therefore, invalid.

Despite their apparent willingness to engage with what they see as the ‘radical’ historiography of medicine a positivistic approach can be discerned in Parssinen and Kerner’s work on the origins of addiction. For instance, they argue that ‘opium’s addictive properties had been noted in the medical literature as early as 1700, but medical men did not take these very seriously.’²⁶ This suggests that addiction was a disease waiting to be ‘discovered.’ Berridge’s use of such language is more cautious, but the largely chronological structure of her work does indicate an element of progression, something that led Harding to criticise her (and Parssinen) for presenting an account directed towards the accumulation of rational thought.²⁷ Harding argues that he has utilised a different methodological approach to opiate use by drawing on the work of Foucault. He asserts that he does not present a survey of the medical or moral responses to givens, or locate when opium dependence first became an issue for concern; instead he has tried to describe the social relations that made these medical/moral statements on opiate use possible.²⁸ However, consideration of some of the most recent work on the concept of addiction would suggest that in many ways Harding made the same mistake for which he castigated

²⁵ *Ibid.* p. xii.

²⁶ Parssinen & Kerner, ‘Development of the disease model of addiction in Britain’, p. 275.

²⁷ Harding, *Opiate Addiction, Morality and Medicine*, pp. 83-84. See also: V. Berridge & G. Edwards, *Opium and the People: Opiate Use in the Nineteenth Century* (London: Allen Lane, 1981); T. Parssinen, *Secret Passions, Secret Remedies: Narcotic Drugs in British Society 1820-1930* (Manchester: Manchester University Press, 1983). Berridge takes issue with this criticism of her work in the revised edition of *Opium and the People*, arguing that she does not present a positivist interpretation of the rise of the disease of addiction. See Berridge, *Opium and the People*, pp. xxvii-xxviii.

²⁸ Harding, *Opiate Addiction, Morality and Medicine*, pp. 84-85.

Berridge and Parssinen. Mariana Valverde, Tim Hickman, Janet Farrell Brodie and Marc Redfield all argue that the ‘modern’ meaning of addiction is an essentially twentieth century concept.²⁹ Valverde asserts that though the terms ‘addiction’ and ‘addict’ were used before this period their meaning was much wider, so that ‘addiction’ was not much different from habit.³⁰ Indeed, the word addiction derives from the Latin *addicere*, which was a Roman legal term meaning a formal giving over or delivery by sentence of court: a surrender, or dedication, of any one to a master. As indicated above, ‘addiction’ was used from the seventeenth century to describe being given to a habit or pursuit, but the earliest recorded use of the term to mean ‘a compulsion to continue taking a drug as a result of taking it in the past’ was in 1906. It was then that the *Journal of the American Medical Association* opined: ‘It matters little whether one speaks of the opium habit, the opium disease or the opium addiction.’³¹ It is then, perhaps, wrong to speak of habitual drug and alcohol use in terms of ‘addiction’ before the early 1900s and more correct to describe these as addiction-like, or ‘practices later called addiction.’³² Harding, Berridge, Parssinen and Kerner are, therefore, guilty of projecting a twentieth century concept back onto an earlier period without fully appreciating the subtleties in differences of definition.

Despite disparities in the location of the emergence of the concept of addiction ranging from the seventeenth to the twentieth centuries, most accounts hint at a surprising degree of continuity surrounding the conceptualisation of addiction as

²⁹ M. Valverde, “‘Slavery from within’: the invention of alcoholism and the question of free will”, *Social History*, 22, (1997) 251-268, p. 257; M. Valverde, *Diseases of the Will: Alcohol and the Dilemmas of Freedom* (Cambridge: Cambridge University Press, 1998) pp. 5-9, pp. 38-42; T.A. Hickman, *The Double Meaning of Addiction: Habitual Narcotic Use, Social Degradation and Professional Medical Authority in the United States, 1870-1920*, Ph.D thesis, University of California, Irvine, 1997, p. 5; J. Farrell Brodie & M. Redfield ‘Introduction’ in J. Farrell Brodie & M. Redfield (eds.) *High Anxieties: Cultural Studies in Addiction* (Berkeley, Los Angeles & London: University of California Press, 2002) p. 2.

³⁰ M. Valverde, “‘Slavery from within’”, p. 257.

³¹ Oxford English Dictionary, <http://dictionary.oed.com>.

³² M. Valverde, “‘Slavery from within’”, p. 257.

medico-moral disease. The work of Foucault has done much to illuminate the relationship between these two seemingly different authorities. His histories of sexuality and of madness indicate that during the nineteenth century an inseparable bond was formed between morality and medicine. In *The History of Sexuality, Volume One* Foucault details the transformation of sex into a discourse. This discourse was governed by the endeavour to eliminate forms of sexuality not amenable to reproduction.³³ The medical profession led Victorian attacks on ‘deviant’ sexual practices.³⁴ For example, doctors argued that masturbation caused insanity and blindness and that it was harmful to the body. This reinforced, and at the same time partially eclipsed, notions that masturbation was sinful and damaging to morality.³⁵ Health and moral purity became entwined. The medical and the moral were not distinct; they were one and the same. Parallels can clearly be drawn with nineteenth-century attitudes towards habitual drug use, where the moral and the medical supported one another in defining and responding to this. The ‘moral-pathological’ view of ‘addiction’ was thus part of a wider trend in which the medical and moral were inseparable.

Medicine’s intervention into areas such as sexuality and drug use was representative of a process Foucault described in *Madness and Civilisation*.³⁶ He argued that the doctor first became involved with the insane not because they had the

³³ M. Foucault, *The History of Sexuality, Volume One: An Introduction* (Middlesex: Penguin, 1990) p. 36.

³⁴ There is an extensive literature on Victorian attempts to eliminate deviancy and regulate sexuality. See, for example, M. Mason, *The Making of Victorian Sexuality* (Oxford: Oxford University Press, 1994); F. Mort, *Dangerous Sexualities: Medico-Moral Politics in Great Britain Since 1830* (London & New York: Routledge, 1987); R. Porter & L. Hall, *The Facts of Life: The Creation of Sexual Knowledge in Britain, 1650-1950* (New Haven & London: Yale University Press, 1995).

³⁵ For a discussion of Victorian responses to masturbation see above and R.P. Neuman, ‘Masturbation, madness and modern concepts of childhood and adolescence’, *Journal of Social History*, 8, (1975) 1-27; R.P. Neuman, ‘The priests of the body and masturbatory insanity in the late nineteenth century’, *Psychohistorical Review*, 6, (1978) 21-32.

³⁶ M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London and New York: Routledge, 2001).

‘objective’ skill and knowledge necessary to deal with madness, but as a result of his position in society as a moral authority: ‘It is not as a scientist that *homo medicus* has authority in the asylum, but as a wise man. If the medical profession is required, it is as a juridical and moral guarantee, not in the name of science.’³⁷ Similar forces were perhaps at play in medicine’s intervention into addiction. The nineteenth century doctor concerned with addiction was as much a moral authority as he was a medical authority. At first medicine could offer no more knowledge about addiction or a different approach to the condition than had already been developed by moralists, resulting in its appropriation of the pre-existing moral-pathological view. However, as medicine embraced science and empirical method it began to offer a ‘rational’ view of addiction, one that resulted in a more ‘medical’ disease model of addiction, appearing to emphasise medicine over morality. The Rolleston report (1926) into morphine and heroin addiction has been characterised as being the epitome of this view, but it could be argued that the medical view of addiction retained moral elements; that science masked an essentially moral discourse.³⁸

Foucault considered the effect of the development of medico-moral discourses in *The History of Sexuality*. He asserted that these produced subjects: for example, a ‘pedagogisation’ of children’s sexuality produced the masturbating child and the ‘psychiatrisation’ of perverse behaviour produced the perverse adult.³⁹ Medical knowledge and expertise accumulated around these subjects, so that an authority on

³⁷ *Ibid.* p. 257. There has also been a considerable amount of work on lunatic asylums in Britain and how here too physicians adopted ‘moral’ methods and made them ‘medical’. See, for example, A. Scull, *Museum of Madness* (New York: 1979); A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven & London: Yale University Press, 1993).

³⁸ The impact of the Rolleston report on views of addiction will be discussed in greater detail below, and in Chapter One. For a discussion of the ‘medical’ view of addiction and the Rolleston report, see V. Berridge, ‘Stamping out addiction’: the work of the Rolleston Committee, 1924-1926’ in H. Freeman & G. Berrios, (eds.) *150 Years of British Psychiatry Vol. 2: The Aftermath* (London: Athlone Press, 1996) 44-60; Berridge, *Opium and the People*, pp. 271-277; Berridge, ‘Concepts of narcotic addiction in Britain, 1820-1926’, p. 84; Parssinen and Kerner, ‘Development of the disease model of addiction’, pp. 289-290.

³⁹ Foucault, *The History of Sexuality*, pp. 103-105.

the particular subject was created. This is a theme that has been developed by Nikolas Rose, in *Governing the Soul*, where he is concerned with how we understand ourselves and how we are understood by those who administer, govern, control and police us. He examines a form of knowledge he calls 'psy,' rising from psychology and affiliated professions, to see how humans make themselves the subjects, objects and targets of knowledge.⁴⁰ Rose argues that regulation based on these 'psy' disciplines and practices created governable subjects by claiming to 'know' the individual.⁴¹ The role of regulation in the production of subjects has received attention from, among others, historians of sexuality. Jeffery Weeks has explored how nineteenth-century regulation of homosexuality led to the 'creation' of the homosexual.⁴² Once more, parallels can potentially be drawn with the regulation of drug use. Farrell Brodie and Redfield argue that: 'Like the homosexual...the addict emerged with development, a little more than a century ago, of a medico-legal discourse capable of preconceiving human identity in the language of pathology.'⁴³ This opens up the possibility that twentieth-century regulation of drugs helped to construct addiction by creating the label 'addict.'

For such an assertion to hold weight 'addiction' and the 'addict' must have a meaning that is agreed upon by all parties involved in regulation; medical, moral, political and so on. The work of Valverde on the alcoholic in the late nineteenth and early twentieth century points to ways in which this identity was undermined, suggesting a challenge to 'the by now conventional Foucauldian thesis regarding the

⁴⁰ N. Rose, *Governing the Soul: The Shaping of the Private Self* (London: Free Association Books, 1999) p. vii.

⁴¹ This is something Rose also discusses in *Inventing Our Selves: Psychology, Power and Personhood* (Cambridge: Cambridge University Press, 1996).

⁴² J. Weeks, *Sex Politics and Society: The Regulation of Sexuality Since 1800* (London: Longman, 1981) pp. 96-117.

⁴³ Farrell Brodie & Redfield, 'Introduction', p. 2.

increasing power of governance through identity categories produced by experts.’⁴⁴

Valverde argues that the medicalisation of alcoholism was damaged by its conception as a disease of the will; alcoholism was not a disease because the only cure lay in the exercise of the patient’s will. She asserts that the discourse of medical experts on alcoholism was constantly being undermined by references to vice and habit.⁴⁵

Valverde explores tensions between medical and moral approaches to addiction ignored by other commentators. She argues that alcoholism was not a coherent diagnosis. The medical profession could not agree on a universally accepted definition of alcoholism or approved treatment method. The medicalisation of alcoholism could, therefore, be said to have failed, but, as Valverde points out, ‘perpetually failing regulatory projects ought not to be simply dismissed as “failures”’: they can be analysed in order to illuminate the structural dilemmas involved in disciplining “deviants” in a liberal society of “free” individuals.’⁴⁶

Valverde’s exposure of tensions within the medicalisation of alcoholism is particularly useful for an exploration of changes in addiction over the twentieth century. Internal and external pressures on medical views of, and responses to, addiction will form a key theme of this thesis. But, a wider consideration of the historiography of addiction has also indicated that a number of consistencies can be detected in ideas about the habitual use of drugs and alcohol since the seventeenth century, as medical and moral forces worked together, as well as in opposition, to define this as a disease. This thesis will, therefore, consider both continuities and changes in the addiction paradigm. There were a range of conflicts within understandings of and responses to addiction between 1960 and 1989, echoing past

⁴⁴ Valverde, “Slavery from within”, p. 268.

⁴⁵ *Ibid.* p. 257. See also Valverde, *Diseases of the Will*, pp. 24-28, pp. 59-67, pp. 68-75.

⁴⁶ Valverde, “Slavery from within”, p. 257. Valverde draws on a similar argument made by Foucault about the ‘failure’ of the prison in *Discipline and Punish: The Birth of the Prison* (New York: Vintage, 1979) pp. 264-265.

tensions as well as reflecting new ones created by the increasingly 'social' dimension to the debate over addiction. Addiction became a social problem as a result of a dramatic increase in drug use numerically and by new cohorts of the population, as older, middle class, therapeutic users were overshadowed by young, working-class recreational users, but also because of wider changes in views of disease and public health. This brought a range of agencies into addiction, presenting a challenge to the authority of the clinic-based psychiatrist who had largely been responsible for the treatment of this condition since the late 1960s.

The fate of addiction in the mid-to late-twentieth century has not received as much academic consideration as in earlier periods. Like Valverde, Carol Smart has criticised the medicalisation thesis as a way to explain ideas about addiction.⁴⁷ She argues that scientific, legal and moral discourses have intermingled in responses to addiction since the nineteenth century; that no one force was solely responsible for the outcome of drug policy. It would be wrong, she states, to see attempts to regulate drug use in the early twentieth century as the outcome of conflict between, on the one hand, doctors who saw addiction as a disease and, therefore, a medical problem and, on the other, the Home Office which saw it as a moral issue and, therefore, a social problem. She asserts that the medical understanding of addiction was imbued with a sense of morality and that doctors did not work in opposition to the Home Office but with it.⁴⁸ This unity, Smart argues, continued into the 1960s and beyond, and is explained by the fact that the same forms of 'rational' knowledge underlay social and medical views of addiction.⁴⁹ Rachel Lart has criticised Smart for not recognising that there was a change in the way addiction was perceived as a threat to public

⁴⁷ C. Smart, 'Social policy and drug addiction: a critical study of policy development', *British Journal of Addiction*, 79, (1984) 31-39.

⁴⁸ *Ibid.* pp. 35-36.

⁴⁹ *Ibid.* p. 37.

health.⁵⁰ She argues that the medical understanding of addiction shifted between the 1920s and the 1960s, a shift that can be seen in the definition of addiction provided in reports into heroin use. The 1926 Rolleston report considered addiction to be a medical disease, whereas the second Brain report of 1965 suggested that addiction was a social disease.⁵¹ Lart contends that increased surveillance of the addict allowed authorities to see a bigger picture of addiction, to chart the course of disease within the social body.⁵² This paralleled broader changes in public health that stressed the relationship between individuals rather than the environment as a cause of disease. Lart considered further changes in perceptions of addiction during the 1970s and 1980s in her doctorate.⁵³ She asserts that in the 1970s the social disease of addiction was replaced with an individualised psychiatric understanding of the condition. In the 1980s this gave way to the concept of the ‘problem drug taker,’ a notion that widened the range of problems associated with drug use but also opened up drug use to something closer to a life-style than a disease by suggesting that drug use was a choice, not a compulsion.⁵⁴

These arguments require investigation in greater detail, but it is worth raising a few points at this stage. Firstly, Lart’s characterisation of addiction as a social disease in the 1960s, a psychiatric disease in the 1970s and a lifestyle choice in the 1980s suggests a degree of coherence and agreement on addiction that was simply not present. This periodisation might represent the dominant view in each decade, but by no means the only one. Indeed, what perhaps dominates the history of addiction is the continuing and considerable conflicts over its treatment both within medicine itself

⁵⁰ R. Lart, ‘Changing images of the addict and addiction’ <http://www.drugtext.org/articles/92333.html>, 1-8. Also in *International Journal on Drug Policy*, 1, (1992), 118-125.

⁵¹ See Chapter One for a deeper consideration of this change and the reasons behind this.

⁵² Lart, ‘Changing images of the addict and addiction’, p. 4.

⁵³ R. Lart, *HIV and English Drug Policy*, Ph.D thesis, University of London, 1996.

⁵⁴ *Ibid.* p. 50.

and between medicine and other interested bodies and authorities. These tensions need to be explored in more detail. Secondly, Lart's emphasis on change ignores some important continuities. The social dimension to addiction did not disappear with the intervention of psychiatry; it took on different forms or became the responsibility of other actors but continued to play a significant role in shaping responses to addiction. Neither did disease-based understandings of addiction vanish with the creation of the 'problem drug taker'; some may have described drug use as a lifestyle choice but this was something quite different to the disease of addiction. Lart's periodisation is, however, useful as a guide to shifting ideas about addiction between 1960 and 1989, and will be referred to throughout this thesis.

2. What was a drug? The historiography of drugs

Work on the emergence or development of the concept of addiction is just one strand of a broader historiography that deals with patterns of drug use and regulation throughout the past. As with addiction, there are problems with definitions. Andrew Sherratt has stated that the term 'drug' 'is used for a category of substances taken into the body for purposes other than nutrition: "drug", in this sense, is opposed to "food".' Within this term there are, he asserts, two broad areas of meaning, 'medicinal preparations and chemically similar compounds consumed primarily for hedonistic purposes – where changes in body chemistry are sought for their psychological rather than physiological effects.'⁵⁵ Even this distinction, however, masks a whole host of binary sub-divisions: legal/illegal, soft/hard, prescription/non-prescription, socially acceptable/socially unacceptable, and so on. And these categories are far from being fixed or stable: the meaning of 'drug' fluctuates over

⁵⁵ A. Sherratt, 'Introduction: peculiar substances' in J. Goodman, P. Lovejoy & A. Sherratt (eds.), *Consuming Habits: Drugs in History and Anthropology*, (London: Routledge, 1995) p. 1.

time, space and context. Cannabis, for example, is a substance that has oscillated between (and within) categories in the past century. Before the 1920s it was a legal (if rarely used in Britain) drug.⁵⁶ Between the 1920s and the 1950s it was illegal and largely socially unacceptable, used by a relatively small, mainly ethnic minority population.⁵⁷ Cannabis remained illegal, but in the 1960s and 1970s it achieved a degree of acceptance amongst many young people as a recreational drug. The 1990s saw increasing pressure for clinical trials of cannabis products for therapeutic purposes, as sufferers of conditions such as multiple sclerosis claimed the drug had beneficial effects.⁵⁸ In 2004, cannabis was downgraded from a Class B to a Class C drug as a result of an Advisory Council on the Misuse of Drugs (ACMD) report which argued that cannabis was less harmful than other drugs placed in the same category created by the Misuse of Drugs Act, 1971.⁵⁹ The government has been quick to point out that re-classification does not mean that the drug is legal; users could still face arrest and up to two years in prison for possession of cannabis.⁶⁰

Boundaries within and between drug categories are, therefore, clearly permeable, defying neat compartmentalism. Yet, the perceived effect of particular substances on the mind, morality, and/or body of the user has evidently played a significant role in determining the response towards these. It is here that ‘addiction’ has been important. Condemnation of a drug has often been linked to the suggestion that it was ‘addictive’; that it compelled the user to continue taking it despite potentially damaging consequences. This section will consider historical approaches

⁵⁶ See J. Mills, *Cannabis Britannica: Empire, Trade and Prohibition 1800-1928* (Oxford: Oxford University Press, 2003).

⁵⁷ Berridge, *Opium and the People*, pp. 280-281; M. Kohn, *Dope Girls: The Birth of the British Drug Underground* (London: Lawrence & Wishart, 1992) pp. 177-190.

⁵⁸ P. Matthews, *Cannabis Culture: A Journey Through Disputed Territory*, (London: Bloomsbury, 1999) pp. 46-55.

⁵⁹ Cannabis was re-classified on 29 January 2004. *The Guardian*, 29 January 2004, p. 4.

⁶⁰ A campaign was launched to inform users that cannabis remains illegal. Advertisements were placed in the national press; see for example, *The Guardian*, 29 January 2004, p. 10.

to drugs that have at some time been considered ‘addictive,’ drawing out parallels and delineating contrasts in order to position the treatment of heroin addiction within a wider historiographical context. It will be seen that the state came to play an increasing role in the regulation of a range of substances over the nineteenth and twentieth centuries. Notions of individual and public health became crucial to this process. There was, therefore, a significant level of cross-fertilisation of ideas about drug use and regulation despite the frequently contrasting regulatory experiences of these. A consideration of historical approaches to drug use and regulation thus facilitates sensitivity to the common themes that relate to heroin as with all drugs, but also to its relative peculiarities.

There are a number of general works on the history of drugs that do allow comparisons to be made. David Courtwright’s *Forces of Habit* is one of the most recent and erudite attempts to link ‘many separate histories in a big picture narrative of the discovery, interchange, and exploitation of the planet’s psychoactive resources.’⁶¹ Courtwright takes a composite approach to the trade, use and regulation of a range of psychoactive substances across the world by comparing what he terms the ‘big three’ – alcohol, tobacco and caffeine with the ‘little three’ – opium, cannabis and coca. According to Courtwright, the scale of production, distribution, consumption and integration into cultures meant that the ‘big three’ were almost impervious to prohibition, whereas the ‘little three’ were less frequently consumed and reformers eventually succeeded in making these the subject of global restriction.⁶² This switch to prohibition was prompted by objections to the non-medical use of drugs. Courtwright argues that these fell into five categories: firstly, that users did direct harm to themselves or others; secondly, that non-medical use inspired criminal

⁶¹ D.T. Courtwright, *Forces of Habit: Drugs and the Making of the Modern World* (Cambridge, Massachusetts & London: Harvard University Press, 2001) pp. 2-3.

⁶² *Ibid.* p. 31.

violence; thirdly, religious disapproval; fourthly, the association of a drug with deviant or disliked groups and finally the perception that drug use endangered the future of the group.⁶³ This is a valuable précis of the potential factors involved in the regulation of drugs, one that could be applied to a range of substances across time and space. *Forces of Habit* is thus a useful introduction to the issues involved in responses to drugs.

Jan-Willem Gerristen has also considered the forces lying behind the regulation of drugs, noting in his history of alcohol and opiates *The Control of Fuddle and Flash*, that the state is usually concerned with the regulation of the consumption of drugs by ‘someone else,’ ‘often outsiders or newcomers: a younger generation, new immigrant groups or a combination of the two.’⁶⁴ Gerristen compares patterns of regulation across time and between countries, looking particularly at England, the Netherlands and the USA. His approach highlights contrasting systems of control; the prohibitive American Harrison Narcotic Act of 1914 has, for example, frequently been compared to the supposedly ‘liberal’ ‘British System’ of drug control which permitted the prescription of drugs to addicts.⁶⁵ In addition, Gerristen’s focus on ‘England’ rather than ‘Britain’ raises an interesting issue. Though the two terms are often conflated when discussing the British drug policy, this was not the same across the entire British Isles. For example, DDUs were not introduced in Scotland in 1968; the treatment of addicts remained in the hands of general psychiatrists and GPs throughout the 1970s, 1980s and beyond. This anomaly has not been sufficiently

⁶³ *Ibid.* pp. 168-171.

⁶⁴ J.W. Gerristen, *The Control of Fuddle and Flash: A Sociological History of the Regulation of Alcohol and Opiates* (Leiden: Brill, 2000) p. 5.

⁶⁵ The significance of the ‘British System’ and the comparisons made with American drug control will be discussed in greater detail in Chapter One. For an analysis of American drug regulation see D. Courtwright, *Dark Paradise: Opiate Addiction in America Before 1940* (Cambridge, Massachusetts & London: Harvard University Press, 1982); C.J. Acker, *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control* (Baltimore: John Hopkins University Press, 2002); J. Jones, *Hep-Cats, Narcs and Pipe Dreams: A History of America’s Romance With Illegal Drugs* (Baltimore: John Hopkins University Press, 1999).

explored. Indeed, it is to the USA that commentators have usually looked for contrasts with UK policy rather than to the home nations or other European countries.⁶⁶ Further research into cross-national parallels is needed and would complement a growing literature on cross-cultural comparisons. Two recent edited volumes Jordan Goodman, Paul Lovejoy and Andrew Sherratt's *Consuming Habits* and Roy Porter and Mikaus Teich's *Drugs and Narcotics in History* have focused on the use, as opposed to regulation, of drugs.⁶⁷ *Consuming Habits* is wider in terms of geographical spread, analysing drug use throughout Europe, North and South America, Asia and Africa, whereas *Drugs and Narcotics in History* is more Euro-centric. Both books cover a broad range of time-periods from prehistory to the present day and both expand perceptions of what constitutes a drug by considering a diverse range of substances. Such an approach suggests an interesting paradox between the continued cultural specificity of some substances such as qat or betel and the ubiquity of others, such as alcohol or tobacco. This is perhaps because, as Goodman and Lovejoy indicate, 'those substances that entered international commerce...as a result of their appropriation by Europeans in the early modern period are especially visible,' but this does not solve the question of why Europeans took away some substances for consumption and not others.⁶⁸

In addition to these scholarly works, the history of drug use has attracted the publication of a number of largely anecdotal accounts such as Brian Inglis' *The Forbidden Game* and more recently, Kevin Williamson's *Drugs and the Party Line*

⁶⁶ See, for example, A. Trebach, *The Heroin Solution* (New Haven & London: Yale University Press, 1982) and E. Schur, *Narcotic Addiction in Britain and America: The Impact of Public Policy* (Bloomington & London: Indiana University Press, 1962).

⁶⁷ Goodman, Lovejoy & Sherratt, *Consuming Habits*; R. Porter & M. Teich, *Drugs and Narcotics in History* (Cambridge: Cambridge University Press, 1995).

⁶⁸ J. Goodman and P. Lovejoy, 'Afterword', in Goodman, Lovejoy & Sherratt, *Consuming Habits*, p. 231.

and Stuart Walton's *Out of It*.⁶⁹ These present interesting, if sometimes questionable, detail, but are generally short on analysis. Furthermore, it is often easy to detect a political agenda which clouds the authors' judgement. Walton, for instance, is clearly in favour of the legalisation of drugs, seeking to liberate us from oppressive laws that deny our rights: 'Intoxication belongs to all of us. It is our birthright, our inheritance and our saving grace.'⁷⁰ This leaves him insensitive to the very real problems created by drug use as he seeks to convince the reader of the benefits of intoxication.

Most approaches to the history of drugs have been devoted to just one substance. Of these, alcohol has received the most attention. Some have considered the place of alcoholic drinks in conjunction with non-alcoholic beverages, such as John Burnett in *Liquid Pleasures*.⁷¹ Others have placed the consumption of alcohol in the framework of 'bad habits,' comparing this to activities such as gambling and swearing.⁷² Most, however, have concentrated on attempts to control drink and drinking during the nineteenth century. Brian Harrison details the efforts of temperance reformers to curb drinking, particularly amongst the working-classes, in *Drink and the Victorians*.⁷³ The temperance movement initially targeted individuals with a campaign of 'moral suasion,' persuading people not to drink alcohol. However, the formation of the United Kingdom Alliance in 1853 to campaign for prohibition of the trade in alcoholic drinks created a split in the movement between the 'moral suasionists' and the 'legislative compulsionists.'⁷⁴ A.E. Dingle considers the work of the United Kingdom Alliance in *The Campaign For Prohibition in*

⁶⁹ B. Inglis, *The Forbidden Game: A Social History of Drugs* (London: Hodder & Stoughton, 1975); K. Williamson, *Drugs and the Party Line* (Edinburgh: Rebel Press, 1997) S. Walton, *Out of It: A Cultural History of Intoxication* (London: Hamish Hamilton, 2001).

⁷⁰ Walton, *Out of It*, p. 264.

⁷¹ J. Burnett, *Liquid Pleasures: A Social History of Drinks in Modern History* (London: Routledge, 1999).

⁷² J.C. Burnham, *Bad Habits: Drinking, Smoking, Taking Drugs, Gambling, Sexual Misbehaviour and Swearing in American History* (New York and London: New York University Press, 1993).

⁷³ B. Harrison, *Drink and the Victorians* (Keele: Keele University Press, 1994).

⁷⁴ *Ibid.* p. 21.

Victorian England.⁷⁵ The Alliance did not achieve a ban on the sale of alcohol and had little success in persuading Parliament to introduce stricter controls either, but this turn to the state rather than the individual to regulate drinking behaviour was a significant move. This suggested that the government had a role to play in controlling alcohol consumption, an important precedent for the later regulation of drugs. Indeed, meaningful controls on the sale of alcohol were swiftly followed by regulation of drugs: the 1915 Defence of the Realm Act that restricted pub opening hours and beer strength was extended in 1916 to prohibit the sale of cocaine, opium and other drugs to members of the armed forces without a prescription.⁷⁶ Work on the regulation of alcohol and its place in society during the mid to late twentieth century is thinner on the ground than that of the nineteenth century. Betsy Thom in *Dealing With Drink* provides one of the few accounts of policy towards alcohol in this period.⁷⁷ Thom's work, particularly on the establishment of specialist Alcohol Treatment Units and the creation, by the Kessel Committee, of the label 'problem drinker' indicates a significant level of cross-fertilisation between alcohol and drug policy which requires further investigation.⁷⁸

Analysis of policy towards tobacco in twentieth-century Britain has been more extensive, expanding considerably in recent years. The regulation of tobacco has

⁷⁵ A.E. Dingle, *The Campaign For Prohibition in Victorian England* (London: Croom Helm, 1980). See also A.E. Dingle, 'Drink and working-class living standards in Britain, 1870-1914' *Economic History Review*, 25 (1972) 608-622.

⁷⁶ This legislation will be discussed in greater detail below, and in Chapter One. See V. Berridge, 'War conditions and narcotics control: the passing of DORA 40B', *Journal of Social Policy*, 7, (1978) 285-304; V. Berridge, 'Drugs and social policy: the establishment of drug control in Britain, 1900-1930', *British Journal of Addiction*, 80, (1985) 233-243; V. Berridge, *Opium and the People*, pp. 246-257; Kohn, *Dope Girls*, p. 29, p. 39, pp. 43-44.

⁷⁷ B. Thom, *Dealing With Drink: Alcohol and Social Policy From Treatment to Management* (London: Free Association Books, 1999). Others have considered the place of alcohol in society, R. Baggott from a social policy perspective in R. Baggott, *Alcohol, Politics and Social Policy* (Aldershot: Avebury, 1990) or using a political science approach such as J. Greenaway, *Drink and British Politics Since 1830: A Study in Policy Making* (Basingstoke: Palgrave Macmillan, 2003) and J. Greenaway, 'Policy learning and the drink question in Britain, 1850-1950', *Political Studies*, 46, (1998) 903-918.

⁷⁸ This is considered in this thesis in Chapter 1 pp. 59-60, and Chapter 2, p. 120. B. Thom, *Dealing With Drink*, pp. 50-66, pp. 120-125; B. Thom & V. Berridge, ' "Special units for common problems": the birth of alcohol treatment units in England', *Social History of Medicine*, 8, (1995) 75-93.

centred predominantly on the potential damage to health caused by smoking. Issues of smoking and health were considered at a symposium at the Wellcome Institute in 1995, resulting in an edited collection of papers entitled *Ashes to Ashes*. Matthew Hilton and Simon Nightingale examined the role of the anti-tobacco movement in the creation of the 1908 Children's Act, which made it illegal to sell tobacco to anyone under the age of 16. Once more, the extent of the relationship between morality and medicine is highlighted, as Hilton and Nightingale demonstrate that the anti-tobacco movement employed both religious and scientific arguments against the use of tobacco by juveniles.⁷⁹ 'Health' was used to legitimate previously moral concerns. In the same collection, Virginia Berridge explored the role of science in determining post-war policy and in more recent work she has also considered how policy 'speaks' to science, particularly through issues such as passive smoking. The implied risk to the health of all, rather than the individual smoker, through passive smoking suggests a social dimension to the regulation of drugs in their broadest sense as the state intervenes to protect the health of non-smokers as well as smokers.⁸⁰ Hilton also analyses the role of scientific and medical evidence in the creation of policy towards tobacco in *Smoking and British Popular Culture*. His consideration of the reception of ideas about the damage to health posed by cigarettes and the place of smoking and smokers in popular culture does, however, suggest limitations to the power of appeals to health as more positive representations of smoking in media, such as film,

⁷⁹ M. Hilton & S. Nightingale, "'A Microbe of the Devil's Own Make': religion and science in the British anti-tobacco movement, 1853-1908" pp. 41-77, in S. Lock, L. Reynolds & E.M. Tansey, *Ashes to Ashes: The History of Smoking and Health*, (Rodopi: Amsterdam, 1998). For a further elaboration of issues connected to juvenile smoking see also M. Hilton, "'Tabs", "Fags" and the "Boy Labour Problem" in late Victorian and early Edwardian Britain' *Journal of Social History*, 28, (1995) 587-607; M. Hilton, *Smoking in British Popular Culture 1800-2000* (Manchester: Manchester University Press, 2000) pp. 192-175; J. Welshman, 'Images of youth: the issue of juvenile smoking, 1880-1914', *Addiction*, 91, (1996) 1379-1386.

⁸⁰ V. Berridge, 'Science and policy: the case of post-war smoking policy' pp. 143-163 in Lock, Reynolds & Tansey, *Ashes to Ashes*; V. Berridge, 'Passive smoking and its pre-history' *Social Science and Medicine*, 49, (1999) 1189-1195.

subverted or even inverted the anti-smoking message.⁸¹ This illustrates the complex and sometimes contradictory relationship between health and policy in relation to drugs and individual behaviour.

Indeed, as James Mills has shown in relation to British policy on cannabis, damage to health was not always the most important factor in motivating the development of regulation to control drugs and drug taking. Domestic policy on cannabis was shaped by international politics, the result of Egyptian insistence that the drug be included on the list of substances to be subjected to worldwide trade restrictions agreed at the Second Opium Conference in Geneva in 1924.⁸² Cannabis was subsequently regulated under the Poisons Schedule, despite medical and scientific opinion that suggested the drug was not substantially harmful to health.⁸³ It is important to remember, however, as Mills indicates, that cannabis was rarely used in Britain before the 1950s, with substantial use only taking place in British colonies, particularly on the Indian sub-continent. Cannabis was not considered a threat to British health because it was simply not used here on any scale.

Mills' book is the first to deal seriously with cannabis use in the past; most other accounts have tended to concentrate on largely apocryphal stories and conspiracy theories.⁸⁴ Indeed, this has been the tone of many histories of drugs and drug use. Work on the history of LSD in particular has emphasised links to the CIA and international espionage rather than concentrating on domestic use or regulation.⁸⁵

⁸¹ Hilton, *Smoking in British Popular Culture*, pp. 179-223, pp. 224-244.

⁸² Mills, *Cannabis Britannica*, pp. 152-187. See also D. Bloom, 'A Potted History': *British attitudes towards cannabis 1920-1928*, unpublished BA Dissertation, University of Birmingham, 2004.

⁸³ Mills, *Cannabis Britannica*, pp. 204-207. According to Mills, the Indian Hemp Drug Commission investigated the potentially damaging effects of cannabis on health (particularly its perceived deleterious effect on sanity) in some detail and concluded that moderate use of the drug was largely harmless. See *Ibid.* pp. 124-151.

⁸⁴ Mills presents a critique of this literature in *Ibid.* pp. 12-13.

⁸⁵ See, for example, D. Black, *Acid: The Secret History of LSD* (London: Vision, 1998); M.A. Lee & B. Schlain, *Acid Dreams – The Complete Social History of LSD: The CIA, The Sixties and Beyond* (New York: Grove Weidenfeld, 1992). Connections have also been made between the CIA and international

There is, however, a growing body of academic work on the history of drugs that considers drug policy in more detail. Of all the currently illegal drugs opium and its derivatives have received the most attention. Berridge's *Opium and the People* is an extensive and authoritative account of the use of opium in the nineteenth and (in the revised edition) early twentieth centuries. Two key themes emerge that are central to more recent encounters with drugs. Firstly, Berridge shows how the use of opium became a matter of public health as infant doping and self-poisoning with the drug posed a potential danger to the health of the population. Secondly, Berridge indicates that 'the question of who was using the drug – and how – was also important.'⁸⁶ The belief that the working-classes were taking opium for its 'stimulant' properties in a 'non-medical' context resulted in the construction of the 'opium problem.'⁸⁷ Opium use amongst the working-class was thought to be damaging to morality and detrimental to production, echoing elements of the temperance movement's attack on alcohol. This combination of public health and fears about working-class 'stimulant' use prompted the inclusion of opium on the list of poisons regulated by the 1868 Pharmacy Act.⁸⁸ But, as Berridge points out, upper-class social controllers largely misunderstood or misinterpreted working-class use of opium, that the boundaries between non-medical and medical use were blurred.⁸⁹ Nonetheless, a distinction was made between 'use' (medical) and 'abuse' (non-medical) that persisted into the twentieth century and beyond.

The Victorian relationship with drugs is also considered by Terry Parssinen in *Secret Passions, Secret Remedies*. Parssinen covers essentially the same ground as

trade in heroin. See A. McCoy, *The Politics of Heroin: CIA Complicity in the Global Drug Trade* (New York: Lawrence Books, 1991).

⁸⁶ Berridge, *Opium and the People*, p. 97.

⁸⁷ *Ibid.* pp. 105-109.

⁸⁸ *Ibid.* pp. 113-122.

⁸⁹ *Ibid.* pp. 105-109.

Berridge, though he does make more of the literary representation of opium, a theme that has been extensively explored by Alethea Hayter, and more recently in relation to a wider range of substances, by Sadie Plant and Marcus Boon.⁹⁰ Martin Booth's *Opium: A History* is a more journalistic account, tracing the drug from ancient times to the present day as well as emphasising the international dimensions to the history of opium, particularly through trade.⁹¹ There is considerably less work on the use of opiates and opioids in the twentieth century despite this being the era in which substantial regulation to control these was introduced for the first time.⁹² The work of Berridge again proves instructive. In a series of articles, and in the revised edition of *Opium and the People*, she examines the regulation of drugs in early twentieth century Britain. Though there was a fairly limited amount of what could be termed 'recreational' use of drugs in this period, concerns were raised about cocaine use amongst troops, resulting in the introduction of the Defence of the Realm Act in 1916, which restricted the sale of opium, morphine, cocaine and other drugs to members of the armed forces.⁹³ This was later extended to include the general population in a climate of 'moral panic' about the use of drugs through the Dangerous Drugs Act of 1920. It is here, perhaps, that Berridge could have made more of her material. Marek Kohn, in *Dope Girls*, adds considerable illustrative flesh to Berridge's outline sketch of the drug 'underworld' of early twentieth century London.⁹⁴ Kohn deals with the popular response to drug taking in newspapers, fiction and film. He argues that drug

⁹⁰ Parssinen, *Secret Passions, Secret Remedies*; A. Hayter, *Opium and the Romantic Imagination: Addiction and Creativity in De Quincey, Coleridge, Baudelaire and Others* (Wellingborough: Crucible, 1988); S. Plant, *Writing on Drugs* (London: Faber & Faber, 1999); M. Boon, *The Road of Excess: A History of Writers on Drugs* (Cambridge, Massachusetts & London: Harvard University Press, 2002).

⁹¹ M. Booth, *Opium: A History* (London: Pocket Books, 1996).

⁹² 'Opiate' is the technical term for a drug derived from the opium poppy, such as opium, or black market heroin. 'Opioid' is the technical term for drugs which are chemically similar but are produced synthetically rather than refined from the poppy itself, such as methadone.

⁹³ V. Berridge, 'Drugs and social policy: the establishment of drug control in Britain, 1900-1930', *British Journal of Addiction*, 80, (1985) 233-243; V. Berridge, 'The origins of the English drug "scene" 1890-1930', *Medical History*, 32, (1988), 51-64; Berridge, *Opium and the People*, pp. 235-267.

⁹⁴ Kohn, *Dope Girls*.

stories and the panic about drug use were a way of articulating deeper fears about the changing social position of women and the immigration of racial minorities: in his terms, ‘drugs permit the terrors of the social subconscious to be voiced.’⁹⁵ By drawing out the themes of race and gender that underpinned this moral panic Kohn more fully places responses to drugs in their social and cultural context.

Kohn does not, however, pay much attention to medical reactions to opiate use, something Berridge analyses in more detail. She examines the forces at work within the Rolleston committee of 1925, tasked with determining whether or not there was a medical case for the continued prescription of morphine and heroin to patients addicted to these.⁹⁶ The committee decided that since addiction was a disease this was permissible (in certain circumstances), as prescription of the drug alleviated the condition. This conclusion, and the report in which it was encapsulated, (the Rolleston report, 1926) has been a key reference point for accounts that deal with drug policy after the 1920s. Richard Davenport-Hines considers the regulation of heroin and other drugs in the mid to late twentieth century in the context of a wider exploration of narcotics from 1500 to 2000, focusing primarily on British and American drug policy.⁹⁷ His account of the post-Rolleston period makes use of selected government papers, newspaper reports, articles in medical journals and interviews with some leading protagonists.⁹⁸ These do present a useful picture of events, but Davenport-Hines has been somewhat selective in his use of evidence and particularly his choice of interviewees. Davenport-Hines has spoken to leading critics of drug policy between 1965 and 1989 such as Ann Dally, Dale Beckett and Kenneth Leech, but not to its defenders, such as Thomas Bewley or Martin Mitcheson. Too

⁹⁵ *Ibid.* p. 2.

⁹⁶ Berridge, “Stamping out addiction”, pp. 44-60; Berridge, *Opium and the People*, pp. 271-278.

⁹⁷ R. Davenport-Hines, *The Pursuit of Oblivion: A Global History of Narcotics 1500-2000* (London: Weinfeld & Nicholson, 2001).

⁹⁸ *Ibid.* See particularly pp. 319-330, pp. 367-383.

often, Davenport-Hines accepts the arguments of his subjects uncritically and uses their words to attack drug policy in this period without adequately presenting the alternative view. *The Pursuit of Oblivion* does not sufficiently engage with both sides of the treatment debate in the 1980s. In addition, though Davenport-Hines' attempts to situate his analysis of policy towards heroin within a wider consideration of drug politics by, for example, relating shifting attitudes on the treatment of heroin addiction to the American led 'war on drugs,' does point to a wider political dimension, this is at the cost of ignoring the peculiarities of the treatment debate in Britain. This was remarkably insular, with policy primarily being directed by clinicians not politicians, something Davenport-Hines fails to sufficiently emphasise.

A stronger picture of the extent of medical involvement in policy emerges from Bing Spear's *Heroin Addiction Care and Control*.⁹⁹ Spear was the Chief Inspector of the Home Office Drugs Branch from 1977 until his retirement in 1986. His book presents an invaluable insider's account of heroin addiction treatment in the period under consideration based primarily, but not exclusively, on his own observations and experiences as an actor in the shaping of policy. This is the book's great asset, but also its great flaw: it is not a balanced work of history but a personal account and Spear's own view (which is nonetheless important) dominates throughout. *Heroin Addiction Care and Control* is extremely detailed and well referenced. Spear (and his posthumous editor, Joy Mott) utilise a range of government papers, Parliamentary debates and journal articles to support Spear's contention that 'the moral high ground was seized by a small group within the medical establishment, and by psychiatrists in particular, who, over the years succeeded in implanting their own ethical and judgemental views on treatment

⁹⁹ H.B. Spear, *Heroin Addiction Care and Control: The British System 1916-1984* (London: Drugscope, 2003).

policy.’¹⁰⁰ Spear’s arguments will be dealt with in more detail throughout the thesis, but it is important to note that though his contention that policy was primarily directed by a small group of consultant psychiatrists is broadly correct, he does not provide a sufficient explanation as to how and why this group were able to direct policy. This thesis aims to answer these key questions by considering the nature of clinical psychiatry’s claim to expertise.

The benefits and drawbacks of Spear’s book illustrate a wider problem with sources that besets historical analysis of the recent past. Whilst there is relatively little historical work on drug policy between 1960 and 1989, there is a plethora of other texts that deal with this subject published during the period in question and from a range of perspectives. The boundary between primary and secondary sources, between active participant and historical commentator, is often indistinct. For example, Professor of Jurisprudence, Arnold Trebach’s *The Heroin Solution* provides useful detail and historical analysis of the so-called ‘British System’ of heroin addiction treatment from the establishment of the Rolleston Committee to the end of the 1970s.¹⁰¹ But, the book was published in 1982 and it includes a section on Trebach’s vision for future treatment services. Trebach was a supporter of the long-term prescription of drugs to addicts and he clearly had a position on the debates he was describing. This is also the case with numerous other texts: Edwin Schur’s *Narcotic Addiction in Britain and America* (1962); Max Glatt’s *The Drug Scene in Great Britain* (1967); Norman Imlah’s *Drugs in Modern Society* (1970); Jock Young’s *The Drugtakers* (1971); Horace Freeland Judson’s *Heroin Addiction in Britain* (1973); Gerry Stimson and Edna Oppenheimer’s *Heroin Addiction: Treatment and Control in Britain* (1982) and Marek Kohn’s *Narcomania* (1987), to name but a

¹⁰⁰ *Ibid.* p. 310.

¹⁰¹ Trebach, *The Heroin Solution*.

few.¹⁰² All have a personal perspective; many played an active role in the processes they are describing. The same can be said of more recent edited collections of articles on drug addiction treatment by academics that contain pieces by leading protagonists, such as John Strang and Michael Gossop's *Heroin Addiction and Drug Policy* or Susanne MacGregor's *Drugs and British Society*.¹⁰³ Again, these need to be examined carefully and not accepted uncritically. This body of work is extremely useful in building up a picture of heroin addiction treatment policy between 1965 and 1987, but balanced historical analysis that engages with the wider issues involved is required.

3. Sources and thesis outline

In order to expose and understand the processes that shaped heroin addiction treatment in this period this thesis will make use of a range of sources to examine heroin addiction treatment policy from the mid 1960s until the late 1980s, before HIV and AIDS. The impact of AIDS on drug policy will be discussed in the Conclusion as a separate influence and as a way of reflecting back on the main issues discussed in the rest of the thesis. Printed primary sources utilised throughout the thesis include books (such as those mentioned above), articles, letters and comment pieces in medical journals and newspapers, Parliamentary debates, committee reports and published oral history sources, particularly a series of interviews with leading protagonists conducted by the *British Journal of Addiction* (now called *Addiction*).

¹⁰² Schur, *Narcotic Addiction in Britain and America*; M. Glatt, et al., *The Drug Scene in Great Britain: Journey Into Loneliness* (London: Edward Arnold, 1967); N. Imlah, *Drugs in Modern Society* (London: G. Chapman, 1970); J. Young, *The Drugtakers: The Sociological Meaning of Drug Taking* (London: Paladin, 1971); H.F. Judson, *Heroin Addiction in Britain* (New York: Harcourt, Brace & Jovanovich, 1973); G.V. Stimson, & E. Oppenheimer, *Heroin Addiction: Treatment and Control in Britain* (London: Tavistock, 1982); M. Kohn, *Narcomania: On Heroin* (London: Faber & Faber, 1987).

¹⁰³ J. Strang & M. Gossop (eds.), *Heroin Addiction and Drug Policy: The British System* (Oxford: Oxford University Press, 1994); S. MacGregor (ed.), *Drugs in British Society: Responses to a Social Problem in the 1980s* (London: Routledge, 1989).

The thesis also makes use of a variety of types of archival material. Chapter One utilises government papers (particularly those of the Ministry of Health) held at the Public Record Office. This material is extremely useful for assessing how policy at the beginning of this period was formulated, but it has been much more difficult to find papers on the practical implementation of policy. Hospitals have rarely retained administrative records and those that do exist are often closed for reasons of patient confidentiality.¹⁰⁴ Of the 14 London teaching hospitals that established DDUs in the late 1960s only two had kept any record of this, and these were merely passing references in annual reports and governors' meetings for St Thomas' Hospital and the Westminster Hospital Group, held at the London Metropolitan Archive. No administrative records for the clinics themselves could be found.¹⁰⁵ This does not, however, mean that a picture of how these operated cannot be discerned. Gerry Stimson and Edna Oppenheimer conducted an extensive study of London DDU operating procedures between 1969 and 1979 and Carol Smart carried out a national survey of DDU treatment policies in 1982.¹⁰⁶ In addition, there are a number of accounts of clinic procedures and methods by the psychiatrists that ran these in contemporary medical journals.¹⁰⁷

¹⁰⁴ In 1991 and 1995 Philip Connell sent two documents he thought might be of historical interest to the *British Journal of Addiction* instead of throwing them away. See P.H. Connell, 'Document: treatment of drug-dependent patients, 1968-1969', *British Journal of Addiction*, 86, (1991) 913-915 and P.H. Connell, 'Historical note: organisation of the treatment and supervision of heroin addiction', *Addiction*, 90 (1995) 843-845. This is indicative of a wider problem where hospitals and those involved in the creation of health policy have only just begun to realise that their administrative papers should be retained.

¹⁰⁵ I wrote to all of the London teaching hospitals in October 2001, and none had kept these records.

¹⁰⁶ Stimson & Oppenheimer, *Heroin Addiction*; C. Smart, 'Drug Dependence Units in England and Wales: the results of a national survey', *Drug and Alcohol Dependence*, 15, (1984) 131-144.

¹⁰⁷ See, for example: R. Gardner & P. Connell, 'One year's experience in a drug-dependence clinic', *Lancet*, (29 August 1970) 455-458; R.C. Hicks, 'The management of heroin addiction at a general hospital drug addiction treatment centre', *British Journal of Addiction*, 64, (1969) 235-243; H.H. Blumberg, 'British users of opiate-type drugs: a follow up study', *British Journal of Addiction*, 71, (1976) 65-77; A.H Ghodse, 'Treatment of drug addiction in London', *Lancet*, (19 March 1983) 636-638; P.H. Connell & M. Mitcheson, 'Necessary safeguards when prescribing opioid drugs to addicts: experience of drug dependence clinics in London', *British Medical Journal*, 288, (10 March 1984) 767-

Extensive use has been made of a collection of personal papers that reveal much about the debates within drug treatment policy in this period and provide material that is simply unavailable elsewhere. Dr Ann Dally was an important figure in the treatment of heroin addiction in this period. She was a leading private psychiatrist involved in the treatment of addiction, an outspoken critic of the clinics and short-term withdrawal, a vocal advocate of maintenance treatment, was the founder of an organisation to improve the position of the non-clinic doctor in the treatment of addiction, a member of a Department of Health and Social Security (DHSS) working group on the production of guidelines of good practice and a frequent contributor to debates on the treatment of addiction in medical journals. It was, however, Dally's appearances before the General Medical Council (GMC) on two separate occasions for serious professional misconduct as a result of prescribing irresponsibly to addict patients, for which she was most renowned. These cases will form the focus of Chapter Three and Chapter Five, but it is argued that they were brought within the context of a wider treatment debate; these cases were representative of disputes within the medical community about the treatment of addiction. The nature and origin of these disputes will be discussed in Chapter Two and Chapter Four. Again, these chapters make use of the Dally papers, coupled with analysis of two central reports on the treatment of heroin addiction, the ACMD's *Treatment and Rehabilitation* and the DHSS's *Guidelines on Good Clinical Practice in the Treatment of Drug Misuse*, and relevant articles, letters and comment pieces in medical journals and newspapers.

Using other sources in addition to the Dally archive is important because this collection clearly has limitations. Dally's papers are often only able to shed light on

769; J. Love & M. Gossop, 'The process of referral and disposal within a London drug dependence clinic', *British Journal of Addiction*, 80, (1985) 435-440.

one side of the debate. They can reveal much about the ‘defence’ of the GMC cases for example, but rather less about the ‘prosecution’ of these. It is easier, therefore, to investigate Dally’s actions and motivations than to get at those of the GMC. This problem is compounded by the fact that comparable papers illustrating the GMC’s perspective are currently unavailable. It is possible that the introduction of the Freedom of Information Act in 2005 might open up access to these papers, if they have been retained, but they were unobtainable at the time of writing, and issues of patient confidentiality would probably prevent these being opened in any case. Subsequently, a focus on the Dally archive is justified for three reasons. Firstly, an analysis of Dally’s view is in itself valid, as she was a key figure in the debate over the treatment of addiction in this period. Understanding her position affords a crucial insight into one side of this debate. Secondly, as indicated above, accessing the other side of the dispute is difficult. There are no sources currently available which allow for an adequate analysis of the DDU or GMC point of view. Finally, the Dally collection itself is now largely closed, as a result of patient confidentiality, for various time periods from 2076 to 2095.¹⁰⁸ Material closed includes the transcripts of both the GMC cases and the papers relating to these. Research for this thesis was conducted before the collection had been catalogued and with the depositor’s permission, so unlimited access was granted. By making use of this material a unique and now largely unrecoverable (at least in living memory) perspective can be explored.

Moreover, the nature of the Dally collection before it was catalogued would suggest that this is not as wholly one-sided as might be expected. The haphazard organisation of material, the inclusion of irrelevant personal items and paraphernalia

¹⁰⁸ A full catalogue of the Dally papers detailing the collection and indicating the access status individual files is available from CMAC at the Wellcome Library and in a limited format online at <http://library.wellcome.ac.uk>.

such as knitting patterns, alongside important documents such as letters from the GMC, indicates that the collection was not carefully sorted before being deposited. Indeed, the presence of material that did not necessarily present Dally in a positive light, such as transcripts of interviews with Home Office Drugs Inspectors, would suggest that there was no deliberate attempt to limit the deposit to only those documents that would support a favourable analysis of Dally's work. Though any account of Dally's actions based solely on Dally's papers would naturally remain biased, relating these to other sources and setting them in context allows a more balanced picture to emerge. That this remains more representative of one side of the debate than the other is understandable, and given the lack of other currently accessible sources, excusable.

The thesis begins with a consideration of how forces characterised as either 'social' or 'medical' shaped the development of heroin addiction treatment policy between 1960 and 1979. Chapter One will argue that whilst both forces were important in directing policy, by the 1970s a particular view of addiction treatment based on principles of clinical practice was increasingly dominant. 'Social' aspects of heroin addiction treatment were retained but took on different forms and were diverted to other areas. This interaction between the social and the medical can be observed in three key areas considered in Chapter One: the introduction of the DDUs in 1968; the increasing involvement of psychiatry; and the changes in the treatment of addiction offered at the DDUs. These had a number of significant implications which will be investigated in the rest of the thesis. As the changes in treatment methods and practices rose from the clinical setting, DDU psychiatrists themselves became the leading authorities on the treatment of addiction. This was vitally important in debates over who should be responsible for the treatment of addiction and what this

should comprise during the 1980s. DDU psychiatrists were seen as the experts on the treatment of addiction and their views and methods were presented as orthodoxy. A consensus on treatment amongst these doctors meant that the same type of treatment was offered to all addicts at all clinics. DDUs became increasingly homogenous. However, this homogeneity inside the clinical sphere encouraged heterogeneity away from the DDU. Increasing numbers of community-based physicians (in both private and general practice) encountered addicts as those dissatisfied with the treatment offered in clinics sought alternatives elsewhere.

Chapter Two considers the resulting tension between specialists (hospital-based DDU psychiatrists) and generalists (community-based general practitioners) over the treatment of addiction. In part, this conflict was rooted in an older divide between specialism and generalism, aggravated by a renaissance in general practice revitalised by its encounter with biographical medicine. Within the treatment of addiction, however, there were additional pressures on the relationship between specialist and generalist. Although many specialists recognised that wider participation in the treatment of addiction by GPs was needed to cope with the increasing numbers of heroin addicts they wanted to control and direct this involvement as it posed a threat to their newly found expert status. At the same time, the position of medicine as the leading authority on drug problems was at risk, as a greater range of agencies and different forms of expertise were beginning to participate in the development of policy. Clinical psychiatrists needed to demonstrate that they were the experts on heroin addiction both to their colleagues within medicine and to other external bodies and individuals.

An additional threat to this authority was posed by the growing involvement of private practitioners in the treatment of addiction. Chapter Three contrasts state

provided care with the treatment of addiction in private practice. The homogeneity of clinics drove some addicts away from treatment on the NHS altogether and they subsequently approached doctors in private practice for help. However, psychiatrists working at NHS DDUs argued that the treatment of addiction in private practice was inappropriate, even dangerous. They asserted that the payment of fees for treatment involving the prescription of opioid drugs was problematic. Addicts might resort to selling some of their prescription in order to pay the doctor's bill, and doctors might prescribe unnecessarily in order to continue receiving their fee. These were issues raised during the Dally case, which came before the GMC in 1983. Dally was accused of prescribing opioid drugs to an addict patient in an irresponsible manner. Closer analysis of the case and the context in which it was brought, however, reveals that this was part of an attack on the treatment of addiction in private practice led by DDU psychiatrists who saw private practitioners as a threat to their authority. As many private practitioners involved in the treatment of heroin addiction were psychiatrists the threat they collectively posed was not to the existence of the treatment of addiction as an area of psychiatric expertise (as with GPs), but was instead an assault on the authority of the particular practices (and those who developed them) of the DDU. The treatment of addiction in private psychiatric practice suggested that there was an alternative locus of expertise in the field, one that existed away from the clinic.

The potency of this threat was enhanced by the fact that doctors involved in the treatment of addiction away from the clinic (whether in private or general practice) frequently offered a different type of treatment to addict patients. Most DDUs practised short-term withdrawal treatment. This comprised of the rapid withdrawal of the drug from the addict over a few weeks, at the end of which they

would be ‘drug-free’ or ‘abstinent.’ It could then be said that the addict was ‘cured’ as he or she was no longer taking their drug of addiction. Many non-DDU doctors offered a different type of treatment. Community-based physicians in private and general practice frequently advocated the long-term prescription of opioid drugs to addicts, a form of treatment known as ‘maintenance.’ Champions of maintenance argued that the addict could not be forced to come off drugs within a specified period, but needed encouragement and help to re-build a stable life before considering removal of the drug altogether. This treatment was aimed not so much at getting the addict off drugs but was instead targeted at enhancing the social functioning of the patient; improving relationships, employment status and health.

Chapter Four will examine the conflict between those who supported short-term withdrawal and those who advocated maintenance for the treatment of heroin addiction. It will argue that this dispute was underpinned by a wider clash between contrasting philosophies of medicine and views on the treatment of disease. It was significant that supporters of short-term withdrawal were largely to be found in NHS DDUs and those who called for long-term maintenance were often in private or general practice. The relative position of these groups, the environment in which they existed and the type of medicine they practised fundamentally affected their understanding of addiction and its treatment. Doctors working in hospital-based DDUs practised clinical medicine. This concerned the diagnosis, treatment and, most importantly of all, *cure*, of disease. The short-term withdrawal treatment offered to addicts in DDUs conformed to these principles; a more ‘medical’ approach to addiction. In contrast, private and general practitioners operating outside hospitals frequently practiced biographical medicine, an approach often characterised as ‘social.’ Here more emphasis was placed on the experience of the sick individual, not

just on ridding them of disease. This explains why private and general practitioners treating addicts developed treatment programmes concentrating on the needs of each patient and were less concerned with rapid removal of drugs and the 'cure' of their condition. It is therefore argued that conflict over the treatment of addiction during the 1980s was caused as much by a clash between different approaches to sickness and disease as by specific concerns about who should treat the addict or how they should be treated.

Caution, however, should be exercised as this divide can be overstated. There were DDU doctors who supported maintenance and private and general practitioners who advocated short-term withdrawal. Furthermore, rapid withdrawal remained the orthodox method of treatment in the mid 1980s and clinicians retained their dominant position within heroin addiction treatment policy. This can be seen in the production of the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* in 1984. Disputes within the working group tasked with the creation of the guidelines by the DHSS were a microcosm of the debate on the treatment of addiction. Analysis of the workings of this committee and the report they produced illustrates the ascendancy of short-term withdrawal as the orthodox treatment method for addiction, as the dominance of the DDU psychiatrists in the wider treatment world was replicated in the committee room. Voices in support of maintenance came from private and general practitioners on the working group, but their views were not included in the final report. Indeed, the *Guidelines* suggested that the treatment of addiction was not a matter for debate; short-term withdrawal was the only acceptable method.

The support the *Guidelines* enjoyed from the leading experts on drug addiction meant these rapidly acquired the status of rules. The *Guidelines* were increasingly used in disciplinary hearings to determine whether or not a doctor was prescribing to

an addict patient irresponsibly. Although it had always been intended that the *Guidelines* be used in such a manner, the one-sided nature of this document meant that it presented rapid withdrawal as the only acceptable way to treat addiction. The *Guidelines* were thus a tool that could be used to enforce short-term withdrawal as the dominant method of treatment, which at the same time confirmed the supremacy of the DDU as the main source of this form of treatment. The *Guidelines* were clearly used in this manner in the GMC's second case against Dally for serious professional misconduct in 1986-1987. Chapter Five will argue that the clash between biographical medicine and clinical medicine, and its manifestation as a conflict between maintenance and withdrawal within the treatment of addiction, was the broader context in which this case was constructed, examined and decided. Despite its dominant position, the clinical approach to addiction practised by the DDUs and embodied in the *Guidelines* remained under threat from the independent doctor offering maintenance to addicts. Clinical medicine needed to prove it had the 'solution' to the problem of addiction by placing Dally, maintenance and biographical medicine on 'trial.' This would demonstrate the superiority of clinical approaches to disease and at the same time show that clinical medicine still had a role to play in the escalating 'war on drugs.' Dally's second appearance before the GMC was, therefore, as with her first, of political significance.

It is clear that there were some problems with the treatment Dally was offering, and these could have brought her to the attention of the GMC quite apart from any deliberate attempt to orchestrate a case against her, but these problems were constructed in a climate that understood short-term withdrawal to be the best method of treatment. The case would not have been brought if this were not the increasingly dominant ideology, one that needed to squeeze out alternatives to ensure its

hegemony. Analysis of the conduct of the GMC hearing indicates that the wider battle over the treatment of addiction ran throughout the case. The hearing was less about Dally's misdemeanours and more about confirming the treatment of addiction as a matter not for the community-based doctor offering long-term prescription. It is all the more surprising, therefore, that whilst Dally was found guilty of irresponsible prescription to one patient, the GMC did not condemn her overall philosophy and methods. The long-term prescription of opioid drugs to addicts was, to some extent, vindicated by this verdict. Indeed, there were signs that a more widespread thawing of attitudes towards maintenance was taking place. Leading DDU psychiatrists publicly stated that a case could be made for long-term prescription to some addicts. Former staunch advocates of rapid withdrawal began to accept that maintenance treatment could have beneficial effects for the addict and for society. This can be partly attributed to a shift in the way addiction was viewed in the light of HIV and AIDS. AIDS was construed as a greater threat to public health than heroin addiction, and a desire to prevent the spread of HIV amongst intravenous drug users, and from them to the general population, legitimated maintenance as a form of treatment believed to be 'attractive' to addicts. However, as the Conclusion will demonstrate, AIDS resulted in the continuation of dominant trends rather than the foundation of an entirely new policy. Clinical psychiatrists had to address the social elements of addiction rather than just the medical aspects if they were to preserve their expert status in an ever-widening drug 'policy community.' Thus, the 'social' and the 'medical' continued to interact in the provision of treatment for addiction, just as they had in the past.

Chapter One

Medical versus Social: Heroin Addiction Treatment Policy 1965-1979

Introduction

From a cursory glance at heroin addiction treatment policy between 1965 and 1979 it could be supposed that there were two discrete forces involved in the creation of distinct approaches to addiction. Firstly, there was the ‘medical’ view in which ‘the addict should be regarded as a sick person’ and ‘should be treated as such.’¹ Secondly, there was a ‘social’ understanding that defined addiction as a problem requiring ‘control,’ as a ‘menace to the community.’² Yet, the fact that both of these quotations are taken from the same source, the 1965 report of the second Interdepartmental Committee on Heroin Addiction (the Brain committee), indicates that medical and social understandings of, and approaches to, addiction were not mutually exclusive. Indeed, the conflation of these two apparently separate forces was perfectly expressed by the Brain committee’s description of addiction as a ‘socially infectious condition’; a label that simultaneously conjured up concern for both individual and collective health, for the disease of the addict and for the sickness of society.³

The relationship between medical and social approaches to addiction, between treatment and control, was clearly complex and multi-faceted but not necessarily contradictory. Such an interpretation contrasts with the stance of many previous commentators who have tended to stress either the social or the medical dimensions to heroin addiction treatment policy in this period. Arnold Trebach, Gerry Stimson and Edna Oppenheimer have all emphasised the control elements inherent within the

¹ *Drug Addiction: The Second Report of the Interdepartmental Committee on Heroin Addiction*, (London: HMSO, 1965), p. 8.

² *Ibid.* p. 8.

³ *Ibid.* p. 8.

‘British System’ after 1968.⁴ Others, such as Griffith Edwards and David Whynes have seen the creation and running of specialised Drug Dependence Units (DDUs) as an inherently medical response to a medical problem.⁵ This chapter will show that *both* elements were present and though tensions between medical and social approaches to addiction can be observed, these worked together as well as in opposition.

The intricacies of this dynamic dialogue can be observed in three areas. The first is the opening of the DDUs in 1968. Here it is argued that the creation of specialised treatment centres was based on Brain’s reformulation of addiction as a social disease, a description that united medical and social concerns. Though the ‘British System’ of heroin addiction treatment had always encompassed social and medical elements this understanding brought the two elements even closer together. It was in this context that DDUs were tasked with treating the individual addict and at the same time preventing the spread of this condition within society. However, putting this policy into practice was problematic, as the Ministry of Health received conflicting advice from the handful of existing ‘experts’ on the treatment of addiction. Furthermore, many of the hospitals and doctors asked to take on this role showed little enthusiasm for the policy of providing those addicts who did not wish to stop taking heroin with the drug in order to prevent the development of a black market. This reluctance to take on a social role suggested a degree of tension between the dual aim of treatment of the diseased addict and control of the social problem of addiction.

⁴ Trebach, *The Heroin Solution*, p. 110; Stimson & Oppenheimer, *Heroin Addiction*, p. 61, pp. 94-113; G. Stimson, ‘Treatment or control? Dilemmas for staff in drug dependency clinics’, in D.J. West (ed.) *Problems of Drug Abuse in Britain: Papers Presented to The Cropwood Round-Table Conference*, (Cambridge: Institute of Criminology, 1978), 52-73.

⁵ G. Edwards quoted in Judson, *Heroin Addiction in Britain*, p. 145; D.K Whynes, ‘Drug problems, drug policies’ in D.K. Whynes & P.T. Bean (eds.), *Policing and Prescribing: The British System of Drug Control* (Basingstoke: Macmillan, 1991), 1-14, p. 3.

Those who did take on the treatment of addiction at the DDU's were predominately psychiatrists. The second section of this chapter considers the growing role played by psychiatrists in the response to addiction. This process, which H.B. 'Bing' Spear (former Chief Inspector of the Home Office Drugs Branch) referred to as the 'psychiatrising' of addiction treatment policy, can be observed in the advice the Ministry of Health received over how to deal with addiction.⁶ Instead of turning to the GPs who were thought to be responsible for the over-prescription of heroin, but who had nonetheless dealt with the majority of addicts, the Ministry appealed to psychiatrists like Thomas Bewley and Philip Connell.⁷ Spear argued that the experience of the addict-friendly GPs was ignored in favour of the 'London psychiatric establishment,' but was unable to offer any explanation for how addiction became the 'fiefdom of the consultant psychiatrist' beyond thinly veiled attacks on the influence of 'medical politicians.'⁸ This is plainly inadequate. The reasons behind the intervention of the psychiatrist require further exploration, as does the whole notion of the 'psychiatrisation' of addiction. This section will contend that there is a need to look beyond the individuals involved to explain the growing role played by the psychiatrist in dealing with addiction. Psychiatry as a whole was expanding in this period. It is in the light of the increasing power and authority of psychiatry and the proliferation of what Nikolas Rose describes as 'psy' practices that explains the 'psychiatrisation' of addiction as much as the actions of a small group of consultants.⁹ Moreover, the psychiatrist was not alone in the field; from the late 1960s onwards there was a proliferation of bodies and individuals interested in the problems posed by

⁶ H.B. Spear, 'The Early Years of the "British System" in practice', in Strang & Gossop, *Heroin Addiction and Drug Policy*, 3-28, p. 24.

⁷ T.H. Bewley, 'Conversation with Thomas Bewley', *Addiction*, 90, (1995) 883-892, p. 885; P.H. Connell, 'Conversation with Philip Connell', *British Journal of Addiction*, 85, (1990) 13-23, pp. 16-17.

⁸ Spear, *Heroin Addiction: Care and Control*, pp. 189-193.

⁹ Rose, *Governing the Soul*, pp. vii-viii.

addiction. There were tensions between these groups and psychiatry, tensions that were underpinned by the continued conflict between the ‘medical’ and the ‘social.’

Indeed, a close examination of the actual practices of the DDUs suggests that social dimensions to the treatment offered persisted despite an apparently more medical, or rather psychiatric, response. The ‘psychiatrisation’ of addiction it seems, cannot be equated with ‘medicalisation.’ The final section of this chapter shows how strong social elements were retained within the treatment of addiction even as DDU psychiatrists tried to formulate a more ‘medical’ response to the condition through the prescription of orally administered methadone (an opioid substitute) to addicts in place of intravenous heroin. Giving addicts methadone instead of heroin was perceived to be a more ‘therapeutic’ response as it was thought to lead more readily to the ‘cure’ of addiction; to the addict coming off drugs altogether. At the same time, enhanced controls were being placed on the individual addict, suggesting the persistence of a social function for the treatment of addiction. Practices such as asking addicts to sign a ‘good-behaviour contract’ spoke more of ‘control’ than ‘treatment.’ DDUs thus continued to offer an amalgamation of the ‘medical’ and the ‘social.’

1. The ‘British System’ and the opening of the DDUs ¹⁰

1.1 The development of the ‘British System’ of drug addiction treatment and control

The ‘British system’ of drug addiction treatment had always encompassed medical and social elements but until the 1960s these remained largely separate entities.

Opiate-based preparations were freely available and widely used in the treatment of a range of common ailments throughout the nineteenth century. As Virginia Berridge

¹⁰ This section is based heavily on an article published by the author. See A. Mold, ‘The “British System” of heroin addiction treatment and the opening of the Drug Dependence Units, 1965-1970’, *Social History of Medicine*, (forthcoming, December 2004).

has indicated, the only constraints placed on the sale of opiates were the same ones that controlled other poisons.¹¹ Specific regulation to control narcotic drugs as a distinct category was introduced during the First World War as anxiety about cocaine use amongst troops led to an extension of the Defence of the Realm Act in 1916. This made it an offence for anyone other than a licensed medical practitioner to supply heroin or cocaine to a member of the armed forces.¹² Regulation was initiated because drug use represented a social menace by undermining military efficiency. The remit of drug control legislation was later extended because of international pressure in a climate of panic about the recreational use of drugs. A salacious drugs underworld was thought to exist, where evil Chinese men doped innocent young women and led them into a life of debauched slavery. Drug use thus posed a threat to sexual and racial purity.¹³ Anxieties about the trade in, and use of, drugs were not confined to Britain. American legislators were particularly vocal on this matter and pressed for international restrictions on the trade in narcotic drugs in addition to domestic policies. Suppression of the traffic in opium and other drugs became one of the responsibilities of the League of Nations in 1919. As a result of these international commitments the Dangerous Drugs Act was created in 1920.¹⁴ This extended the controls placed on the supply of drugs to soldiers to include the general population. Buying, selling or being in possession of cocaine, heroin and other opiate drugs without a prescription became a criminal offence. This, according to Berridge, was the beginning of an increasingly penal era of drug policy.¹⁵

¹¹ Berridge, *Opium and the People*, pp. 113-122.

¹² *Ibid.* pp. 246-257; Berridge, 'War conditions and narcotics control'; Berridge, 'Drugs and social policy', pp. 17-29.

¹³ Kohn, *Dope Girls*.

¹⁴ Berridge, *Opium and the People*, pp. 258-60; pp. 262-264.

¹⁵ *Ibid.* pp. 264-247

Medicine, however, was not completely excluded from the debate. Indeed, the period saw the production of the Rolleston Report which firmly established medicine's interest in drug taking and addiction. Concern about the amount of opiates being prescribed to patients prompted the government to consider the nature of addiction and the treatment required. The Departmental Committee on Morphine and Heroin Addiction (the Rolleston Committee) was convened in 1924 to consider whether the prescription of morphine and heroin to addicts was medically viable.¹⁶ The committee found that addicts were few in number, mostly middle-aged, middle-class and had usually become addicted to morphine as a result of taking opiate-based drugs as part of a treatment for another illness.¹⁷ This undoubtedly influenced the committee's recommendations and they defined addiction not as a vice or a crime, but as a disease.¹⁸ A medical response was legitimated whereby addicts could be prescribed drugs to treat their addiction, as with any other illness. Addicts could, therefore, be maintained indefinitely on their drug of addiction under the care of a General Practitioner when previous attempts at withdrawing the drug had failed. This was the so-called 'British System,' its liberal approach being justified by the small, apparently socially conformist addict population who did not constitute a 'problem.'¹⁹ By establishing addiction as a disease requiring medical treatment Rolleston carved out a distinct role for medicine in the control and regulation of drug use. Medicine was responsible for the treatment of addiction that could result from drug taking, but there was also a penal system for dealing with the social consequences of the use of

¹⁶ *Report of the Departmental Committee on Morphine and Heroin Addiction*, (London: HMSO, 1926) p. 2.

¹⁷ *Ibid*, pp. 9-13; Berridge, "Stamping out addiction", pp. 52-53; Berridge, *Opium and the People*, pp. 271-278.

¹⁸ *Report of the Departmental Committee*, p. 11.

¹⁹ Berridge, *Opium and the People*, pp. 277-278; Kohn, *Narcomania*, pp. 99-100.

drugs. This was a ‘medico-legal alliance’ of ‘policing and prescribing’ where the medical and the penal had distinct, but co-existing roles.²⁰

The significance of the ‘British System’ established by Rolleston has been the subject of much debate, both by historians and by those who played a more direct role in shaping drug policy. Britain, for many years, was the only country to allow the unsupervised prescription of injectable opiate drugs to addicts on a long-term basis. Other countries such as the Netherlands and Switzerland have only begun to adopt similar policies more recently. Yet, it is likely that the importance of the ‘British System’ is as much symbolic as practical. Berridge argues that the ‘British System’ represented an example of liberal drug policy to aspire to by reformers (particularly in the USA) seeking to change their own legislation, giving the appearance of more cohesion than was really justified.²¹ Those who were involved in the development of the ‘British System’ have also expressed doubts as to its existence. Addiction specialist John Strang and psychologist Michael Gossop stated that the ‘British System’ was largely a ‘mythical creature.’ The ‘plain truth of the matter’ they asserted, ‘is that there is no British System.’²² There was no clear set of rules or coherent policy underpinning the ‘British System,’ rather this was a pragmatic, flexible set of responses to a constantly changing situation.²³ Griffith Edwards (Director of the Addiction Research Unit) and ‘Bing’ Spear also deny that the ‘British System’ ever existed, or at least not in the way that many commentators have portrayed it.²⁴ They argue that concentration on Rolleston’s justification for the prescription of drugs to addicts has ignored the elements of control within the ‘British

²⁰ Berridge, *Opium and the People*, p. 278; Whyne, ‘Drug problems, drug policies’ p. 2.

²¹ *Ibid.* pp. 277-278.

²² J. Strang & M. Gossop ‘The “British System”: visionary anticipation or masterly inactivity?’, in Strang & Gossop, *Heroin Addiction and British Drug Policy*, 343-351, p. 343.

²³ *Ibid.* p. 349.

²⁴ G. Edwards, ‘Some years on: evolutions in the “British System”’, in West, *Problems of Drug Abuse in Britain*, 1-51. Spear, ‘The early years of the “British System”’, 6-27.

System,’ such as the enforcement of regulations concerning the supply and distribution of drugs. Indeed, other protagonists, including Strang, have argued that the ‘British System’ was based on a medical approach within a penal framework.²⁵ Whilst it is clear that the ‘British System’ was more mirage than machine, its importance as a symbol, even though it is often misunderstood, persists.

1.2 Re-evaluating the ‘British System’: the Brain Committee and the establishment of DDUs

The ‘British System,’ such as it was, remained in place without review until 1958 when the Brain Committee was appointed to re-assess Rolleston’s advice.²⁶ The committee found that little had altered; addicts were still small in number and apparently socially conservative in nature. This led them to conclude that no new measures needed to be introduced.²⁷ Yet, almost as soon as the report was published, there seemed to be a dramatic rise in the prevalence of heroin addiction.²⁸ The total number of addicts known to the Home Office between 1959 and 1964 had risen from 454 to 753, 47 and 328 respectively being heroin addicts.²⁹ Of more significance than the number of addicts was the type of person becoming addicted to drugs. Firstly, addicts were younger: in 1959 11 per cent were under 35 years of age, but by 1964 40 per cent were in this group.³⁰ Secondly, the new addicts had started taking drugs for

²⁵ J. Witton, F. Keaney & J. Strang, ‘Opiate addiction and the “British System”’: looking back on the twentieth century and trying to see its shape in the future’ in J. Sheridan & J. Strang, *Drug Misuse and Community Pharmacy* (London: Taylor & Francis, 2003) 5-16, p. 7.

²⁶ *Drug Addiction: Report of the Interdepartmental Committee*, (London: HMSO, 1961) p. 3.

²⁷ *Ibid.* pp. 16-17.

²⁸ Kenneth Leech argues that these were not necessarily ‘new’ addicts, but existing addicts that had only just come to the attention of the Home Office. K. Leech, ‘The junkies’ doctors and the London drug scene in the 1960s: some remembered fragments’ in Whynes & Bean, *Policing and Prescribing*, 35-59, p. 36.

²⁹ See Figure 2, p. 97.

³⁰ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 5.

pleasure rather than as a consequence of medical treatment: 94 per cent of newly reported addicts in 1964 were of non-therapeutic origin.³¹

The Brain Committee was hastily reconvened to review its findings. Central to their recommendations was a different interpretation of addiction. Whilst the committee accepted that ‘the addict should be regarded as a sick person and treated as such’ their proposals reveal concerns that ran beyond the treatment of the individual addict.³² The committee recommended that incidences of addiction be notified to a central authority, as with infectious diseases. This analogy was felt to be particularly apt ‘for addiction is a socially infectious condition and its notification may offer a means for epidemiological assessment and control.’³³ Epidemiological information had already proved crucial in highlighting the potential dangers to health of smoking tobacco.³⁴ Brain’s report must, therefore, be read within a context of greater authority being given to epidemiology in this period, as this became an important way of describing and responding to disease.³⁵ The ‘infectiousness’ of addiction was reflected in the key recommendation made by the committee: that treatment for heroin addiction should be located in specialised institutions, or treatment centres. Furthermore, as the source of most of the heroin and cocaine being used was found to come from over-prescription by GPs and private practitioners it was suggested that the ability to prescribe these drugs be confined to doctors working at the treatment centres.³⁶ Doctors outside DDUs would still be able to prescribe heroin for pain

³¹ Public Record Office (hereafter PRO) MH 149/166, quoted in Home Office Memorandum presented to the Interdepartmental Committee on Drug Addiction, 1964.

³² *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 8.

³³ *Ibid.* p. 8.

³⁴ Hilton, *Smoking in British Popular Culture*, pp. 179-180; pp. 189-190.

³⁵ An epidemiological approach to heroin addiction can be discerned in a number of articles published after the second Brain report. See, for example, T.H. Bewley, ‘Heroin and cocaine addiction’, *Lancet*, (10 April 1965) 808-810; H.B. Spear, ‘The growth of heroin addiction in the United Kingdom’, *British Journal of Addiction*, 64, (1969), 245-255.

³⁶ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 9; PRO MH 149/165, Third meeting of the Second Interdepartmental Committee, 4 December 1964; PRO MH 149/166, Home

relief, but not for those patients addicted to the drug, a proposal that would restrict doctors' freedom to prescribe drugs for the first time.

Analysis of the second Brain report suggests that these recommendations were the result of a shift in the definition of, and response to, drug addiction. As sociologists Gerry Stimson and Edna Oppenheimer argue 'Hitherto most discussions had focused on the medical treatment of addicted individuals. The new element introduced in the 1960s was the emphasis on the social control of addiction.'³⁷ This change was attributed to a transformation in the population of addicts. Addicts were younger and had become addicted not as the consequence of medical treatment, but as the result of 'recreational' drug use. The 'British medical leadership,' according to commentator on heroin policy Arnold Trebach, could not countenance 'the prospect of treating defiant young heroin addicts the same as the deserving aged and infirm.'³⁸ Heroin addiction was now a greater social problem. This did not, however, herald in an era of enhanced social control over a population of addicts to the exclusion of medical treatment of the individual. Drug addiction treatment and control policy after 1968 was about just that: treatment and control. This combination slotted neatly into the existing 'British System' as it aimed to both limit the drug problem and care for the addict. What was new after Brain reported was a greater conflation of these goals.

The emergence of this concept of addiction as a social disease was not based solely on the changed addict, but was also the result of shifting perceptions about the location of disease within society. David Armstrong, in *The Political Anatomy of the Body*, maintains that the spread of contagious diseases like tuberculosis prompted

Office Memorandum presented to the Interdepartmental Committee on Drug Addiction, 1964. Spear and Leech both argue that some of the doctors prescribing to addicts were unfairly blamed for the availability of heroin. They assert a small group of GPs and private practitioners were treating addicts responsibly and not over-prescribing. See: Leech, 'The junkies' doctors', p. 39; Spear, *Heroin Addiction Care and Control*, pp. 126-130, pp. 144-148, pp. 292-293.

³⁷ Stimson & Oppenheimer, *Heroin Addiction*, p. 54.

³⁸ Trebach, *The Heroin Solution*, p. 174.

doctors to examine the relationships between people, and not just the environment, as a cause of disease.³⁹ This encouraged the extension of the medical ‘gaze’ (a concept developed by Michel Foucault in *The Birth of the Clinic*) from the individual to the whole community.⁴⁰ Disease was thus located not just in the individual body, but also in the social body. Such a conceptualisation has been utilised by Rachel Lart to explain the comparable shifts in the location of addiction.⁴¹ She argues that the collation of records of prescriptions to addicts from 1934 onwards made the addict more visible through increasing surveillance, which enabled the observation of not just the individual addict, but of the pattern of disease within society.⁴² Locating disease in society allows for the intervention of government to protect that society and prevent disease from spreading. This is central to long-standing notions of public health, but here too there was a shift in focus away from the environment to society, as campaigns began to target the health of the individual.⁴³ It is clear that the Brain report was drawing on these concepts of public health when it argued that drug addiction, if allowed to spread, could become a ‘menace to the community.’⁴⁴ This menace, however, was not just the risk of contracting a physiological disease, but as Carol Smart indicates, the threat that the behaviour of drug addicts represented to the fabric of society.⁴⁵ The social threat that addicts posed was not just that they may spread their disease to others, but also a more general concern that underlies public health; that it was a waste of human resources. Addiction was a disease that was

³⁹ D. Armstrong, *The Political Anatomy of the Body*, (Cambridge: Cambridge University Press, 1983).

⁴⁰ Foucault, *The Birth of the Clinic*.

⁴¹ Lart, ‘Changing Images of the Addict and Addiction’, pp. 1-8 Lart elaborates on these themes in her Ph.D thesis *HIV and English Drugs Policy*, p. 40, pp. 51-55.

⁴² *Ibid.* Here Lart is clearly drawing on notions of surveillance and discipline in Foucault, *Discipline and Punish*.

⁴³ V. Berridge, *Health and Society in Britain Since 1939*, (Cambridge: Cambridge University Press, 1999) pp. 48-54. See also Porter, *Health, Civilisation and the State* and J. Welshman, *Municipal Medicine: Public Health in Twentieth-Century Britain*, (Oxford & Bern: Peter Lang, 2000).

⁴⁴ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 8.

⁴⁵ Smart, ‘Social policy and drug addiction’, pp. 35-36.

wasteful and unproductive, thus posing a threat to the economic, as well as social and physical health of the community. The combination of medical and social ‘danger’ expressed in public health rhetoric necessitated both the treatment and control of drug addiction. It is often very difficult to separate these as two distinct strands of drug addiction policy. As Stimson has pointed out, staff at clinics fulfilled both treatment and control roles.⁴⁶ Although these had always been the concern of drug policy the DDUs represented a closer union of what had been characterised as ‘medical’ and ‘social’ responses. This development was facilitated by broader changes in the perception and location of disease, enabling Brain and his colleagues to describe addiction as a ‘social’ disease.

There is little evidence to suggest the wider medical profession were profoundly moved by this view of addiction. Doctors were more concerned about the potential threat to their autonomy posed by the increased regulation of the treatment of addiction than deeper conceptual changes. An editorial in the *British Medical Journal* found notification of addiction to the Home Office to be a ‘sound and acceptable’ idea but was concerned about the proposed restrictions to the right to prescribe freely.⁴⁷ Their main objection was that ‘Because of the weakness – or worse – of a handful of doctors’ prescription was to be restricted and this would be ‘a grave step.’⁴⁸ It seems that the *British Medical Journal*’s objection was based more on the defence of a principle than a specific complaint about the recommendations, as the article conceded that treatment centres were ‘acceptable’ and ‘Any practitioner with a case of addiction to heroin or cocaine will feel relieved if he knows he can send

⁴⁶ Stimson & Oppenheimer, *Heroin Addiction*, p. 94, pp. 205-219; G. Stimson, ‘Treatment or control?’, pp. 52-73.

⁴⁷ *British Medical Journal*, (27 November 1965), pp. 1259-1260.

⁴⁸ *Ibid.*

such a patient for treatment elsewhere.’⁴⁹ This was supported by the observation that few practitioners were actually willing to see addicts. An investigation by *The Times* found there were only two dozen doctors in London prepared to treat addicts because of the trouble they caused, and as Stimson and Oppenheimer note, protests about the restriction of prescription were ‘muted’ because ‘the proposals would remove from the majority of doctors any need to do the medical “dirty work” of treating addicts.’⁵⁰ The *Lancet* raised even fewer objections to the Brain report than the *British Medical Journal*. Whilst commenting that ‘It certainly seems very hard that the whole profession should suffer this limitation on its professional judgement’ it argued that doctors ‘might be wise to accept the limitation, which is likely to save much frustration in an area where therapy by non-specialists is virtually impossible.’⁵¹ The process which led the medical profession to accept restrictions to their powers of prescription was thus a dual one: on the one hand addiction was seen as a social problem and not, therefore, the responsibility of the doctor; but on the other, the treatment of addiction was being portrayed as an increasingly specialised area of medicine, beyond the capacities of the generalist.

This complex inter-play between the social and medical can also be observed in the reaction to one of Brain’s other central recommendations – notification. Despite both the *British Medical Journal* and the *Lancet* accepting the need to notify addicts to a central authority, Ministry of Health files reveal that not all sections of the medical community were happy with this proposal. The Scottish branch of the British Medical Association (BMA) were particularly displeased with notification commenting ‘it is very difficult for a doctor to accept that he can, and indeed must,

⁴⁹ *Ibid.*

⁵⁰ *The Times*, (21 December 1965), p. 5; Stimson & Oppenheimer, *Heroin Addiction* p. 54.

⁵¹ *Lancet*, (27 November 1965), pp. 1113-1114.

notify his patient without that patient's consent.'⁵² Doctors, however, offered no organised resistance to notification. Indeed, many were already informing the Home Office when they came into contact with an addict, so regulations introduced in 1968 making it a legal requirement for doctors to notify the Chief Medical Officer aroused little comment.⁵³ This lack of dissent over the issue of notification at first appears to be surprising given that it would seem to threaten the confidentiality of the doctor-patient relationship, yet this can be explained by the new way in which addiction was portrayed. By emphasising the social infectiousness of the disease of addiction the Brain committee encouraged doctors to see it in the same way as other dangerous communicable diseases, like tuberculosis. Viewed in this light, noting incidences of addiction was an acceptable loss of a few patients' rights for the good of society. As a Home Office official remarked to Trebach, 'Addicts have no rights simply because they are addicts.'⁵⁴

Harmony on notification did not, however, mean that there was a broad consensus on how to approach heroin addiction more generally. The Brain report placed the treatment centre at the centre of the response to drug addiction, but achieving agreement on exactly what this should be was difficult. A Ministry of Health spokesman neatly summed up the situation in 1967 when he commented "“there is an experimental feel about this whole policy.””⁵⁵ The Ministry were groping in the dark; they had little idea how to implement a policy that would control the spread of addiction at the same time as providing for the treatment of individual addicts. Officials checked that Brain had really envisaged that clinics should have this dual function. A secretary of the committee confirmed they had 'intended that

⁵² PRO MH 149/170, Letter from the Scottish BMA to Sharp, 6 December 1966.

⁵³ Dangerous Drugs Act, 1967; Dangerous Drugs (Notification of Addicts) Regulations, 1968.

⁵⁴ Trebach, *The Heroin Solution*, p. 183.

⁵⁵ *The Times*, (26 July 1967), p. 3.

treatment centres have two roles – treatment of addicts who desired cure (withdrawal of the drug, rehabilitation etc.) and the regular supply of heroin or other drugs to addicts who were not willing to accept treatment.’⁵⁶ Brain clearly thought that clinics could both control the spread of addiction in the wider population and treat the individual addict.

When the Ministry of Health consulted a number of experts on drug addiction, they found that this dual function appeared to be somewhat contradictory. Although there were relatively few psychiatrists who had much experience of dealing with addiction in the mid 1960s those that did could roughly be divided into two camps. Some of the specialists consulted by officials recognised the social ‘danger’ of the spread of addiction and realised that not all addicts would be willing to come off drugs. Such addicts needed drugs to avoid the development of withdrawal symptoms, and it was thought that providing them with drugs prevented them from seeking supplies on the black market.⁵⁷ Doctors like Dale Beckett, who operated the Salter Unit for the treatment of drug addicts at Cane Hill Hospital, favoured a policy which would allow addicts who could not, or would not, give up heroin to be ‘maintained’ on the drug.⁵⁸ This, it was hoped, would prevent the development of an illicit market and the worsening of social problems associated with addiction.

Thomas Bewley represented a second school of thought. He dismissed the prescription of heroin to addicts, arguing instead for transferring them to the synthetic opiate substitute, methadone.⁵⁹ He placed a greater emphasis on ‘curing’ the

⁵⁶ PRO MH 149/170, Meeting between representatives of the Ministry of Health and Dr Goulding, 10 May 1966.

⁵⁷ PRO MH 149/170, Meeting between representatives of the Ministry of Health and Dr Goulding, 10 May 1966.

⁵⁸ H.D. Beckett, ‘Society at Work: Maintaining Heroin Addicts’, *New Society*, (14 September 1967) 360-361; H.D. Beckett, ‘The Salter Unit – an experimental in-patient treatment centre for narcotic addiction in men’, *British Journal of Addiction*, 63, (1968) 51-53.

⁵⁹ See ‘Conversation with Thomas Bewley’, p. 887; T.H. Bewley, ‘Advantages of special centres’, *British Medical Journal*, (1967), 498-499; Bewley, ‘Heroin and cocaine addiction’, 808-810; PRO MH

individual addict rather than allowing them to remain hooked on drugs. The Ministry were unconvinced by this argument feeling that they were 'faced not with a bad and a good solution but with in fact a choice of evils. The great need was for containment in order to prevent the development of an international black market.'⁶⁰ For this reason they decided that clinics would be permitted to prescribe heroin on a maintenance basis. This was translated into policy through a Ministry of Health memorandum to doctors in 1967 which stated that 'The aim is to contain the spread of heroin addiction by continuing to supply this drug in minimum quantities where this is necessary in the opinion of the doctor, and where possible to get the addict to accept withdrawal treatment.'⁶¹

1.3 Implementation: the purpose and practice of the DDUs

The central purpose of clinic policy having been established, the Ministry of Health began negotiations with those who would be asked to implement it. Brain had reported that most of the new drug addicts were to be found in London, so it seemed logical that attention be focused on the capital.⁶² The Ministry proposed that treatment of addiction should be offered in outpatient units set up in the London undergraduate teaching hospitals.⁶³ This emphasis on outpatient treatment reflects a general trend towards non-residential care for psychiatric conditions and mirrors similar changes in the treatment of alcoholism. As Betsy Thom has shown, Alcohol

149/172, Meeting between representatives of the Ministry of Health and Dr Bewley and Dr Monro, 1966.

⁶⁰ PRO MH 149/172, Meeting between representatives of the Ministry of Health and Dr Bewley and Dr Monro, 1966.

⁶¹ PRO MH 150/369, HM 67 (16) 'Treatment and Supervision of Heroin Addiction', (March 1967). This memorandum is also summarised in R.V. Phillipson, 'The implementation of the second report of the Interdepartmental Committee on Drug Addiction' in R.V. Phillipson, (ed.) *Modern Trends in Drug Dependence and Alcoholism* (London: Butterworths, 1970), 75-89, pp. 84-89.

⁶² *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 8.

⁶³ PRO MH 149/172, Outline scheme for implementing the recommendations of the Brain Committee, 31 October 1966.

Treatment Units established in 1962 initially offered treatment for alcoholism primarily on an inpatient basis, but by the latter half of the decade, alcoholics were increasingly being seen as outpatients.⁶⁴ Although there were clear parallels with treatment provision for alcoholism, the creation of hospital-based treatment centres for heroin addiction contrasted with a more general reduction in the role of the institution in the provision of mental health services in the late 1960s and early 1970s in favour of a community-based approach.⁶⁵ Heroin addiction seemed to require a centrally controlled, institutional response, as had earlier ‘social diseases’ such as tuberculosis and venereal disease.⁶⁶

Despite this apparent social imperative, officials found ‘little enthusiasm’ amongst staff at London teaching hospitals for the creation of outpatient addiction treatment centres.⁶⁷ Throughout the spring of 1967 representatives of the Ministry of Health visited London teaching hospitals to assess their individual reactions to setting up outpatient clinics for addicts.⁶⁸ These varied, but it is clear that there were three main concerns. Firstly, many were sceptical about the Ministry’s suggestion that addicts be maintained on heroin if necessary. Doctors at Guy’s Hospital did not want to ‘become a dispensing service on demand to addicts.’⁶⁹ The board of St Mary’s Hospital were ‘dubious about the merits of “maintenance treatment”’ but were happy

⁶⁴ Thom, *Dealing With Drink*, pp. 45- 66; Thom & Berridge, “Special units for common problems”: pp. 75-93.

⁶⁵ D. Bennett, ‘The drive towards the community’, in G.E. Berrios & H. Freeman, (eds.) *150 Years of British Psychiatry, 1841-1991*, (London: Royal College of Psychiatrists, 1991) 321-332; K. Jones, *Asylums and After: A Revised History of the Mental Health Services From the Early Eighteenth Century to the 1990s*, (London: Athlone Press, 1993) pp. 181-193; E. Shorter, *A History of Psychiatry From the Era of the Asylum to the Age of Prozac*, (New York: John Wiley & Sons Inc., 1997) pp. 277-281; Berridge, *Health and Society*, pp. 30-32.

⁶⁶ See D. Evans, ‘Tackling the “hideous scourge”: the creation of the venereal disease treatment centres in early twentieth-century Britain’, *Social History of Medicine*, 5, (1992), 413-433 and for a discussion of the dispensaries established to treat tuberculosis see Armstrong, *Political Anatomy of the Body*, pp. 7-18.

⁶⁷ PRO MH 160/709, Memorandum from Moyes (Ministry of Health) to Slater, 9 February 1967.

⁶⁸ PRO MH 160/709.

⁶⁹ PRO MH 160/709, Note of meeting between Winner (Ministry of Health) and Clark (Guy’s Hospital), 15 December 1966.

to co-operate if there were extra funds available.⁷⁰ This highlights the second issue; cost. Those hospitals that agreed to take on the outpatient treatment of addicts were unanimous that they would require an increase in funds to do so. An official noted hospitals were ‘hardly likely to give this priority over other cherished projects, and if they were to do anything it would have to be on the basis of some additional money for the purpose.’⁷¹ Although the Ministry had previously anticipated that the running costs of the clinics would be ‘inconsiderable’ investigation proved this assumption incorrect.⁷² An initial estimate of annual costs was in the region of £15,000 per clinic, approximately 20 per cent of the extra revenue allocation given to hospitals for projects in 1967/8.⁷³ The Ministry’s initial tactic was to assure hospital boards that funding would be available if they began to run short towards the end of the financial year (this was in line with more general limitations to public spending), but by September 1967 grants covering full costs were being made to hospitals to set up clinics.⁷⁴ The third problem raised by the teaching hospitals was that the new centres would need staff yet few doctors were prepared to treat addicts. Furthermore, those that did were concerned about the effect this could have on their careers. The House Governor of the Westminster Hospital warned ‘for the sake of his future no psychiatrist should be restricted to the subject of heroin addiction.’⁷⁵ This sentiment was echoed by doctors from St Thomas’ hospital, who, in a letter to the Ministry argued that the treatment of addicts was ‘a demanding but limiting sphere of work and

⁷⁰ PRO MH 160/709, Note of meeting between Moyes, Tooth, (Principal Medical Officer, Ministry of Health) and Powditch (St. Mary’s Hospital), 7 February 1967.

⁷¹ PRO MH 160/709, Note of meeting between Winner and Clark, 15 December 1966.

⁷² PRO MH 149/170, Letter to Hodges from Adams, 18 November 1965.

⁷³ PRO MH 160/709, Memorandum from Moyes to Slater, 9 February 1967.

⁷⁴ PRO MH 160/710, Letter from Driscoll at St Thomas’ Hospital to Moyes, 26 September 1967; Estimate of Costs of Unit for the Treatment of Addiction, no date.

⁷⁵ PRO MH 160/709, Letter to Hauff from the House Governor of the Westminster Hospital, 7 June 1967.

no doctor should be encouraged to do this work and nothing else.’⁷⁶ The Ministry of Health appeared reluctant to approve rises in staffing levels at a number of hospitals, maintaining that the clinics could be manned by existing employees. This resulted in a dispute between officials and staff at Guy’s, resolved only when the existence of the unit was in ‘jeopardy.’⁷⁷ What these negotiations reveal is that a fundamental scepticism existed amongst doctors working at the London teaching hospitals about the Ministry’s proposals. Doctors were unsure about the merits of the service they were to offer as ‘treatment’ and were reluctant to become involved in a project that was more concerned with the social control of addiction. This was recognised by Beckett, who observed in an article in *New Society* in 1967, that the development of DDUs was being held up by ‘the doubts of the hospital boards and the doctors who will run them’ and these doubts were the result of fundamental differences in approach.⁷⁸ Beckett argued that psychiatrists are ‘orientated medically, not sociologically, as in line with their training.’⁷⁹ Doctors, he implied, were more interested in curing the addict than attempting to control the social problem of addiction.

The prolonged negotiations between the Ministry of Health and the teaching hospitals meant that the Government appeared slow to act upon the advice of the Brain Committee, stimulating party-political interest in heroin addiction. Before 1966, there had been a cross party consensus over the drugs issue, with members from both sides stressing the need for action.⁸⁰ As time went on, however, members of the

⁷⁶ London Metropolitan Archive (hereafter LMA) H1/ST/A128/13, Letter to the Ministry of Health from the Chairman of the Medical Committee, St Thomas’ Hospital, 3 April 1967.

⁷⁷ PRO MH 160/710, Slater to Tooth and Shore, 28 July 1967.

⁷⁸ Beckett, ‘Society at Work: Maintaining Heroin Addicts’ pp. 360-361.

⁷⁹ *Ibid.*

⁸⁰ *The Hansard Journal of Parliamentary Debates: House of Commons*, Vol. 732, 21 July 1966, 856; question by W. Deedes, 24 May 1966 vol. 729, 283-284; question by R. Short, 21 July 1966 vol. 732, 865-866.

Conservative Opposition began to express their frustration at the lack of progress. The Conservative MP for Ashford, William Deedes, (speaking as much from his own interest in the drugs problem than as a representative of any organised Tory policy on the issue) did not believe ‘that the Government have measured up to the situation’ branding the absence of action as ‘inexcusable tardiness.’⁸¹ The Health Minister, Kenneth Robinson denied this, maintaining that time had been well spent.⁸² Yet, there was little transparency outside Whitehall about what the Ministry of Health were actually planning to do about the drug ‘problem.’ The *Sunday Times* quoted Lawrence Abel, a doctor who had sat on the first Brain Committee and now represented the National Association on Drug Addiction, as remarking “‘Anyone who finds out what the Ministry is planning is a miracle worker.’”⁸³ The *Guardian* were no clearer about the provision of facilities for addicts several months later, citing a doctor ‘closely associated’ with the new system as saying that when this came into force “‘there will be nothing but bloody chaos.’”⁸⁴ This lack of clarity is hardly surprising given that the Ministry of Health itself was unsure about the policy it was to implement.

The issue came to a head when a letter from a London GP complaining about the absence of facilities for drug addicts was published in *The Times* in July 1967.⁸⁵ Dr A.J. Hawes was struggling to cope with a flood of addict patients, but his chief concern was that he did not know where he could refer these patients when he was no longer able to treat them. Hawes also sent a copy of his letter to the Ministry of

⁸¹ See for example, W. Deedes, *The Drugs Epidemic* (London: Tom Stacey, 1970); *Hansard: Commons*, 30 January 1967, Vol. 740, 121-174.

⁸² *Ibid.*

⁸³ *The Sunday Times*, (20 August 1967), p. 3.

⁸⁴ *Guardian*, (16 November 1967), p. 4.

⁸⁵ *The Times*, (8 July 1967), p. 1.

Health, where it caused much consternation.⁸⁶ The hospitals that were in the process of setting up clinics had told the Ministry that they did not want the existence of these to become widely known before they were completed for fear of being ‘swamped’ by addicts.⁸⁷ When officials replied to Hawes, they gave him a list of hospitals providing ‘facilities’ for the treatment of addiction and warned him that until these were available ‘it would be premature, and unhelpful to addicts as a whole, to give any publicity to the units concerned.’⁸⁸ Hawes ignored this advice, and after checking with the hospitals on the list about the ‘facilities’ they were said to have, wrote to *The Times* alleging that the Ministry had deliberately misled him.⁸⁹ This made front-page news when it emerged that of the nine hospitals listed as offering treatment for drug addiction, only six of these provided outpatient treatment, and not all of these were available on a regular basis. The situation was confused still further by the Government’s Spokesman on Health in the House of Lords, Baroness Philips, who stated in a speech to the House that there were eleven outpatient clinics in London, and plans for four more.⁹⁰ A Ministry spokesman tried to excuse the gaffe by explaining that ‘facilities’ were different to ‘units,’ and these were not the same as ‘centres’ or ‘clinics,’ and that the letter sent to Hawes was simply meant to give an idea of the hospitals where addicts could be treated by doctors ‘knowledgeable in their problems.’⁹¹ This prompted a spate of negative articles in the press.⁹² Hawes continued to be a thorn in the Ministry’s side, arguing in the *Lancet* that ‘I see not the

⁸⁶ PRO MH 160/709, Letter from Dr A. Hawes to K. Robinson, 31 May 1967.

⁸⁷ PRO MH 160/709, Moyes to Slater on the options of how to deal with Hawes, 15 June 1967.

⁸⁸ PRO MH 160/709, Reply to Hawes, 22 June 1967. The teaching hospitals’ replies to Hawes’ letters are also reproduced in an appendix to an article by Kenneth Leech, then a curate in Hoxton and later a drug voluntary organisation leader. See: Leech, ‘The junkies’ doctors’, pp. 58-59.

⁸⁹ *The Times*, (8 July 1967), p. 1

⁹⁰ *Ibid.*

⁹¹ *Ibid.*

⁹² See for example *The Times*, (14 July 1967), p. 7, *The Times*, (18 July 1967), p. 8 and *The Sunday Times*, (20 August 1967). The debacle is also outlined by Leech, ‘The junkies’ doctors’, pp. 47-50.

slightest reason why addict clinics should not be set up in every hospital in London and all large cities – and that within a week.’⁹³

The confusion over the location of the clinics is indicative of a wider confusion as to their purpose. An editorial in the *British Medical Journal* in 1967 asked ‘What are the realistic aims of treatment – cure or containment?’ a question they were still unable to answer in March 1968, just a month before the clinics opened.⁹⁴ The Ministry of Health seemed to recognise there were contradictions in their policy. In a report used for the basis of the memorandum *Treatment and Supervision*, an official noted that the clinics were expected to ‘try and contain heroin addiction and at the same time bring as many patients as possible under treatment.’⁹⁵ In this sense, the policy the Ministry were trying to implement encompassed both medical treatment and social control. This was to have a number of implications for the practical ‘treatment’ of drug addiction in clinics, as what was good for the health of the individual addict was not necessarily good for society. These apparent tensions between social control and medical treatment can be observed in the opening of the DDUs. On the one hand, the memorandum that dictated how drug addiction was to be treated prioritised social control, emphasising the need to control addiction through control of prescription.⁹⁶ For this reason doctors working at clinics would be allowed to prescribe heroin on a maintenance basis to stop the development of a black market and the spread of addiction. On the other hand, clinics were established at key London hospitals run by psychiatrists and support staff. The involvement of psychiatrists would indicate that there was a desire to ‘cure’ addicts of their addiction rather than just maintain them.

⁹³ A. Hawes, *Lancet*, (22 July 1967), p. 208.

⁹⁴ *British Medical Journal*, (11 February 1967), pp. 319-320; *British Medical Journal*, (2 March 1968), p. 719.

⁹⁵ PRO MH 160/709, Organisation of the Treatment and Supervision of Heroin Addiction, no date.

⁹⁶ PRO MH 150/369, HM 67 (16) ‘Treatment and Supervision of Heroin Addiction’, March 1967.

This dual policy was put into action in April 1968 when the Dangerous Drugs (Prescription to Addicts) Regulations were imposed. Only those doctors in possession of a licence to prescribe Dangerous Drugs could prescribe heroin to addicts. Approximately 600 of these licenses were granted by the Home Secretary, almost universally to doctors working in clinics. A total of 15 clinics opened in London, and by October there were 1,139 addict patients attending treatment centres, 80 per cent of these in the capital.⁹⁷ The centres were all funded by the Ministry of Health, but facilities varied enormously. What is more, the location and even the description of these indicate that drug addiction occupied an ambiguous space. Some clinics were incorporated into the main body of the hospital, often as part of the psychiatric department and were clearly labelled ‘Drug Dependency Clinic.’ Others were hidden away in the bowels of the hospital, sometimes reached by a separate entrance and were more euphemistically entitled ‘Psychiatric Unit Annexe’ or ‘Special Psychiatric Clinic.’⁹⁸ A county medical officer in Cambridgeshire described the drug addiction facilities in his region as the ‘containment unit.’⁹⁹ Many hospitals had made it a condition of their accepting the establishment of a clinic that it would be in separate facilities or held at different times to other outpatient surgeries to avoid the ‘spread’ of addiction to other patients. Dr Randall at Charing Cross Hospital, for example, insisted on holding the addiction clinic in the evenings to prevent mixing with ‘ordinary’ patients, and addicts were asked to enter the hospital through the back door.¹⁰⁰ Some psychiatrists working with addicts even claimed they were ostracised

⁹⁷ Figures quoted in Stimson and Oppenheimer, *Heroin Addiction*, p. 81.

⁹⁸ *Ibid*, pp. 81-82.

⁹⁹ PRO MH 150/369, Letter from County Medical Officer of Health, Cambridgeshire to the Ministry of Health, 4 March 1968.

¹⁰⁰ PRO MH 160/709, Report of visit to Charing Cross Hospital.

by other staff.¹⁰¹ Addiction, it seemed, really was the ‘socially infectious condition’ depicted by Brain. Martin Mitcheson, a psychiatrist at the drug clinic at University College Hospital, commented that ‘addiction has succeeded tuberculosis as a social disease and you hide addicts at the back of hospitals.’¹⁰²

2. Psychiatry, addiction and research – the MRC, the ACDD and the ARU

2.1 ‘Psychiatrising’ addiction

Such a characterisation did not mean, however, that the social had superseded the medical in understandings of addiction. Though addiction was described as a social disease the central response to this was articulated through a medical framework. Allied with descriptions of addiction as a social disease was an equally powerful, and not necessarily mutually exclusive, notion of addiction as a psychiatric condition. Psychiatry was becoming increasingly important in determining the response to drug addiction. This coincided with a period of expansion and increasing self-confidence within British psychiatry more generally, a mood epitomised by the foundation of the Royal College of Psychiatrists in 1971.¹⁰³ As Roy Porter remarked, the decline of the psychiatric institution in the latter part of the twentieth century ‘did not entail any withering away of psychiatry itself. Far from it: there was to be marked and continued growth in the numbers receiving psychiatric treatment.’¹⁰⁴ Indeed, as demonstrated by Rose, the post-war period saw the growth of a ‘therapeutic society’ where a whole range of ‘psy’ practices based on psychotherapeutic techniques offered

¹⁰¹ M. Tripp quoted in Judson, *Heroin Addiction in Britain*, p. 93 and D. Beckett quoted in Davenport-Hines, *The Pursuit of Oblivion*, pp. 321-322.

¹⁰² Quoted in Judson, *Heroin Addiction in Britain*, p. 87.

¹⁰³ J.G. Howells, ‘The establishment of the Royal College of Psychiatrists’ in Berrios & Freeman, *150 Years of British Psychiatry*, 117-134; Jones, *Asylums and After*, p. 184.

¹⁰⁴ R. Porter, ‘Two cheers for psychiatry! The social history of mental disorder in twentieth century Britain’ in Freeman & Berrios, (eds.) *150 Years of British Psychiatry Vol.2*, 383-406, p. 399.

counsel to individuals for an equally large range of problems.¹⁰⁵ Emphasis shifted from severe mental illnesses to seemingly less serious conditions that were believed to be more widespread such as depression, phobias, alcoholism and drug addiction.¹⁰⁶ Partly as a result of these conceptual changes the position of psychiatry within healthcare services shifted. Treatment for mental illness was increasingly provided in the same way as for other disease: psychiatric hospitals were brought within the remit of the NHS in 1948 and mental health services were re-organised in the context of general medical services in the ‘Hospital Plan’ of 1962.¹⁰⁷ The ‘Hospital Plan’ consolidated a drift towards community as opposed to hospital-based care for the mentally ill, a development which went some way to addressing the critique of the anti-psychiatrists whose most vociferous attacks were reserved for psychiatric institutions.¹⁰⁸

Psychiatry was thus well placed conceptually and organisationally to take on the treatment of addiction. Though it was Rolleston that had first suggested that addiction was more likely to be found in those with a history of ‘mental or nervous instability,’ Brain was later unequivocal that addiction was ‘an expression of mental disorder’ and the best place for the treatment of the addict was the psychiatric ward of

¹⁰⁵ Rose, *Governing the Soul*, pp. vii-viii, pp. 217-235.

¹⁰⁶ Porter, ‘Two cheers for psychiatry!’, p. 399. David Armstrong details how increased psychiatric observation of the population and an emphasis on mental hygiene during World War Two highlighted psychoses and neuroses in supposedly normal, healthy individuals. Armstrong, *Political Anatomy of the Body*, pp. 64-72.

¹⁰⁷ Bennett, ‘The drive towards the community’, pp. 326-327; C. Webster, ‘Psychiatry and the early National Health Service: the role of the Mental Health Standing Committee’ in Berrios & Freeman, *150 Years of British Psychiatry*, 103-116. For a more general account of the Hospital Plan see C. Ham, *Health Policy in Britain: The Politics and Organisation of the National Health Service* (Basingstoke: Macmillan, 1992) pp. 18-19, pp. 69-70; R. Klein, *The Politics of the National Health Service*, (London: Longman, 1989) pp. 73-81; Berridge, *Health and Society*, pp. 27-28; pp. 30-31; C. Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2nd ed., 2002).

¹⁰⁸ For a thorough exploration of the impact of the Hospital Plan on mental health services and the development of community care see Jones, *Asylums and After*, pp. 181-192 and Bennett, ‘The drive towards the community’, pp. 326-327. On anti-psychiatry see: N. Crossley, ‘R.D. Laing and the British anti-psychiatry movement: a socio-historical analysis’, *Social Science and Medicine*, 47, (1998), 877-889; D. Tantam, ‘The anti-psychiatry movement’, in Berrios & Freeman, *150 Years of British Psychiatry*, 333-347 and Shorter, *A History of Psychiatry*, pp. 272-276.

a general hospital.¹⁰⁹ Indeed, by the late 1960s addiction was increasingly being seen as a disease without clear biological cause. The Chairman of the Biological Council's Coordinating Committee for Symposia on Drug Action suggested in his introduction to a paper session on the social and clinical aspects of drug abuse in 1968 that 'there is little evidence to suggest that addiction is a disease in the biological sense.'

Instead, 'social and psychological factors may have determined the onset of drug use.'¹¹⁰ It appeared to officials that psychiatrists, long tasked with dealing with the seemingly similar disease of alcoholism, knew more about this kind of problem than any other medical specialty.¹¹¹ Many of the doctors the Ministry of Health turned to for advice on the creation of the DDUs were psychiatrists with experience of treating alcoholics. Max Glatt, a leading name in the treatment of alcoholism, together with other psychiatrists specialising in this area, was heavily involved in the establishment and early running of the DDUs.¹¹² Few, however, of these doctors had actually seen many drug addicts. Bewley told an interviewer from the journal *Addiction* that he became an 'expert' on addiction in 1964 when he had seen only 20 addict patients, but this was far more than any other doctor had seen. He commented 'This was how I became an "expert." I knew little, but everyone else knew less.'¹¹³ Spear has been critical of the nature of this early expertise. He argued that psychiatrists credited with expert status in this area by the Ministry of Health were a 'Who's Who of the London psychiatric establishment'; that doctors with any real experience of dealing with

¹⁰⁹ *Departmental Committee on Morphine and Heroin Addiction*, p. 11; *Drug Addiction: Report of the Interdepartmental Committee*, pp. 9-10.

¹¹⁰ 'Chairman's Introduction' in H. Steinberg, *Scientific Basis of Drug Dependence*, (London: J & A Churchill, 1969), 286-290, p. 286.

¹¹¹ For the role of psychiatry in alcoholism see Valverde, *Diseases of the Will*, pp. 48-50, pp. 99-101, pp. 106-111 and Thom & Berridge, 'Special units for common problems', p. 80.

¹¹² M. Glatt, 'Conversation with Max Glatt', *British Journal of Addiction*, 78, (1983) 231-243, pp. 240-241.

¹¹³ 'Conversation with Thomas Bewley', p. 885.

addicts, including the over-prescribing GPs and a handful of unconventional psychiatrists, were not consulted.¹¹⁴

To explain this, the processes that led to the creation of an area of expertise need to be considered. For addiction to be thoroughly ‘psychiatrised’ psychiatry had to exclude generalists and those who did not adhere to the standard interpretation of addiction and its treatment in order to construct a unified body of expert knowledge. The exclusivity of addiction was reinforced by a change in the way the condition was described, as ‘addiction’ became ‘drug dependence.’ At the Medical Research Council (MRC) Conference on Research into Drug Dependence in 1968 the Deputy Chairman, Sir Harold Himsworth, proposed that ‘for the sake of semantic clarity the term “drug dependence” be used in place of all similar terms.’¹¹⁵ It is likely that the MRC were taking their lead from the World Health Organisation’s (WHO) Expert Committee on Addiction-Producing Drugs who proposed in 1965 that the term ‘drug dependence’ be used instead of ‘drug addiction,’ as this would eliminate the confusion of existing terminology.¹¹⁶ This linguistic shift was, however, more than simple clarification; it confirmed the ‘psychiatrisation’ of addiction by creating a psychiatric term for the condition. Berridge has argued that ‘addiction’ seemed to place too much emphasis on the physical consequences of drug taking, whereas ‘dependence’ was intended to convey the psychological aspects of this condition.¹¹⁷ Both terms were used seemingly interchangeably during the 1960s and 1970s, but ‘drug dependence’ was the more ‘official’ description – as exemplified by the use of

¹¹⁴ Spear, *Heroin Addiction Care and Control*, pp. 192-193.

¹¹⁵ PRO FD 7/1583, Minutes of the Medical Research Council Conference on research into drug dependence, 18 January 1968.

¹¹⁶ Eddy et al., ‘Drug dependence: its significance and characteristics’, *World Health Organisation Bulletin*, 32, (1965), cited in Young, *The Drugtakers*, p. 44.

¹¹⁷ Berridge, ‘Opium and the doctors: disease theory and policy’, p. 101.

‘Drug Dependence Unit,’ ‘Advisory Committee on Drug Dependence’ and the MRC ‘Working Parties on Drug Dependence.’

The use of this term strongly suggests that the psychiatrisation of addiction was closely entwined with the formation of drug policy. Indeed, further evidence for the increasingly powerful role played by psychiatrists can be found by examining their position in the establishment and running of a number of bodies tasked with investigating addiction and advising on appropriate methods of dealing with this. Psychiatrists dominated the MRC working group set up in 1968 to evaluate different methods of treatment for drug dependence and make recommendations on specific research projects to be funded by the Council.¹¹⁸ Although Anthony Dornhorst, a physiologist, chaired the group the rest of the party were nearly all psychiatrists: Connell, Bewley, Owens and Willis all ran DDUs and Gelder and Cawley worked at the Maudsley (the foremost psychiatric hospital in Britain). The remaining members were Spicer, a medical statistician and D’Obran, a prison medical officer.¹¹⁹

Psychiatrists were also heavily represented on the Advisory Committee on Drug Dependence (ACDD). The ACDD was convened in 1966 as a result of the Brain committee’s recommendation that a standing advisory committee be established to monitor the ‘whole problem of drug addiction.’¹²⁰ It was tasked with keeping ‘under review the misuse of narcotic and other drugs which are likely to produce dependence and to advise on remedial measures that might be taken.’¹²¹ The committee were appointed for three years initially, they were re-appointed in 1969,

¹¹⁸ PRO FD 7/1584, Terms of reference for working party, May 1968. There were also working parties on the epidemiology of addiction and the biochemical and pharmacological aspects of drug dependence. See PRO FD 7/875-879, PRO FD 7/1580-1582, PRO FD 7/1587-1589, PRO FD 7/1600-1605.

¹¹⁹ PRO FD 7/1583, Letter from Faulkner, (Medical Research Council, hereafter MRC) to Professor Dornhorst, 22 February 1968.

¹²⁰ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 13.

¹²¹ *The Hansard Journal of Political Debates*, Vol. 732, 26 July 1966, 248.

and continued to operate until 1971 when the Advisory Council on the Misuse of Drugs (ACMD) was created through the Misuse of Drugs Act to replace them.¹²² It had been agreed that the committee be chaired by Lord Brain, but when he died later that year he was replaced by Sir Edward Wayne, Professor of Medicine at Glasgow University, and former Professor of Pharmacology and Therapeutics at Sheffield University. Though the committee clearly contained the ‘broadly-based representation’ envisaged by Brain including two MPs, two journalists, one magistrate, one senior police officer, one retail pharmacist, one pharmacologist, one prison governor, one probation officer, one researcher into student problems, one sociologist, one headmaster, the general manager of the Glaxo Group and Baroness Wootton of Abinger, the fact that of the six doctors on the group half were psychiatrists was deeply significant.¹²³ The initial membership of the ACDD thus reflected the diversity of groups and individuals becoming interested in drug addiction and at the same time reiterated the central importance being accorded to the psychiatrist in dealing with this condition.

2.2 Researching addiction

The establishment of the Addiction Research Unit (ARU) at the Institute of Psychiatry in 1967 also appeared to enhance the role of the psychiatrist. The Institute was based at the Maudsley (which itself had an excellent reputation for psychiatric teaching and research) and under the leadership of Aubrey Lewis was credited with some of the

¹²² PRO MH 149/162, Minute regarding the re-appointment of the ACDD December 1969; Misuse of Drugs Act 1971, *Public General Acts and Measures of 1971*, Part I, Chapters 1-49, Chapter 38, 639-680, pp. 639-640.

¹²³ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 13; PRO MH 149/162, Membership of the ACDD, October 1966.

key developments in British psychiatry in this period.¹²⁴ The creation of the ARU at such an important centre for psychiatry was indicative of the extent to which addiction was regarded as a psychiatric condition. The Ministry of Health had also received a ‘reassuring response’ from Guy’s Hospital and University College Hospital about the possibility of setting up a unit but the Chief Medical Officer was in no doubt ‘that the Maudsley is the right place for our main effort.’¹²⁵ Headed by a psychiatrist (Griffith Edwards) and supported by a number of other consultant and academic psychiatrists the ARU was, on one level, another example of the increasing power and authority of the psychiatrist in dealing with addiction.¹²⁶ However, a closer examination of the early research conducted by the unit points to the importance of the social sciences in assessing addiction, an occurrence that fostered tensions between clinical psychiatry and the social sciences, and between treatment and research which could be read as a resurgence of the conflict between the medical and the social.

In addition to its psychiatrically trained personnel the ARU also employed a team of social psychologists, social investigators and research assistants, so that by 1969 they had 21 research staff.¹²⁷ The inclusion of these social scientists in the work of the ARU indicates there were non-psychiatric approaches to addiction in this period. Indeed, Smart argues that the ARU was a ‘manifestation of the optimism that flourished during the 1960s, which was based on a belief that (social) scientific work could discover the cause, and hence provide the remedy, to complex social

¹²⁴ For a consideration of the Maudsley and the Institute of Psychiatry and its interaction with drug addiction treatment, see Judson, *Heroin Addiction in Britain*, p. 12; Berridge, *Health and Society in Britain Since 1939*, p. 32. For a more general account of the Maudsley see A. Walk, ‘Medico-psychologists, Maudsley and the Maudsley’ in Murray & Turner, *Lectures in the History of Psychiatry*, 12-27.

¹²⁵ PRO MH 150/94, Letter from Sir George Godber to Sir Denis Hill, 6 January 1967.

¹²⁶ PRO MH 150/94, Proposal for the establishment of a centre for drug addiction research at the Institute of Psychiatry, January 1967.

¹²⁷ PRO MH 150/94, Proposal for the Consolidation of the Addiction Research Unit, August 1969.

problems.’¹²⁸ The existence of an alternative locus of expertise on addiction accompanied by a view of the condition that stressed its social rather than medical elements could have posed a threat to the exclusive authority of the psychiatrist, and there were tensions between those who conducted research into addiction and those who offered treatment for this condition.

This tension between treatment and research can be observed in the discrepancy between the kind of research projects proposed by the ARU and the MRC working groups and the actual studies conducted. Initial research to be carried out at the ARU was intended to provide ‘basic data which can be expected to provide the answers needed for effective action to reverse the present upward trend in incidence [of addiction].’ Studies were to ‘evaluate, as soon as possible, the best methods for treating addicts and preventing further spread of addiction.’¹²⁹ It was therefore proposed that not only should there be socio-psychological and epidemiological studies of addiction but also some research into treatment, including a study comparing the rapid withdrawal of drugs from addicts with continued prescription (maintenance).¹³⁰ However, a report on the ARU’s first year suggests that the research being carried out at the unit was primarily concerned with the social context of heroin use rather than investigating treatment methods. Projects begun or contemplated included: heroin use in a provincial town, a study on the effects of injected methedrine, a survey of drug taking amongst inner city London school children, a follow up study of persons known to use heroin, a study of heroin users and their siblings, an examination of the lifestyles of heroin addicts, an investigation into the natural history of heroin use in a provincial town and a study on the social

¹²⁸ C. Smart, ‘Social policy and drug dependence: an historical case study’, *Drug and Alcohol Dependence*, 16, (1985), 169-180, p. 171.

¹²⁹ PRO MH 150/94, Proposal for the establishment of drug addiction research at the Institute of Psychiatry, January 1967.

¹³⁰ *Ibid.*

functioning of heroin users.¹³¹ There were no studies assessing the relative benefits of different forms of treatment.

Nor was this research conducted under the auspices of the MRC, despite the council's working group on treatment methods also identifying the evaluation of these as a high priority. The group had pointed to two main areas requiring investigation. The first concerned the role of the DDUs. Members of the working group pointed out 'that it was an article of faith that the treatment centre was a useful institution, serving a valuable purpose in the treatment and "cure" (however defined) of heroin addicts' but, 'the role and value' of these 'had never been objectively assessed, and that in view of the money and manpower being invested in them, it was of crucial importance to make some attempt to do this.'¹³² The second area they believed required investigation was the relative merits of prescribing methadone as opposed to heroin in the maintenance treatment of addicts. The working group 'hoped that regular methadone is less harmful than heroin in its physical and psychological effects, and may allow more opportunity for eventual withdrawal.' They noted that 'These propositions require to be proved [sic], but the intention is therapeutic.'¹³³ This connection with methadone with a more 'therapeutic' approach to the treatment of heroin addiction will be discussed at greater length below, but it would appear that the Working Party had noted a shift in the prescription policies of clinics towards methadone as a replacement for heroin, and felt that this should be investigated.¹³⁴

¹³¹ PRO MH 150/94, Report on the activities of the Addiction Research Unit, Institute of Psychiatry, September 1968. See also some of the published studies supported by the ARU, such as: A. Kosviner et al, 'Heroin use in a provincial town', *Lancet*, (1 June 1968) 1189-1191; H.H. Blumberg, 'British users of opiate-type drugs: a follow up study', *British Journal of Addiction*, 71, (1976) 65-77; N.H. Rathod, 'The use of heroin and methadone by injection in a New Town', *British Journal of Addiction*, 67 (1972) 113-122.

¹³² PRO FD 7/878, Minutes of the Working Party meeting, 30 October 1969.

¹³³ PRO FD 7/1591, Third draft of Working Party report, April 1970.

¹³⁴ An MRC official on 9 March 1970 noted that methadone was already being widely used. PRO FD 7/878, Note for file, N.H. Winterton, 9 March 1970.

A combined Home Office and MRC survey of research in progress on drug dependence presented to the Council in 1972 indicates that the work on the evaluation of treatment methods remained undone. The report listed 108 projects, nine of which were ‘considered irrelevant to the problems under consideration’ and only 15 of the remaining 99 were on ‘general clinical aspects, including treatment.’¹³⁵ Of these 15, three were concerned with drugs other than heroin, such as cannabis or methyamphetamine. The 12 studies that dealt with heroin and drug dependence more generally, with just one exception, were not concerned directly with treatment practices.¹³⁶ There were descriptive studies, such as Bewley’s survey of heroin users attending three treatment centres. There was a study on the effect of addiction on the addicts’ general health conducted by Professor Marks and an examination of the effects of drug addiction on pregnancy by Elizabeth Tylden. There was even a comparative study comparing British and American treatment methods, but very little of this research was directed towards the practical treatment of addiction.¹³⁷

This absence did not go unnoticed. A review of British heroin addiction treatment policy ten years after the establishment of the clinics by Griffith Edwards, the director of the ARU, presented a dismal picture of the state of research into the treatment response to heroin addiction. He asserted that ‘Discussion of the future of treatment policies is much handicapped by a lack of current information on what is

¹³⁵ PRO FD 7/1599, Working group on drug dependence: survey of research into drug dependence in progress in the UK, 1971-1972.

¹³⁶ The exception was a controlled study of oral maintenance on substitute drugs for heroin users conducted by Dr Peter Chapple of the charity-run National Addiction and Research Centre, an organisation viewed with suspicion by the Ministry of Health and some drug addiction experts, as a result of Chapple’s unorthodox views and the fact he operated in private practice. See PRO MH 154/431 National Addiction and Research Day Centre, Chelsea; Spear, *Heroin Addiction Care and Control*, p. 193, p. 205; H.D. Beckett, ‘Obituary: Peter Arbuthnot Lane Chapple – A personal appreciation’, *British Journal of Addiction*, 71 (1976) 295-296.

¹³⁷ PRO FD 7/1599, Working group on drug dependence: survey of research into drug dependence in progress in the UK, 1971-1972.

actually being done and what is actually effective.’¹³⁸ There was no clinical trial either of maintenance versus withdrawal, or the relative values of prescribing methadone rather than heroin until Richard Hartnoll and Martin Mitcheson’s study on heroin maintenance was published in 1980.¹³⁹ The implications of this highly contentious study will be discussed in detail below, but it is worth noting at this point that it was not until the National Treatment Outcome Research Study (NTORS) was initiated in 1995 that a thorough survey of the relative benefits of treatment methods was conducted.¹⁴⁰ According to Edwards, important questions remained unanswered about the effectiveness of the strategies employed by the DDUs throughout the 1970s and into the 1980s.¹⁴¹ An assessment of the clinics and the services they offered was not conducted until 1982. In her national survey of the DDUs sociologist Carol Smart noted that

it is perhaps surprising that relatively little is known about how DDUs, especially those outside London, are staffed and organised and that even less is known about the broad treatment policy that individual DDUs might adopt. What studies we have of DDUs have tended to concentrate on London and have also tended to say more about the people using treatment centres than about DDUs themselves.

Smart contended that her study would provide the kind of ‘empirical research’ so far lacking in the drug dependence field and on which policy decisions should, she asserted, be made.¹⁴²

Smart was not the sole proponent of such an argument. Gerry Stimson in his assessment of drug policy and research in the 1980s noted that ‘there has been a marked lack of research on treatment, then and now’ and that ‘treatment policies

¹³⁸ G. Edwards, ‘British policies on opiate addiction: ten years working of the revised response, and options for the future’, *British Journal of Psychiatry*, 134, (1979), 1-13, p. 11.

¹³⁹ R. Hartnoll et al., ‘Evaluation of heroin maintenance in controlled trial’, *Archives of General Psychiatry*, 37, (1980), 877-884.

¹⁴⁰ Spear, *Heroin Addiction Care and Control*, pp. 309-310.

¹⁴¹ Edwards, ‘British policies on opiate addiction’, p. 9.

¹⁴² Smart, ‘Drug Dependence Units in England and Wales: the results of a national survey’, p. 131, p. 132.

proceed largely without empirical investigation.’¹⁴³ Jayne Love and Michael Gossop in their examination of the processes of referral and disposal within a London DDU in 1983 asserted that there was ‘surprisingly little detailed information about the operation of the drug clinics’ and not much was known about ‘what actually happens to the addict within a drug dependence clinic,’ that ‘few studies have looked at this issue on an empirical basis.’¹⁴⁴ Dr David Owen, MP, in a lecture to the Society of Clinical Psychiatrists Research Fund in 1985 also bemoaned the ‘paucity of research’ and the way policy decisions were taken ‘ad hoc without a sustained medical strategy that was deeply rooted in medical and scientific evidence.’¹⁴⁵

An explanation for the absence of this kind of research and the apparent lack of an empirical basis to treatment policies lies in the nature of the relationship between clinical practice and research in this period. The notion that research findings should strongly influence clinical practice is a relatively new concept. Since the 1990s ‘evidence-based medicine’ has gained ground.¹⁴⁶ Recent guidelines on good clinical practice (including those on the treatment of addiction) have made extensive use of evidence derived from research, but this was largely not the case in the 1970s and 1980s when these were much more closely based on clinical practice and experience.¹⁴⁷ Treatment policy, as will be seen in the final section of this

¹⁴³ G.V. Stimson, ‘British drug policies in the 1980s: a preliminary analysis and some suggestions for research’, *British Journal of Addiction*, 82, (1987) 477-488, p. 480.

¹⁴⁴ Love & Gossop, ‘The process of referral and disposal within a London Drug Dependence Clinic’, p. 440.

¹⁴⁵ D. Owen, ‘Need for a scientific strategy to curb the epidemic of drug abuse in the United Kingdom, lecture to the Society of Clinical Psychiatrists Research Fund’, 15 October 1985’ *Lancet*, (26 October 1985) p. 958.

¹⁴⁶ For an account of the nature and influence of evidence-based medicine see R. Baggott, *Health and Health Care in Britain*, (Basingstoke: Macmillan, 1998) pp. 56-57 and Berridge, *Health and Society in Britain Since 1939*, p. 83.

¹⁴⁷ On the role of evidence-based medicine in the creation of clinical guidelines see A. Hutchinson & R. Baker (eds.) *Making Use of Guidelines in Clinical Practice*, (Oxford: Radcliffe Medical Press, 1999), especially A. Breen & G. Feder, ‘Where does the evidence come from?’, 15-28 and M. Eccles, B. Higgins & P. Adams, ‘Developing evidence-based guidelines: experiences from the North of England Evidence-Based Guideline Development Project’, 29-46. The importance of the 1984

chapter, evolved from the clinical setting and was directed by those psychiatrists actually involved in the treatment of addiction, not social scientists tasked with evaluating these.

Indeed, there appeared to be a good deal of tension between those engaged in treatment and those conducting research. At the same time as the ARU was established Connell created the Drug Dependence Clinical Research and Treatment Unit, also based at the Maudsley.¹⁴⁸ The unit provided in and outpatient treatment for addiction as well as promoting research.¹⁴⁹ There was obviously a degree of competition between this unit and the ARU. Discussions amongst Ministry of Health officials over a proposed visit by the Duke of Edinburgh to the Maudsley stressed that if the Duke were to visit the hospital he must see both Edwards' and Connell's units 'as there is a certain amount of rivalry between the two and a visit to one and not the other might cause difficulty.'¹⁵⁰ Connell's dislike of the Institute of Psychiatry and his motives for setting up his own unit were revealed in an interview he gave to the *British Journal of Addiction*. He asserted that including the term 'research' in his unit's name meant that research could be

funnelled to the unit under my direction, rather than things having to go through the Institute of Psychiatry, which I later learned to my cost was interested in furthering its own research and service interests rather than trying to make a contribution to a very complex and unrewarding field.¹⁵¹

This suggests that Connell was not opposed to research per se; indeed, he had outlined the need for research into addiction on a number of occasions throughout the late

Guidelines of Good Clinical Practice in the Treatment of Drug Misuse will be dealt with in Chapter Four. For a discussion of the 1999 guidelines see Conclusion, pp. 285-286.

¹⁴⁸ P.H. Connell, '“I need heroin”. Thirty years of drug dependence and of the medical challenges at local, national, international and political level. What next?', *British Journal of Addiction*, 81, (1986), 461-472, p. 462; Connell, 'Conversation with Philip Connell', p. 16; Spear, *Heroin Addiction Care and Control* p. 291.

¹⁴⁹ Connell, 'Conversation with Philip Connell', p. 16; PRO MH 154/431, Dr Baker to Miss Hedley, 12 August 1969.

¹⁵⁰ PRO MH 154/431, Minute from Miss Hedley to Brown and Cashman, Ministry of Health, 14 August 1969.

¹⁵¹ Connell, 'Conversation with Philip Connell', p. 16.

1960s, but rather he objected to research conducted by someone else into matters he did not consider important.¹⁵² For Connell and other clinical psychiatrists there was a sharp distinction between the research conducted by epidemiologists, sociologists and other social scientists ‘to produce by careful research, data relating to the causes of drug taking, methods of spread and suggestions relating to prevention’ and ‘the challenge to physicians to produce hard data relating to treatment programmes in order that [the] most effective methods can be delimited.’¹⁵³ The implication was that social scientists investigated the ‘social’ side of addiction but the ‘medical’ side, research into and the development of treatment methods, was left to psychiatrists.

3. The development of clinical practice in the treatment of heroin addiction,

3.1 Going to the clinic

A consideration of the development of clinical practice in the treatment of addiction strongly supports the notion that such a divide existed. Treatment policy between 1968 and 1979 developed under the direction of psychiatrists with little input from social scientists, politicians, government officials, or any other bodies and individuals. This should not, however, necessarily be read as a victory for the ‘medical’ over the ‘social’; these two forces continued to interact and work together to shape the treatment of addiction. This can be observed in the way the DDUs operated and the way they dealt with their addict patients. When the clinics opened in April 1968 the doctors running them were woefully inexperienced. As has already been noted, there was a distinct lack of expertise in dealing with drug addiction, and subsequently many clinic doctors had never encountered a heroin addict prior to the establishment of the

¹⁵² See, for example, P.H. Connell, ‘Drug dependence in Great Britain: a challenge to the practice of medicine’ in Steinberg, *Scientific Basis of Drug Dependence*, 291-299; P.H. Connell, ‘Importance of research’, *British Medical Journal*, 20 May 1967, 499-500.

¹⁵³ Connell, ‘Drug dependence in Great Britain: a challenge to the practice of medicine’, pp. 298-299.

DDUs.¹⁵⁴ The first problem that presented itself to clinic staff was how to determine if a patient was addicted to heroin, and if they were, how much should be prescribed. Gardner and Connell at the Bethlem and Maudsley found that a positive urine test for the presence of opiate drugs could assist in diagnosis, but this did not prove that the patient was an addict, nor did it indicate what dose was required to prevent the onset of withdrawal symptoms.¹⁵⁵ Determining the correct amount to prescribe to an addict was a crucial decision, but there was no reliable test on which to base this assessment.¹⁵⁶ In their study of DDU practices Stimson and Oppenheimer found that in order to arrive at a dose clinic psychiatrists questioned addicts about their use of drugs, checked for needle marks and conducted urine tests, but that the most reliable method for assessing dosage level was to admit the addict to hospital where reactions to different amounts of opiates could be closely monitored. However, this seemed to be a rare occurrence, as inpatient admission was costly and time-consuming, and many DDUs lacked the facilities to admit patients for this purpose.¹⁵⁷ The most common way of determining the amount to prescribe, according to Stimson and Oppenheimer, was for the doctor to ask the addict what they would like to be prescribed, and then divide it by two. This decision was based not on any 'scientific' evidence, but on 'a simple rule of thumb.'¹⁵⁸ It is likely that these unreliable methods of dosage determination, coupled with doctors' inexperience, led to the over-prescription of heroin to addicts attending clinics in the first year of their operation.¹⁵⁹

¹⁵⁴ M. Mitcheson, 'Drug clinics in the 1970s' in Strang & Gossop, *Heroin Addiction and Drug Policy*, 178-191, p. 178; Stimson & Oppenheimer, *Heroin Addiction*, p. 94; Trebach, *The Heroin Solution*, p. 186; Spear, *Heroin Addiction Care and Control*, pp. 205-211.

¹⁵⁵ Gardner & Connell, 'One year's experience in a Drug-Dependence Clinic', p. 455.

¹⁵⁶ The need for such a test was recognised by, among others, Connell in 1967. See Connell, 'The importance of research', p. 500.

¹⁵⁷ Stimson and Oppenheimer, *Heroin Addiction*, pp. 84-85.

¹⁵⁸ *Ibid.* p. 85.

¹⁵⁹ *Ibid.* p. 90; Judson, *Heroin Addiction in Britain*, p. 93; Smart, 'Social policy and drug dependence', p. 177.

Doctors working at DDUs found that addicts were unlike patients that they had encountered in other areas of medicine. Margaret Tripp, a psychiatrist who ran the DDU at St Clement's Hospital between 1968 and 1971, noted that many addicts did not consider themselves to be 'sick.'¹⁶⁰ This had implications for the doctor-patient relationship (between clinician and addict) and the treatment offered as part of this. Being, or allowing, oneself to be labelled as 'sick' conferred certain attributes. Talcott Parsons in *The Social System* developed one of the most important models describing the social expectations and obligations of taking on the sick role.¹⁶¹ He found that becoming sick allowed an individual to be excused from the performance of normal social obligations and also exempted that person from responsibility for their own state. However, these were contingent on two obligations: to want to get well as soon as possible, and to seek technically competent help and cooperate with medical experts.¹⁶² Although Parsons' formulation has been criticised, few have been able to offer a viable alternative and his basic assumptions about expectations and obligations seem to hold true.¹⁶³

The addict-patient often failed to fulfil the two basic obligations expected of them and this affected their relationship with the doctor, and thus the doctors' view of their condition and its treatment. Stimson and Oppenheimer found that addicts frequently went to clinics because they wanted a clean, legitimate, regular supply of drugs 'but such attendance did not, for many, commit them to seeing that they needed "treatment" in the sense of medical help, a "cure", and eventual abstinence.'¹⁶⁴ What is more, addicts were often in direct conflict with DDU doctors, demanding, cajoling,

¹⁶⁰ Judson, *Heroin Addiction in Britain*, p. 94.

¹⁶¹ T. Parsons, *The Social System*, (Glencoe, Illinois: Free Press, 1951).

¹⁶² Discussion of Parsons' formulation of the sick role in M. Morgan, M. Calan & N. Manning, *Sociological Approaches to Health and Medicine*, (London: Croom Helm, 1985) pp. 45-52.

¹⁶³ *Ibid.* pp. 52-56.

¹⁶⁴ Stimson & Oppenheimer, *Heroin Addiction*, p. 88.

threatening and pleading with staff to be prescribed more drugs.¹⁶⁵ If addicts did not want to get well, and did not co-operate with medical staff their status as ‘sick’ was clearly dubious. Questioning the sickness of the addict threatened the disease-based nature of addiction and thus the doctor’s role in ‘treating’ this. Many doctors working in clinics raised these same issues. ‘Treatment’ in the early years of the DDUs varied widely from clinic to clinic.¹⁶⁶ Some clinics prescribed intravenous heroin, others prescribed intravenous methadone, others would only give addicts oral methadone. There were even variations within clinics, with some patients receiving prescriptions for heroin and others methadone. Still others were not offered drugs at all, but instead were given psychotherapy, group therapy and or occupational therapy.¹⁶⁷

More significant than the range of treatments initially on offer at the DDUs was the rationale behind these. Stimson and Oppenheimer noted that ‘treatment’ was ‘often a euphemism for other goals and we have to look not just at what was done to or for the patients, but also at the clinicians motivations in so acting.’¹⁶⁸ They found that many of the psychiatrists they spoke to in 1976 regarded their work as ‘control’ or ‘containment’ of the drug problem, and talked about the ‘benefits to society’ of their work. Therapy was still a concern, but Stimson and Oppenheimer felt it was unusual to see such a concern for social control within medical practice.¹⁶⁹ Treatment of the addict and social control of addiction through clinical practice came then not just from the stated dual purpose of the clinics, but also from the treatment setting. Doctors found that it was difficult to ‘treat’ a ‘patient’ who did not accept that he or

¹⁶⁵ *Ibid.* pp. 85-86.

¹⁶⁶ Smart, ‘Social policy and drug dependence’, p. 177; Judson, *Heroin Addiction in Britain*, p. 107; G. Stimson & R. Lart, ‘The relationship between the State and local practice in the development of national policy on drugs between 1920 and 1990’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 331-341, pp. 333-334.

¹⁶⁷ Stimson and Oppenheimer, *Heroin Addiction*, pp. 96-97.

¹⁶⁸ *Ibid.* p. 97.

¹⁶⁹ *Ibid.* p. 97.

she was sick. Their work then took on the function of social control. However, some clinicians were uncomfortable with their role as social controllers. A clinic doctor interviewed by Stimson and Oppenheimer said that they resented having to act like ‘policemen with white coats on.’¹⁷⁰ If psychiatrists were simply handing out prescriptions to addicts with no attempt to get them off drugs they could be said to be ‘overpaid grocer[s]’ or ‘dealers by appointment to H.M. Government.’¹⁷¹ Many DDU doctors disliked prescribing heroin to addicts on a maintenance basis because it conflicted with ‘therapeutic ideals, for patients who were maintained, it was argued, were not being cured of their addiction.’¹⁷² Prescribing heroin to heroin addicts might benefit society but it did not appear to cure the individual addict of their disease.

3.2 Treatment, control and the shift from intravenous heroin to orally administered methadone

A change in the prescription policies of the DDUs in the early 1970s suggested a rejection of the social control of addiction through maintenance and a resurgence of a more ‘medical’ form of treatment directed towards the ‘cure’ of addiction. There was a discernable shift away from the prescription of injectable heroin, first to injectable methadone, and then later to orally administered methadone. In July 1968 2,690 grams of heroin was prescribed to patients attending DDUs. By December 1970, this amount had fallen to 1,358 grams.¹⁷³ It was estimated that between 60 and 80 per cent of addicts were receiving prescriptions for heroin, or heroin and methadone in

¹⁷⁰ *Ibid.* p. 216.

¹⁷¹ J. Strang, S. Ruben, M. Farrell & M. Gossop, ‘Prescribing heroin and other injectable drugs’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 192-203, p. 202; W. Self, quoted in Davenport-Hines, *The Pursuit of Oblivion*, p. 202.

¹⁷² Stimson & Oppenheimer, *Heroin Addiction*, p. 216.

¹⁷³ J. Glancy, ‘The treatment of narcotic dependence in the United Kingdom’, *Bulletin on Narcotics*, 24, (1972), pp. 1-9, cited in Spear, *Heroin Addiction Care and Control*, p. 235.

1968, compared to 31 per cent of addicts in 1970.¹⁷⁴ At the same time as the amount of heroin being prescribed and the proportion of addicts receiving prescriptions for this drug were falling, the amount of methadone prescribed and percentage of addicts taking opiate substitutes increased. In August 1969, 918 grams of methadone was prescribed by clinics to addicts, but just 16 months later, in December 1970, this increased to 1,131 grams.¹⁷⁵ This meant that in 1970 51 per cent of addicts were receiving prescriptions for methadone or other heroin substitutes.¹⁷⁶ Over the decade this trend continued, so that by 1978 71 per cent of addicts were being prescribed methadone, and just nine per cent were receiving scripts for heroin, or heroin and methadone.¹⁷⁷ Thus, there was a definite move away from the prescription of heroin to addicts towards the prescription of substitute drugs such as methadone between 1968 and 1978.

This shift was not based on a policy decision taken by government ministers, civil servants or advisory bodies such as the ACDD; it evolved through clinical practice.¹⁷⁸ Clinic doctors gradually began to prescribe less heroin and more methadone to their addict patients. This development requires explanation on two levels. Firstly, to explain how methadone replaced heroin as the main drug being prescribed to addicts and secondly, to understand why this change took place. Prescribing methadone rather than heroin did have a number of advantages. Its longer half-life meant that it could be taken less frequently, allowing the addict a more 'normal' life without the constant interruptions of having to inject.¹⁷⁹ Injectable methadone was cheaper than injectable heroin, although surprisingly little reference is

¹⁷⁴ Stimson & Oppenheimer, *Heroin Addiction*, p. 102.

¹⁷⁵ Glancy, 'The treatment of narcotic dependence in the United Kingdom', pp. 1-9, cited in Spear, *Heroin Addiction Care and Control*, p. 235.

¹⁷⁶ Stimson & Oppenheimer, *Heroin Addiction*, p. 102.

¹⁷⁷ *Ibid.*

¹⁷⁸ Trebach, *The Heroin Solution*, p. 201.

¹⁷⁹ Strang, Ruben, Farrell, & Gossop, 'Prescribing heroin and other injectable drugs', p. 198.

made to this in the contemporary literature, suggesting that this was not a major factor in the decision to adopt the drug.¹⁸⁰ Methadone could also be administered orally, thus removing the dangers of infection that came with intravenous injection.¹⁸¹

Methadone's 'image' however, was as important as the practical benefits its use conferred. Vincent Dole and Marie Nyswander pioneered the use of methadone in the treatment of heroin addiction in New York during the mid 1960s.¹⁸² Dole and Nyswander prescribed heroin addicts orally administered methadone on a maintenance basis, a move that was seen as progressive and 'trail-blazing' against the backdrop of the much more tightly regulated addiction treatment in the USA, where prescription of heroin to addicts was prohibited and all previous efforts had been directed at curing addiction, not maintaining it.¹⁸³ This project came to the notice of British drug addiction specialists, such as Bewley, who reviewed it in conjunction with other American work.¹⁸⁴ Yet, Dole and Nyswander's experiment initially seemed to offer little in terms of direct applicability to treatment in DDUs. Firstly, Dole and Nyswander gave addicts methadone orally, which had to be taken in front of the doctor or nurse, whereas British addicts in the early days of the clinics were accustomed to prescriptions of injectable heroin to be consumed in private.¹⁸⁵

Secondly, Dole and Nyswander claimed that if methadone were taken at sufficiently

¹⁸⁰ Current estimates put the cost of heroin maintenance at £10-15,000 a year per addict, compared to £2,000 a year for methadone. *Drugscope News*, 31 January 2001, http://www.drugscope.org.uk/news_item.asp?a=1&intlID=679; *The Guardian*, 15 January 2001, <http://www.guardian.co.uk/Archive/Article/0,4273,4335607,00.html>. Spear argues that heroin prescription only became expensive when injectable tablets were replaced with freeze-dried ampoules, but he makes no mention of the relative cost of methadone. See Spear, *Heroin Addiction Care and Control*, pp. 244-245.

¹⁸¹ Mitcheson, 'Drug clinics in the 1970s', pp. 182-188.

¹⁸² V. Dole, M. Nyswander, M. Kreek, 'Narcotic blockade', *Archives of Internal Medicine*, 118, (1966), 304-309. For discussion of this work see also: Gerritsen, *The Control of Fuddle and Flash*, pp. 198-199; Spear, *Heroin Addiction Care and Control*, pp. 237-238; Judson, *Heroin Addiction in Britain*, p. 88; Mitcheson, 'Drug clinics in the 1970s', pp. 179-180.

¹⁸³ Gerritsen, *The Control of Fuddle and Flash*, p. 198.

¹⁸⁴ PRO FD 7/1584, 'Drug dependence in the USA' Bewley Report to the WHO on five and a half week visit to study drug dependence programmes, 1968; T.H. Bewley, 'Drug dependence in the USA', *Bulletin on Narcotics*, 21, (1969), 13-20.

¹⁸⁵ Mitcheson, 'Drug clinics in the 1970s', p. 180.

high doses it would saturate the addicts' nerves and prevent them from getting 'high' if they took heroin whilst also being prescribed methadone.¹⁸⁶ British experts were sceptical about this 'methadone blockade,' and it was suggested that this would not work with British addicts, as they were already accustomed to higher doses of heroin.¹⁸⁷ Dole and Nyswander's experiment's real importance for British drug treatment was that it gave methadone a 'respectable image.'¹⁸⁸ According to Strang, Ruben, Farrell and Gossop, methadone 'in public and professional eyes' was a 'medicinal drug' whereas heroin was a 'drug of abuse.'¹⁸⁹ Prescribing addicts methadone had the appearance of being a more medical approach, having acquired this status from its use in the USA, and also because it was not the drug most addicts were taking before they presented for medical treatment. Prescribing methadone thus differentiated what DDUs were prescribing from addicts' own self-medication with illicit heroin.

A study evaluating the prescription of these two drugs to addicts appeared to many DDU psychiatrists to endorse the prescription of methadone to addict-patients. In 1972 Martin Mitcheson and Richard Hartnoll conducted a randomised controlled trial at University College Hospital DDU to compare the prescription of injectable heroin to addicts with the prescription of oral methadone. Over a three-year period a total of 96 addicts were randomly allocated into two groups, the first were prescribed heroin on a maintenance basis (HM) the second were prescribed oral methadone on a maintenance basis (OM).¹⁹⁰ Hartnoll and Mitcheson assessed patients at the end of the trial period on drop out rate, illicit opiate use, frequency of injection, non-opiate

¹⁸⁶ Judson, *Heroin Addiction in Britain*, p. 88.

¹⁸⁷ *Ibid.*, pp. 109-111; Spear, *Heroin Addiction Care and Control*, pp. 237-238.

¹⁸⁸ Mitcheson, 'Drug clinics in the 1970s', p. 179.

¹⁸⁹ Strang, Ruben, Farrell, & Gossop, 'Prescribing heroin and other injectable drugs', p. 198.

¹⁹⁰ Hartnoll et al., 'Evaluation of heroin maintenance in controlled trial', pp. 877-884; Mitcheson, 'Drug clinics in the 1970s', pp. 182-183.

use, involvement with drug subculture, employment, health and criminal activity. Amongst the most significant of their findings was that 90 per cent of the HM group were still injecting heroin one year later, compared to 57 per cent of the OM group.¹⁹¹ Hartnoll and his colleagues interpreted this to mean that prescribing heroin to addicts maintained the 'status quo,' with the addict showing little signs of change in lifestyle or in coming off drugs, whereas prescribing methadone to addicts instead 'may be seen as a more active policy of confrontation that is associated with greater change.'¹⁹² There were, however, other consequences of refusing to prescribe heroin to addicts and giving them methadone instead. Hartnoll and Mitcheson noted that 70 per cent of the OM group were convicted of a crime during the trial period, compared with only half of the HM group.¹⁹³ They also found that 76 per cent of the HM group were still visiting the clinic one year later, whereas only 29 per cent of the OM group were regularly attending.¹⁹⁴ This would indicate that prescribing heroin led to less criminal activity amongst addicts and also resulted in more of them remaining in contact with treatment services when compared with prescription of methadone.

The study's authors were rather guarded in their conclusions. Hartnoll and his colleagues argued that their findings should 'contribute to a more informed discussion' of treatment options 'rather than provide an unequivocal [sic.] answer' and that these needed to be considered in conjunction with the desired treatment outcome and who it should benefit; society, or the individual.¹⁹⁵ This was not, however, how the study was received. Mitcheson observed that his research was 'perceived by many staff in London clinics as clear evidence for replacing injectable

¹⁹¹ R. Hartnoll & M. Mitcheson, 'Conflicts in deciding treatment within drug dependency clinics' in *Problems of Drug Abuse in Britain: Papers Presented to the Cropwood Round Table Conference 74-78*, p. 76.

¹⁹² Hartnoll et al., 'Evaluation of heroin maintenance in controlled trial', pp. 882-883.

¹⁹³ Hartnoll & Mitcheson, 'Conflicts in deciding treatment within drug dependency clinics' p. 76.

¹⁹⁴ *Ibid.*

¹⁹⁵ Hartnoll et al., 'Evaluation of heroin maintenance in controlled trial', p. 884.

heroin maintenance with oral prescribing’ and ‘this probably reflected the already formulated opinion that the policy of prescribing injectable drugs was, either or both, unhelpful to the patient and/or insupportable to therapeutically inclined staff.’¹⁹⁶

This assertion is supported by the relative amounts of heroin and methadone being prescribed; the figures quoted above indicate that methadone was already beginning to replace heroin as the primary drug being prescribed to addicts by clinics before the study was published in 1980. As Hartnoll and Mitcheson presented their findings prior to publication it is likely that many clinic doctors knew of the study and its results as early as 1976, but this was still after the switch to methadone had been made.¹⁹⁷ Indeed, Mitcheson felt the study was ‘used as an after-the-decision confirmation.’¹⁹⁸ Stimson and Oppenheimer found that although most clinic doctors had heard of the study, few had actually read it, nor did they appreciate the caution that Hartnoll and his associates had expressed about the direct applicability of their results to a treatment situation. Instead, ‘What concerned them more, as several consultants indicated, was that here was scientific justification for a policy change that was already emerging from the work context.’¹⁹⁹

This remark hints at another reason for the change from the prescription of heroin to the prescription of oral methadone – clinical frustration. Psychiatrists working in treatment centres began to question the value of prescribing heroin to addicts on a number of grounds. By the mid 1970s it was clear that clinics were no longer able to undercut the black market by prescribing heroin to addicts.²⁰⁰ Illicit ‘Chinese’ heroin could be bought in London’s West End from 1967, but its popularity

¹⁹⁶ Mitcheson, ‘Drug clinics in the 1970s’, p. 183.

¹⁹⁷ Mitcheson states that this research was presented to staff at other clinics in 1976, Mitcheson, ‘Drug clinics in the 1970s’, p. 182 and he and Hartnoll presented their findings at the Cropwood conference in 1977, see Hartnoll & Mitcheson, ‘Conflicts in deciding treatment within drug dependency clinics’.

¹⁹⁸ Mitcheson quoted in Trebach, *The Heroin Solution*, p. 193.

¹⁹⁹ Stimson & Oppenheimer, *Heroin Addiction*, pp. 218-219.

²⁰⁰ *Ibid.* p. 217.

grew as clinics took over the treatment of addicts and the availability of pharmaceutical heroin decreased.²⁰¹ There were other concerns that sprang directly from the treatment situation. As already indicated, addicts could be ‘difficult’ patients and this coupled with the lack of therapeutic success resulting from treatment (Stimson and Oppenheimer found that only 38 per cent of their sample of addict-patients had become abstinent in ten years) led to ‘battle-fatigue,’ ‘stagnation’ and ‘frustration’ amongst ‘demoralised’ clinic staff.²⁰² This prompted a move towards the prescription of methadone instead of heroin to addicts, as methadone was seen to be more ‘respectable,’ ‘therapeutic’ and could be used in a more ‘confrontational’ treatment response designed to provoke change in addict behaviour.²⁰³ The introduction of methadone, it was hoped, would ‘cure’ addicts.

A greater emphasis on the ‘cure’ of addiction was given additional importance by the changing administrative context in which the DDUs operated. Increasing evaluation of the DDUs encouraged a response that more readily moved addicts through the clinic system, resulting in ‘cure.’ In 1975 the ACMD set up a working group to review the treatment facilities provided by the DDUs, producing an interim report in 1977.²⁰⁴ Though the report made few recommendations, recognising that a much wider investigation of treatment services was required, (the resulting report, *Treatment and Rehabilitation* is discussed in more detail in Chapter Two) it represented a more evaluative approach to the work of the DDUs. As drug use began to rise exponentially, attention refocused on the success or otherwise of the DDUs in dealing with drug addiction. An editorial in the *Lancet* in 1982 opined that the policy

²⁰¹ Spear, *Heroin Addiction Care and Control*, pp. 228-231.

²⁰² Stimson & Oppenheimer, *Heroin Addiction*, p. 5; Spear, *Heroin Addiction Care and Control*, p. 247; P. Fleming, ‘Prescribing policy in the UK: a swing away from harm reduction?’, *International Journal of Drug Policy*, 6, (1995), 173-177, p. 172.

²⁰³ Mitcheson, ‘Drug clinics in the 1970s’, p. 175; Hartnoll et al, ‘Evaluation of heroin maintenance in controlled trial’, p. 883; doctors quoted in Stimson & Oppenheimer, *Heroin Addiction*, p. 219.

²⁰⁴ ACMD, *Treatment and Rehabilitation*, p. 3. See also Chapter Two, pp. 117-118.

of long-term prescription to some patients left the DDUs ‘in a position akin to that of a geriatric ward with its beds blocked.’²⁰⁵ Addict patients were not leaving the DDU as they were not being ‘cured.’ The prescription of oral methadone on a fixed term basis seemed to offer a chance to reverse this trend by providing a more ‘confrontational’ response, provoking change in the addict, leading to their ‘cure’ and subsequent removal from DDU patient lists. The administrative and financial implication of this was not lost on Mitcheson; he noted that the ‘prior introduction of time limited prescribing [in the 1970s] may...have subsequently enabled clinics to respond to the increased number of new referrals [in the early 1980s], without necessitating increasing staff and budgets.’²⁰⁶

Despite these non-medical factors involved in the adoption of the prescription of methadone by the DDUs this was largely interpreted as a more ‘medical’ response because of its emphasis on ‘cure.’ Moreover, it was an approach that was not just ‘medical’ but seen as specifically ‘psychiatric.’ In her study of DDU practices Smart found that 90 per cent of the clinics surveyed thought that individual psychotherapy was either a ‘very important’ or an ‘important’ part of the treatment they offered, compared to the 97 per cent that believed heroin maintenance was not important or not their policy.²⁰⁷ Lart asserted that this was indicative of a shift in emphasis on the part of DDU psychiatrists from trying to contain the epidemic of drug use to focus on the addicts they saw. Methadone was thus a way of ‘Challenging those patients [addicts] therapeutically, and perhaps changing some of them.’ That: “‘curing” them of the disease of addiction, was more important than trying to control society’s drug

²⁰⁵ ‘Drug addiction: British System failing’, *Lancet*, (9 January 1982) 83-84, p. 83.

²⁰⁶ Mitcheson, ‘Drug clinics in the 1970s’, p. 189. The administrative and economic consequences of maintenance over withdrawal for the DDUs during the 1980s are discussed in more detail in Chapter Four, pp. 189-190.

²⁰⁷ Smart, ‘Drug Dependence Units in England and Wales’, p. 139.

use.’²⁰⁸ However, this characterisation ignores the retention of a strong social dimension to the treatment provided by the DDUs. DDUs did not just offer treatment for addiction: they attempted to control the spread of this condition by placing strict controls on the behaviour of addict-patients. Addicts were required to pick up prescriptions on a daily basis so they would never have a surplus that could be sold to other addicts.²⁰⁹ Addicts were asked to sign ‘contracts’ agreeing to attend regular treatment sessions, reduce their drug dosage by fixed amounts and be drug-free by a certain date.²¹⁰ The introduction of these methods would suggest that DDU psychiatrists did not entirely reject their role as social controllers, but at the same time enhanced control measures also had some value as ‘treatment’, providing the addict with a structure, stability and targets.²¹¹ Treatment and control, the ‘medical’ and the ‘social,’ were thus bound even more tightly together through DDU practices.

Implications: growing homogeneity in the treatment of addiction

In contrast to their early heterogeneous response to addiction the DDUs gradually became more homogenous, so that by the end of the 1970s all clinics offered

²⁰⁸ Lart, *HIV and English Drugs Policy*, p. 66.

²⁰⁹ P.H. Connell & J. Strang, ‘The creation of the clinics: clinical demand and the formation of policy’, in Strang & Gossop, *Heroin Addiction and Drug Policy*, 167-177, p. 173.

²¹⁰ For an account of the increasing controls placed over addicts and an example of a ‘good behaviour contract’ see Stimson & Oppenheimer, *Heroin Addiction*, pp. 101-113; Mitcheson, ‘Drug clinics in the 1970s’, pp. 184-186. The operation of these policies and their implications in the 1980s will be considered in greater detail in Chapter Two.

²¹¹ That is not to imply that a doctor taking on a role in social control is anything new. As Gareth Stedman Jones points out ‘social control’ is a sufficiently broad phrase to encompass all political and ideological institutions and their agents. See G. Stedman Jones, ‘Class expression versus social control? A critique of recent trends in the social history of leisure’, *History Workshop Journal*, 4, (1977), 162-170, p. 164. Other commentators have dealt more closely with the role medicine plays in social control. Revisiting the works of Talcott Parsons and others Uta Gerhardt examines the relationship between sociology and medicine in the labelling of ‘deviants’ and the linkages this has to social control in U. Gerhardt, ‘The dilemma of social pathology’ in D. Porter, (ed.) *Social Medicine and Medical Sociology in the Twentieth Century*, (Amsterdam: Rodopi, 1997), 137-164. Returning to the issue of social control and addiction, Trebach makes the point that doctors are agents of social control, and separating treatment and control in drug addiction treatment often sets up a false dichotomy. See Trebach, *The Heroin Solution*, p. 224.

essentially the same treatment to addict-patients.²¹² Replacing intravenously administered heroin with oral methadone became the orthodox method of treatment for new patients presenting at DDUs from 1976/7.²¹³ Stimson and Oppenheimer found in 1978 that there were only three clinics in London that would prescribe injectable drugs to new patients.²¹⁴ Consensus on this issue was based around an informal code of practice and maintained through peer pressure within the group of London DDU consultants.²¹⁵ These doctors met regularly from 1968 onwards, first at the Department of Health and Social Security and later at the Home Office, to discuss treatment policies.²¹⁶ Spear, who attended these meetings, stated that ceasing the prescription of injectable drugs to addicts was first mooted in 1975 when the proposal was greeted with general acceptance amongst clinic psychiatrists.²¹⁷ Although some doctors continued to prescribe injectable heroin to addicts during this period, this became less and less common. James Willis, consultant psychiatrist at Guy's Hospital DDU, argued that the situation deteriorated into a 'race' to see who could prescribe the least heroin.²¹⁸ Influential DDU psychiatrists such as Connell called for 'a uniform approach' to the prescription of drugs to stop addicts 'shopping around' for extra, or larger supplies of drugs.²¹⁹ Uniformity on prescription rapidly turned into uniformity on treatment as all DDUs offered essentially the same approach. But,

²¹² On differences in early clinical practice at the DDUs see Smart, 'Social policy and drug dependence', p. 178.

²¹³ Spear, *Heroin Addiction Care and Control*, p. 243; Mitcheson, 'Drug clinics in the 1970s', p. 183; Bewley, 'Interview with Thomas Bewley', p. 889.

²¹⁴ Stimson & Oppenheimer, *Heroin Addiction*, p. 219.

²¹⁵ This code of practice was drawn up by Connell, and was reproduced in the *British Journal of Addiction* in 1991. See P.H. Connell, 'Document: treatment of drug dependent patients, 1968-1969', *British Journal of Addiction*, 86, (1991) 913-915. On peer pressure see, Smart, 'Social policy and drug dependence', p. 178 and Spear, *Heroin Addiction Care and Control*, p. 304.

²¹⁶ Too much should not be read into the move from the DHSS to the Home Office; Spear claims this was simply because there were more parking spaces at the Home Office. Spear, *Heroin Addiction Care and Control*, p. 243.

²¹⁷ *Ibid.* p. 242.

²¹⁸ J. Willis, Letter to the *British Medical Journal*, (13 August 1983) p. 500.

²¹⁹ Connell, 'Drug dependence in Britain', p. 298; Connell, 'Document: treatment of drug dependent patients', p. 914.

as clinics narrowed the range of treatment on offer they also narrowed the range of addicts who could be treated successfully. A handful of doctors recognised that greater uniformity in DDU treatment policies might discourage some addicts from attending clinics altogether.²²⁰ Stimson and Oppenheimer spoke to a consultant who prescribed only oral methadone, but admitted that this was something of a ‘cul-de-sac’ response, as it disregarded individual difference and treated all addicts the same.²²¹

Addicts who did not find suitable the treatment response put forward by the DDUs sought drugs, and/or treatment, elsewhere. The ACMD’s 1982 report *Treatment and Rehabilitation* found that in 1970 46 per cent of notifications of heroin addiction came from treatment centres, 48 per cent from prison medical officers and just six per cent from GPs. By 1981 the proportion of notifications from treatment centres had fallen to 36 per cent, as had those by prison medical officers to 16 per cent, but GPs now accounted for 48 per cent of notifications (Figure 1).²²²

Figure 1: Source of first notifications of heroin addiction, 1970, 1975, 1980 and 1981

	1970	1975	1980	1981
Treatment Centres (DDUs)	163 (46%)	202 (40%)	463 (39%)	602 (36%)
GPs	20 (6%)	118 (23%)	499 (42%)	791 (48%)
Prison Medical Officers	170 (48%)	191 (37%)	219 (19%)	267 (16%)

Source: ACMD, *Treatment and Rehabilitation*, p. 120

²²⁰ Spear, *Heroin Addiction Care and Control*, p. 243; Trebach, *The Heroin Solution*, p. 200.

²²¹ Stimson & Oppenheimer, *Heroin Addiction*, p. 220.

²²² ACMD, *Treatment and Rehabilitation*, (London: HMSO, 1982) p. 120.

This shift towards the generalist was, stated the report, an ‘unplanned development’ over which there were a ‘number of causes for concern.’²²³ The issues raised by this development require thorough exploration and will be dealt with in Chapter Two, but it is clear that there was a growing trend towards the involvement of doctors outside the DDUs in treating addiction from the late 1970s and into the early 1980s: that the very homogeneity of the clinic response led to heterogeneity in the treatment of addiction outside the DDU.

²²³ *Ibid.* p. 51.

Chapter Two

Specialist versus Generalist: the Changing Response to Heroin Addiction 1979-1985

Introduction

This chapter examines tensions between specialists (hospital-based DDU psychiatrists) and generalists (community-based General Practitioners) in the treatment of addiction. A threat to the newly created expert status of the psychiatrist was posed by the growing involvement of the GP in this area. The participation of the generalist suggested the specialist approach was either flawed or unnecessary. This threat was all the more potent given that it occurred at a time when the dominance of medicine in defining the response to drug use appeared to be challenged. According to sociologists Susanne MacGregor and Betsy Ettore an increase in the size and nature of drug use in the 1980s coupled with ‘the failure of the existing treatment system’ resulted in a ‘crisis of drug misuse.’¹ The existence of this ‘crisis’ prompted a dramatic increase in the attention devoted to drug problems by a range of different agencies. Politicians, local authorities, law enforcement agencies, voluntary organisations and the media all became involved in dealing with the consequences of drug use as never before. This led Gerry Stimson to argue that medicine was being displaced from its central role in determining the direction of drug policy.² Medicine (or more specifically clinical psychiatry) had to compete for a position within what Berridge has described as the drug ‘policy community,’ made up of ‘revisionist doctors, the voluntary agencies, researchers and, most crucially, like-minded civil

¹ S. MacGregor & B. Ettore, ‘From treatment to rehabilitation – aspects of the evolution of British policy on the care of drug takers’ in N. Dorn & N. South, (eds.) *A Land Fit For Heroin? Drug Policies, Prevention and Practice*, (Basingstoke: Macmillan, 1987) 125-145, pp.126-127.

² Stimson, ‘British drug policies in the 1980s’, pp. 477-488.

servants within the Department of Health.’³ The reaction of clinical psychiatry to its new position within the ‘policy community’ and the changed drug problem of the 1980s require further exploration, as this was a central component of the context to a series of other conflicts within the treatment of addiction highlighted by this thesis.

Key themes in the formulation of a response to heroin addiction in the 1980s can be discerned in Advisory Council on the Misuse of Drugs’ (ACMD) 1982 report *Treatment and Rehabilitation*. The ACMD found that treatment provision for addicts was largely inadequate. There were too few clinics and too many addicts. Addicts were seeking alternatives, either on the black market or by turning to private or general practitioners for help. GPs now accounted for the largest proportion of notifications to the Home Office of instances of addiction. This, the ACMD noted, was an unforeseen and unplanned development.⁴ Close scrutiny of the Council’s reaction to this development reveals that whilst *Treatment and Rehabilitation* claimed to present a pluralist view of addiction treatment, encouraging a range of medical and non-medical agencies to become involved in dealing with what it described as ‘problem drug use,’ the report contained a powerful sub-text that reinforced the specialist nature of treatment for heroin addiction. Under the influence of DDU psychiatrists the ACMD recommended that though GPs might have a role to play in the treatment of addiction this should only be under the close supervision of experts in the field. This could be seen as an essentially defensive move, as drug addiction specialists sought to protect their expert status by affording the generalist a fairly limited role and insisting that this be under their direction.

Tensions between specialists and generalists within medical practice, were of course, nothing ‘new,’ but the divide between the hospital-based consultant and the

³ Berridge, ‘AIDS and British drug policy: continuity or change?’, p. 141.

⁴ ACMD, *Treatment and Rehabilitation*, p. 51.

community-based GP was strengthened in this period. There was something of a resurgence of generalism in the 1970s and 1980s after a long drift towards specialism. General practice was revitalised through its encounter with biographical medicine, which placed the patient instead of the disease at the centre of therapeutic endeavour. Here, attention focused less on the diagnosis of disease than on the meaning of illness, less on the body and more on the patient him or herself. This gave the work of the GP new meaning and significance, helping to reinvigorate general practice and elevate its status. Increasingly self-confident and self-reliant GPs therefore posed a greater danger to the authority of the specialist than they had done previously, particularly in areas such as addiction where the nature of that specialism was tenuous and already under threat from other bodies and authorities. Moreover, biographical medicine encouraged GPs and other community-based doctors to ‘see’ the ‘disease’ of addiction in a different way to their hospital-based, specialist colleagues. This resulted in further conflict between these groups, this time over treatment methods, a conflict that will be explored in greater detail throughout the rest of this thesis.

1. The changing nature of heroin addiction in the 1980s

1.1 The changing pattern of heroin use

Heroin addiction in the 1980s appeared to be a very different problem to the one encountered in previous decades. Gone was the confidence of the mid-1970s when addiction seemed to have ‘fizzled out, like Hong Kong ‘flu.’⁵ The first indication that the pattern of heroin use was altering came in the form of an increase in the numbers of notified addicts. Brian Turner, of the voluntary organisation Standing Conference on Drug Abuse (SCODA), told the *Daily Telegraph* in 1979 that Britain was on the

⁵ *Sunday Times*, (4 May 1975), p. 14.

brink of a heroin epidemic.⁶ This assertion was repeated by SCODA's chairman, the Earl of Denbigh, in the House of Lords and echoed by Sir Bernard Braine MP (Conservative, Essex South-East) in the House of Commons later that year.⁷ Braine and Denbigh found evidence for this 'heroin epidemic' in a sudden rise in the number of addicts notified to the Home Office.⁸ The number of known heroin addicts had remained relatively static in the early 1970s, increasing by a few hundred between 1971 and 1973, and even decreasing between 1974 and 1976 [see Figure 2, p. 100].⁹ But from 1977 onwards the number of known addicts rose from 2,016 to 2,402 in 1978 and to 2,666 in 1979.¹⁰ This trend continued into the 1980s. Between 1980 and 1981 the number of notified addicts increased by almost a thousand.¹¹ This represented a 44 per cent increase in the number of new notifications; a rise Bing Spear argued, that could not just be attributed to more accurate data collection.¹² Notifications to the Home Office continued to rise throughout the decade so that by 1987 there were 10,389 known addicts.¹³ Despite better reporting of addiction, official figures were notoriously unreliable, so that the 'real' number of drug addicts could have been as much as five or even ten times greater than the reported figures.¹⁴

⁶ *Daily Telegraph*, (20 July 1979), p. 8.

⁷ *The Hansard Journal of Parliamentary Debates: Lords*, 30 October 1979, Vol. 402, 1979-1980, 353-356; *The Hansard Journal of Parliamentary Debates: Commons*, 21 December 1979, Vol. 976, 1979-1980, 1066-1072.

⁸ *The Hansard Journal of Parliamentary Debates: Lords*, 30 October 1979, 353; *The Hansard Journal of Parliamentary Debates: Commons*, 21 December 1979, 1066.

⁹ *Treatment and Rehabilitation*, Table 1, p. 115.

¹⁰ Home Office, *Statistics of Drug Addicts Notified to the Home Office, United Kingdom, 1988* (London: HMSO, 1989).

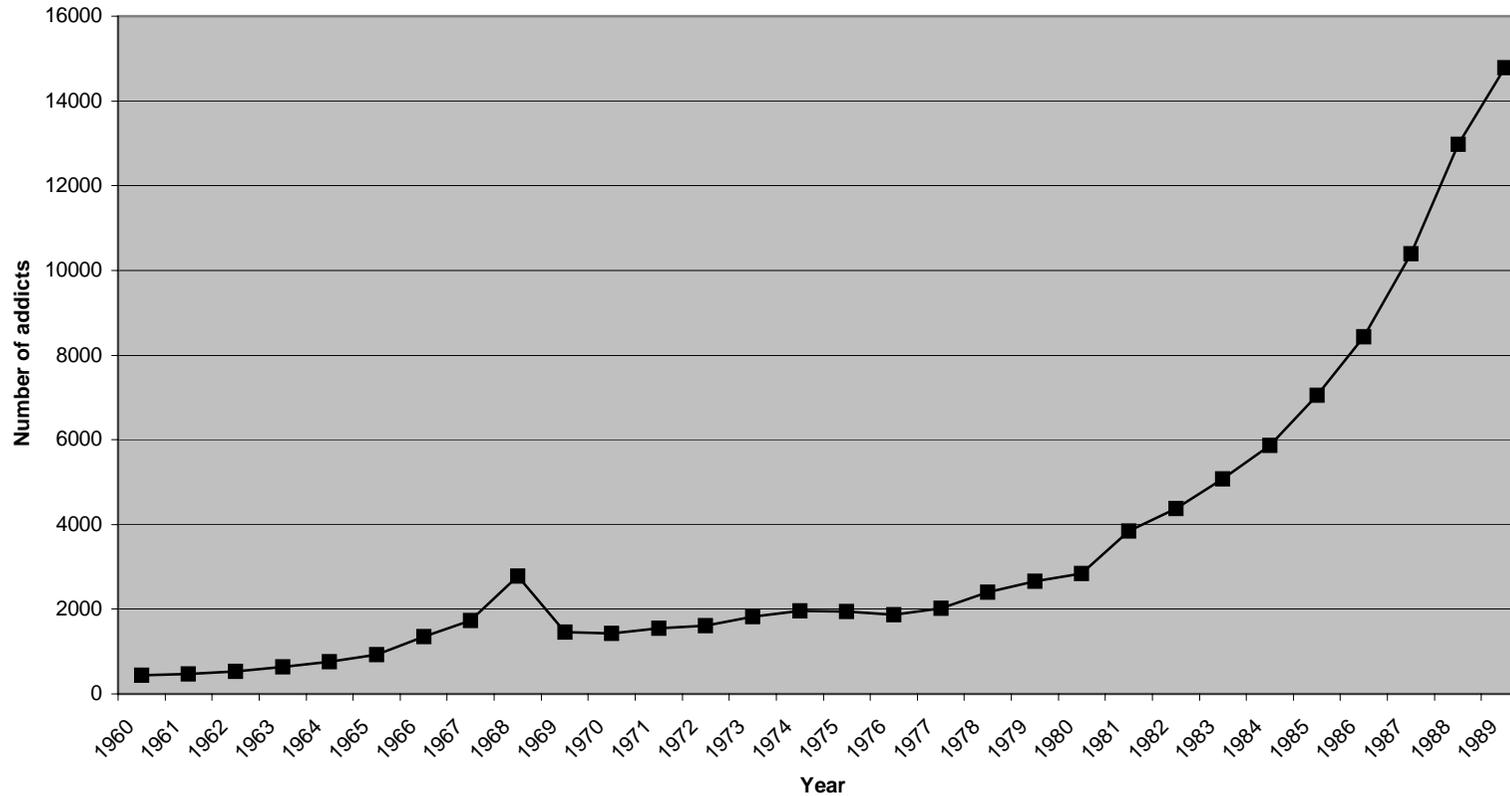
¹¹ *Ibid.*

¹² Spear, *Heroin Addiction Care and Control*, p. 272.

¹³ *Statistics of Drug Addicts Notified to the Home Office, 1988*.

¹⁴ Stimson, 'British drug policies in the 1980s', p. 480 and J. Mott, 'Notification and the Home Office' in Strang & Gossop, *Heroin Addiction and Drug Policy*, 271-291, p. 287. The ACMD also noted the inadequacy of data on drug users and suggested that the number notified to the Home Office only represented a fraction of the total, ACMD, *Treatment and Rehabilitation*, p. 4.

Figure 2: Addicts notified to Home Office, 1960-1989



Sources: Spear, 'The growth of heroin addiction in the United Kingdom', p. 247; Stimson & Oppenheimer, *Heroin Addiction*, pp. 208-9; Home Office, *Statistics of Drug Addicts Notified to the Home Office, 1988*; Home Office, *Statistics of Drug Addicts Notified to the Home Office, 1996*

Heroin addiction was not just increasing numerically; it also appeared to be spreading geographically. When the second Brain committee reported in 1964, it was thought that heroin addiction was largely confined to London.¹⁵ By the end of the 1970s it was clear that this was no longer the case. Denbigh, in his speech to the House of Lords on drug addiction in 1979, stated that over the past seven years there had been a 127 per cent increase in the number of addicts notified who resided outside the London area.¹⁶ Manchester, Merseyside and Glasgow were particularly affected, but opiate use was increasingly to be found in urban areas throughout the UK.¹⁷ Although drug use researchers Geoffrey Pearson and Mark Gilman argue that the ‘heroin epidemic’ of the 1980s was not truly a ‘national’ problem, pointing to considerable regional differences in heroin use, the broader implications of heroin addiction were being felt on a national scale for the first time.¹⁸ This was recognised by the ACMD in their report *Treatment and Rehabilitation* when they noted that by 1982 notifications of addiction were received from most parts of the country, reinforcing the view that this was no longer a problem experienced by Greater London alone.¹⁹

The growing numbers of heroin addicts in 1980s Britain were not necessarily confined to a particular social grouping. Gerry Stimson argues that as drug use became less associated with Bohemian or counter-cultural groups it became more ‘common’ and not associated with any particular view on life.²⁰ Whilst some commentators pointed to a link between rising drug use and increased urban

¹⁵ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 8.

¹⁶ *The Hansard Journal of Parliamentary Debates: Lords*, 30 October 1979, 355.

¹⁷ G. Pearson, ‘Social deprivation, unemployment and patterns of heroin use’ in Dorn & South, *A Land Fit for Heroin?* 62-94, pp. 65-67; Spear, *Heroin Addiction Care and Control*, p. 273.

¹⁸ G. Pearson & M. Gilman, ‘Local and regional variations in drug misuse: the British heroin epidemic of the 1980s’, in Strang and Gossop, *Heroin Addiction and Drug Policy*, 102-120, p. 102.

¹⁹ ACMD, *Treatment and Rehabilitation*, p. 25.

²⁰ G.V. Stimson, ‘The war on heroin: British policy and the international trade in illicit drugs’ in N. Dorn & N. South, (eds.) *A Land Fit for Heroin?*, 35-61, p. 39.

deprivation and unemployment, others were keen to stress that drugs were an evil to be found at all social levels.²¹ The nature of the relationship between deprivation and drug use was complex, and according to Susanne MacGregor, rapidly politicised. Those on the 'Right' tended to stress 'the corruption of young people by outside elements – pushers and dealers.' Subsequently, 'criminal subversive elements were the root of the problem, together with the moral weakness of some young people who had not been brought up to say no.'²² Individuals who supported this argument asserted that drug use was to be found at all levels of society; it was not deprivation that caused drug addiction, but moral corruption.²³ This view was often reinforced by the media. Marek Kohn explored tabloid stories of upper class and working-class drug use and concluded that heroin was seen as a problem of the estates; the country ones and the council ones.²⁴ An alternative view was frequently put forward by those on the 'Left.' Labour MPs, often in deprived, Northern, urban constituencies were quick to suggest there was a strong link between unemployment and addiction. Allan Roberts, Labour MP for Bootle told the *Yorkshire Post* in 1984 that 'The Thatcher years are "the hard-drug years"...A whole generation is being sacrificed. The Government are directly responsible...unemployed youngsters and teenagers with no hope or stake in their future are easy prey to the drug pusher.'²⁵ Attributing escalating drug addiction to deprivation allowed the 'Left' blame the Conservative government and attack its poor record on unemployment and public spending. Any potential link between drug use and unemployment, crime, or social deprivation remained politically sensitive despite widely reported clusters of addiction in areas with high

²¹ Pearson, 'Social deprivation, unemployment and patterns of heroin use', pp. 62-63.

²² S. MacGregor, 'The public debate in the 1980s' in MacGregor, *Drugs in British Society*, p. 3.

²³ *Ibid*, p. 4.

²⁴ Kohn, *Narcomania*, p. 114.

²⁵ Quoted in MacGregor, 'The public debate in the 1980s', pp. 4-5.

rates of unemployment, such as Glasgow and Liverpool.²⁶ Indeed, linking drug use with deprivation has only recently become uncontroversial: Griffith Edwards, chair of the working group that produced the ACMD's 1998 report *Drug Misuse and the Environment*, noted that this was 'the first occasion on which the ACMD had told the government that deprivation is a strongly relevant item on the drug policy agenda.'²⁷

Heroin use in the 1980s expanded in scale at the same time as the black market in illegally produced and distributed drugs grew. Illicit 'Chinese' heroin could be bought in London during the late 1960s and early 1970s, but it was thought that most of the illegally produced drugs that reached Britain's shores at this time were in transit for distribution elsewhere.²⁸ However, in 1979 the domestic market for illicit drugs expanded dramatically. This was partly due to changes in supply. Heroin from Iran flooded the market, as exiles from the revolution sought ways to move capital out of the country.²⁹ The amount of heroin seized by police and customs, likely to represent just a fraction of the total smuggled into the UK, rose considerably. The authorities seized just 3.3 kilograms of heroin in 1973, compared to 93.4 kilograms seized in 1981.³⁰ At the same time, demand increased, as DDUs cut down on the amount of heroin prescribed to addicts, replacing it with methadone instead. Buying drugs on the black market was an attractive proposition for addicts who disliked methadone, as illicitly produced heroin at this time was both relatively pure and relatively cheap. In real terms, the price of black market heroin fell by as much as 25 per cent between

²⁶ Pearson & Gilman, 'Local and regional variations in drug misuse', p. 103, pp. 106-111; Pearson, 'Social deprivation, unemployment and patterns of heroin use', pp. 62-63.

²⁷ G. Edwards, *Matters of Substance: Drugs – And Why Everyone's a User* (London: Allen Lane, 2004), p. 269.

²⁸ Spear, *Heroin Addiction Care and Control*, p. 228, p. 271; ACMD, *Treatment and Rehabilitation*, p. 25.

²⁹ Davenport-Hines, *The Pursuit of Oblivion*, p. 364; R. Power, 'Drug trends since 1968' in Strang and Gossop, *Heroin Addiction and Drug Policy*, 27-41, pp. 34-35.

³⁰ ACMD, *Treatment and Rehabilitation*, p. 130.

1980 and 1983.³¹ By the mid-1980s it was clear that a large, organised black market in illegally produced and distributed heroin existed, in contrast to the ‘grey’ market in traded pharmaceutical opioids of previous decades.³²

The influx of heroin from Iran, and later Afghanistan and Pakistan, had an important impact on the character of the British heroin problem and may have led to an increase in addiction quite apart from the usual issues of supply and demand. Heroin imported from these countries was particularly well suited to smoking rather than injecting.³³ Subsequently, there was an increase in ‘chasing the dragon’ (smoking heroin) in Britain during the 1980s. In 1979 most heroin users first took the drug intravenously, but by the end of the 1980s Strang and his colleagues found that the majority of new users began taking the drug by inhalation.³⁴ This was significant; smoking heroin did not carry the dangers and stigma of injection, and may have resulted in some individuals taking the drug who were repelled (initially at least) by intravenous use.³⁵

Quantifying how important this change in the mode of administration was to the rise in heroin addiction overall is of course difficult, but the increase in the smoking of heroin needs to be seen in the context of an increasingly ‘polydrug’ problem.³⁶ Heroin users were not just injecting heroin, they were often taking a range of other drugs by a variety of routes. As the prescription of heroin to addicts became more strictly controlled many users turned to other opioid drugs that could be obtained from doctors without a license to prescribe heroin. The synthetic opioid

³¹ P. Griffiths, M. Gossop & J. Strang, ‘Chasing the dragon: the development of heroin smoking in the United Kingdom’, in Strang and Gossop, *Heroin Addiction and Drug Policy*, 121-133, p. 124.

³² Stimson, ‘The war on heroin’, pp. 39-41; R. Lewis, ‘Flexible hierarchies and dynamic disorder – the trading and distribution of illicit heroin in Britain and Europe, 1970-1990’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 42-65; Spear, *Heroin Addiction Care and Control*, pp. 255-274.

³³ Griffiths, Gossop & Strang, ‘Chasing the dragon’, p. 125.

³⁴ Strang et al quoted in, *Ibid.* p. 121.

³⁵ Griffiths, Gossop & Strang, ‘Chasing the dragon’, p. 121; Davenport-Hines, *The Pursuit of Oblivion*, p. 365.

³⁶ Griffiths, Gossop & Strang, ‘Chasing the dragon’, pp. 128-129.

Diconal was particularly popular during the 1970s and early 1980s.³⁷ Prescribed in tablet form, which was then crushed and injected, Diconal use grew until 1984 when it was added to the list of drugs for which a doctor required a license to supply to addicts.³⁸ Heroin addicts were also increasingly using non-opiate drugs in addition to, or as a temporary substitute for, heroin. Barbiturates, amphetamines and benzodiazepines could be acquired from doctors or bought on the 'grey' market of legally produced but illegally distributed pharmaceutical drugs.³⁹ The use of these drugs by heroin addicts led the *Lancet* in 1979 to note that 'Polydrug abuse, rather than dependence on a single drug, is now the entrenched pattern of drug abuse' and that it was 'misleading to speak of opiate addicts and polydrug abusers as two separate populations requiring different treatment approaches.'⁴⁰ This holistic approach to the treatment of drug addiction was apparently not one adopted by the DDUs. Street agencies and casualty departments were increasingly encountering polydrug users who were not catered for by the treatment centres.⁴¹ There was, according to another editorial in the *Lancet* in 1982, 'a near total preoccupation with opiate dependence' at DDUs.⁴² Treatment facilities established in the late 1960s were not designed to cope with the changing nature of the drug problem in the 1980s.

This did not escape the notice of those outside the medical community. Political interest in the drugs issue heightened over the period, spurred on by an apparent 'panic' over heroin use. As MacGregor has shown, increased drug use was described as a problem, a crisis, an epidemic and a plague by the media and

³⁷ Power, 'Drug trends since 1968', p. 31; Spear, *Heroin Addiction Care and Control*, pp. 259-266.

³⁸ Spear, *Heroin Addiction Care and Control*, p. 265.

³⁹ *Ibid.* pp. 255-259; Power, 'Drug trends since 1968', pp. 32-34, pp. 38-39.

⁴⁰ 'Drug addiction: time for reappraisal', *Lancet*, (11 August 1979) 289-290, p. 289.

⁴¹ A.H. Ghodse, 'Casualty departments and the monitoring of drug dependence', *British Medical Journal*, (1977) 1381-1382; D. Turner, 'The development of the voluntary sector: no further need for pioneers?' in Strang & Gossop, *Heroin Addiction and Drug Policy*, 222-230, p. 225; Mitcheson, 'Drug clinics in the 1970s', p. 184.

⁴² 'Drug addiction: British System failing', *Lancet*, (9 January 1982) 83-84, p. 83.

politicians.⁴³ According to Kohn articles in the popular press ‘loaded with sensationalism, titillation and moral indignation...convinced the public that the nation’s youth was threatened by a plague of heroin.’⁴⁴ The broadsheets did not escape the sense of hysteria. In 1985 there were 61 separate stories in *The Times* specifically concerning heroin (more than one a week) and many more on related issues such as the traffic of drugs and the prevention and treatment of addiction.⁴⁵ Compared to the 25 heroin stories in the same newspaper two years before, it would seem that 1984-1985 were the peak years of the heroin panic.⁴⁶ Kohn found an explanation for the timing of this in the contemporary socio-political context. Heroin became the focus of attention during the miners’ strike.⁴⁷ Kohn argued that as the strike deepened social divisions and began to turn people against the Thatcher government, it became important to find an issue that could re-unite the country. He asserted ‘Heroin is the consensus issue *par excellence* [his italics]. Everybody is against it. Even most junkies are against it.’⁴⁸ It was hoped that a war on heroin, like the recent war in the Falklands, would bring people together against a common enemy. Kohn found evidence for this in the different ways in which drugs were represented in the 1980s. Drug stories of the 1950s, 1960s and 1970s often stressed the deviance of the user. In contrast, stories about heroin use in the 1980s emphasised its universality; that drug use did not just occur within a limited group of people.⁴⁹

Kohn’s line of analysis suggests there was a ‘moral panic’ over the use of heroin similar to those described by Stanley Cohen in *Folk Devils and Moral*

⁴³ MacGregor, ‘The public debate in the 1980s’, pp. 1-3.

⁴⁴ Kohn, *Narcomania*, p. 119.

⁴⁵ *The Times Index*, January-December 1985, pp. 255-256.

⁴⁶ *The Times Index*, January-December 1983, p. 301.

⁴⁷ Kohn, *Narcomania*, p. 107. Stimson also notes that 1984 was the year that heroin became a major media issue. See Stimson, ‘British drug policies in the 1980s’, p. 481.

⁴⁸ Kohn, *Narcomania*, p. 109.

⁴⁹ *Ibid.* p. 109.

Panics.⁵⁰ MacGregor analysed some key contemporary newspaper reports and found the emphasis on the decay, corruption and hopelessness of heroin addiction betrayed a distinctly moral tone.⁵¹ Nicholas Dorn and Nigel South assessed the validity of applying the term 'moral panic' to the furore surrounding heroin in the 1980s. They argued that the significant increase in drug use in Britain during this period coupled with long held fears about the abuse of the body and the use of drugs for 'selfish pleasure' suggested deeper forces were at play than could be explained by the notion of a 'moral panic.'⁵² Yet, the sense of fear and impending danger engendered by media reports refused to disappear and was even directly reflected in a controversial government initiative aimed at reducing drug use amongst young people. In 1985-1986 the Central Office of Information launched an anti-drug campaign targeting heroin users. Designed by top advertising agency Yellowhammer and costing £2 million the campaign consisted of advertisements in teenage magazines, bill-board posters and even a 30 second television commercial.⁵³ Based around the tag line 'Heroin Screws You Up' the advertisements depicted the consequences of heroin use in graphic detail. One image, entitled 'Your Mind Isn't The Only Thing Heroin Damages,' depicted a pale, sick-looking, young man in a sweat-soaked shirt, sitting hunched over on the floor. Surrounding him were some of the physical complications of intravenous heroin use, including skin infections and blood diseases as well as the symptoms of withdrawal, such as aching limbs and wasted muscles. [See Plate 1, p. 108].

⁵⁰ S. Cohen, *Folk Devils and Moral Panics*, (London: MacGibbon & Kee, 1972).

⁵¹ MacGregor, 'The public debate in the 1980s', pp. 1-5, pp. 8-9.

⁵² See 'Introduction', in Dorn & South, *A Land Fit For Heroin*, 1-10, pp. 2-3.

⁵³ R. Ashton, *This Is Heroin*, (London: Sanctuary House, 2002) p. 136.

Plate 1: 'Heroin Screws You Up', 1985-1986

**YOUR MIND ISN'T
THE ONLY THING
HEROIN DAMAGES.**



Skin Infections

Mental Problems

Wasted Limbs

Blood Diseases

Wasted Muscles

Liver Complaints

Constipation

It can also have some pretty nasty effects on your body. All of which you can start suffering long before you become addicted.

You'll probably start looking ill, losing weight and feeling like death.

You'll begin to take heroin not to get high any more, but just to feel normal.

And, as you lose control of your body's health, you could lose control of your mind too.

Until one day you'll wake up knowing that, instead of you controlling heroin, it now controls you.

So, if a friend offers you heroin, use your brain while you still can.

And say no.

HEROIN SCREWS YOU UP.

The images were clearly designed to shock, drawing heavily on contemporary fears about the consequences of heroin use. However, some advisors to the government (including members of the DHSS) warned that it was doubtful whether the campaign would make a significant impact on those already using heroin and would dissuade only those unlikely to take the drug in any case from doing so.⁵⁴ Indeed, the campaign appears to have backfired. Some young people read the staunchly anti-drug message as an example of government hypocrisy and displayed the posters on their bedroom walls as signs of their anti-establishment rebellion.⁵⁵

The 'Heroin Screws You Up' campaign was part of a much more sustained interest in drugs issues on the part of central government than had been seen in previous years. In July 1984 a Ministerial Group on the Misuse of Drugs was set up under the chairmanship of Junior Home Office Minister, David Mellor. The group's report, *Tackling Drug Misuse*, stated that 'the misuse of drugs is one of the most worrying problems facing our society today' and suggested 'a coherent strategy which attacks drug misuse by simultaneous action on five main fronts.' These were: firstly, 'reducing supplies from abroad,' secondly, 'tightening controls on drugs produced and prescribed in the UK,' thirdly, 'making policing more effective,' fourthly, 'strengthening deterrence' and finally 'improving prevention, treatment and rehabilitation.'⁵⁶ *Tackling Drug Misuse* concentrated predominately on controlling the production and supply of drugs, a move Stimson saw as representative of a decline of the 'medico-centric' view of drug policy and the emergence of a new emphasis on control, in what he termed the 'criminal-economic model.'⁵⁷ This enhanced emphasis

⁵⁴ *Ibid.* p. 137; Davenport-Hines, *The Pursuit of Oblivion*, p. 375.

⁵⁵ Ashton, *This Is Heroin*, p. 137. This suggests an almost sub-cultural inversion of the dominant message. See D. Hebdige, *Subculture: The Meaning of Style*, (London: Routledge, 1979, 1991).

⁵⁶ Home Office, *Tackling Drug Misuse: A Summary of the Government's Strategy*, (London: HMSO, 1985), Foreword.

⁵⁷ Stimson, 'The war on heroin', p. 43.

on law enforcement reflected international developments, particularly in the USA. Although Richard Nixon was the first American President to declare 'war' on drugs it was Ronald Reagan's televised address to the nation in 1986 that placed drugs on the global agenda as never before.⁵⁸ Reagan promised an extra \$600 million to fight an all-out 'war' on drugs directed at pushers 'who are killing America and terrorising it.'⁵⁹ The American 'war on drugs' undoubtedly influenced British drug policy. British law enforcement agencies assisted by the armed forces adopted many of the tactics of the American Drug Enforcement Agency (DEA) and began to target drug traffickers and their assets, as well as substituting and eradicating drug crops in other countries.⁶⁰ Furthermore, penalties for drug offences were stiffened; the maximum sentence for trafficking in Class A drugs (such as heroin) was increased to life imprisonment.⁶¹

Party-political and parliamentary involvement in drug issues also grew in the mid 1980s. Drugs were on the agenda of the Conservative Party Conference in 1984, the leader of the Social Democratic Party (SDP) David Owen discussed drugs in conjunction with unemployment in a speech in 1985, and the Labour party included drugs in their statement on health produced in 1986.⁶² According to MacGregor, drugs were often described as a particularly Conservative issue, allowing the government to demonstrate concern about a social issue that they could not be blamed for causing.⁶³ Cross-party committees also began to inquire into the 'misuse' of drugs in 1985. The House of Commons Home Affairs Committee examined the production

⁵⁸ Davenport-Hines, *The Pursuit of Oblivion*, p. 338, p. 340, p. 351; MacGregor, 'The public debate in the 1980s', p. 7.

⁵⁹ Quoted in MacGregor, 'The public debate in the 1980s', p. 7.

⁶⁰ Davenport-Hines, *The Pursuit of Oblivion*, p. 346; Stimson, 'The war on heroin', p. 43

⁶¹ R. Hartnoll, 'The international context' in S. MacGregor, (ed.) *Drugs in British Society*, 36-51.

⁶² Stimson, 'The war on heroin', pp. 41-42. David Owen also gave a speech to the Society of Clinical Psychiatrists Research Fund on the need for a scientific strategy to curb the epidemic of drug 'abuse' in October 1985. See Owen, 'Need for a scientific strategy'.

⁶³ MacGregor, 'The public debate in the 1980s', p. 13.

and traffic of illegal drugs and the Social Services Committee concentrated on the treatment and rehabilitation of drug ‘misusers.’⁶⁴ The Social Services Committee found that:

The misuse of drugs, and particularly misuse of heroin and cocaine, is a serious and growing problem. It demands an immediate, determined response from Government and society as a whole. Existing services are woefully inadequate to cope with the increasing pressure. Treatment facilities are few, underfunded, often inaccessible and always have long-waiting lists.⁶⁵

Interest in drug issues was clearly not limited to law enforcement and trafficking; treatment remained an issue of paramount importance.

1.2 The changing treatment response

Treatment, though, was in turmoil. DDUs, which had formed the cornerstone of heroin addiction treatment policy since 1968, were increasingly unable or unwilling to respond to the needs of some patients. An editorial in the *Lancet* in 1982 branded the ‘British System’ as ‘failing,’ arguing that ‘the “clinic system” which is the focal point of the response to drug dependence in the UK, is now completely inadequate.’⁶⁶ The DDUs faced two main difficulties in dealing with heroin addiction in the 1980s. Firstly, they were under-resourced and under-staffed. Tight controls on public expenditure exercised by the Conservative government meant that spending on the NHS grew very slowly in the 1980s.⁶⁷ Over the decade, spending on hospital and community health services rose by just ten per cent in real terms.⁶⁸ Drug addiction treatment facilities were not in a good position to compete for scarce resources within

⁶⁴ House of Commons Social Services Committee, *Misuse of Drugs With Special Reference to the Treatment and Rehabilitation of Misusers of Hard Drugs, Session 1984-1985* (London: HMSO, 1984-1986); House of Commons Home Affairs Committee, *First Report From the Home Affairs Committee, Session 1985-1986: Misuse of Hard Drugs*, (London: HMSO, 1985-86).

⁶⁵ House of Commons Social Services Committee, *Misuse of Drugs*, p. liii.

⁶⁶ *Lancet*, (9 January 1982) 83-84, p. 83. The *Sunday Times* echoed these sentiments in 1983. See *Sunday Times*, (27 February 1983) p. 18.

⁶⁷ Ham, *Health Policy in Britain*, p. 41; Klein, *The Politics of the NHS*, pp. 201-204, pp. 229-235 and Baggott, *Health Care in Britain*, pp. 178-179.

⁶⁸ Klein, *The Politics of the NHS*, p. 229.

the health service, as they were traditionally accorded a low priority.⁶⁹ Despite DHSS guidance to local health authorities asserting that the improvement of services for drug addicts was to be accorded the ‘highest priority’ (along with improvements to other ‘Cinderella’ services such as provision for the mentally ill and the elderly) money did not always get through.⁷⁰ As MacGregor and Ettore remarked, ‘Health Authorities find it difficult to put services for drug misusers ahead of those for, say, kidney transplants or old people.’⁷¹ DDUs subsequently lacked the resources to deal with an influx of new patients. Waiting lists for treatment at clinics lengthened: many addicts had to wait more than six weeks for a first assessment appointment at a DDU.⁷² Long waiting periods, as the Social Services Committee noted, could prove a disincentive to those seeking treatment.⁷³

Those that did manage to be seen at a DDU often found the treatment on offer did not suit them. This was the second major problem encountered by the DDUs: they had failed to adapt to changing patterns of drug use in the 1980s. As seen in Chapter One, DDUs had changed their prescription policies over the previous decade. Clinics stopped prescribing injectable heroin to new addict patients, giving addicts (first injectable and later oral) methadone. Prescriptions were usually over a short period and directed towards total abstinence from drugs rather than indefinite maintenance. All the London DDUs were the same, ‘the resultant uniformity of treatment’ according to the *Lancet*, had ‘stultified research into different treatment

⁶⁹ ACMD, *Treatment and Rehabilitation*, p. 26, p. 37.

⁷⁰ DHSS, *Health Service Development: Services For Drug Misusers Health Circular (84) 14 and Local Authority Circular (84) 12*, (London: DHSS, 1984). For an elaboration on ‘Cinderella’ services see Ham, *Health Policy in Britain*, pp. 23-24 and Baggott, *Health and Health Care in Britain*, p. 98.

⁷¹ MacGregor & Ettore, ‘From treatment to rehabilitation’, p. 145.

⁷² A. Burr ‘Increased sale of opiates on the blackmarket [sic.] in the Piccadilly area’, *British Medical Journal*, (24 September 1983) 883-885, p. 883. Jayne Love and Michael Gossop in their study of the workings of one London DDU between June and December 1983 found that waiting periods of approximately one month between each stage of treatment was not uncommon. See Love & Gossop, ‘The processes of referral and disposal within a London Drug Dependence Clinic’, p. 438.

⁷³ House of Commons Social Services Committee, *Misuse of Drugs*, p. xxxv.

options.’⁷⁴ Indeed, the form of treatment on offer at the DDUs did not meet the needs of all addicts. Psychiatrist John Strang argued that the restrictions placed on those seeking treatment at a DDU for the first time meant that ‘it is virtually impossible for some new patients to obtain service of any valuable nature from the drug clinics.’⁷⁵ DDUs were inflexible and homogenous and simply unable to cope with the influx of addicts in the 1980s.

Addicts subsequently began to seek treatment elsewhere. In 1982 the *Lancet* observed that ‘many drug abusers now prefer to stay outside the system and approach non-clinic doctors’ a move the journal attributed to a greater willingness on the part of doctors outside the DDUs to prescribe injectable opioids.⁷⁶ Yet, more generous prescriptions were not the only reason for addicts’ abandonment of DDUs. One addict who had left his local clinic in favour of a private practitioner asserted that he would have been ‘quite happy to attend [NHS clinics] if they were any good.’⁷⁷ He complained that not only was he prescribed an inadequate dose of methadone at the DDU he was being forced to reduce this to nothing over a period of six months, was required to pick up his prescription on a daily basis which made working difficult and had to attend counselling sessions which he found to be ‘arrogant and patronising.’ In contrast, he asserted that the treatment provided by the private doctor enabled him to ‘hold down my job and live a reasonable life’ in addition to ‘reduc[ing] my intake of injectable and oral methadone at a rate which I can cope with.’⁷⁸ Undoubtedly, non-clinic doctors were increasingly encountering addicts. The number of notifications of addiction to the Home Office from GPs steadily rose as notifications from DDUs declined. In 1970 just 6 per cent of notifications of addiction came from GPs, 46 per

⁷⁴ *Lancet*, (9 January 1982) p. 83.

⁷⁵ J. Strang, ‘Personal View’, *British Medical Journal*, 283, (1 August 1981) p. 376.

⁷⁶ *Lancet*, (9 January 1982) p. 83.

⁷⁷ A.B. Robertson, letter to the *British Medical Journal*, 287, (9 July 1983) p. 126.

⁷⁸ *Ibid.* p. 126.

cent from DDUs and 48 per cent from prison medical officers. In 1981 48 per cent of notifications came from GPs, 36 per cent from DDUs and 16 per cent from prison medical officers (see Figure One, p. 94).⁷⁹ This trend continued over the decade with over half of all new notifications coming from GPs throughout the period (Figure 3).⁸⁰

Figure 3: Percentage of all new notifications of addiction to the Home Office by notifying authority, 1982-1987

	1982	1983	1984	1985	1986 ⁸¹	1987
GPs	53	53	55	51	49	52
DDUs	35	34	30	31	31	33
Prison medical officers	12	11	15	18	21	15

Source: Home Office, *Statistics of Drug Addicts Notified to the Home Office, United Kingdom, 1988* (London: HMSO, 1989)

In a national survey of GPs conducted in 1985 Alan Glanz and Colin Taylor of the ARU found that one in five GPs saw a patient addicted to opiate drugs over a four-week period, amounting to between 30,000 and 44,000 new cases of opiate use presenting to General Practitioners a year. These figures were far higher than the Home Office notification statistics and were inflated by some duplication of addict names, but in other ways may actually have been more accurate, as they accounted for

⁷⁹ ACMD, *Treatment and Rehabilitation*, p. 120.

⁸⁰ Home Office, *Statistics of Drug Addicts Notified to the Home Office, 1988*.

⁸¹ The 1986 figures add up to 101 per cent. These are the figures reported in the Home Office *Statistics of Drug Addicts Notified to the Home Office, 1988*, but in more recent editions this has been corrected so that the percentage notified by GPs is 48 per cent. See Home Office, *Statistics of Drug Addicts Notified to the Home Office, 1996*.

under-notification of addicts by GPs.⁸² Whatever the precise numbers involved, the trend towards increasing involvement of the GP in the treatment of addiction was obvious. This led Glanz and Taylor to conclude that the role of the GP should be ‘given serious consideration in the development of a national strategy for responding to the current drugs problem.’⁸³ Yet, the increasing involvement of non-clinic doctors in the treatment of addiction was, according to the ACMD, an ‘unplanned development’ which they viewed with ‘some concern.’⁸⁴ How the GP came to play a greater role in the treatment of addiction and the reasons why this was regarded with ‘concern’ by the ACMD and others requires further consideration.

2. *Treatment and Rehabilitation: a specialist or a generalist approach?*

The ACMD’s 1982 report *Treatment and Rehabilitation* played an important role in setting the parameters of the debate over the treatment of heroin addiction in the 1980s. It has been viewed in two slightly different ways. Stimson argued that the transition from the ‘addict’ of the 1960s Brain reports to the ‘problem drug taker’ described by *Treatment and Rehabilitation* indicated the emergence of a more ‘diffuse understanding [of drug taking]...with medicine taking a much less central position in the response.’⁸⁵ For MacGregor too the report marked the acceptance of a ‘reformist’ rather than ‘medical’ model for drug policy.⁸⁶ Other commentators, however, pointed to the retention of a strong medical influence, particularly over the report’s recommendations on the treatment of addiction. Moreover, the view on treatment

⁸² A. Glanz & C. Taylor, ‘Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: extent of contact with opiate misusers’, *British Medical Journal*, 293, (16 August 1986) 427-430, p. 427, p. 430.

⁸³ *Ibid.* p. 430.

⁸⁴ ACMD, *Treatment and Rehabilitation*, p. 51, p. 2.

⁸⁵ Stimson, ‘Drug policies in the 1980s’, p. 478.

⁸⁶ S. MacGregor, ‘Choices for policy and practice’ in S. MacGregor, (ed.) *Drugs in British Society*, 170-200, p. 173.

presented was that of a particular section of the medical community, the DDU psychiatrist. These doctors felt threatened by the intervention of other agencies and individuals, especially general and private practitioners. *Treatment and Rehabilitation* represented a defence of the specialist's role in the treatment of addiction. Spear suggested that it was not 'over-fanciful' that 'the more politically motivated and forceful members' of a group of consultants at the London DDUs 'saw in the Advisory Council's review of treatment services an opportunity to regain the influence they feared they were in danger of losing.' He asserts that these psychiatrists made 'The elimination of both the independent doctor and the NHS general practitioner from the field' their 'primary objective' and to do this they persuaded the working group to listen to their views and include them in the final report.⁸⁷ Spear's view was endorsed by some contemporary analysis of the report. Rowdy Yates, a project coordinator at the street agency the Lifeline Project, asserted that the ACMD's recommendations effectively extended the power of DDUs over non-specialist services, so that GPs would be allowed to treat addicts only in conjunction with advice from clinic doctors.⁸⁸ This proposal led Mike Ashton, of the Institute for the Study of Drug Dependence (ISDD) to argue that 'It took little imagination to see the Advisory Council's recommendations as an attempt to legislate the non-hospital doctor out of addiction treatment.'⁸⁹

Such a view would seem to contradict the diffuse model of treatment policy found in *Treatment and Rehabilitation* by Stimson and MacGregor. However, these two approaches are not necessarily contradictory. Indeed, the one explains the other: the very diffusion of the general response to drug use put forward by the ACMD

⁸⁷ Spear, *Heroin Addiction Care and Control*, p. 276.

⁸⁸ R. Yates, 'Treatment and Rehabilitation: report of the Advisory Council on the Misuse of Drugs, 1982. View from a street agency: money-shy', *British Journal of Addiction*, 78, (1983) 122-124, pp. 123-124.

⁸⁹ M. Ashton, 'Doctors at war, part one', *Druglink*, (May/June 1986,) 13-15, p. 13.

encouraged the purveyors of the main medical response (the DDU psychiatrists) to defend their specialism from the encroachments of the GP and the private practitioner. The DDU psychiatrist faced two kinds of threat to their position as the authority on drug problems: from external non-medical agencies, such as voluntary organisations, politicians and local authorities, who threatened the powerful position of medicine in defining and shaping the response to drug use, and from internal alternative medical agencies such as general and private practitioners who threatened the existence of the treatment of addiction as a psychiatric speciality. To retain a role in the ‘policy community’ the DDU psychiatrist needed to present a unified, cohesive ‘medical’ approach. In order to do this, the GP, and the private practitioner (the issues surrounding private practice will be dealt with separately in Chapter Three) needed to be removed from the treatment of addiction, or at least marginalized, so that psychiatrists could present a powerful claim to authority within the increasingly diverse ‘policy community’ based on their specialist status.

A close analysis of *Treatment and Rehabilitation* supports such a notion by revealing the presence of both currents; the move away from a purely medical approach to drugs towards a more diffuse response, and within the specialist medical approach a reaction to this diffusion in the form of an attempt to reduce the role of the generalist. The Treatment and Rehabilitation Working Group of the ACMD was set up in 1975 to ‘undertake a comprehensive review of the treatment and rehabilitation services for drug misusers and to make recommendations for dealing with both immediate problems and the situation generally.’⁹⁰ The composition of the working group reveals the increase in the range of bodies and individuals interested in drug addiction and at the same time pointed to the continued importance of the clinical

⁹⁰ ACMD, *Treatment and Rehabilitation*, p. 3.

psychiatrist. There were social workers, probation officers and representatives from voluntary agencies suggesting a broad view of drug problems and their consequences. However, the persistence of a strong medical view was indicated by the continued dominance of doctors. There were six doctors on the committee and of these four were psychiatrists involved in the treatment of addiction, the largest single group.⁹¹ They were Parr, a Brighton consultant psychiatrist, Thorley, a consultant psychiatrist at Newcastle Hospital and director of the Parkwood House Alcohol and Drug Dependence Unit, and most crucially of all, Bewley, consultant psychiatrist at St Thomas' Hospital and Connell, director of the DDU at the Maudsley, the leading experts on the treatment of addiction. It is highly likely that Connell and Bewley were the 'medical politicians' darkly referred to by Spear.⁹² The presence of these men on the ACMD working group points not only to the continued importance of psychiatry in responding to drug use but also hints at a potentially powerful political incentive for Connell and Bewley, who in order to preserve their expert status needed to diminish the importance of the generalist in the treatment of addiction.

In order to gather evidence for their report the working group visited a number of treatment centres and took evidence from groups and individuals 'concerned with the problems of drug misuse.'⁹³ In 1977 they produced an interim report recommending some immediate action, but also suggested that a more wide-ranging study of drug 'misuse' was necessary.⁹⁴ The group examined the available data on drug use and sent questionnaires to 34 treatment centres in England and Wales. In

⁹¹ *Ibid.* pp. 87-88.

⁹² Connell and Bewley are not referred to directly by Spear at this point, but as he goes on to list papers they presented as evidence for the way London DDU psychiatrists tried to preserve their monopoly on treatment, it is likely it is to them he refers. Spear, *Heroin Addiction Care and Control*, p. 276.

⁹³ ACMD, *Treatment and Rehabilitation*, p. 3

⁹⁴ *Ibid.* An editorial in the *British Journal of Addiction* suggested that this report was not properly published, but was available on demand from the DHSS. 'Editorial: An informed and thinking basis for debate', *British Journal of Addiction*, 78 (1983) 113-114, p. 113.

addition, they spoke to voluntary workers about rehabilitation facilities for recovering addicts. They published their findings in *Treatment and Rehabilitation* in 1982. The report considered the shortcomings of the current services in the light of the changing pattern of drug use and proposed 'a new approach to the problems of the drug misuser and a framework under which services could be developed.'⁹⁵ They examined the implications of the increased involvement of the private and general practitioner and made recommendations on safeguards for prescribing controlled drugs. The report also looked at the need for training and research, and the difficulties of funding services for drug misusers.

Treatment and Rehabilitation noted changes in drug use and the response to this already apparent to many of those working in the field. The report discussed the increasingly polydrug problem, the overall rise in number of people using drugs, the geographical spread of this use, the increased availability of illicit drugs, the growing proportion of those first notified who claimed to be addicted to heroin rather than any other drug and the increased proportion of addicts being notified by doctors in private and general practice.⁹⁶ The ACMD also noted that treatment and rehabilitation facilities were largely inadequate in many areas.⁹⁷ To address these problems and improve services *Treatment and Rehabilitation* presented a new way of looking at drug users. They also appeared to be questioning elements of the disease-based notion of addiction or dependence by stating that:

Most authorities from a range of disciplines would agree that not all individuals suffer from a disease of drug dependence. Whilst many drug misusers do incur medical problems through their use of drugs, some do not. The majority are relatively stable individuals who have more in common with the general population than with any essentially pathological sub-group.⁹⁸

⁹⁵ ACMD, *Treatment and Rehabilitation*, p. 5.

⁹⁶ *Ibid.* pp. 23-25.

⁹⁷ *Ibid.* pp. 26-29.

⁹⁸ *Ibid.* p. 31.

The working group thus shifted emphasis away from a purely medical, or treatment based approach to the problem of addiction. They found that there was no evidence for the existence of a ‘typical’ addict or person with drug problems. There should, therefore, be a range of treatment and rehabilitation services available to suit each individual. To this end, the report suggested that services should not be orientated towards specific client groups, heroin addicts, amphetamine users and so on.

According to the working group, the needs of different types of drug user were similar, so ‘Services in the future need to be geared to solve common problems rather than be merely substance or diagnosis centred.’ The approach should be ‘problem orientated.’⁹⁹ Here the ACMD were drawing on the findings of the Advisory Committee on Alcoholism (the Kessel Committee) who published a report in 1978 detailing *The Pattern and Range of Services for Problem Drinkers*.¹⁰⁰ This report marked a shift from dealing with ‘alcoholics’ to providing for a wider group of ‘problem drinkers.’¹⁰¹ Similarly, *Treatment and Rehabilitation* represented a transition from the ‘addict’ to the ‘problem drug taker.’ The problem drug taker was defined as:

a person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his own use of drugs or other chemical substances (excluding alcohol and tobacco).¹⁰²

Problem drug takers were, therefore, not just ‘addicts,’ but any individual who experienced problems with drug use. According to Stimson, the adoption of this definition indicated ‘a major shift away from the disease model and the opiate

⁹⁹ *Ibid.* p. 34.

¹⁰⁰ *Ibid.* p. 4, p. 34; Advisory Committee on Alcoholism, *The Pattern and Range of Services for Problem Drinkers: Report by the Advisory Committee on Alcoholism*, (London: HMSO, 1978). For a discussion of the Kessel Committee and its findings see Thom, *Dealing With Drink*, pp. 120-125.

¹⁰¹ Thom, *Dealing With Drink*, p. 120.

¹⁰² ACMD, *Treatment and Rehabilitation*, p. 34.

addict.’¹⁰³ Lart concurred, noting that the use of the term ‘problem drug taker’ resulted in a move ‘away from the narrow conception of addiction’ which ‘open[ed] up the range of aspects of a drug user’s life of legitimate concern to services.’¹⁰⁴ Subsequently, services were to be developed with the ‘problem drug taker’ in mind. The ACMD stated that these should recognise the medical, legal and social problems for an individual and the community as a result of drug taking.¹⁰⁵ Responses to the ‘problem drug taker’ could come from hospital-based treatment services, detoxification services, street agencies and various other voluntary and non-statutory agencies.¹⁰⁶ Official sanction was therefore given to the involvement of a range of bodies and authorities. Stimson saw the report as indicating that service provision would be less dominated by doctors and instead involve ‘workers with many different skills.’¹⁰⁷

Despite stressing a multi-disciplinary view of the problems of those using drugs *Treatment and Rehabilitation* paid particular attention to the role of the doctor, suggesting the persistence of medical approaches to drug use. The report stated that ‘for the majority of problem drug takers, treatment by doctors will be an important component of the help they receive.’ This was because ‘only doctors may prescribe drugs and they will be expected to treat the physical and psychological consequences of problem drug taking.’¹⁰⁸ The emphasis on treatment led Tony Slater of the therapeutic community Phoenix House to comment in the *British Journal of Addiction* that the report seemed to be ‘very heavily slanted towards supporting the medical

¹⁰³ G.V. Stimson, ‘Treatment and Rehabilitation: report of the Advisory Council on the Misuse of Drugs, 1982. Views of a sociologist: drug problems as an everyday part of our society’, *British Journal of Addiction*, 78, (1983) 120-122, p. 121.

¹⁰⁴ Lart, *HIV and English Drugs Policy*, p. 78.

¹⁰⁵ ACMD, *Treatment and Rehabilitation*, p. 34.

¹⁰⁶ *Ibid.* p. 36.

¹⁰⁷ Stimson, ‘Views of a sociologist’, p. 121.

¹⁰⁸ ACMD, *Treatment and Rehabilitation*, p. 51.

model of treatment’ and did not ‘understand all of the needs facing the “problem drug taker” and his or her subsequent rehabilitation.’¹⁰⁹ This paralleled criticism of the Kessel Committee’s report on problem drinkers. Thom notes that although the committee believed they had rejected medical understandings of alcoholism in favour of a community-based notion of the problem drinker, some critics found evidence for the continued existence of the medical model through the emphasis placed on treatment.¹¹⁰ By placing a strong emphasis on treatment offered by doctors rather than rehabilitation offered by other agencies *Treatment and Rehabilitation* appeared to be prioritising the medical approach over the more ‘social’ alternatives.

The nature of this medical approach is revealed by the recommendations of the ACMD on prescribing safeguards, which betrayed a less than inclusive view of who should be offering treatment to ‘problem drug takers.’ The report highlighted the trend towards drug users seeking medical help from doctors not based at hospitals and noted that according to the Home Office, doctors working at the DHSS, and the views expressed in a number of medical journals this gave rise to ‘a number of causes for concern.’¹¹¹ These fell into four categories. Firstly, they were worried that doctors working with problem drug takers lacked sufficient training and expertise to treat addicts adequately in isolation from specialist advice. Secondly, they feared that drugs supplied to problem drug takers might be diverted to the black market, noting that only DDUs tended to prescribe to addicts on a daily basis as they had special forms that allowed drugs to be dispensed in this way. Thirdly, concerns were

¹⁰⁹ T. Slater, ‘Treatment and Rehabilitation: report of the Advisory Council on the Misuse of Drugs, 1982. View from a therapeutic community: the spirit of the thing’, *British Journal of Addiction*, 78, (1983) 118-119, p. 118. For more on the emergence of the therapeutic communities and concept houses see D. Warren Holland, ‘The development of “Concept Houses” in Great Britain and Southern Ireland, 1967-1976’ in West, (ed.) *Problems of Drug Abuse in Britain*, 125-135 and P. Toon & R. Lynch, ‘Changes in therapeutic communities in the UK’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 231-247.

¹¹⁰ Thom, *Dealing With Drink*, p. 123.

¹¹¹ ACMD, *Treatment and Rehabilitation*, p. 51.

expressed about the pressure that doctors who prescribed to addicts might become subject; aggressive and persuasive addicts could exploit elderly doctors or those working alone. Finally, it was noted that few doctors had access to the kind of support staff and facilities available at the DDUs.¹¹² The consequence of this was that controlled drugs were being prescribed ‘injudiciously’ giving rise to two major problems. The first was that liberal prescribing encouraged some patients to leave DDUs and obtain larger doses of drugs from non-clinic doctors. The second was that the amount of legally manufactured drugs on the black market had risen considerably.¹¹³ This last assertion does not appear to have been backed up with any figures, but it led the ACMD to contend that there had been a recurrence of the same problems that caused concern to the second Brain Committee, where doctors were providing addicts with drugs in too liberal a manner, therefore feeding the black market. The ACMD therefore recommended that a role could be afforded doctors outside DDUs in the treatment of addiction only with ‘strict safeguards.’¹¹⁴ These included close liaison with hospital based services, links with other agencies such as social services and opportunities for further training. The working group were not convinced that these measures alone would be sufficient. They subsequently recommended that guidelines be established on good practice, the possibility of extending licensing for the prescription of all controlled drugs to addicts be examined and wider use be made of the tribunal system for irresponsible prescription.¹¹⁵

Some of those who read *Treatment and Rehabilitation* felt that these recommendations would do little to encourage GPs and private practitioners to become involved in the treatment of addiction and actually dissuade many. Yates

¹¹² *Ibid.* pp. 52-53.

¹¹³ *Ibid.* p. 53.

¹¹⁴ *Ibid.* pp. 55-56.

¹¹⁵ *Ibid.* p. 56.

argued in the *British Journal of Addiction* that the report ignored ‘any discussion of enhancing the *positive* [his italics] role of General Practitioners in the treatment of addiction.’ He went on to note that it did not deal with the fact that the majority of GPs were reluctant to see drug users and its recommendations were ‘tantamount to a green light to GPs to continue to avoid any responsibility for this group.’¹¹⁶ This, it could be argued, was exactly what some members of the ACMD working group (the DDU psychiatrists like Connell and Bewley) wanted. *Treatment and Rehabilitation* recognised that GPs and private practitioners were increasingly involved in the treatment of addiction, and whilst it purported to represent a ‘community-based’ response and advocated the participation of a range of bodies in dealing with the ‘problems’ of drug users, its recommendations on treatment were a good deal less inclusive. By raising the problems associated with the treatment of addiction in private and general practice and not considering the possible benefits, the report was making a covert attack on this mode of treatment. What is more, it drew lines for battle by recommending a number of measures which became key issues in the dispute over who should treat the addict (generalist, specialist or private practitioner) and also how they should be treated (short-term withdrawal or long-term maintenance) such as the need for guidelines on good practice. *Treatment and Rehabilitation* thus had a vital role to play in setting the parameters of the debate between specialists and generalists in the treatment of addiction.

3. The revitalisation of general practice and the treatment of heroin addiction

3.1 Generalists and specialists: an old divide renewed?

¹¹⁶ Yates, ‘View from a street agency: money-shy’, p. 124.

A divide between community based General Practitioners and hospital based consultants or specialists existed in Britain as early as the mid-nineteenth century. According to Anne Digby, this divide was not, however, necessarily a clear one as the respective roles of the specialist and the generalist were ill defined throughout the Victorian period leading to ‘intra-professional disputes.’¹¹⁷ It was not until the 1930s that formalised definitions of specialist and generalist emerged. A consultant or specialist was defined as a doctor who ‘confines himself [sic.] entirely to “consultation” work’ in relation to a particular part of the body and was usually on the staff of the local hospital.¹¹⁸ Significantly, Digby found that ‘within the profession the status of the GP was lower than that of the consultant.’¹¹⁹ The creation of the National Health Service (NHS) in 1948 perpetuated this divide.¹²⁰ Consultants were given privileged status and allowed to continue private work and the ‘difference between general practitioners and consultants’ was underlined by the ‘increasing difficulty of crossing the divide between them.’¹²¹ GPs were not controlled by the Regional Hospital Boards but by their own executive councils and employed by the local authorities, not the NHS directly. A considerable gulf developed between specialists and generalists as medical and technical developments led to the creation of specialist knowledge about particular diseases and conditions. The status of the GP declined as more and more of their original functions were transferred to hospital-based specialists.¹²² According to Jefferys and Sachs, by the late 1950s and early

¹¹⁷ A. Digby, *The Evolution of British General Practice, 1850-1948*, (Oxford: Oxford University Press, 1999), p. 290.

¹¹⁸ PEP Report, 1937 quoted in *Ibid.* p. 292.

¹¹⁹ *Ibid.* p. 292.

¹²⁰ F. Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice From Hospital Care, 1911-1968* (London: Kogan Page, 1979), p. 2, pp. 298-302.

¹²¹ Digby, *The Evolution of British General Practice*, pp. 293-294. See also D. Morrell, ‘Introduction and overview’ in I. Loudon, J. Horder & C. Webster, *General Practice Under the National Health Service, 1948-1997*, (Oxford: Oxford University Press, 1998) 1-19.

¹²² A. Glanz, ‘The fall and rise of the general practitioner’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 151-166, p. 154.

1960s this had the effect of ‘giving the public, as well as both branches of the medical profession the impression that general practitioners, when compared to hospital based consultants, were second-class doctors.’¹²³ Furthermore, it was not just the general public that viewed general practice with some disdain; a survey of final year medical students between 1961 and 1966 found that only a quarter gave this as their first choice of career.¹²⁴ General practice reached something of a nadir during the 1960s and there was ‘tension and mutual suspicion, if not hostility’ between the two branches of medicine.¹²⁵

However, by the end of the decade, and into the next one, there were signs that general practice was beginning to fight back. In 1967 GP’s pay was increased to roughly that of some hospital-based specialists, helping to improve status.¹²⁶ Elimination from the hospital made GPs increasingly aware of their collective identity and practices. Through the Royal College of General Practitioners (founded in 1953) a new approach to general practice and a different way of seeing medicine and disease emerged.¹²⁷ This placed the patient and their symptoms rather than the disease itself at the centre of the medical gaze. Although the notion of seeing the ‘patient as a person’ rather than as a disease had existed since the early twentieth century, this approach was most fully realised in Dr Michael Balint’s *The Doctor, His Patient and*

¹²³ M. Jefferys & H. Sachs, *Rethinking General Practice: Dilemmas in Primary Medical Care*, (London: Tavistock, 1983), p. 46.

¹²⁴ Glanz, ‘The fall and rise of the general practitioner’, p. 155.

¹²⁵ Jefferys & Sachs, *Rethinking General Practice*, p. 47.

¹²⁶ J. Tudor-Hart, *A New Kind of Doctor: The General Practitioner’s Part in the Health of the Community*, (London: Merlin Press, 1988), p. 93.

¹²⁷ D. Armstrong, ‘The emancipation of biographical medicine’, *Social Science and Medicine*, 13A, (1979) 1-8, p. 5. For more information on the foundation of the RCGP see J. Howie, ‘Research in general practice’ 146-164, pp. 148-151 in Loudon, Horder & Webster (eds) *General Practice Under the NHS*; M. Dury, ‘The General Practitioner and professional organisations’ 205-223, pp. 211-217 in *Ibid* and Tudor-Hart, *A New Kind of Doctor*, pp. 85-87.

The Illness in 1957.¹²⁸ Balint was a Hungarian psychoanalyst who began working with GPs in 1950. By applying psychotherapeutic techniques to the general practice setting a shift of focus from the diagnosis of disease to the meaning of illness, from the illness to the patient, and from the patient to the doctor-patient relationship occurred.¹²⁹ Armstrong argues that for Balint ‘the medical gaze was no longer to be directed to the silent interior of the body but to the patient’s biography and environment.’ This approach, which Armstrong describes as ‘biographical medicine,’ did not deny the existence of organic pathology, but reduced its significance, paying more attention to the symptoms of disease as experienced by the individual patient. The patient was no longer the ‘passive receptacle of organic pathology’ but transformed into the ‘centre of the medical problematic.’¹³⁰ Balint’s work influenced GPs who attended the seminars he hosted and his ideas were communicated to the wider field of general practice when these doctors became leaders of the RCGP.¹³¹ These same GPs were also key figures in the publication of the College’s iconic teaching manual *The Future General Practitioner* in 1972.¹³² According to Professor of General Practice, Marshall Marinker, this marked ‘a massive breaking-away from intellectual and emotional chains of a predominately instrumental and reductionist hospital-orientated medicine.’¹³³ *The Future General Practitioner* adopted the ideas of Balint and placed the patient and their social environment at the centre of therapeutic endeavour. Balint’s work thus provided a new epistemological basis for general practice, one that was gradually internalised through the use of *The Future*

¹²⁸ For the early history of the patient-as-a-person movement see R. Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity From Antiquity to the Present*, (London: Harper Collins, 1997), pp. 682-683; Armstrong, *The Political Anatomy of the Body*, pp. 105-108.

¹²⁹ M. Marinker, ‘“What is wrong” and “how we know it”: changing concepts of illness in General Practice’ in Loudon, Horder & Webster, *General Practice Under the NHS*, 65-91, p. 74.

¹³⁰ Armstrong, ‘The emancipation of biographical medicine’, p. 5.

¹³¹ Marinker ‘“What is wrong”’ p. 73; Tudor-Hart, *A New Kind of Doctor*, p. 88.

¹³² Marinker ‘“What is wrong”’ p. 73, p. 78.

¹³³ *Ibid.* p. 71.

General Practitioner in the training of new GPs throughout the 1970s and 1980s and crucial to the foundation of an ideology of general practice independent of hospital specialism.¹³⁴ The divide between specialist and generalist was thus reinforced as GPs became more confident in their own worth and the services they could offer as distinct from the hospital-based consultant.

3.2 General Practitioners and the treatment of addiction

Alan Glanz has argued that the re-intervention of the GP into addiction treatment in the late 1970s and early 1980s can be seen in this context of an improving position for general practice within medicine. Through biographical medicine ‘the whole position of general practice had been strengthened and the GP could meaningfully be called upon to play a significant role in the treatment of drug misuse.’¹³⁵ The specific consequences of biographical medicine for the methods used in the treatment of addiction in general practice will be dealt with in more detail in Chapter Four, it is sufficient to note here that the confidence of GPs in their own abilities and outlook allowed them to take on, and even challenge, a previously specialist domain. In addition, there were a number of more practical reasons why the GP became more involved in the treatment of addiction during the 1980s. The growing scale of the drug problem meant that specialist facilities were overloaded and, failing an expansion in these, addict-patients would have to be seen elsewhere by other doctors. The GP was a natural and obvious choice. General Practitioners were to be found all over the country and were often the first source of medical help turned to by

¹³⁴ *Ibid.* p. 78; Tudor-Hart, *A New Kind of Doctor*, p. 89.

¹³⁵ Glanz, ‘The fall and rise of the general practitioner’, pp. 158-159.

addicts. John Strang also suggested that as the numbers of drug takers increased and they became more 'normal' it was logical that treatment services become more 'normal' in response.¹³⁶ Involving the GP was thus, at least in part, a pragmatic reaction to the changing nature of drug use in this period.

Attempting to assess why addicts approached GPs for treatment highlights the politicised divide between those who supported the growing involvement of the GP in the treatment of addiction, and those who opposed it. Those specialists who opposed the treatment of addiction in general practice argued that addicts went to GPs because they more readily prescribed opioid drugs than DDUs. It was a commonly held concern amongst DDU psychiatrists that GPs working alone with limited knowledge of the wiles of the addict and no access to diagnostic testing facilities could be put under pressure to over-prescribe.¹³⁷ Connell and Mitcheson expressed an oft-repeated fear when they asserted that unlike most treatment centres, where a team approach was practiced, the single-handed doctor 'who has little or no experience of addicts is a vulnerable target for the drug seeker.'¹³⁸ GPs, it was strongly implied, were more easily duped than DDU staff into prescribing inappropriately large doses of opioids. DDUs, therefore, were the best place for the addict to receive treatment as they were less likely to over-prescribe drugs which would feed the 'grey' market.

In contrast, those who were critical of the DDUs, such as Ann Dally, argued that it was the practices of these that were driving addicts into general practice. She argued that forcing addicts on to reducing doses of oral methadone and refusing to

¹³⁶ J. Strang, 'A model service: turning the generalist on to drugs' in MacGregor (ed.) *Drugs in British Society*, 143-169, p. 147.

¹³⁷ P.H. Connell & M. Mitcheson, 'Necessary safeguards when prescribing opioid drugs to addicts: experience of drug dependence clinics in London', 288, (10 March 1984) 767-769; T.H. Bewley, 'Prescribing psychoactive drugs to addicts', *British Medical Journal*, (16 August 1980) 497-498 and T.H. Bewley, A.H. Ghodse, 'Unacceptable face of private practice', *British Medical Journal*, 286, (11 June 1983) 1876-1877; Ghodse, 'Treatment of drug addiction in London', *Lancet*, pp. 636-638.

¹³⁸ Connell and Mitcheson, 'Necessary safeguards', p. 769.

treat them as individuals encouraged them to seek treatment elsewhere, with GPs or sympathetic private practitioners like herself.¹³⁹ Some reports published in the medical press also suggested that psychiatric services were inappropriate for the treatment of addiction. Aidan Bucknall, a researcher on the Edinburgh Drug Addiction Study, Roy Robertson, a GP and James Strachan, a consultant psychiatrist, surveyed referrals to psychiatric services (there were no DDUs in Scotland) for the treatment of addiction from a general practice in Edinburgh. Bucknall and his colleagues found there was no evidence to ‘indicate that patients receiving treatment from the psychiatric drug treatment service have a higher rate of abstinence than those not starting treatment, casting doubt on the value of this kind of service.’¹⁴⁰ Furthermore, the study’s authors took the high rates of non-attendance amongst the patients referred to these services to mean that ‘patients find the service both uncomfortable and inappropriate.’¹⁴¹ This was, at least in part, because few of the patients encountered by Bucknall, Robertson and Strachan considered themselves to be suffering from a psychiatric illness. This led the researchers to argue that ‘The relevance of referral for every drug abuser is debatable, particularly if treatment is largely limited to withdrawal.’ Instead, they contended that ‘General Practitioners may be in the best position to cope with the extended management of drug users, and certainly community based treatment seems more likely to maintain contacts [with the drug user].’¹⁴² Similar conclusions were reached in another report produced by some of the same researchers. A study of the medical facilities used by a group of addicts found that general practice was ‘the main interface between the drug users and the

¹³⁹ A. Dally, *A Doctor’s Story*, (Basingstoke: Macmillan, 1990) pp. 62-69, pp. 79-80, p. 83. The treatment policies of Dally are discussed in more detail in Chapter Three, pp. 140-146.

¹⁴⁰ A.B.V. Bucknall, J.R. Robertson & J.G. Strachan, ‘The use of psychiatric treatment services by heroin users from general practice’, *British Medical Journal*, 292, (12 April 1986) 997-999, p. 999.

¹⁴¹ *Ibid.* p. 999.

¹⁴² *Ibid.* p. 999.

medical establishment (even accounting for selecting the study group through general practice).’ The authors felt that this had not been sufficiently taken into account in the response to drug addiction, leading them to argue that ‘the historical emphasis placed on intervention based in hospital (normally psychiatric) for the education and general management of drug users appears to be inappropriate.’¹⁴³ Taken together, these studies could be construed as a counter-attack on the specialist nature of treatment of addiction. If psychiatric services were of little use in treating addiction then the generalists’ position was automatically enhanced at the cost of the ‘expertise’ of the psychiatrist.

However, examining the actual role played by the GP in the treatment of addiction at first seems to indicate that this was insignificant in the mid-1980s, posing little real threat to the authority of psychiatry in this area. A national survey of a random sample of GPs conducted by Glanz in 1985 found that two thirds of GPs referred addict-patients on to either a DDU or general psychiatric services.¹⁴⁴ Furthermore, they noted that many GPs were not keen about taking addicts on as patients; less than a third of the GPs surveyed said they would take on opiate users as willingly as other patients, and two thirds thought the treatment required by addicts was beyond the competence of the general practitioner.¹⁴⁵ Yet, the flip side of this research would indicate that there was a sizeable minority of GPs who were interested in addicts and their problems, GPs that did not simply refer opiate users on to the specialist services. Going by Glanz and Taylor’s more conservative estimate of 30,000 ‘new’ cases of opiate misuse presenting to GPs a year at least 10,000 addicts

¹⁴³ A.B.V. Bucknall, J.R. Robertson & K. Foster, ‘Medical facilities used by heroin users’, *British Medical Journal*, 293, (8 November 1986) 1215-1216, p. 1216.

¹⁴⁴ A. Glanz, ‘Findings of a national survey of the role of general practitioners in the treatment of opiate misuse: dealing with the opiate misuser’, 293, (23 August 1986) 482-488, p. 487.

¹⁴⁵ A. Glanz, ‘Findings of a national survey on the role of general practitioners in the treatment of opiate misuse: views on treatment’, 293, (30 August 1986) 543-546, p. 544.

were not being seen by specialists.¹⁴⁶ This would suggest that there was not a total monopoly of the treatment of addiction by clinical psychiatrists. Indeed, not all GPs were totally averse to addict patients: 55 per cent of those surveyed said they thought they could play a positive role in the treatment of addicts even if they were not prepared to come off drugs.¹⁴⁷ Moreover, positive attitudes towards the treatment of addict patients were more often found in those GPs most recently qualified. Around 40 per cent of GPs surveyed who qualified in the 1970s and the 1980s said they were prepared to treat addict patients as willingly as any other patient, compared to just 25 per cent of those who qualified before this period.¹⁴⁸ This would suggest that the new generation of GPs trained in the principles of biographical medicine were more amenable to treating addicts. This needs further investigation, as does what happened to the third of addicts who remained under the care of the General Practitioner. Glanz's study was not designed to answer this question and his figures do not really allow for direct comparison, but he found that those GPs who did prescribe to addicts were just as likely to prescribe opiate drugs on a long-term basis (over two weeks) as on a short-term basis.¹⁴⁹ The involvement of the GP with maintenance and the impact of biographical medicine on the treatment offered in community-based practice will be discussed in more detail in Chapter Four, but it is clear that the GP could and did play a significant role in the treatment of addiction, which in turn posed a threat to the expert status of the psychiatrist in this field.

Specialist versus generalist: an ongoing battle?

¹⁴⁶ Glanz & Taylor, 'Extent of contact with opiate users', p. 427.

¹⁴⁷ Glanz, 'Views on treatment', p. 544.

¹⁴⁸ *Ibid.* p. 544.

¹⁴⁹ Glanz, 'Dealing with the opiate misuser', p. 487.

This threat was particularly potent when placed in the overall context of a burgeoning 'policy community' around drugs. As the number of bodies and individuals interested in drug problems increased, psychiatrists had to defend their claim to a powerful position in this community by pointing to their expertise in treatment. Yet, their claim here was also being challenged. A new generation of self-confident GPs revitalised by biographical medicine were less willing to accept that addiction was inherently an area of specialist knowledge. When combined with existing problems in catering for a growing number of increasingly diverse drug users it was unsurprising that more GPs were becoming involved in the treatment of addiction. This brought them into conflict with hospital-based psychiatrists, particularly those in DDUs, who felt their position was being threatened. In response, a group of psychiatrists attempted to reduce the role played by the generalist in the treatment of addiction by trying to bring the GP under the control of the DDU, a recommendation made in *Treatment and Rehabilitation*. In addition, clinic psychiatrists tried to discourage GPs from becoming involved in this area by outlining some of the 'difficulties' involved with the treatment of addiction in the pages of medical journals and elsewhere, thus reinforcing the notion that this was a specialist area of medical knowledge.

There were, therefore, particular reasons as to why there was a conflict between the specialist and the generalist in the treatment of addiction, but this can also be read as a manifestation of the old divide between specialist and generalist redrawn. General practice, revitalised through its encounter with biographical medicine, was reinventing itself and taking an interest in areas that had previously been considered solely the domain of the specialist, such as addiction. Indeed, biographical medicine was to bring GPs involved in the treatment of addiction into further conflict with the specialist. The community-based physician came to view disease and its treatment in

a different way. Subsequently, many GPs and private practitioners who treated addicts offered a different form of treatment to that found in the DDUs, one that drew on the principles of biographical medicine and placed the patient at the centre of the endeavour. This led to further conflict between the specialists and the generalists over the treatment of addiction, a conflict that will be discussed in Chapter Four and Chapter Five. Before moving on to discuss this conflict it is first necessary to consider another conflict involving the DDU psychiatrist, this time with the private practitioner. As will be seen in Chapter Three, this was inter-twined with the conflict between specialists and generalists and between those who supported the short-term withdrawal of drugs from addiction and those who supported long-term prescription, adding another dimension to the debate over the treatment of addiction in this period.

Chapter Three

Public versus Private: the Contested Role of the Private Doctor – the GMC versus Dr Ann Dally, 1983

Introduction

The GP was not the only doctor treating addicts away from the DDUs. Some addicts abandoned publicly funded treatment on the NHS altogether, preferring instead to seek treatment from private doctors, many of whom were also psychiatrists. Though there were no accurate figures charting this development and doctors and officials had little idea how many addicts were actually being treated privately, it was a trend that provoked particular ire. The ACMD noted in *Treatment and Rehabilitation* that ‘although doctors in private practice are legally entitled to prescribe controlled drugs to problem drug takers, this is undesirable.’ There were, they asserted, ‘moral and ethical aspects’ that gave ‘grave cause for concern.’¹ As with the concern voiced over the increasing role being played in the treatment of addiction by the GP, this was motivated in part by the existence of genuine problems with the treatment of addiction in private practice, but also because this posed a threat to the power and authority of the DDU psychiatrist. The nature of this threat was different to that posed by the GP, as many of the doctors treating addicts privately were psychiatrists, or psychiatrically trained. Instead of challenging the treatment of addiction as an area of psychiatric expertise these doctors were presenting an assault on the actual practices of the DDU and those who developed them. The existence of the private practitioner suggested there was an alternative locus of expertise within psychiatry, but away from the DDU and NHS provided care. This was construed, therefore, as a more personal assault on the knowledge, methods and expertise of a group of individuals (the DDU

¹ ACMD, *Treatment and Rehabilitation*, p. 54.

psychiatrists) who, until recently, had been unchallenged in their position as the leading authority on drug users and their problems, but were now facing threats to their status and position from all sides.

This chapter will analyse the contested role of the private practitioner in the treatment of addiction by examining this from both the public and private perspectives. Though private medicine expanded considerably in this period the increase in private treatment for addiction was not necessarily part of this broader expansion, but was motivated more by perceived failings within NHS treatment provision. Addicts began to turn to private practitioners for the same reasons others approached GPs or resorted to the black market; they were dissatisfied with the treatment on offer at the DDUs. Examining the work of private practitioner Dr Ann Dally shows that private doctors often responded to these criticisms of clinic practices when developing their own treatment policies. Dally argued that she provided treatment for the long-term stable addict who found the DDUs unsuitable. In her view, long-term addicts required long-term prescription. Each patient was to be treated as an individual: there should be no forced reductions in dose or limitations to the duration of prescription. Dally was a particularly important figure in the public/private debate within the treatment of addiction; as an active practitioner, a vocal critic of NHS DDUs and founder of the Association of Independent Doctors in Addiction (AIDA) which supported and promoted the role of the 'independent' doctor (private and general practitioners) in the treatment of addiction.

AIDA was created in a climate where opinion was increasingly turning against the involvement of the private doctor in the treatment of addiction. DDU psychiatrists raised a number of problems with private treatment in this field. These centred mainly on the payment of a fee for treatment that involved the prescription of an

opioid drug. Many DDU doctors felt that addicts would be unable to afford this treatment without resorting to selling some of the drugs prescribed. It was argued that addicts would over-state the amount of drug they needed in order to have a surplus to sell on to other addicts. Clinic-based psychiatrists also pointed out that there was a financial incentive for the private doctor to prescribe to the addict patient regardless of their need; the addict would attend as long as they were getting a supply of drugs and the doctor would continue to collect their fee. The private doctor, the NHS DDU psychiatrist argued, had a vested interest in maintaining addiction, not curing it.

This attack on private practice formed the backdrop to the GMC's case against Dally for serious professional misconduct as a result of irresponsible prescription to an addict patient in 1983. Dally was accused of prescribing irresponsibly to an addict patient who could only afford her fees by selling his part of prescription. Dally argued that she had not prescribed excessively to the patient and to the best of her knowledge he had been able to pay her without selling drugs, but the GMC remained unconvinced. She was found guilty of serious professional misconduct and admonished for her behaviour. Although there were undoubtedly some flaws in Dally's handling of the patient in question it is impossible not to see this judgement in the light of the wider political debate about the desirability or otherwise of the treatment of addiction in private practice. Contemporaries recognised that the case was about publicly disciplining a leading private practitioner involved in the treatment of addiction and was motivated more by a desire to prevent the proliferation of a private alternative to the treatment on offer at the DDUs than censuring an individual doctor. Indeed, it was this alternative that was a problem for DDU psychiatrists as much as the fact that it existed outside the NHS, as it posed a further threat to their

position and authority which had already been weakened by the increasing involvement of the generalist and other non-medical agencies.

1. Private: the role of the private practitioner in the treatment of addiction

1.1 The expansion of private practice

The increase in private treatment for addiction paralleled a more general growth in private medicine in this period, but there were a number of anomalies between the overall pattern of private healthcare provision and the treatment of addiction in private practice that suggested there were different reasons for expansion in this area.

Private healthcare services have co-existed with state provision since the foundation of the NHS, but expanded considerably during the 1980s, spurred on by the Thatcher government who believed that ‘the private sector was more efficient, better managed and more responsive to the consumer than the public sector.’² A review of spending in 1983 resulted in policies designed to achieve greater efficiency within the NHS also encouraged the development of health insurance and private care to exist alongside collective provision.³ This led to a rapid growth in the private sector, so that by 1988 there were around 200 private or voluntary hospitals in Britain, treating eight per cent of all inpatients.⁴ Private medical services were most commonly used for elective repair surgery for non-life threatening conditions where there were long waiting lists for NHS operations.⁵ Much of this care was provided through health care insurance policies. Subscriptions to medical insurance policies rose steadily over the decade: in 1979 2.7 million Britons (just under 5 per cent of the population) were insured by such schemes, compared to 6.2 million Britons (around 10 per cent of the

² Baggott, *Health and Health Care in Britain*, p. 161.

³ Ham, *Health Policy in Britain*, pp. 46-47.

⁴ *Ibid.* p. 47.

⁵ Klein, *The Politics of the NHS*, p. 215.

population) in 1989.⁶ Treatment for addiction, however, was rarely, if ever, provided for under such schemes. Addicts generally paid for treatment at the point of service, paying fees directly to the doctor concerned. So, whilst the increase in private treatment for addiction was concomitant with an upsurge in private medicine, it was not necessarily part of the more general pattern in terms of the way services were provided.

However, the relationship between public and private provision of healthcare does provide some clues as to why the private treatment of addiction expanded in the 1980s. Despite the ideological fury sometimes aroused by the issue of private practice Rudolf Klein saw the relationship between the NHS and the private sector as essentially a symbiotic one. He argued that for the NHS the private sector was a 'safety valve,' catering for some demands not met by state provision, and for the private sector, the NHS offered services that could not be provided in private medicine, or at least not at a profit.⁷ In this way, the private market in healthcare could be used to gauge where the NHS was lacking, or perceived to be lacking, by those who could afford to opt out of the state system.⁸ The existence of private treatment for addiction in this period might, therefore, suggest that the NHS was 'failing' some of its addict patients. This was the view of Lyn Perry, Assistant Director of drugs advice charity Release, who said in a statement supporting Dally in 1986 that 'In many areas, only private practitioners are prepared to offer flexible treatment options, and are stepping into the breach where state services are patchy or inadequate.'⁹ This argument requires further exploration. Addicts, like any other

⁶ Figures in Berridge, *Health and Society in Britain*, Table 4, pp. 107-109.

⁷ Klein, *The Politics of the National Health Service*, pp. 157-158.

⁸ *Ibid.* p. 154.

⁹ Contemporary Medical Archives Centre at the Wellcome Library for the History and Understanding of Medicine, London (hereafter CMAC), private papers of Dr Ann Dally, (hereafter PP/DAL) CMAC

patients, must have had good reasons for leaving free public services to pay for private treatment. The services offered by private practitioners therefore need investigation.

1.2 The private practitioner and the treatment of addiction – Dr Ann Dally

The role of the private doctor will be considered by examining the work of private psychiatrist Dr Ann Dally. Dally practiced privately in rooms off Harley Street from 1963 onwards.¹⁰ Although she had no formal qualifications in the field, she regarded herself as a psychiatrist and not a general practitioner, maintaining that she had gained training and experience wherever possible.¹¹ In her work as a general psychiatrist Dally had encountered heroin addicts, but stated that after 1979 she was referred increasing numbers of this type of patient by GPs.¹² This was the result, she argued, of serious deficiencies in the treatment offered by the DDUs.¹³ Dally asserted that ‘all clinics are geared to the addict who is young, recently addicted, unemployed, single and male.’¹⁴ She believed that DDUs concentrated on young, ‘new’ addicts as they felt that there was a greater likelihood of ‘success’ in getting them off drugs.¹⁵ This meant that clinics favoured a prescription policy concentrating on withdrawing drugs from the addict with abstinence as a clear, immediate goal. The addict would be prescribed a rapidly reducing dose of orally administered methadone with the aim of being ‘drug free’ in a short, fixed period of time. Dally thought this was unrealistic

PP/DAL/E/4/12, Statement from Lyn Perry, Assistant Director of Release, with respect to Ann Dally, 27 January 1986.

¹⁰ Dally, *A Doctor's Story*, p. 44, p. 57.

¹¹ CMAC PP/DAL/E/17, Transcripts of the General Medical Council Professional Conduct Committee Hearing, 1986-1987, (hereafter PCC Hearing, 1986-7), 27 January 1987, pp. 15-16.

¹² Dally, *A Doctor's Story*, pp. 57-58.

¹³ *Ibid.* p. 62. See also A. Dally, ‘Personal view’, *British Medical Journal*, 283 (26 September 1981) p. 857.

¹⁴ CMAC PP/DAL/E/4/20, ‘Analysis of my addict practice’ by Dally, prepared for her lawyers, January 1987.

¹⁵ CMAC PP/DAL/E/4/20, ‘Maintenance’, by Dally, prepared for her lawyers, January 1987.

for addicts who had been addicted to heroin for a long time. She stated in a document prepared for her defence at a GMC professional misconduct hearing in 1986/7 that she found some truth in the notion that ‘it takes as long to wean an addict off drugs as the time he has been taking those drugs.’¹⁶ Long-term addiction, in her opinion, required long-term treatment.

The duration of treatment was not the only criticism Dally, and the addicts that came to her, had of the DDUs. Many clinics introduced a ‘contract system,’ whereby addicts would agree to reduce their intake of opiate drugs by a certain amount over a fixed period, and also set a limit on the overall duration of prescription.¹⁷ Dally argued that these contracts were usually the same for all patients regardless of how long they had been addicted and that these were ineffective for many addicts.¹⁸ Those who came to Dally told her that they were not treated as individuals by clinics and disliked the attitudes of the staff that worked there. One addict commented that ‘the treatment provided by the NHS is at best dogged by an excess of very generalised and rigid rules and regulations, which take little or no account of an individual’s needs and expectations.’¹⁹ Another felt they were ‘treated like a criminal rather than a patient.’²⁰ Many addicts told Dally that the way clinics operated made it impossible to continue in paid employment. One addict remarked that clinics were ‘more concerned with keeping strict adherence to appointment dates/times, than they are with patient’s keeping their jobs.’²¹ Most clinics insisted that addicts collect their

¹⁶ CMAC PP/DAL/E/4/22, Draft statement of Dr Ann Dally, 20 October 1986.

¹⁷ Connell & Mitcheson, ‘Necessary safeguards’, p. 768; Stimson and Oppenheimer, *Heroin Addiction*, pp. 106-110.

¹⁸ Dally, *A Doctor’s Story*, p. 79.

¹⁹ N.B. Aliases have been used where addicts’ real names are mentioned. Where possible these are the same ones used by Dally in her book, *A Doctor’s Story*. CMAC PP/DAL/E/4/11, Reply from ‘John’ to Dally’s letter of December 1985.

²⁰ CMAC PP/DAL/E/4/11, Reply from ‘Mark’ to Dally’s letter of December 1985.

²¹ CMAC PP/DAL/E/4/11, Reply from ‘James’ to Dally’s letter of December 1985.

prescriptions on a daily basis.²² This was supposed to prevent the addict from overdosing or selling their drugs, but it also made holding down a job difficult as the addict had to visit the chemist every day, often at a specific time, to collect their drugs.²³ Clinics also required patients to attend regular treatment sessions usually held during office hours, again something that made continuing to work problematic.²⁴

Dally used these criticisms of DDU treatment policy to develop her own treatment philosophy and methods. She maintained that the treatment she offered was directed at a series of clear, mutually dependent goals: 'to improve their [the addicts] general health and social situation and to help them reduce their drug need, with the hope that they would eventually become drug free.'²⁵ Her aim was to get addicts to 'stabilise their lives' and then 'help them towards a drug-free life.'²⁶ To achieve this, Dally prescribed sufficient opiate substitutes (usually methadone) to prevent withdrawal and had regular sessions with the patient directed towards helping the patient acquire greater self confidence and a more 'stable' life, at which point work could be undertaken to reduce the dosage of drugs.²⁷ Prescription could be over a prolonged period. Dally thought that long-term addicts required long-term prescription. She did not, however, regard this treatment as 'maintenance.' Dally disliked the term, and thought 'that the idea of simply giving an addict a regular dose of a drug forever and not doing any more to help him is quite wrong, or at least not the function of a doctor.'²⁸ Instead, she preferred to think of this as a 'stabilisation

²² Connell & Mitcheson, 'Necessary safeguards', p. 768.

²³ Stimson & Oppenheimer, *Heroin Addiction*, p. 106.

²⁴ Connell & Mitcheson, 'Necessary safeguards', p. 768

²⁵ CMAC PP/DAL/E/4/17, PCC Hearing 1986-7, 26 January 1987, pp. 52-54.

²⁶ CMAC PP/DAL/E/4/22, Draft statement of Dr Ann Dally, October 1986.

²⁷ Dally, *A Doctor's Story*, p. 80

²⁸ CMAC PP/DAL/E/4/20, 'Maintenance', by Dally, prepared for her lawyers, January 1987.

dosage' and her treatment as 'long-term detoxification.'²⁹ Dally summarised her prescription policy as being 'to prescribe as little as possible and to reduce the dose as fast as possible, but only within the capacity of the individual patient.'³⁰

In order to determine that the patient she was treating was indeed addicted to opiate drugs Dally relied chiefly upon an examination of the patient. She concentrated on looking for the physical signs of repeated injection, scars over veins in the arms, legs and groin area called 'track marks.' Dally argued that these were difficult to fake, but an addict patient who appeared as a witness at her professional conduct hearing in 1986/7 claimed that she had marked her arms deliberately in order to convince Dally she was an addict.³¹ The more 'scientific' way of determining whether or not someone was an addict, and the method used by the DDUs, was to conduct urine analysis for the presence of opiate drugs.³² Dally argued that addicts could easily fake the results of these tests.³³ What is more, she did not have the facilities to conduct this kind of testing at her surgery and would have had to send samples for analysis elsewhere. As a private doctor she would have been required to pay for this service, and pass the cost onto her patient.³⁴ Her dislike of urine testing as a method for determining whether or not a patient was taking opiate drugs set her apart from her clinic-based peers. Even if urine analysis was a dubious diagnostic tool, not using it opened Dally up to criticism in a climate where testing was the

²⁹ *Ibid.*

³⁰ Dally, *A Doctor's Story*, p. 82

³¹ CMAC PP/DAL/E/4/17, PCC Hearing 1986-7, 11 December 1986, pp. 16-25; CMAC PP/DAL/E/4/6 Statement of 'Miss B.', 4 September 1986.

³² Smart found that 80 per cent of the DDUs in England and Wales that she surveyed in 1982 had urine testing facilities. See, Smart, 'Drug dependence units in England and Wales', p. 137. See also: Chapter One, p. 81; Ghodse, 'Treatment of drug addiction in London', p. 637; Connell & Mitcheson, 'Necessary safeguards', p. 768; Gardner & Connell, 'One year's experience in a drug-dependence clinic', p. 455; Stimson & Oppenheimer, *Heroin Addiction*, pp. 98-99.

³³ A. Dally, 'Drug users and urine testing' letter to the *Lancet*, (3 September 1983) p. 575; Dally, *A Doctor's Story*, pp. 202-203, p. 293; CMAC PP/DAL/E/2/4, PCC Hearing 1983, 6 July 1983, p. 21.

³⁴ Annette Lingham, Dally's secretary and receptionist, in a statement taken for Dally's defence in 1986 said that urine tests, when carried out, cost £15-£18. See CMAC PP/DAL/E/4/12, Statement of Annette Lingham, 20 November 1986.

orthodoxy. Urine analysis could indicate the presence of opioid drugs but it was of little use in determining what dose to prescribe. Dally, like other doctors treating addicts tended to use a ‘rule of thumb’ in absence of any other accurate method.³⁵ When she first began to treat addicts Dally stated that she read all the scientific literature available on the subject and decided not to prescribe more than 180 milligrams of methadone per day to any patient, although she contended that in practice she rarely prescribed more than 80 milligrams a day and never actually reached her upper limit.³⁶

Dally argued that she built her treatment philosophy and methods around a different kind of patient to the ones seen in DDU. Dally’s patients were older than those usually seen by clinics. In an analysis of her practice produced in 1987, Dally found that the average age of her patients was 35 years for men, 33 years for women.³⁷ This was higher than those attending clinics, where the majority of addicts were in their twenties.³⁸ According to Dally, her addict patients almost universally had been addicted to opiates for a long period of time. She estimated that 90 per cent of her addict patients had been addicted for at least three years.³⁹ Most of the addicts she treated had jobs; indeed, Dally stated that she made it a condition of treatment to provide some form of documentation to prove employment or sufficient funds.⁴⁰ This was vital, as she needed to ensure that patients could afford to pay her fees. Dally

³⁵ See Chapter One, p. 81.

³⁶ Dally, *A Doctor’s Story*, p. 84.

³⁷ CMAC PP/DAL/E/4/20, ‘Analysis of my addict practice’ by Dally, prepared for her lawyers, January 1987.

³⁸ *Ibid.* See also Hicks, ‘The management of heroin addiction at a General Hospital Drug Addiction Treatment Centre’, pp. 235-243, where the average age of patients attending was stated as 22.8 years, Love & Gossop, ‘The process of referral and disposal within a London Drug Dependence Clinic’, where 68% of patients were 25-29 years old and M. Sheenan, E. Oppenheimer & C. Taylor, ‘Why drug users sought help from one London Drug Clinic’, *British Journal of Addiction*, 81, (1986) 765-775, where the mean age of the sample was 24.6 years.

³⁹ CMAC PP/DAL/E/4/20, ‘Analysis of my addict practice’ by Dally, prepared for her lawyers, January 1987.

⁴⁰ Dally asserted the need to check employment records of her addict patients when she gave evidence at the 1986/7 hearing. See CMAC PP/DAL/E/4/17, PCC Hearing 1986-7, 26 January 1987, p. 58.

charged £50 for an initial visit and £30 a session after this.⁴¹ This was less than her ‘non-addict’ rate, and her fees remained the same from 1979 until 1987 when she stopped seeing addicts.⁴² In addition to the consultation fee, addicts had to pay for their prescriptions privately. This was more expensive than getting prescriptions through the NHS, as the NHS charged a flat rate for the drugs prescribed and paid the pharmacists’ dispensing fee. Drugs dispensed on a private prescription were paid for at market value; this was around £20 to £30 for the average methadone or other opiate substitute script.⁴³ In addition, pharmacists charged a dispensing fee for private prescriptions, and this ranged from £2 to £12.⁴⁴ The payment of fees for treatment of heroin addiction was a key issue in the debate over the involvement of the private practitioner in this field, and this will be dealt with in more detail below, but it is important to note that Dally had to check that her addict-patients had sufficient funds not only so that she could ensure that the patient could pay her fees, but also to guard against the likelihood of a patient selling drugs prescribed to him or her to a third person. Patients initially saw Dally once a week, but when they were ‘stable,’ or she felt they could be trusted, they came once every few weeks, or even once a month.⁴⁵ She argued that this meant that the addict had to take less time off from work to attend treatment sessions. Crucially, too, Dally allowed addicts to collect their prescriptions once a week, in contrast to many clinics, which required addicts to obtain their drugs one day at a time. Dally stated that she had four reasons for weekly prescription. Firstly, those that worked found getting to the pharmacy each day almost impossible. Secondly, she found that many of her patients had difficulty finding a pharmacy that

⁴¹ CMAC PP/DAL/E/4/12, Statement of Annette Lingham, 20 November 1986.

⁴² Dally charged non-addict patients £65 for an initial visit, and £35 to £50 per consultation after this. See *Ibid.*

⁴³ CMAC PP/DAL/E/4/9, Miscellaneous statements from patients, 1986.

⁴⁴ CMAC PP/DAL/E/4/20, ‘Frequency of my prescription’ by Dally, prepared for her lawyers, 28 January 1987.

⁴⁵ Dally, *A Doctor’s Story*, p. 75, p. 78.

would make up a private prescription, except in the Harley Street area. Thirdly, Dally wanted to limit prescription costs to a minimum and as private patients had to pay a dispensing fee each time a script was cashed, weekly prescription was clearly considerably cheaper. Finally, Dally felt that her patients were more mature and stable than many of those who attended clinics, so they could be trusted with weekly, rather than daily, prescriptions.⁴⁶

The kind of treatment offered by Dally clearly differed from that found in the DDUs. Dally was prepared to prescribe to addict-patients over a longer period of time than clinic psychiatrists. She was less insistent that addicts abide by common DDU practices such as collecting prescriptions daily or submitting regular urine samples for analysis. It was for these reasons that addict patients consulted her, but it was these same aspects of her treatment philosophy and methodology that brought her into direct conflict with DDU psychiatrists. This conflict was based partly on the problems as they saw it with her methods, but also because she presented a critique of their methods, and therefore, an attack on their status and position.

1.3 AIDA – a critique of the NHS DDUs?

This assault on the DDUs and their methods was consolidated by Dally's outspoken criticism of clinics' practices and her strong advocacy for the increased involvement of what she termed the 'independent' practitioner in addiction. Dally argued that doctors independent of the DDUs, be they GPs or general psychiatrists, in private practice or working for the NHS, had a role to play in the treatment of heroin addiction.⁴⁷ To strengthen this claim, and to campaign for the wider involvement of

⁴⁶ CMAC PP/DAL/E/4/20, 'Frequency of prescription', by Dally, prepared for her lawyers, 28 January 1987.

⁴⁷ Dally, *A Doctor's Story*, p. 85.

the independent doctor, Dally established the Association of Independent Doctors in Addiction (AIDA) in 1981. Its purpose was to:

promote high standards of practice among doctors (both National Health Service and private) who are interested in treating drug addicts outside clinics and to encourage and teach National Health Service general practitioners to look after their own addicts.⁴⁸

Dally canvassed support for her organisation by persuading medical journals to insert notices about AIDA.⁴⁹ She claimed that she received several hundred replies from doctors all over the world, but AIDA's membership was actually quite limited.⁵⁰ In a document prepared for her lawyers prior to the 1986/7 professional conduct hearing Dally stated that AIDA had ten 'active' members, and a further 30 members 'world-wide.'⁵¹ Elsewhere Dally conceded that many of the practising doctors rarely attended meetings, and 'some of [the] membership [is] really a mailing list.'⁵² Those who joined AIDA, according to Dally, were 'doctors like myself who were trying to help addicts and to treat them in a humane and effective way and who wished to meet and discuss with others of like mind.'⁵³ Despite Dally's protestations, AIDA was frequently seen as an organisation consisting purely of private doctors. A researcher who had observed the work of the DDU's noted in a letter to the *Lancet* that 'most' members of AIDA were private doctors.⁵⁴ Dally was quick to reply that 'Private practitioners form a substantial minority [of AIDA's members], but it is a minority.'⁵⁵ The veracity of this is unclear. Of the ten 'active' members, including Dally herself,

⁴⁸ A. Dally, 'Drug addicts in Piccadilly', letter to the *British Medical Journal*, 287, (22 October 1983) p. 1219.

⁴⁹ Dally, *A Doctor's Story*, p. 85; Notices, *Lancet*, (12 December 1981) p. 1358.

⁵⁰ Dally, *A Doctor's Story*, p. 85.

⁵¹ CMAC PP/DAL/E/4/20, 'Expansion on my skeleton document about the unpaid work I do and have done in relation to drug addiction' by Dally, prepared for her lawyers, 5 December 1986.

⁵² See CMAC PP/DAL/E/4/20, 'List of witnesses, definite and possible' by Dally, prepared for her lawyers, 1986.

⁵³ Dally, *A Doctor's Story*, p 85

⁵⁴ L. Hewitt, 'Drug Clinics Today' letter to the *Lancet* (30 April 1983) p. 990.

⁵⁵ A. Dally, 'Drug Clinics Today' letter to the *Lancet* (28 May 1983) p. 1223

listed in 1986 six practised privately (some in addition to NHS work) and only one practised exclusively within the NHS.⁵⁶

AIDA's reputation was not enhanced by being associated with a number of doctors who had their names deleted from the GMC's register of licensed medical practitioners. A former AIDA member, Dr Ali Khan, was struck off in 1982 for irresponsible prescription to addicts.⁵⁷ Dally stated that this happened before the organisation had really got going and that they had persuaded Khan to change his prescription practices, but by then it was too late.⁵⁸ Dally maintained that he was the only member of AIDA to be struck off by the GMC, but this was not necessarily widely understood. At a meeting of the DHSS Working Party on Drug Misuse constituted to create guidelines on good clinical treatment of addiction in 1984, Bewley confidently asserted that members of AIDA had been struck off.⁵⁹ Dally admitted that there were other doctors of dubious clinical reputation who became associated with AIDA. Dr Peter Tansey, Dr Rai and Dr Rahman had all been found guilty of irresponsible prescription by the GMC and were all 'cited by our critics as being members,' although Rai and Rahman attended only one meeting.⁶⁰

AIDA did, however, have a number of more positive associations. According to Dally, Bing Spear was 'enthusiastic' and he felt that an organisation like AIDA had

⁵⁶ The members of AIDA in 1986 listed by Dally were: Dr Charles Cohen, status unknown; Dr Leighton Charles, private psychiatrist, stopped treating addicts in June 1986; Dr Patrick O'Connor, status unknown; Dr A.W. Beard, former NHS Consultant Psychiatrist at Middlesex Hospital, but then treating addicts privately; Dr Margaret McNair, private General Practitioner; Dr John Poncia, NHS consultant psychiatrist at various hospitals including Broadmoor, but also treated addicts privately; Dr Tessa Hare, NHS GP and Dr Badrawy, private practitioner, Harley Street. See CMAC PP/DAL/E/4/20, List of AIDA members, 24 January 1987. Not included on this list, but a prominent member, was Dr Dale Beckett, a retired NHS consultant psychiatrist who also treated addicts privately. See CMAC PP/DAL/E/4/20, 'List of witnesses, definite and possible' by Dally, prepared for her lawyers, 1986.

⁵⁷ Dally, *A Doctor's Story*, p. 112.

⁵⁸ CMAC PP/DAL/B/5/1/2, Letter from Ann Dally to Dr Dorothy Black, Senior Medical Officer at the DHSS, and representative of the DHSS to the Working Party on Drug Misuse, 26 March 1984.

⁵⁹ *Ibid.*; Dally, *A Doctor's Story*, p. 130.

⁶⁰ See CMAC PP/DAL/E/4/20, 'List of witnesses, definite and possible' by Dally, prepared for her lawyers, 1986.

‘long been needed and offered help.’⁶¹ Spear initially allowed AIDA to meet at the Home Office, giving Dally the impression of support, allowing her to boast in a letter to the *Lancet* in 1982 that ‘We are meeting regularly together with observers from the Home Office and the Department of Health and Social Security.’⁶² They were later forced to reconvene at Dally’s home after protests about AIDA meeting at the Home Office from what she describes as the ‘drug dependency Mafia’ led, Dally alleged, by Bewley.⁶³ Dally believed that ‘meeting there [at the Home Office] had given us a respectability that was unacceptable in some quarters.’⁶⁴ This may have been more than paranoia: Spear noted that ‘the London consultants did not take too kindly to the contact the Drugs Inspectorate had with AIDA and individual private practitioners.’⁶⁵ However, Spear viewed AIDA more equivocally than perhaps Dally realised. He noted that his contact with the organisation was

perfectly consistent with our [the Home Office Drugs Inspectorate’s] long-established policy of keeping in contact with anyone working in the drug dependence field. It did not imply approval, or disapproval, of the clinical judgements of those concerned.⁶⁶

Spear’s interest in AIDA, therefore, did not necessarily equate with support for its members or their goals.⁶⁷

The work of AIDA was primarily advisory. There was an attempt to provide a practical solution to some of the problems in the treatment of drug addiction identified by AIDA when the organisation tried to establish its own non-profit making clinic. This clinic would ‘try to help the large numbers of addicts who do not benefit from

⁶¹ Dally, *A Doctor’s Story*, p. 85.

⁶² A. Dally, ‘Drug addiction and the independent practitioner’ letter to the *Lancet*, (23 January 1982) p. 228.

⁶³ CMAC PP/DAL/E/4/20, ‘Expansion on my skeleton document about the unpaid work I do and have done in relation to drug addiction’ by Dally, prepared for her lawyers, 5 December 1986; Dally, *A Doctor’s Story*, pp. 85-86.

⁶⁴ Dally, *A Doctor’s Story*, p. 100.

⁶⁵ Spear, *Heroin Addiction Care and Control*, p. 287.

⁶⁶ *Ibid.* p. 287.

⁶⁷ CMAC PP/DAL/E/2/4, PCC Hearing 1983, 6 July 1983, p. 53.

the NHS but cannot afford private treatment.’⁶⁸ Patients would be seen on referral from their GPs and the addict would pay a small fee ‘in accordance with their means’ for treatment.⁶⁹ AIDA applied to the DHSS for a grant to pay staff working at the clinic on a per session basis. Dally maintained that they did not hear anything about the success or otherwise of their application, and AIDA’s attempt to set up a clinic never came to fruition.⁷⁰ The greatest potential for AIDA to influence the development of drug addiction treatment came in 1984 when they were asked to send a representative to sit on the working party of drug addiction experts tasked with drawing up guidelines on the good clinical treatment of addiction by the DHSS. AIDA elected Dally as their representative, and another AIDA member, Dr Dale Beckett, also sat on the working party.⁷¹ A more extensive discussion of the working party and the guidelines produced will take place in Chapter Four, but it is clear that Dally and Beckett were very much minority voices on the committee. They were unable to have a significant influence on the content, wording or style of the final guidelines, to the extent that AIDA felt moved to produce their own comments on the document.⁷²

AIDA were also asked to give evidence to the House of Commons Social Services Committee in 1985.⁷³ AIDA submitted a memorandum and gave verbal evidence raising a number of issues with current drug treatment policies. They stated that the ‘proper person to treat most addicts is the general practitioner’ and suggested that some kind of additional payment could be made to GPs willing to take on addict

⁶⁸ A. Dally, letter to the *Lancet*, ‘Drug clinics today’, (28 May 1983) 1223-1224.

⁶⁹ CMAC PP/DAL/E/4/20, ‘Expansion on my skeleton document about the unpaid work I do and have done in relation to drug addiction’ by Dally, prepared for her lawyers, 5 December 1986.

⁷⁰ *Ibid.*

⁷¹ Dally, *A Doctor’s Story*, p. 127

⁷² CMAC PP/DAL/B/4/1/1/8, Association of Independent Doctors in Addiction comments on *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, July 1985.

⁷³ Social Services Committee, *Misuse of Drugs*, Evidence of AIDA, 27 February 1985, pp. 108-124.

patients.⁷⁴ There is some evidence to indicate that the committee took on board this suggestion, as they recommended the DHSS examine the feasibility of such a scheme.⁷⁵ Indeed, the committee commended the role of the GP in the treatment of addiction more generally, and suggested that there was no reason why GPs should not treat addicts with gradually diminishing doses of oral methadone on a short-term basis, provided they were properly trained and had access to specialist support and advice.⁷⁶ It is unlikely, however, that AIDA were solely responsible in shaping this recommendation, as the committee heard evidence from a number of bodies and individuals who stressed the role of the GP in the treatment of addiction, including the Royal College of General Practitioners.⁷⁷

AIDA was very much Dally's organisation. She was its founder and president, and believed that she did most of its work, complaining she was the only doctor in the organisation who spoke out or criticised the DDUs.⁷⁸ Most of the documents produced in AIDA's name were drafted entirely by Dally and it is almost impossible to differentiate between AIDA's collective views and Dally's personal opinions. It is revealing, for instance, to compare the written comments Dally sent to Dr Dorothy Black at the DHSS on the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* (the *Guidelines*) and those sent out under the auspices of AIDA.⁷⁹ The two documents make almost identical points, and though similarities might be expected, nothing separated the supposed 'consensus views' of AIDA from

⁷⁴ *Ibid.* p. 109, p. 110, pp. 120-121.

⁷⁵ *Ibid.* p. xxix, p. lvi.

⁷⁶ *Ibid.* pp. xxviii-xxx, p. lvi

⁷⁷ *Ibid.* Minutes of evidence 6 February 1985, memorandum submitted by the Royal College of General Practitioners, pp. 13-14; examination of witnesses, pp. 15-21.

⁷⁸ CMAC PP/DAL/E/4/20, 'The drug clinic consultant group' by Dally, prepared for her lawyers, 18 October 1986.

⁷⁹ CMAC PP/DAL/B/5/1/6, Dally's General Comments on the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* sent to Dr Dorothy Black, DHSS, September 1984, and CMAC PP/DAL/B/4/1/1/8, Association of Independent Doctors in Addiction comments on *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, July 1985.

Dally's own beliefs.⁸⁰ Dally was without doubt AIDA's most vocal representative but the other members did play a role in the organisation's work. Dr Tessa Hare was an AIDA member and NHS GP who treated addicts in a similar fashion to Dally, emphasising the need for helping addicts to develop a stable life. In an interview with *General Practitioner* in 1983 she mentioned her membership of AIDA, and she and Dally gave evidence jointly on behalf of the organisation to the Social Services Committee on the Misuse of Drugs in 1985.⁸¹ AIDA members were called upon to support Dally when she faced the GMC on charges of irresponsible prescription to addicts in 1983 and again in 1986/7, but there was no broad-scale campaign to publicise her case or her position. Dr Beard, an AIDA member, submitted written character evidence in support of Dally at her 1983 hearing and Beckett appeared as a witness for the 'defence' at in 1986/7.⁸² Beckett was one of Dally's greatest supporters, but whether this was as a friend, or as a fellow AIDA member is unclear.

Questions can therefore be raised about the extent to which AIDA had any significant impact on heroin addiction treatment policy in this period. Though they gave advice to both the DHSS committee on the production of the *Guidelines* and the Social Services Committee their views were largely ignored. Most of the membership, apart from Dally, Hare and Beckett showed little sign of becoming actively involved in the organisation's work or the broader debate over the treatment of addiction. Yet, AIDA was important for two reasons. Firstly, AIDA's true significance lay in the fact that it existed at all. The presence of an organisation founded to support and defend the role of NHS GPs and private practitioners

⁸⁰ CMAC PP/DAL/B/4/1/1/8, Association of Independent Doctors in Addiction comments on *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, July 1985.

⁸¹ 'Rebellious GP who takes on rejected addicts', *General Practitioner*, (12 August 1983) p. 21; Social Services Committee, *Misuse of Drugs*, 112-124.

⁸² CMAC PP/DAL/E/2/4, PCC Hearing 1983, written evidence of Dr A.W. Beard, 6 July 1983; CMAC PP/DAL/E/4/17, PCC Hearing 1986/7 evidence of Dr Dale Beckett, 27 January 1987, pp. 3-13.

interested in the treatment of addiction indicated that these doctors were playing an increasing role in this area and this was provoking conflict with the DDU's. AIDA was created because a broader debate was taking place over who could most effectively treat the addict: the DDU psychiatrist, the GP, or the private doctor.

Secondly, Dally, as AIDA's founder, president and prime activist dramatically raised her own profile in the field through the organisation. This enhanced her claim to be an 'expert,' something she was later to rely on in her GMC disciplinary hearings, but her high profile also made her a target for those keen to eliminate the 'independent' doctor from the treatment of addiction. AIDA was thus significant for Dally personally and the private practitioner more generally.

2. Public: the attack on the private treatment of addiction

2.1 Drugs and money: the problems of private treatment of addiction

An organisation such as AIDA had much to contend with when it came to improving the position of the private practitioner in the treatment of addiction. The image of private treatment for heroin addiction had been somewhat tarnished by the activities of some notorious 'prescribers,' doctors who prescribed controlled drugs to addicts freely, seemingly without limitation. Of the six doctors identified by the Brain Committee as being responsible for the over-prescription of drugs the most notorious was Lady Frankau, who worked in private practice.⁸³ In 1962 Frankau prescribed a total of six kilograms (600,000 tablets) of heroin.⁸⁴ On one occasion she prescribed nine grams (900 tablets) of heroin to an addict and gave the same patient a further six

⁸³ Spear, *Heroin Addiction Care and Control*, p. 145.

⁸⁴ According to Spear, Frankau was the doctor responsible for the over prescribing excesses listed in the Brain report, see *Ibid.* p. 144. Figures taken from *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 6.

grams (600 tablets) three days later to ‘replace pills lost in an accident.’⁸⁵ When Frankau died in 1967 Dr John Petro took over many of her patients. Petro easily equalled his predecessor in terms of notoriety amongst addicts and also the wider newspaper reading public, as his sad and sordid story of decline from practising in a consulting room in Wimpole Street, to writing scripts for addicts in a series of cheap hotels, and then the buffet at Baker Street tube station and finally from the back of a Vauxhall Viva, hit the headlines.⁸⁶ Petro had his name struck off the Medical Register in 1968, but other ‘prescribers’ like Dr Christopher Michael Swan continued to over-prescribe controlled drugs to addicts, until he too was struck off and sentenced to fifteen years imprisonment in 1970.⁸⁷ Strong connections were thus made between private practice and dubious prescribing practices.

Tales of ludicrous over-prescription by private doctors fed into attacks directed at the private treatment of heroin addiction in the 1980s. Critics argued that this was unethical. The ACMD, in *Treatment and Rehabilitation*, noted that the charging of a fee for consultation and prescription raised the question of how those patients with no regular income were to pay for this. Furthermore, it was suggested that ‘Payment of fees may also inhibit the establishment of an effective therapeutic relationship between doctor and patient.’⁸⁸ John Strang offered the opinion in the *British Medical Journal* in 1982 that ‘most addicts view the payment of the fee as being direct payment for the prescription of drugs and not for any medical, psychiatric, or psychotherapeutic service.’⁸⁹ An editorial in the *Lancet*, also in 1982, suggested that the private treatment of addicts could be banned because ‘the prescription of a dependence-producing drug in return for a fee smacks so strongly of

⁸⁵ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 6.

⁸⁶ Spear, *Heroin Addiction Care and Control*, pp. 214-218; Kohn, *Narcomania*, p. 100.

⁸⁷ Spear, *Heroin Addiction Care and Control*, p. 214.

⁸⁸ ACMD, *Treatment and Rehabilitation*, p. 54.

⁸⁹ J. Strang, ‘Personal view’, *British Medical Journal*, 284, (27 March 1982) p. 972.

legalised drug-dealing with potentially enormous financial rewards.’⁹⁰ These financial rewards were the subject of some debate. Bewley estimated that if an addict being treated privately paid £25 a consultation, once a week, a doctor would need to see 20 such patients to earn £500 a week, or £25,000 a year.⁹¹ In a later paper, co-written with Hamid Ghodse, a consultant psychiatrist at St George’s and Tooting Bec Hospitals, working on the same figures, but by upping the number of addicts seen to 20 a day, it was argued that a private doctor ‘could receive over £100,000 a year solely by prescribing controlled drugs to addicts.’⁹² This statement suggested that doctors involved in private practice were not interested in treating addicts but only in giving them drugs and receiving their fee, but it is unclear if this practice was ever widespread. There was no suggestion, for example, that Dally had been financially motivated in offering treatment to addicts; even the Home Office agreed on this point.⁹³

Bewley’s later paper clearly represented a more sustained assault on the position of the private practitioner. A number of individuals took issue with Bewley’s claims. A.B. Robertson, an addict receiving private treatment wrote to the *British Medical Journal* arguing that he did not ‘consider that I am being sold a batch of drugs at every visit. Doctors must charge fees, or how else are they to live?’⁹⁴ Beckett also wrote to the *British Medical Journal* protesting about Bewley and Ghodse’s article, stating that their assertion about being able to earn £100,000 made him ‘angry’ as in his practice ‘a session with an addict lasts an hour, and usually I

⁹⁰ ‘Editorial: Drug addiction: British System failing’, *Lancet*, (9 January 1982) p. 83.

⁹¹ Bewley, ‘Prescribing psychoactive drugs to addicts’, p. 497.

⁹² Bewley & Ghodse, ‘Unacceptable face of private practice’, p. 1877.

⁹³ See Chapter Five, p. 241-242.

⁹⁴ A.B. Robertson, ‘Prescription of controlled drugs to addicts’, letter to *British Medical Journal*, 287, (9 July 1983) p.126.

spend a long time afterwards writing out prescriptions.’⁹⁵ Dally argued in her book *A Doctor’s Story* that those who viewed private medicine as a ‘money-making racket’ were unaware of the expenses of private practice.⁹⁶ At the time of writing (the book was published in 1990) Dally noted that annual rents on rooms from which a doctor could practice in the Harley Street area were £14,000-£15,000. Other expenses, including a secretary, doubled this amount, leading Dally to argue that a doctor who gave up two NHS sessions had to earn at least £1,000 a week to cover costs and compensate for loss of earnings.⁹⁷

The precise amount that a private doctor could earn by prescribing to addicts was less of an issue than how addict patients were to find the money to pay for this. Bewley stated that if the patient was unemployed they might sell some of the drugs prescribed to support themselves and to pay the doctor’s fee, as did an editorial in the *Lancet*.⁹⁸ This suspicion was seemingly confirmed by social anthropologist Angela Burr, who spent some time observing the operation of the black market in legally prescribed but illegally sold drugs in the Piccadilly area.⁹⁹ She found that ‘most’ drug users prescribed drugs on a private basis sold some of their supply to pay doctors’ and chemists’ fees. This led her to assert that private practitioners were clearly prescribing addicts larger amounts of controlled drugs than was necessary for the alleviation of withdrawal symptoms if addicts had a surplus left over to sell to fund treatment.¹⁰⁰ This was supported by a survey of addict patients conducted by Bewley and Ghodse. They asked 69 addict patients why addicts went to see private doctors

⁹⁵ D. Beckett, ‘Prescription of controlled drugs to addicts’, letter to *British Medical Journal*, 287, (9 July 1983) p. 127.

⁹⁶ Dally, *A Doctor’s Story*, p. 46

⁹⁷ *Ibid.* p. 47.

⁹⁸ Bewley, ‘Prescribing psychoactive drugs to addicts’, p. 497; Bewley & Ghodse, ‘Unacceptable face of private practice’, p. 1877; ‘Drug addiction: British System failing’, *Lancet*, (9 January 1982) p. 83.

⁹⁹ A. Burr, ‘The Piccadilly drug scene’, *British Journal of Addiction*, 78, (1983) 5-19; Burr, ‘Increased sale of opiates on the blackmarket in the Piccadilly area’ 883-885.

¹⁰⁰ Burr, ‘Increased sale of opiates on the blackmarket in the Piccadilly area’, p. 884.

and came up with a list of reasons. It was suggested that private practitioners prescribed injectable drugs, they prescribed more than one drug, they prescribed weekly, they prescribed in larger doses and they were easier to con.¹⁰¹ Bewley argued elsewhere that such doctors acquired a reputation as being an “easy writer,” a label Spear claimed he had never heard addicts use.¹⁰² What appeared to concern the DDU doctors most about the actions of private practitioners was their supposed readiness to prescribe large doses of opiates. Strang argued that private doctors prescribed higher doses of drugs than the DDUs, often in injectable form.¹⁰³ According to the *Lancet* private practitioners and those working outside the clinics ‘may be casual in the quantities that they prescribe and what they overprescribe [sic.] can readily find its way to the black market.’¹⁰⁴ This led the journal to conclude that whilst these doctors might be well intentioned ‘many people well placed to judge the consequences of their actions argue that they [non-clinic doctors] are aggravating an already grim scene.’¹⁰⁵ Bewley and Ghodse suggested that there were only two ways to remedy the situation; Home Office tribunals or the GMC should act to stop private doctors deliberately over-prescribing to addicts and failing that, the licensing system for the prescription of heroin to addicts should be extended to include all controlled drugs.¹⁰⁶ This would result in the effective exclusion of the non-clinic doctor, as licenses for the prescription of heroin were generally limited to DDU psychiatrists.

The studies conducted and editorials penned certainly painted a bleak picture of the work of the private practitioner in the treatment of addiction. The impression given was that private doctors over-prescribed opioid drugs to their addict patients

¹⁰¹ Bewley & Ghodse, ‘Unacceptable face of private practice’, p. 1877.

¹⁰² Bewley, ‘Prescribing psychoactive drugs to addicts’, p. 497; Spear, *Heroin Addiction Care and Control*, p. 284.

¹⁰³ Strang, ‘Personal view’, (1982) p. 972.

¹⁰⁴ ‘Editorial: Drug dependence in Britain: a critical time’, *Lancet*, (27 August 1983) 493-494, p. 493.

¹⁰⁵ *Ibid.* p. 493.

¹⁰⁶ Bewley & Ghodse, ‘Unacceptable face of private practice’, p. 1877.

either unwittingly, due to a lack of experience, or deliberately in order to make money for themselves. Regardless of motive this had the consequence that more drugs found their way onto the black market as addicts sold their surplus, sometimes to help fund private treatment. However, over-spill of legitimate drugs onto the illegitimate market came from NHS doctors as well as private practitioners. Burr found that drugs bought and sold on the Piccadilly black market came from DDUs as well as from private doctors.¹⁰⁷ Furthermore, the significance of this 'grey' market in pharmaceutical drugs may well have been exaggerated: illicitly produced, imported and traded drugs were freely available by the early 1980s and this 'black' market easily exceeded the 'grey' market in terms of size.¹⁰⁸ Other studies, such as Bewley and Ghodse's, were based on somewhat questionable evidence that revealed more about the study's author's views on the private treatment of addiction than an accurate picture of the consequences of this. Bewley and Ghodse's study was based on a survey of addict patients attending DDUs. They asked them a series of rather leading questions such as if they considered private doctors were more easily 'conned' than clinic doctors, or if private practitioners prescribed larger doses than could be obtained from DDUs.¹⁰⁹ However, as only half of the 69 respondents had actually consulted a private doctor half of the responses were not based on personal experience, but rather on rumour and supposition. The article subsequently came in for a good deal of criticism.¹¹⁰ G. Milner of the Worcester Royal Infirmary argued that 'it would be wrong to blame only private practitioners for the spread of

¹⁰⁷ Burr, 'The Piccadilly drug scene', p. 8.

¹⁰⁸ See Chapter Two, pp. 104-105, p. 129.

¹⁰⁹ Bewley & Ghodse, 'Unacceptable face', p. 1877.

¹¹⁰ See Correspondence pages, *British Medical Journal*, 287, (9 July 1983) 126-127; Correspondence pages, *British Medical Journal*, 287, (13 August 1983) p. 500. See also M. Ashton, 'Doctors at war, part two', *Druglink*, July/August 1986, 14-16, p. 15; Dally, *A Doctor's Story*, pp. 115-117 and Spear, *Heroin Addiction Care and Control*, pp. 287-288.

addiction.’¹¹¹ Beckett asserted that ‘the *BMJ* has published propaganda disguised as a scientific paper.’¹¹² Spear later contended that ‘between them the critics laid bare the true purpose of the paper,’ which was an ‘establishment attack on the private sector.’¹¹³

2.2 Motivations

It is clear that the motivation for this attack on the private treatment of addiction came not just from the particular problems facing private practice in this field. Though it may be tempting to suggest that this could be read as a more generalised attack on private medicine, examining the actions of some of the key protagonists indicates this was unlikely. Dally believed that Bewley was totally opposed to private medicine. She asserted that ‘Bewley had a strong dislike of private practice and made no attempt to hide it.’¹¹⁴ Yet, in response to a direct question about his views on the private treatment of addiction in an interview with the *British Journal of Addiction*, Bewley replied:

I don’t see any objection in principle to the private practice treatment of addicts. It can be difficult for a single-handed practitioner. They can get themselves into difficulties because they are isolated and have not got an NHS team to support them, and they may not have colleagues. There are fewer difficulties for those working in a private hospital. It is the single-handed practitioners in Harley Street who have run into difficulties. In that sense there can be difficulties for private practitioners.¹¹⁵

This response would suggest that Bewley was not necessarily wholly against the treatment of addiction in private practice or private practice in general. Indeed, other key figures such as Connell practised privately, and even treated addict patients in this

¹¹¹ G. Milner, letter to *British Medical Journal*, 287, (9 July 1983) p. 127.

¹¹² D. Beckett, letter to *British Medical Journal*, 287, (9 July 1983) p. 127.

¹¹³ Spear, *Heroin Addiction Care and Control*, p. 288, p. 287.

¹¹⁴ Dally, *A Doctor’s Story*, p. 115.

¹¹⁵ Bewley, ‘Conversation with Thomas Bewley’, p. 890.

capacity.¹¹⁶ Connell told the Social Services Committee that he did ‘a very small amount of private practice’ though he stated that ‘I personally would not prescribe drugs to a patient in private practice unless it was very clearly on a withdrawal scheme that was stuck to whatever happened.’¹¹⁷ Philip Fleming, consultant psychiatrist and director of Wessex Regional Drug Dependence Services, who gave evidence against Dally at the 1986/7 GMC hearing also did private work, though he did not treat addicts in his private practice.¹¹⁸ This indicates that leading DDU consultants, and even those most closely involved in the assault on the private treatment of addiction, were not opposed to private medicine in principle. Surprisingly, nor were they necessarily against the treatment of addiction in private practice, as long as this was under their control and conducted in a manner they approved of.

It is this response that provides a clue to the motivation behind the attack on the private treatment of addiction in the 1980s. This appeared to be the result not of an ideological opposition to private practice or even necessarily a dislike of addiction treatment conducted in this manner, but because it posed a potential threat to the authority of a group of DDU doctors. Spear asserted that:

The intrusion of the independent practitioner into the drug addiction treatment field was seen as a direct challenge to the pre-eminence and prestige of a few influential clinicians, whose personal views and prejudices dominated treatment policy in London.¹¹⁹

Though Spear’s contention may be correct in spirit it does not explain how or why these doctors were influential, beyond hinting at the existence of conspiracy on the part of a group of psychiatrists to impose ‘their own ethical and judgemental values

¹¹⁶ Connell, ‘Conversation with Philip Connell’, p. 15.

¹¹⁷ Social Services Committee, *Misuse of Drugs*, 6 March 1985, Evidence of Philip Connell, p. 125.

¹¹⁸ CMAC PP/DAL/E/4/17, PCC Hearing 1986/7, 11 December 1986, p. 69.

¹¹⁹ Spear, *Heroin Addiction Care and Control*, p. 283.

on treatment policy.’¹²⁰ Instead of looking to a ‘conspiracy’ to explain the influence of the DDU psychiatrists (particularly those in London) it is necessary to consider the nature of expertise and the way in which it was employed by these doctors. DDU psychiatrists established themselves as ‘experts’ in the field through their claim that psychiatry was best able to treat the addict (see Chapter One) and also because they were well connected to the medical and drug dependency ‘establishment.’ Connell was the consultant in charge of the DDU at the Maudsley and Bethlem hospitals, the foremost psychiatric facility in Britain. He was a member of the ACDD and later the ACMD, chairing this body between 1982 and 1988. He was Chairman of the DHSS Medical Working Group on Drug Dependence that produced the *Guidelines* and Chairman of the ISDD. He was a consultant advisor to the DHSS on addiction from 1971 until 1986, and a member of the Royal College of Psychiatrists Special Committee on Drugs and Drug Dependence. Connell also became involved in a number of other bodies not directly connected to drug addiction. He was Vice-President of the Royal College of Psychiatrists from 1979 until 1981, and a member of the GMC from 1979 until 1990, where he acted as the Preliminary Screener for the Health Committee. Bewley’s list of distinctions and committee memberships was almost as long. He was a member of the ACDD from 1966 until 1971, a member of the ACMD between 1972 and 1984, and a member and joint co-founder of the ISDD. He acted as consultant advisor on drug addiction to the DHSS from 1972 until 1981 and for the WHO between 1969 and 1978. In addition, Bewley was President of the Royal College of Psychiatrists from 1984 until 1987. Although not a member of the GMC himself, Bewley’s wife, Beulah, sat on the council.

¹²⁰ *Ibid.* p. 310.

These connections allowed men like Bewley and Connell to exert considerable influence in the drug dependency field. And, as much of the criticism of private practitioners came from DDU doctors, including Connell and Bewley specifically, Spear found it difficult to avoid the conclusion that they orchestrated the campaign against private practice.¹²¹ Spear was in a good position to observe the drive to exclude the private doctor as he frequently attended meetings of the London DDU consultants. He noted that in September 1981 the consultants considered making a formal complaint to the GMC about the private treatment of addiction, but were persuaded by one of their number that an ‘informal’ approach might be better. Nonetheless, Spear argued that as a result the GMC Professional Standards Committee took up the issue for examination.¹²² The GMC were thus aware of the arguments against the involvement of the private doctor in heroin addiction and the potential problems with this kind of treatment. It is also clear that the campaign against the private practitioner was not being won on the pages of the medical press as these doctors continued to treat addicts. Action was required. It was in this environment that a case was brought against Ann Dally for serious professional misconduct in respect to irresponsible prescription to an addict patient in 1983. Though there is no concrete evidence to suggest that the DDU doctors set up the case their influence was crucial in the construction of a climate of opinion that was strongly against the treatment of addiction in private practice. The Dally case therefore warrants close attention.

3. Public versus private: the GMC vs. Dr Ann Dally, 1983

3.1 The GMC: discipline and the drug doctor

¹²¹ *Ibid.* pp. 283-284.

¹²² *Ibid.* p. 289.

The General Medical Council is a statutory body granted powers by Parliament to regulate the medical profession. It was created as a result of the Medical Act in 1858 to administer a single register of all medical men designed to differentiate between the qualified practitioner and a range of unqualified healers.¹²³ In essence, the function of the GMC has remained the same since its establishment. The GMC controls who may enter the register of licensed medical practitioners by deciding what qualifications are necessary to practice medicine and can remove those deemed unfit to continue. To this end, it approves medical schools and investigates complaints or convictions against licensed medical practitioners.¹²⁴ It has no inspectorate, and relies upon complaints or convictions reported to the GMC to learn of suspected instances of serious professional misconduct. The GMC is responsible to the Privy Council, and appeals against the GMC's findings are heard there. The GMC is a self-regulating professional body, but has included 'lay,' non-medical members as a statutory requirement since 1950.¹²⁵ In 1983 the GMC had 83 medical members and seven lay members.¹²⁶ It is independent of the NHS and the Government, and is funded directly by its members. But, according to medical sociologist and one time lay member of the GMC, Margaret Stacey, it is part of the state because of its statutory position.¹²⁷

A re-examination of the GMC's role came in 1975 with the Merrison Enquiry. Merrison found that the GMC was not a complaints machine for patients but existed to protect the public from unqualified practitioners. Its purpose, therefore, was not to punish doctors, but to maintain the standards of the profession.¹²⁸ Merrison endorsed

¹²³ M. Stacey, *Regulating British Medicine: The General Medical Council*, (Chichester: John Wiley & Sons, 1992) pp. 15-17.

¹²⁴ *Ibid.* p. 12.

¹²⁵ *Ibid.* p. 23.

¹²⁶ *Ibid.* p. 13.

¹²⁷ *Ibid.* p. 13.

¹²⁸ *Ibid.* p. 56. This was also the view expressed in the GMC's Annual Report in 1987. See R.G. Smith, *Medical Discipline: The Professional Conduct Jurisdiction of the General Medical Council, 1858-1990*, (Oxford: Clarendon Press, 1994) p. 2.

the position that doctors could only be removed from the register if they had been convicted of a criminal offence which suggested they were unfit to practice, or if they were found guilty of serious professional misconduct.¹²⁹ Serious professional misconduct was defined by the Medical Act in 1969 as being ‘serious misconduct judged according to the rules, written or unwritten, governing the profession.’¹³⁰ In order to clarify what kinds of behaviour could be constituted as serious professional misconduct Merrison suggested that the GMC’s guidance to doctors, *Professional Conduct and Discipline: Fitness to Prescribe*, known as the ‘Blue Book,’ should be expanded.¹³¹ According to the ‘Blue Book’ professional misconduct fell into four categories. The first was neglect by doctors of their professional responsibilities to patients for their care and treatment. The second was the abuse of professional privileges or skills. The third concerned the personal behaviour of the doctor and encompassed conduct seen to be derogatory to the reputation of the medical profession. The last prohibited the advertising of professional services by doctors.¹³² Determining whether a doctor’s actions constituted professional misconduct was the responsibility of the Professional Conduct Committee (PCC) of the GMC.¹³³ This was the last stage in the disciplinary process that began with the initial complaint being passed to a Preliminary Screener.¹³⁴ The screener decided whether or not action should be taken, and if this was in the affirmative, passed the complaint to the Preliminary Proceedings Committee (PPC). If the PPC found there was a case to answer, they referred the case to the PCC to investigate. Very few cases actually reached the PCC in the 1980s. Stacey found that in 1983 57 per cent of cases were

¹²⁹ *Ibid.* p. 56.

¹³⁰ Lord Justice Scruton, 1930, quoted in GMC, *Professional Conduct and Discipline: Fitness to Prescribe, April 1985, Part I* [known as the ‘Blue Book’] (GMC: London, 1985) p. 3.

¹³¹ Stacey, *Regulating British Medicine*, p. 57.

¹³² GMC, *Professional Conduct and Discipline: Fitness to Prescribe*, p. 12.

¹³³ Smith, *Medical Discipline*, p. 34.

¹³⁴ Stacey, *Regulating British Medicine*, p. 151.

dealt with by the Preliminary Screener alone, 15 per cent reached the PPC and just 4 per cent got as far as the PCC.¹³⁵

The PCC were elected annually by the Council, and had 20 members. A maximum of 10 of these were allowed to sit on a case alongside two lay members.¹³⁶ The committee were advised by a Legal Assessor, present at hearings to prevent the committee from making any legal mistakes and to rule on disputed questions (often the admissibility of evidence).¹³⁷ The PCC usually sat in public and its procedure was similar to that of a court of law. Doctors were allowed legal representation and the same standards of proof were required as in a court; the charge of serious professional misconduct had to be proven beyond reasonable doubt.¹³⁸ If the charge was proved, the committee had four basic options open to them. They could simply conclude the case if they felt the doctor had already suffered enough, they could admonish the doctor and then conclude the case, they could suspend the doctor for a fixed period of time up to a year and finally they could have the doctor's name erased from the register, meaning that he or she would no longer be able to practice medicine.¹³⁹ The PCC were also able to make continued registration conditional on whatever they deemed appropriate for a maximum period of three years.¹⁴⁰

The GMC had traditionally been reluctant to play a role in disciplining doctors believed to be over-prescribing opiate drugs to addicts. The Rolleston Committee recommended that tribunals be established to deal with doctor addicts and those who dispensed drugs to addicts too freely.¹⁴¹ The Dangerous Drugs Regulations of 1926 provided the statutory basis for tribunals, permitting the Home Secretary to remove

¹³⁵ *Ibid.* pp. 152-154.

¹³⁶ GMC, *Professional Conduct and Discipline: Fitness to Prescribe*, p. 3.

¹³⁷ Smith, *Medical Discipline*, p. 83.

¹³⁸ Stacey, *Regulating British Medicine*, p. 142.

¹³⁹ *Ibid.* p. 142; GMC, *Professional Conduct and Discipline: Fitness to Prescribe*, p.5.

¹⁴⁰ GMC, *Professional Conduct and Discipline: Fitness to Prescribe*, p. 1.

¹⁴¹ *Report of the Departmental Committee on Morphine and Heroin Addiction*, p. 26.

the doctor's right to prescribe controlled drugs if found guilty, but these were never used.¹⁴² When the first Brain Committee examined the issue in 1961 they were not convinced that tribunals were either practical or necessary given 'the infrequency of these irregularities.'¹⁴³ The over-prescription of drugs to addicts by a handful of doctors prompted the second Brain Committee to reconsider. However, they decided that should disciplinary proceedings be necessary, the appropriate tribunal would be the Disciplinary Committee (later the Professional Conduct Committee) of the GMC.¹⁴⁴ If the charge was proved, the GMC should have the authority to remove the doctor's right to prescribe controlled drugs.¹⁴⁵ According to Smart, the GMC refused to take on this responsibility.¹⁴⁶ The then President of the GMC, Lord Cohen, did not believe that the Council should act as 'a police authority for the medical profession.'¹⁴⁷

To deal with doctors who prescribed drugs to addicts in an irresponsible manner, Home Office tribunals were to be revived under the Misuse of Drugs Act, 1971.¹⁴⁸ It was not until 1974 that these came into being, by which time the GMC had changed its stance on the issue and were increasingly prepared to consider 'the prescription of drugs other than in the course of bona fide treatment' as being serious

¹⁴² *Drug Addiction: Report of the Interdepartmental Committee*, p. 12; Berridge, *Opium and the People*, p. 281; Spear, *Heroin Addiction Care and Control*, p. 45; P.T. Bean, 'Policing the medical profession: the use of tribunals' in Whyne & Bean, *Policing and Prescribing*, 60-70, p. 62.

¹⁴³ *Drug Addiction: Report of the Interdepartmental Committee*, p. 12. For more information on why Brain did not consider tribunals to be necessary see Spear, *Heroin Addiction Care and Control*, pp. 107-110.

¹⁴⁴ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 11. For an account of the discussions that led to this recommendation see Spear, *Heroin Addiction Care and Control*, pp. 137-141.

¹⁴⁵ *Drug Addiction: Report of the Second Interdepartmental Committee*, p. 11.

¹⁴⁶ Smart, 'Social policy and drug dependence', pp. 174-175.

¹⁴⁷ Lord Cohen's Presidential Address to the GMC in 1969 quoted in *Ibid.* p. 175. Cohen made similar comments in the *BMJ* in 1970, quoted in Spear, *Heroin Addiction Care and Control*, p. 62.

¹⁴⁸ Misuse of Drugs Act, 1971; Bean, 'Policing the medical profession', pp. 63-64.

professional misconduct.¹⁴⁹ Why the GMC changed its position is unclear, but they heard 39 cases of improper prescribing between 1972 and 1984, resulting in 18 doctors having their names erased from the medical register.¹⁵⁰ Home Office tribunals were not widely used to pursue cases of irresponsible prescription until the early 1980s; between 1974 and 1982 just nine tribunals were held.¹⁵¹ The ACMD were critical of this, noting that a narrow and legalistic approach had been adopted, resulting in only those cases where there was clear evidence of gross irresponsible prescription being heard.¹⁵² Stung into action, the Home Office tribunal prohibited three doctors from prescribing controlled drugs in 1983, another three in 1984, and a further three were prevented from doing so on a temporary basis.¹⁵³ This meant that there were two separate bodies pursuing the discipline of doctors prescribing irresponsibly to addicts, the Home Office tribunals and also the GMC. The two differed in the charge they could levy and the punishment they could exact, but were effectively trying the same offence. Tribunals tried doctors for irresponsible prescription and if found guilty could remove the doctor's right to prescribe controlled drugs. The GMC assessed whether or not a doctor's prescription of drugs to an addict was part of bona fide treatment, and if they decided it was not, could charge the doctor with serious professional misconduct and censure him or her in whatever way they saw fit.

To confuse matters still further, the two systems were not in contact with one another and there did not seem to be a clear reason why a doctor should face a

¹⁴⁹ GMC, *Professional Conduct and Discipline: Fitness to Prescribe*, Part III: Considerations and forms of professional misconduct that may lead to disciplinary proceedings; Spear, *Heroin Addiction Care and Control*, p. 62, p. 64, p.268.

¹⁵⁰ Social Services Committee, *Misuse of Drugs*, minutes of evidence from the GMC, 20 February 1985, pp. 68-69.

¹⁵¹ ACMD, *Treatment and Rehabilitation*, p. 61.

¹⁵² *Ibid.* p. 61.

¹⁵³ Social Services Committee, *Misuse of Drugs*, p. xxiii; CMAC PP/DAL/E/2/4, GMC PCC Hearing 1983, 6 July 1983, p. 57.

tribunal and not the GMC, or vice-versa. Being found guilty of irresponsible prescription by the Home Office did not automatically lead to a GMC hearing on charges of suspected serious professional misconduct.¹⁵⁴ The two systems existed because of the GMC's initial reticence to become involved in disciplining doctors thought to be prescribing in an inappropriate manner, so the Home Office instigated their own methods. By the time these had been put into place, the GMC were more amenable to the idea of considering over-prescription to addicts as serious professional misconduct, so there were two pieces of machinery to deal with the same problem. Deciding which body a doctor should face was probably down to the peculiarities of the individual case. Unravelling the reasons behind this is less revealing than the overall upward trend in the use of both tribunals and GMC PCC hearings. By 1983 there was a more general willingness to use these bodies to pursue doctors believed to be prescribing to addicts irresponsibly.¹⁵⁵ According to Ashton, the disciplinary mechanisms were being 'oiled-up and put to use.'¹⁵⁶ This suggests that either more doctors were prescribing irresponsibly, and/or there was more interest in these cases, resulting in a greater number coming before the Home Office and the GMC. Dally's case was thus part of an increase in the use of the available machinery to discipline doctors thought to be prescribing to addicts irresponsibly.

¹⁵⁴ Social Services Committee, *Misuse of Drugs*, p. xxiv, pp. 70-71.

¹⁵⁵ See figures quoted above for Home Office tribunals and Smith, *Medical Discipline*, p. 104, for a graph illustrating the upward trend in number of cases involving the prescription of drugs that came before the GMC.

¹⁵⁶ Ashton, 'Doctors at war, part one', p. 15.

3.2 The GMC vs. Dr Ann Dally, 1983

The case which brought Dally before the PCC in July 1983 centred on her treatment of one addict patient, Brian Sigsworth.¹⁵⁷ Dally first saw Sigsworth in 1981. He had been addicted to heroin for 17 years and was then taking Diconal as a substitute on prescription from his GP.¹⁵⁸ He had a long criminal record and had spent time in prison, always, it seemed, for offences committed to obtain money for drugs.¹⁵⁹ Dally found his case interesting. He told her that he had not learnt to read and write until he was 16, but since then, during spells in prison, had passed A-Levels and read for a degree with the Open University.¹⁶⁰ When he first went to see Dally Sigsworth was studying at Coventry Polytechnic. Dally thought that he ‘was the sort of addict who most needed my help. Unable to benefit from the clinic system, he was forced to lead a criminal life.’¹⁶¹ Dally spoke to Ian Heaton, a Drugs Inspector at the Home Office about Sigsworth’s criminal record. Heaton told her that Sigsworth had a bad police record, but there was nothing to suggest that he had ever tried to deceive doctors or forge prescriptions for controlled drugs.¹⁶² Dally stated that she was concerned that Sigsworth was living in Coventry, as she tried to accept only patients that lived in London, but as there were no facilities for treating him there, and the city was less than a two hour journey away, she agreed to take him on.¹⁶³

Treating Sigsworth, however, rapidly became problematic. Dally instructed him to come to weekly consultations, at least initially.¹⁶⁴ Yet, over the 18-month period that she was treating Sigsworth Dally saw him just half a dozen or so times,

¹⁵⁷ This was his real name. Dally uses it in *A Doctor’s Story*, presumably because Sigsworth died a few years after the case came to light.

¹⁵⁸ Dally, *A Doctor’s Story*, pp. 103-104; CMAC PP/DAL/E/2/4, PCC Hearing 1983, 5 July 1983, p. 21.

¹⁵⁹ Dally, *A Doctor’s Story*, p. 104; CMAC PP/DAL/E/2/4, PCC Hearing 1983, 5 July 1983, p. 16.

¹⁶⁰ Dally, *A Doctor’s Story*, p. 105.

¹⁶¹ *Ibid.* p. 105.

¹⁶² *Ibid.* p. 106; CMAC PP/DAL/E/2/4, PCC Hearing 1983, 6 July 1983, pp. 61-63.

¹⁶³ Dally, *A Doctor’s Story*, p. 106.

¹⁶⁴ *Ibid.* p. 106.

and he missed more appointments than he kept.¹⁶⁵ When he failed to attend, Dally sent his prescription directly to the pharmacist and on one occasion allowed a friend of Sigsworth's to pick up his script.¹⁶⁶ Sigsworth told Dally that he was unable to come to consultations because he was in bed with a bad back. It appears that Sigsworth genuinely did have chronic back problems, as he had previously needed surgery, so Dally was prepared to give him a little leeway.¹⁶⁷ A year and a half after Dally started treating Sigsworth she received a telephone call from Spear, informing her that Sigsworth had been arrested and charged with supplying drugs to another person, and was in jail on remand.¹⁶⁸ It later emerged that Sigsworth had also been found guilty of breaking into a doctor's surgery in Coventry, so it could never be proved that the drugs he supplied had come from Dally.¹⁶⁹ Although no official complaint was made to the GMC about Dally's prescription to Sigsworth, the case came to their notice and she received a letter laying out the allegation of serious professional misconduct by issuing prescriptions to Sigsworth other than in the course of bona-fide treatment.¹⁷⁰

Dally's case came before the PCC on 5 July 1983. The committee was presided over by Sir John Walton, the President of the GMC. Dally was represented by Adrian Whitfield QC and Timothy Preston QC appeared on behalf of the GMC. The charge laid against Dally was that between June and November of 1981 she abused her position as a medical practitioner by issuing prescriptions for controlled

¹⁶⁵ CMAC PP/DAL/E/2/4, PCC Hearing 1983, 5 July 1983, p. 21.

¹⁶⁶ *Ibid.* p. 21.

¹⁶⁷ *Ibid.* p. 18; CMAC PP/DAL/E/2/4, PCC Hearing 1983, 6 July 1983, pp. 17-19.

¹⁶⁸ Dally, *A Doctor's Story*, p. 106.

¹⁶⁹ *Ibid.* p. 117.

¹⁷⁰ CMAC PP/DAL/E/2/7, Letter from Waterhouse solicitors on behalf of the GMC calling Ann Dally to a PCC hearing, 3 June 1983.

drugs (Ritalin and Diconal) other than in the course of bona-fide treatment.¹⁷¹

Preston's main contention was that

Even if it be right in rare cases to prescribe large quantities of controlled drugs to acknowledged addicts so as to forestall their obtaining those drugs on the black market and with a view to ultimately reducing the dosage and therefore weaning them from their addiction, that course of treatment should be done only in the strictest of conditions.¹⁷²

Dally, he argued, had not observed these conditions. He suggested that precautions should include not issuing prescriptions to a third person, that a clinical examination of the patient be carried out to check that he was not injecting the drugs prescribed, and also to see if these drugs were being taken at all. Preston also drew the committee's attention to the fact that Dally was treating Sigsworth privately, and the special responsibilities that this placed on the practitioner. He noted that the fee charged should not be so great as to tempt the patient to sell drugs on in order to finance treatment. This, he argued was particularly pertinent in the case of a patient like Sigsworth who had a criminal record.¹⁷³ Preston's concern was that Sigsworth, as an unemployed student living on a grant, travelling from Coventry to London to see a private doctor who charged £30 a consultation, paying an average of £7 to have his prescription filled, would find the temptation to sell some of his script to raise money was too great.¹⁷⁴ The question, therefore, was whether it ought to have occurred to Dally that Sigsworth might sell some of the Diconal she prescribed him.¹⁷⁵

Preston called a number of witnesses to provide evidence to help him prove his case. The first was Brian Sigsworth himself. His appearance on the stand did little to help Dally, despite the fact that he initially refused to give evidence 'to the

¹⁷¹ CMAC PP/DAL/E/2/4, PCC Hearing 1983, 5 July 1983, p. 1.

¹⁷² *Ibid.* 5 July 1983, pp. 10-11.

¹⁷³ *Ibid.* 5 July 1983, pp. 10-11.

¹⁷⁴ *Ibid.* 5 July 1983, p. 9.

¹⁷⁵ *Ibid.* 5 July 1983, p. 9.

detriment of Dr Dally.’¹⁷⁶ He admitted that he had lied to Dally about his income, saying he had around £2,500 a year rather than £1,600.¹⁷⁷ He also stated that Dally had sometimes examined his arms for ‘track marks,’ but on other occasions she did not. Preston’s next witness was Dr Finlayson, Sigsworth’s GP in Coventry.¹⁷⁸ When asked to comment on Dally’s prescription of 105 tablets a week (15 a day) to Sigsworth Finalyson said that he would prescribe six tablets a day at the most, and he was ‘concerned at a dose of 105 a week.’¹⁷⁹ He also remarked that he would have felt ‘uncomfortable’ about prescribing Diconal to Sigsworth, as he thought it possible that he might sell it on.¹⁸⁰ The question of dosage arose again during the evidence of Bing Spear.¹⁸¹ He could not recall a case where such a large amount of Diconal was being prescribed to a patient, although he knew of other cases where as large or larger doses of equivalent opioids were prescribed.¹⁸² The implication was that Dally prescribed more Diconal to Sigsworth than was necessary for treatment of his addiction. Preston then used the evidence of further witnesses to suggest that Dally should have known that Sigsworth was a ‘dodgy’ patient and likely to re-sell some of his prescription. Heaton, the Home Office Drugs Inspector Dally had first spoken to about Sigsworth, stated that Sigsworth’s criminal offences were relatively minor, but was forced to concede that this was a ‘slight misnomer’ when Preston pointed out that during the past seven years Sigsworth had spent two and a half years in jail and had just received another sentence of five years imprisonment for offences which included burglary of a chemists’ shop and possession of controlled drugs.¹⁸³ Preston concluded his case by

¹⁷⁶ *Ibid.* 5 July 1983, p. 14.

¹⁷⁷ *Ibid.* 5 July 1983, p. 20.

¹⁷⁸ *Ibid.* 5 July 1983, pp. 31-34.

¹⁷⁹ *Ibid.* 5 July 1983, p. 34.

¹⁸⁰ *Ibid.* 5 July 1983, p. 46.

¹⁸¹ *Ibid.* 6 July 1983, pp. 52-60.

¹⁸² *Ibid.* 6 July 1983, p. 54.

¹⁸³ *Ibid.* 6 July 1983, pp. 63-64.

arguing that a doctor prescribing drugs to an addict had a duty not just to their patient, but also to the public at large to ensure that only the person for whom they were intended used the drugs supplied. If Dally had ‘closed her eyes to that possibility’ or ‘given the circumstances of this case probability,’ that the patient might sell drugs to a third party that would be treatment in bad faith, and would, therefore, constitute serious professional misconduct.¹⁸⁴ Preston contended that elementary enquiries would have shown Dally that Sigsworth could not afford the fees charged, the transport to London, and the cost of having the prescription filled without selling some of his tablets.¹⁸⁵

Dally defended her treatment of Sigsworth by arguing that her prescription to him had not been excessive and she believed that he could afford her fees by taking on extra work if necessary. She maintained that she only prescribed Diconal to patients who could manage on nothing else, and only to those who would not inject the drug.¹⁸⁶ As Sigsworth had initially asked for 20 tablets of Diconal a day, 15 was actually something of a reduction.¹⁸⁷ Furthermore, Dally asserted that if one thought of opioids as being interchangeable 15 tablets a day was the equivalent of 150mg of opioid a day.¹⁸⁸ The British National Formulary (the official guide to dosage prescription) of 1981 stated that up to 18 tablets a day could be prescribed for chronic pain, so on this basis her prescription was not excessive.¹⁸⁹ Dally maintained that Sigsworth was able to finance her treatment of him through legitimate means by ‘day labour.’¹⁹⁰ When asked by a member of the committee how she thought Sigsworth could labour with a bad back Dally countered that she did not know if he meant work

¹⁸⁴ *Ibid.* 6 July 1983, p. 65.

¹⁸⁵ *Ibid.* 6 July 1983, p. 66.

¹⁸⁶ *Ibid.* 6 July 1983, p. 11.

¹⁸⁷ *Ibid.* 5 July 1983, p. 26; *Ibid.* 6 July 1983, p. 38.

¹⁸⁸ *Ibid.* 6 July 1983, p. 14.

¹⁸⁹ *Ibid.* 5 July 1983, p. 40.

¹⁹⁰ *Ibid.* 6 July 1983, p. 17.

in the physical sense, but he could always get ‘brain work’ if he wanted it.¹⁹¹ She could not accept that Sigsworth would sell some of his prescription in order to pay her fees, as he, in her opinion, needed the drugs prescribed. If he wanted money, Dally asserted that Sigsworth was more likely to commit a burglary, and in any case her fees were considerably less than buying drugs on the black market, where he was paying £40 a day, not £40 a week.¹⁹² Dally’s barrister, Whitfield, argued that there was no suggestion of bad faith in Dally’s prescription of Diconal to Sigsworth, and even if guilty of prescribing too liberally this did not constitute serious professional misconduct.¹⁹³ He noted that there were not many cases where allegations of irresponsible prescription were made and members of the Drugs Inspectorate could be called upon to defend the practitioner concerned.¹⁹⁴ Whitfield also pointed out that the Home Office were not interested in calling Dally to a tribunal.¹⁹⁵ He concluded that on examining the facts of the case ‘this lady appears as one who was doing her best.’¹⁹⁶

Before the committee retired to consider their verdict the Legal Assessor was asked to provide more evidence on how irresponsible prescription could be considered male-fide treatment and, therefore, serious professional misconduct. He determined that a doctor could be found to be acting not in the course of bona-fide treatment if they knew, or did not care if, controlled drugs prescribed by them were being sold by a patient.¹⁹⁷ Dally believed that the wording of the charge was being changed so as to find her guilty, an assertion supported to some extent by reports of journalists overhearing a person ‘associated’ with the GMC or its lawyers remarking

¹⁹¹ *Ibid.* 6 July 1983, p. 36.

¹⁹² *Ibid.* 6 July 1983, p. 34, p. 25.

¹⁹³ *Ibid.* 6 July 1983, p. 73.

¹⁹⁴ *Ibid.* 6 July 1983, p. 75.

¹⁹⁵ *Ibid.* 6 July 1983, p. 72.

¹⁹⁶ *Ibid.* 6 July 1983, pp. 79-80.

¹⁹⁷ *Ibid.* 6 July 1983, pp. 84-90.

that the ‘prosecution’ were unlikely to win their case because of the wording of the charge, and subsequently the charge was altered.¹⁹⁸ After consideration, the committee decided that Dally had been prescribing Diconal to Sigsworth not in the course of bona-fide treatment, and was, therefore, guilty of serious professional misconduct. The President told Dally that as the medical profession had been given special responsibilities in relation to the prescription of controlled drugs to addicts the GMC were ‘bound to take a serious view of a case such as yours where it has been proved to their satisfaction that you have disregarded those special responsibilities.’¹⁹⁹ The Committee found that Dally had prescribed large amounts of drugs to a patient and the circumstances in which the prescriptions were issued did not amount to a sufficient level of supervision. They believed that she had not taken satisfactory steps to establish adequate therapeutic reasons for prescribing Diconal to Sigsworth, and she did not monitor his progress well enough.²⁰⁰ The committee took into account ‘the many references and representations made’ on Dally’s behalf, and decided to admonish her, and conclude the case.²⁰¹

Examining the evidence presented and the verdict reached in Dally’s case raises some key points about the treatment of addiction and the role of the private practitioner. Dally’s handling of Sigsworth was flawed given the climate of opinion about the treatment of addicts. She prescribed large doses of an opiate substitute on a weekly basis, did not carry out extensive clinical examinations or urine tests and rarely even saw her patient. Yet, it was the peculiar problems of the treatment of addiction in private practice that raised the biggest questions over Dally’s treatment of

¹⁹⁸ CMAC PP/DAL/E/2/11, ‘Some thoughts on a lost case’, by Dally, 18 July 1983. The assertion that the charge was changed to allow the prosecution to win the case was also reported by Michael O’Donnell in his column in the *British Medical Journal*. See: M. O’Donnell, ‘One man’s burden’, *British Medical Journal*, 287 (1 October 1983), p. 990.

¹⁹⁹ CMAC PP/DAL/E/2/4, PCC Hearing 1983, 6 July 1983, p. 93.

²⁰⁰ *Ibid.*

²⁰¹ *Ibid.*

Sigsworth. As a private doctor Dally charged Sigsworth a fee for consultations. In order to fund this treatment, as an addict patient on a low income, who had committed criminal acts in the past to get money for drugs, it was perfectly possible that Sigsworth could or would sell some of the pills prescribed by Dally. Of course, Sigsworth could just as easily have sold drugs prescribed to him by an NHS doctor, but he would not have had to pay for treatment, or as much for his prescription. There was less of an inducement, as there was less of an incentive. Viewing the case on its merits alone, however, would suggest that to find that Dally had acted in bad faith when prescribing to Sigsworth was something of a curious verdict. She was certainly naïve and imprudent in her handling of a ‘dodgy’ patient, but that her motives were entirely honourable was indisputable; even Preston in his opening statement to the committee concurred. To explain this verdict, the context in which it was delivered needs to be considered. Views on the private treatment of addiction were increasingly polarised and a powerful, well-supported group of DDU psychiatrists wanted to eliminate the private practitioner from the treatment of addiction. Dally was a figurehead for the private doctor treating addicts and, therefore, an obvious target in the war over drug addiction treatment.

3.3 A political trial? Reactions to the Dally case

Evidence for this view can be found in the reaction to the GMC’s verdict in the medical press and elsewhere. Dally’s case had a number of significant implications not just for those treating addicts, but also for the methods used. The GMC, it appeared, was not above using the PCC to conduct ‘political’ trials. Jean Robinson, a former chairperson of the Patients’ Association sat on the GMC PCC during the 1980s. In a wide-ranging critique of the Council she argued that although the

members of the PCC tried to do an honest job in the end they ‘merely become instruments for the occasional ritual sacrifice.’²⁰² Michael O’Donnell, doctor, medical commentator and member of the GMC (he was one of the ‘rebels’ appointed in 1970) made it clear that this was what had happened to Dally when he opened his attack on the case by referring to the medical establishment as having offered up a ‘sacrificial lamb.’²⁰³ O’Donnell recognised that the debate about the treatment of addiction and the view that the clinics were ‘failing’ was the backdrop to the GMC’s case against Dally. He wondered if without the ‘background political noise’ Dally would have faced the ‘full ritual of a “public trial.”’ O’Donnell could well understand the view of journalists watching proceedings that ‘this was a political trial in which the “establishment” was out to “get” Dr Dally because of her heretical views.’ Because Dally had dared to ‘question the party line on the management of drug addiction’ she was subjected to a ‘trial’ by the GMC.²⁰⁴

O’Donnell and Dally both referred to the dismay of journalists in the public gallery at the PCC’s verdict, yet none of this outrage spilled out into articles in the broadsheet press.²⁰⁵ Most newspapers just confined themselves to the details of the case, only *The Guardian* hinted at wider political reasons for the hearing.²⁰⁶ The article stated that Dally had ‘publicly set herself up in opposition to the government-run clinics for drug addicts’ suggesting that the case might be about adjudicating a debate over treatment.²⁰⁷ The medical press covered the case in more detail. An editorial in the *Lancet* noted that there was ‘speculation’ about ‘the motives behind

²⁰² Jean Robinson quoted in Stacey, *Regulating British Medicine*, p. 196.

²⁰³ *Ibid.* p. 39; O’Donnell, ‘One man’s burden’, p. 990.

²⁰⁴ O’Donnell, ‘One man’s burden’, p. 990.

²⁰⁵ *Ibid.*; Dally, *A Doctor’s Story*, p. 122.

²⁰⁶ See, for example, *Daily Telegraph*, (8 July 1983) p. 2.

²⁰⁷ *The Guardian*, (8 July 1983) p. 2.

the charge.’²⁰⁸ Furthermore, the evidence against Dally was not ‘compelling.’²⁰⁹ This was a theme continued by the *Lancet*’s legal correspondent, barrister Diana Brahams. Brahams argued that the case was ‘disquieting’ for two reasons. Firstly, the way in which the charge was interpreted by the legal assessor and the committee, and secondly, the unjustness of a system that did not allow the right to appeal when a doctor had been found guilty of serious professional misconduct but not suspended or struck off.²¹⁰ Brahams also mentioned the ‘background of concern about the role of private doctors in the treatment of drug dependence,’ again hinting at the broader implications of the case. Brahams too found that the evidence submitted during the hearing fell ‘well short of proof of a lack of good faith.’ She suggested that the outcome of the case indicated that guidelines were required on the treatment of drug addiction in private practice, and also that there should always be a right to appeal if a doctor was found guilty of serious professional misconduct.²¹¹

There was some attempt on the part of the GMC to fight back against the criticism directed at the PCC’s findings in Dally’s case. Sir John Walton wrote to the *British Medical Journal* defending his committee’s verdict and challenging some of the allegations made by O’Donnell.²¹² He argued that the PCC did not take decisions lightly and ‘least of all vindictively.’²¹³ The case, he maintained, was not about the benefits or drawbacks of a particular method of treating addicts, but about determining whether or not Dally had abused her position as a medical practitioner by issuing prescriptions to a patient other than in the course of bona fide treatment.

²⁰⁸ ‘Editorial: GMC Professional Conduct Committee: right of appeal’, *Lancet*, (22 October 1983) p. 951.

²⁰⁹ *Ibid.* p. 951.

²¹⁰ D. Brahams, ‘Medicine and the law: no right of appeal against GMC finding of serious professional misconduct without suspension or erasure’, *Lancet*, (22 October 1983) 979-981, p. 979.

²¹¹ *Ibid.* p. 980.

²¹² J. Walton, ‘Verdict of the professional conduct committee’ letter to the *British Medical Journal*, 287, (29 October 1983) p. 1300.

²¹³ *Ibid.* p. 1300.

According to Walton, that alone was the issue on which the PCC adjudicated and found the charge to be proved to their satisfaction.²¹⁴ The climate in which the case was brought, however, must have shaped its outcome. Ashton, in his piece on ‘doctors at war’ pointed out that debate about the involvement of the private doctor in the treatment of addiction had reached its height just a few months before Dally appeared before the GMC.²¹⁵ He argued that what mattered was not so much whether the judgement against Dally was ‘right’ or ‘wrong’ but the significance this verdict held in terms of the controls placed on the prescription of drugs to addicts. For Ashton the decision represented ‘a tougher line on addiction treatment.’²¹⁶

Implications

Taken as a whole, these articles indicate that Dally’s case was about more than Dally. And, when in seen in context of the debate about the role of the private practitioner in the treatment of addiction that took place immediately prior to the hearing, it is difficult not to conclude that Dally was the ‘sacrificial lamb’ referred to by O’Donnell. Her treatment of Sigsworth was not without mistakes, but prescribing drugs to addicts was a risky business. Whether in private practice or working at an NHS DDU, drugs prescribed legitimately by doctors did find their way onto the black market. The risks were, of course, greater with private prescription as the costs involved increased the likelihood that drugs could be sold to finance treatment, but these drugs constituted just a small proportion of those available to addicts wishing to buy drugs illegally; most drugs by the 1980s came from illicit sources. This, however, was not widely acknowledged by those who wished to halt the intervention of the private doctor in the treatment of addiction. Flagging up the problems of

²¹⁴ *Ibid.* p. 1300.

²¹⁵ Ashton, ‘Doctors at war – part two’, p. 15.

²¹⁶ *Ibid.* p. 14.

private practice in *Treatment and Rehabilitation* and in countless letters and articles in medical journals had not stopped the involvement of private doctors and GPs in this field. But, by finding a key private practitioner treating addicts guilty of serious professional misconduct the Dally case could also serve as a warning to other private doctors and prevent them from becoming involved. The GMC were, therefore, assuming a position in the conflict over the role of the private practitioner in the treatment of addiction through this verdict. It was no coincidence that this position was broadly that of the DDU psychiatrists, the respected ‘experts’ in the field who had strong links to the medical establishment and even the GMC itself. That is not to say there was necessarily a ‘campaign’ to ‘get’ Dally, rather that the position and authority of the leading DDU doctors allowed them to indirectly influence the PPC’s decision.²¹⁷

Yet, to some extent the GMC PCC hearing can be said to have ‘failed.’ It did not stop Dally practising and treating addicts, nor did it completely halt the intervention of the private doctor. Moreover, astute commentators recognised the political significance of the PCC’s findings. As well as raising the well-aired concerns about who should treat the addict Dally’s case pointed to a number of other issues around which the treatment debate continued to revolve. The hearing demonstrated that there was a great need for guidelines on the treatment of addiction, both to help practitioners determine the correct course to follow, and also as a standard against which doctors thought be prescribing to addicts irresponsibly could be held. Running through the case was an undercurrent concerning not just private practice treatment of addiction, but all treatment of addiction. Some of the criticisms directed at Dally’s treatment methods were not just attributable to her status as a

²¹⁷ Dally described the actions of the ‘drug dependency mafia’ as she termed them as a ‘campaign’ against her. See Dally, *A Doctor’s Story*, p. 139. This, and the notion that there was a ‘conspiracy’ against Dally and other doctors will be explored more fully in Chapter Five.

private doctor, but raised issues with her underlying treatment philosophy. Indeed the debate within the treatment of addiction moved away from issues of whether or not private or general practitioners should be involved in the treatment of addiction and instead began to focus on the type of treatment offered. It is to the consideration of this issue that the remainder of this thesis will be directed.

Chapter Four

Withdrawal versus Maintenance: the Growing Dominance of Short-term Withdrawal Treatment, 1984-1986

Introduction

In the mid 1980s tension existed not only between DDU psychiatrists and private and general practitioners involved in the treatment of addiction, but also between those doctors who offered short-term, abstinence orientated withdrawal treatment and those who prescribed for addicts on a long-term, or maintenance basis. Director of the Liverpool DDU, John Marks, asserted that ‘The debate about controlled drug prescribing has split the profession down the middle.’¹ Those who supported the rapid withdrawal of drugs from addicts prescribed diminishing doses of an opiate substitute (usually orally administered methadone) over a short period of time at the end of which the addict would be ‘abstinent’ or ‘drug free.’ It could then be said that the addict was ‘cured,’ as he or she was, officially, no longer taking their drug of addiction. Doctors who supported maintenance prescribed drugs to addicts over a much longer period and were less inclined to reduce the dose. This treatment was aimed not so much at getting the addict off drugs, but was instead targeted at enhancing the social functioning of the patient; improving relationships, employment and general health. The treatment offered by the respective groups thus differed in the duration of prescription but also over the expected outcome.

Furthermore, the position and the type of medicine practised frequently separated advocates of short-term withdrawal and those who offered maintenance. Supporters of short-term abstinence orientated treatment were largely to be found in NHS DDUs, whereas those who called for long-term maintenance were often found in

¹ J. Marks, ‘Opium, the religion of the people’, *Lancet*, (22 June 1985) 1439-1440, p. 1439.

private or general practice. This chapter will argue that this division was no coincidence; indeed it can be used to explain why disputes over the treatment of addiction were so bitterly fought. The relative position of these groups, the environment in which they existed and the types of medicine they practised fundamentally affected their understanding of addiction and its treatment. Doctors working in hospital-based DDUs practised clinical medicine. This aimed to ‘identify, record and analyse the symptoms presented in sickness; determine deviations from the norms demonstrated by physiological research; and on those bases develop valuable therapeutic interventions.’² Disease was abstracted from the ‘sick man,’ who became a pathological body studied with lesions.³ Further subjugated by the disciplinary mechanisms of the hospital the ‘patient,’ was reduced ‘to the status of walking stomachs, blood sugars, heart valves or whatever [was] the seat of their disease.’⁴ The treatment offered to addicts in DDUs conformed to these principles. Psychiatrists saw only the disease to be treated and paid less attention to the social situation of the individual addict patient. Addicts were examined and if the diagnosis of addiction was made, treatment offered. Doses of opioids were reduced as rapidly as possible, as this was ‘treatment’ more likely to result in ‘cure’ – the patient being drug-free.

In contrast, private and general practitioners operating outside hospitals frequently practiced biographical medicine.⁵ Here, emphasis was placed more on the patient rather than the disease. The patient was not an inert vessel in which disease resided, but an individual.⁶ Through biographical medicine, according to Armstrong, the ‘sick man’ re-emerged; attention was paid to the experience of the sick individual

² Porter, *The Greatest Benefit to Mankind*, p. 561.

³ This is a notion developed by Foucault in *The Birth of the Clinic*.

⁴ Armstrong, ‘The emancipation of biographical medicine’, p. 1; quotation from Porter, *The Greatest Benefit to Mankind*, p. 671.

⁵ On the impact of biographical medicine on general practice see Chapter Two, pp. 126-127, pp. 131-132.

⁶ Markiner, “What is wrong” and “How we know it”, p. 68.

and not just to ridding them of disease.⁷ This explains why private and general practitioners treating addicts developed treatment programmes concentrating on the needs of each patient and were less concerned with the rapid removal of the drug from the body of the addict. These doctors were more aware of the context in which the addict and their illness resided and therefore were more interested in improving social functioning rather than withdrawing the drug. It is, therefore, argued that conflict over the treatment of addiction during the 1980s was caused as much by a clash between different approaches to sickness and disease as by specific concerns about who should treat the addict (specialist or generalist, NHS doctor or private practitioner) or how they should be treated.

Caution, however, should be exercised. The distinction between the different groups and their positions can be too tightly drawn. There were exceptions to the rule. As a hospital-based clinician running a DDU in Liverpool it would be expected that Marks supported abstinence orientated rapid withdrawal of opioid drugs from addicts. Yet Marks offered the majority of his patients long-term maintenance prescriptions and developed a treatment philosophy concerned primarily with 'improving the physical health of the patient and improving the quality of their lives.'⁸ Marks offered a more biographical medicine type approach despite his clinical position. Furthermore, short-term withdrawal and long-term maintenance had existed as suggested forms of treatment since at least the nineteenth century.⁹ Those who worked with drug addicts were divided over which method was to be preferred during the 1920s: supporters of the rapid withdrawal of drugs from addicts were to be found on the Rolleston Committee despite their eventual endorsement of

⁷ Armstrong, 'The emancipation of biographical medicine', p. 5.

⁸ CMAC PP/DAL/B/4/2/8, C.S.J. Fazey, 'The evaluation of Liverpool Drug Dependency Clinic. The first two years, 1985-1987', (1988) pp. 29-30.

⁹ Berridge, 'Morality and medical science', p. 79.

maintenance.¹⁰ As seen in Chapter One, this same split in expert opinion existed in the 1960s, leading to confusion about the treatment offered in the new clinics within the Ministry of Health and those hospitals asked to establish them. Although the DDUs initially offered maintenance treatment to addicts by the late 1970s most had switched to the rapid withdrawal of opioid drugs from addict patients, believing it to be a more therapeutic response. During this period the numbers of addicts seeking treatment increased and at the same time many grew disillusioned with the short-term withdrawal treatment available from clinics. Some addict patients turned to private and general practitioners operating outside DDUs for treatment. These doctors were often more inclined to offer maintenance prescription, arguing that it improved the social functioning of the patient. Thus, the clash between withdrawal and maintenance occurred anew, and with added vehemence, in the 1980s.

This chapter will consider this conflict by examining the case put for withdrawal and the case put for maintenance in more detail, taking into account the position and outlook of key protagonists. Despite the increasing confidence of community-based practitioners in dealing with conditions they had previously left to specialists, in addiction the specialists appeared to remain dominant. Short-term withdrawal, therefore, became the ‘orthodox’ method of treatment. This can be observed in the production of the *Guidelines of Good Practice in the Treatment of Drug Misuse* (hereafter the *Guidelines*) in 1983-4. The *Guidelines* strongly suggested that the most appropriate form of treatment for addiction was short-term abstinence orientated withdrawal, and implied that though the non-DDU doctor could have a role to play in the treatment of this condition this was fairly limited. Yet, the supposed ‘consensus’ presented in the *Guidelines* belied the diversity of opinions amongst the

¹⁰ Berridge, *Opium and the People*, pp. 274-275; Berridge, “Stamping out addiction”, pp. 49-50.

working group members that produced this document and the wider drug addiction treatment community.¹¹ Though short-term withdrawal was the dominant method of treatment it was not the only one. Maintenance treatment continued to be offered by some doctors. The ‘battle’ between these two methods and philosophies was clearly not over.

1. The treatment debate: short-term withdrawal versus long-term maintenance

1.1 Short-term withdrawal

It is almost impossible to distinguish short-term withdrawal from the practice of the DDUs. DDU doctors were its strongest advocates and it was at clinics that the method was most widely practised. A survey of the treatment offered at DDUs conducted in 1982 found that clinics ranked ‘help with withdrawal’ as their most important treatment policy. In contrast, they did not believe that maintenance played a significant role in the treatment they offered. An overwhelming majority of the DDUs surveyed (97 per cent) believed that heroin maintenance was either not important or not their policy, 84 per cent thought the same about maintenance with injectable methadone and 29 per cent found that maintenance on oral methadone was not acceptable either.¹² By the mid-1980s, few clinics were prepared to prescribe new addict patients opioid drugs over a long period of time. In 1984 Strang stated that all of the last 100 patients treated at his DDU in Manchester had been placed on a withdrawal regime to be completed in a fixed period between three and twenty weeks. In every case the drug prescribed was to be administered orally.¹³ Short-term

¹¹ Medical Working Group on Drug Dependence, *Guidelines*, p. 4.

¹² Smart, ‘Drug Dependence Units in England and Wales: the results of a national survey’, pp. 138-139.

¹³ J. Strang, ‘Abstinence or abundance – what goal?’, *British Medical Journal*, 289, (8 September 1984) 604, p. 604.

prescription of oral drugs (usually methadone) aimed at abstinence was the method of treatment offered by most DDUs and championed by many drug addiction experts.

Explaining why this was adopted and how it became the orthodox method of treatment is as much about the perceived disadvantages of maintenance as the advantages of short-term withdrawal. There were six main arguments put forward against maintenance and in support of rapid withdrawal. The first was that prescription of a drug to an addict maintained the addiction. Psychiatrists at a DDU in Sheffield felt that ‘prescribing drugs of addiction [to an addict] comes close to colluding with and maintaining the habit.’¹⁴ The choice of words in this statement is particularly interesting. ‘Collusion’ suggests that by prescribing drugs to an addict a doctor was complicit in perpetuating a ‘habit,’ not providing treatment for a medical condition. Maintenance was, therefore, unacceptable as it fed a habit and did not treat the disease. This belief was underlain by an essentially moral objection to maintenance. Connell told the Social Services Committee in March 1985 that maintenance might be suitable for a small group of ‘chaotic’ individuals, under very strict control, but as a whole this method was not appropriate. By posing the rhetorical question ‘Is society required to provide something like a sweet or a drug because somebody wants it?’ and countering that ‘Those who are trying to treat this seriously are a little worried about adopting this view, which is of course the view that the person dependent upon the drug likes to put forward’ Connell implied that giving an addict a drug simply because he or she asked for it was unacceptable.¹⁵ Moreover, he suggested that prescribing addicts drugs of addiction was not treating the condition ‘seriously.’ This was the second argument made against maintenance; that as it perpetuated the disease of addiction it did not constitute treatment and was not,

¹⁴ F.A. Jenner & P.V. Gill, ‘Helping heroin addicts kick the habit’, letter to the *British Medical Journal*, 291 (3 August 1985) 344-345, p. 345.

¹⁵ Social Services Committee, *Misuse of Drugs*, Evidence of Dr Connell, March 1985, p. 126.

therefore, the role of the doctor. This was not a new argument, but it was frequently repeated. Dr Strachan of the Royal Edinburgh Hospital asserted at a meeting of the Northern Drug Addiction Psychiatrists in 1985 that ‘NHS facilities should be used for those who want treatment not sociomedical [sic.] control nor prevention of crime.’¹⁶ Even if maintenance had advantages in terms of controlling addiction or reducing crime, it was not the responsibility of a doctor to prescribe drugs to addicts.

Similar arguments had been made twenty years earlier when the Ministry of Health tried to determine the function of the DDUs and the treatment they should offer. Maintenance was tentatively endorsed because civil servants and doctors alike wanted to avoid the development of a black market in drugs and thought this could be prevented by providing addicts with a legal supply through the clinics.¹⁷ The third argument raised by those who opposed maintenance was that this reason for long-term prescription was redundant by the 1980s. According to addiction specialist J. Madden maintenance therapy ‘had not forestalled an expansion of the drug market.’¹⁸ Furthermore, addicts prescribed drugs on a maintenance basis frequently sold their drugs to other addicts, or bought illegal drugs to supplement their legal supply, the fourth and fifth arguments made against long-term prescription. A study of the Piccadilly drug scene in 1983 by anthropologist Angela Burr found a thriving market in the illicit trading of drugs prescribed by DDUs and GPs.¹⁹ Many drug addiction specialists, such as Connell and Bewley, were anxious about over-spill from the prescription of drugs to addicts to the black market. Subsequently, they encouraged the development of restrictions as to when an addict could be prescribed drugs and

¹⁶ CMAC PP/DAL/B/4/1/5, Minutes of the 1985 meeting of the Northern Drug Addiction Psychiatrists (DAPS) held at Liverpool Drug Dependence Clinic, 8 March 1985.

¹⁷ See Chapter One, pp. 59-67.

¹⁸ J.S. Madden, ‘Editorial: The decline of long-term prescribing to opioid users in the United Kingdom’, *British Journal of Addiction*, 82 (1987) 457-459, p. 457.

¹⁹ Burr, ‘The Piccadilly drug scene’; Burr, ‘Increased sale of opiates on the blackmarket in the Piccadilly area’.

under what conditions in an effort to reduce over-prescription.²⁰ Connell also stated in an interview with the *British Journal of Addiction* that even when he had prescribed addicts heroin in the 1960s, they continued to buy drugs on the side.²¹ Other doctors involved in the treatment of addiction such as Jenner and Gill argued that they adopted a non-prescribing policy when treating addicts because they were ‘frequently being misled and cheated.’²² The simplest way to avoid this was not to prescribe to addicts at all, or to do so over a very short period.

The final argument put forward against maintenance was essentially an economic one. The ACMD noted in *Treatment and Rehabilitation* that maintenance treatment offered to ‘old’ existing patients at DDUs ‘may be a factor in blocking the ready access of new patients to the clinics.’²³ This view was endorsed by Strang, who noted that the ‘constant flow of patients into the clinic system was not matched by any equivalent flow of patients out of the system.’ As clinics were faced with static or diminishing resources they ‘found it necessary to look at shorter, more cost effective (and perhaps more appropriate) types of response.’ Adopting short-term prescription instead of maintenance was, therefore, ‘a pragmatically derived approach.’²⁴ Short-term prescription was cheaper than long-term maintenance as fewer drugs were required over a shorter period. What is more, resources were being applied to those most likely to be ‘cured’ of addiction; when asked what happened to the majority of addicts who did not want treatment at a meeting of the Northern Drug Addiction Psychiatrists Strachan replied that there were enough patients who wanted withdrawal

²⁰ See, for example: Bewley, ‘Prescribing psychoactive drugs to addicts’, Gardner & Connell, ‘Necessary safeguards’.

²¹ Connell, ‘Conversation with Philip Connell’, p. 20.

²² Jenner & Gill, ‘Helping heroin addicts kick the habit’, p. 344

²³ ACMD, *Treatment and Rehabilitation*, p. 28

²⁴ Strang, ‘Abstinence or abundance – what goal?’, p. 604.

to keep DDUs busy.²⁵ And, in the increasingly evaluative context in which the DDUs were operating, where 'results' were expected, withdrawal offered a tangible outcome in the form of 'cure.'²⁶ The potential benefits of maintenance for the individual and for society were much more difficult to assess. In addition, maintenance was expensive, 'blocked' clinics from those most likely to benefit from their services and, it was argued, was not cost-effective.

The case against maintenance was, therefore, a powerful one, covering a range of arguments and supported by many doctors credited with expertise in the treatment of addiction. Maintenance did not cure addicts of their addiction and could not subsequently be considered 'treatment' and the responsibility of the doctor. The experiment with maintenance flirted with by DDUs in the 1960s and early 1970s had not prevented the development of a black market, nor had it stopped addicts trading in the drugs they were prescribed. And in addition to being ineffective, it was expensive. Arguing against maintenance prescription was easy, but this did not necessarily amount to an automatic endorsement for short-term withdrawal. There were far fewer positive assertions portraying the benefits of short-term treatment than negative comments about maintenance. Indeed, those who supported rapid withdrawal tended to concentrate on the damaging effects of maintenance rather than the plus points of short-term treatment. This can be attributed, in part, to a lack of 'evidence' to support either short-term prescription or maintenance. The Hartnoll-Mitcheson trial comparing injectable heroin with oral methadone published in 1980 compared the drugs, not the method of treatment, as both drugs were prescribed on a maintenance basis. The study did indicate that prescribing oral methadone to addicts

²⁵ CMAC PP/DAL/B/4/1/5, Minutes of the 1985 meeting of the Northern Drug Addiction Psychiatrists (DAPS) held at Liverpool Drug Dependence Clinic, 8 March 1985.

²⁶ For more on the administrative context of the DDUs and how this affected treatment offered see Chapter One, pp. 90-91.

was associated with greater change; that those prescribed methadone were more likely to be abstinent from drugs than those prescribed injectable heroin.²⁷ These findings were used to explain the widespread adoption of oral methadone as opposed to injectable opioids in the DDUs, but this change also indicated a shift in the orientation of the treatment offered in clinics towards abstinence. Strang noted in 1984 that the service offered to addicts at his DDU was now 'predominantly geared towards helping the drug taker to become and remain drug free.'²⁸ It had long seemed counter-intuitive to many doctors to prescribe a drug that perpetuated a medical condition and this view was strengthened by disillusionment with maintenance as method of treatment for addiction. A new emphasis was placed on helping the addict to become abstinent from drugs by withdrawing the drug in a short a period as possible.

This method fitted with the view of disease and its treatment that arose from the clinical context and operational environment of the hospital-based DDU psychiatrist. Through their rejection of maintenance and adoption of short-term withdrawal psychiatrists were returning to their expected clinical role: to diagnose disease and to treat it. Anomoclinical medicine was 'born' at the beginning of the nineteenth century.²⁹ Detailed methods of examination (clinical practice) searched for the existence of a pathological lesion inside the body as the source of disease. Foucault argued that medicine's 'gaze' was thus directed to the body of the patient, simultaneously locating and constituting disease within that body.³⁰ Although this gaze created the body of the patient it saw only the disease. The patient was a 'case' rather than a unique individual; indeed the disease was seen as being contaminated by

²⁷ Hartnoll et al, 'Evaluation of heroin maintenance in controlled trial', p. 883.

²⁸ Strang, 'Abstinence or abundance – what goal?', p. 604.

²⁹ See W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994); Porter, *The Greatest Benefit to Mankind*, pp. 305-347.

³⁰ Foucault, *The Birth of the Clinic*.

the presence of the 'sick man.'³¹ To facilitate this way of seeing disease a disciplinary mechanism developed which subjugated the patient: the hospital. Based on clinical practices hospital medicine abstracted the disease from the patient and located it in pathology.³² This type of medicine dominated nineteenth and twentieth century medical practice. It was further strengthened by a turn towards scientific method and the emergence of 'clinical science' which gathered pace in the post-war period.³³ Coupled with technological developments, hospital medicine became increasingly specialised. Specialists focused on a specific disease or the functions of a particular part of the body.³⁴ In this way some conditions were rendered visible, but others were necessarily ignored.³⁵ Attention became still more focused on the specific disease or condition. Hospital-based specialists could simply not 'see' the whole patient as their gaze was directed towards a specific condition or disorder. Specialisation thus reduced sensitivity to the social context of illness, such that the view that the 'clinical aspects of human illness [were] inextricably linked with their social aspects' was not something that was 'self-evident to all, or even most doctors.'³⁶ In this context the social dimensions to a condition such as addiction were not considered relevant.

Even within psychiatry, the social setting of illness was not paramount. Indeed, in the 1970s there was something of a resurgence of biological psychiatry which heightened interest in the organic or genetic causes of mental illness rather than those relating to the experiences of the individual. Shorter noted that instead of

³¹ Armstrong, 'The emancipation of biographical medicine', p. 3.

³² *Ibid.* p. 1

³³ *Ibid.* p. 2.

³⁴ D. Armstrong, 'The social space of illness' in D. Porter, *Social Medicine and Medical Sociology in the Twentieth Century*, (Amsterdam: Rodopi, 1997) 165-174, p. 166.

³⁵ Armstrong, *Political Anatomy of the Body*, p. 2.

³⁶ N. Oswald, 'Training doctors for the National Health Service: social medicine, medical education and the GMC, 1936-48' in Porter, *Social Medicine and Medical Sociology*, 59-80, p. 59.

attributing psychiatric conditions to ‘faulty child rearing or environmental stress, curable through in depth psychotherapy’ psychiatrists in this period more readily accepted the view that ‘psychiatric illness rested on a substrate of disordered brain chemistry and development.’³⁷ Moreover, these could be treated through the use of psychotropic drugs: ‘a veritable cornucopia of antipsychotic, antimanic, and antidepressant drugs poured forth, changing psychiatry from a branch of social work to a field that called for the most precise knowledge of pharmacology.’³⁸ The ‘wonder drugs’ of the ‘pharmacological revolution’ suggested that mental illness could be managed or even cured.³⁹ In this context of therapeutic optimism maintaining the condition of addiction instead of trying to rid the addict of their disease appeared to be a contradiction for many psychiatrists. The irony was that the treatment of addiction, unlike the treatment of other psychiatric conditions, involved the removal of a drug rather than the prescription of one. Yet, as short-term abstinence orientated treatment was directed more readily towards the ‘cure’ of addiction it conformed more readily to the principles of clinical psychiatry and thus became the ‘orthodox’ method of treatment advocated by the leading specialists in the field.

Indeed, the emergence of short-term withdrawal as the ‘orthodox’ method of treatment was facilitated by the perceived ‘expert’ status of those who promoted short-term treatment and their connections to the medical and psychiatric ‘establishment.’ Connell was probably the leading expert on drug addiction in Britain during the 1980s, closely followed by Bewley. Both men were advocates of rapid withdrawal, both were considered to be experts in the field and both held powerful positions within the medical establishment as well as advising the government on

³⁷ Shorter, *A History of Psychiatry*, p. 239.

³⁸ *Ibid.* p. 255.

³⁹ Jones, *After the Asylum*, pp. 179-180.

drug addiction related issues (see Chapter Three). It has been suggested that Connell had particular influence in political as well as medico-political circles. Dally contended that Connell had the ‘ear’ of the Home Office Minister in charge of drugs issues, David Mellor, and was thus partly responsible for Mellor’s ‘prohibitionist’ attitudes.⁴⁰ Mellor was certainly opposed to maintenance; he described the comments made by Dr Henry Marjot in favour of reviewing the prescription of heroin to heroin addicts as “grotesque and fatheaded.”⁴¹ Connections such as these allowed men like Connell and Bewley to influence the direction of drug addiction treatment policy within central government which was becoming more involved in drug issues in this period. However, their influence within the within the medical community was just as important, if not more so, as this was where most of the crucial changes in drug addiction treatment were initiated. Here, the support Bewley and Connell received from other DDU doctors, particularly in London, was vital. Consultant psychiatrists at London clinics all advocated the short-term withdrawal of opioid drugs from addicts, at least in public. As noted in Chapter One, regular meetings of the London DDU doctors ensured a high degree of uniformity of practice across clinics in the capital.⁴² Furthermore, these doctors were regarded as ‘experts’ in their own right, particularly those who held posts at teaching hospitals which commanded higher status than those in non-teaching facilities.⁴³ Thus, there appeared to be a high degree of expertise in favour of short-term withdrawal, encompassing the leading figures in

⁴⁰ CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 11 June 1987, p. 262; CMAC PP/DAL/E/4/20, ‘The drug clinic consultant group’ by Dally, prepared for her lawyers, 18 October 1986; Dally, *A Doctor’s Story*, p. 139.

⁴¹ Quoted in Spear, *Heroin Addiction Care and Control*, p. 305.

⁴² Chapter One, pp. 93-94.

⁴³ Teaching hospitals had higher status than non-teaching hospitals retaining a greater degree of autonomy from national structures through their own boards of governors. See Porter, *The Greatest Benefit to Mankind*, p. 653; Klein, *The Politics of the NHS*, pp. 20-21.

drug addiction treatment at a practical and advisory level. This meant that short-term withdrawal was rapidly becoming the dominant treatment method for addiction.

1.2 Long-term maintenance

However, a small but vocal group of doctors continued to advocate the long-term prescription of drugs to addicts despite the climate of powerful opposition to this method within medico-political circles. Support for maintenance treatment came mainly, but not exclusively, from doctors operating outside DDUs. Some of these doctors, like Dally and Beckett, worked in private practice. Others, such as Banks and Hare, were NHS GPs.⁴⁴ There were also a few consultant psychiatrists working in NHS DDUs that advocated the long-term prescription of opioid drugs to addicts. The most prominent of these was Dr John Marks, Clinical Director and consultant psychiatrist at Liverpool DDU. A handful of other supporters of long-term prescription to addicts could be found in provincial DDUs, particularly in the north of England. In Scotland there were no DDUs, so treatment for addiction was carried out either within general psychiatric services, or more often in general practice.⁴⁵

Subsequently, there was more criticism of short-term withdrawal and support for maintenance in these areas. Some doctors who attended meetings of the Northern Drug Addiction Psychiatrists such as Dr Basson of the Royal Edinburgh and Dr Sefari, consultant at Macclesfield DDU attacked short-term withdrawal and expressed tacit support for maintenance (see below). Marks estimated that around 25 per cent of regional clinics offered some form of long-term prescription to addicts, with the remaining 75 per cent following the London DDUs and advocating rapid reduction.⁴⁶

It is significant that support for maintenance treatment by DDU doctors occurred

⁴⁴ See Chapter Three, p. 152 for Hare's views and methods of treating addiction.

⁴⁵ Berridge discusses the greater role GPs played in the treatment of addiction in 'AIDS and British drug policy', pp. 146-147 and in V. Berridge, *AIDS in the UK The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996) p. 92.

⁴⁶ CMAC PP/DAL/E/4/17 PCC Hearing, 1986-1987, 29 January 1987, p. 41.

away from the capital. Regional differences in the heroin ‘problem’ might account for the differences in approach, but it is more likely that the relative remoteness of Northern DDUs from the power networks of London doctors and drug addiction experts allowed them a degree of autonomy not afforded clinic doctors in the capital.⁴⁷ This permitted a few regional clinic doctors to adopt an ‘unorthodox’ line and offer maintenance prescription to some addict patients.

Those doctors that advocated long-term prescription of opioid drugs whether working at a DDU, or in private or general practice, held a common view of addiction and the addict. They felt that addicts usually took drugs as a result of other psychiatric problems and could only be taken off drugs when they were able to deal with these. Marks asserted that ‘Addicts give up when they are ready to and special detoxification units do little to expedite this.’ Instead, treatment should ‘discover why addicts abuse drugs or alcohol and then work with them to seek alternative methods of dealing with the problems muffled by drug dependence.’⁴⁸ There was a feeling that withholding drugs from addicts did not result in them becoming abstinent. Sefari stated at a meeting of the Northern Drug Addiction Psychiatrists in 1986 that ‘the natural history of drug addiction suggests that people will continue to take drugs one way or another, legally or illegally, whether there is prohibition or not.’⁴⁹ Marks too, argued that heroin addicts tended to maintain their addiction themselves if they were not prescribed drugs.⁵⁰ Furthermore, as authors of a study of drug addiction in Edinburgh pointed out, withdrawal from heroin or another opioid drug constituted a minor part of treatment because ‘heroin abuse, like alcohol abuse, is a remitting and

⁴⁷ Basson mentioned regional differences in the pattern of drug addiction and the impact that this had on local demands in J.V. Basson, ‘Attitudes to drug abuse’, *British Medical Journal*, 292 (29 March 1986) 847-848, p. 848.

⁴⁸ Marks, ‘Opium, the religion of the people’, p. 1440.

⁴⁹ CMAC PP/DAL/B/4/1/5, Minutes of the 1986 meeting of the Northern Drug Addiction Psychiatrists (DAPS) held at the Royal Edinburgh Hospital, 7 March 1986.

⁵⁰ Marks, ‘Opium, the religion of the people’, p. 1440.

relapsing disorder, with users spontaneously abstaining with little or no medical intervention.’ Abstinance, they argued, did not always equate with ‘cure.’⁵¹

Nonetheless, abstinence was the ultimate goal of treatment involving long-term prescription, just as it was with more rapid withdrawal. Dally argued that her philosophy was to prescribe a minimum dose to her addict patients and to reduce this gradually ‘with the aim of eventually achieving a drug-free life.’⁵² Hare also asserted that it was her policy that addict patients ‘come off the drug sometime.’⁵³ At the Liverpool DDU the first stated goal was ‘to return the patient to a drug free life style.’⁵⁴ Where those who offered maintenance differed from those who advocated rapid withdrawal was over the time period after which abstinence was expected. At Marks’ clinic a drug-free lifestyle might be a ‘short, medium or long-term goal according to age, previous drug history and motivation of the patient.’⁵⁵ Dally also stressed the reduction of a patient’s drug intake, but only within their individual capacity.⁵⁶ This differed from the policy of many DDUs, which set a fixed time limit to the duration of prescription.

Getting the addict off drugs might have been the hoped for outcome of treatment, but this was not to be achieved at the cost of the social functioning of the patient. The treatment offered by the Liverpool DDU under Marks was aimed at improving the health and quality of addicts’ lives.⁵⁷ The idea was to switch injecting heroin addicts to oral methadone and to reduce drug consumption so long as this did not compromise the social functioning of the patient. Treatment was to improve the

⁵¹ Bucknall, Robertson & Strachan, ‘Use of psychiatric drug treatment services by heroin users from general practice’, p. 999.

⁵² Social Services Committee, *Misuse of Drugs*, Evidence of AIDA, 27 February 1985, p. 114.

⁵³ *Ibid.* p. 119.

⁵⁴ CMAC PP/DAL/B/4/2/8, Fazey, ‘The evaluation of Liverpool Drug Dependency Clinic’, pp. 29-30.

⁵⁵ *Ibid.*

⁵⁶ Dally, *A Doctor’s Story* p. 82.

⁵⁷ CMAC PP/DAL/B/4/2/8, Fazey, ‘The evaluation of Liverpool Drug Dependency Clinic’, pp. 29-30.

physical and mental health of the addict, stabilise their lifestyle, improve family relationships, decrease the amount of black market drugs being bought, reduce the level of criminal activity of the patient and increase the employment prospects of the patient.⁵⁸ In order to achieve these goals, prescription of an opioid drug was permitted whilst the problems hidden by addiction were dealt with. This did not result in blanket maintenance prescriptions for all addict patients attending the Liverpool DDU. Between 1985 and 1987 17.5 per cent of patients were prescribed oral opioids on a maintenance basis after the first consultation and just 6.2 per cent were maintained on injectable drugs. The majority of patients, 58.9 per cent, were placed on some sort of withdrawal regime, but arbitrary limits of the amount prescribed and the duration of prescription were not set.⁵⁹ Reduction was achieved on an individual basis. Dally used a similar justification for maintenance prescription to some of her addict patients. She argued that she prescribed the minimum dose necessary for the individual patient to lead a 'normal' life; earning a legal living, looking after a family and children, and so on.⁶⁰ Once more, stress was placed on the individual patient, rather than on a specific treatment programme designed for all.

The emphasis on the individual was indicative of a change in the perceived function of maintenance treatment. During the late 1960s maintenance was described as a form of social control; it was seen as a way to prevent the development of a major heroin addiction problem by providing addicts with drugs so that they would not need to buy these on a black market. This would reduce the social problems associated with addiction and at the same time prevent the spread of the disease of addiction within the community by limiting the contact between infected persons (addicts) and healthy individuals. Maintenance was seen as largely being for the good of society,

⁵⁸ *Ibid.*

⁵⁹ *Ibid.* p. 61

⁶⁰ Social Services Committee, *Misuse of Drugs*, Evidence of AIDA, 27 February 1985, p. 114.

rather than the good of the addict. In the 1980s, those who supported maintenance spoke not of social control of addiction but of the social functioning of the addict. The explanation for this shift lies partly in the public health context in which the condition was being described. In the 1960s addiction was located in the relationships between people, leading it to be described as a social disease. Twenty years later public health looked not at the relationships between people as a source of disease, but to individual behaviours. The 'new public health' was concerned with 'lifestyles' and the potential 'risks' to individual health through voluntary actions such as drinking, smoking and taking drugs.⁶¹ The discourse about maintenance in the 1980s drew on some of these concepts by placing the behaviour of the individual at the centre of treatment. Long-term prescription in order to improve social functioning concentrated on enhancing the 'lifestyle' of the addict and reducing the risk of drug taking to their general health, relationships, employment and so on. Individual behaviour was thus not just a cause of disease, but also its potential cure.

Those who practised short-term withdrawal were not immune to the increased attention being placed on individual behaviour. Here too there was talk of social functioning. Strang argued in 1985 that the 'pure medical component of therapeutic intervention' into heroin addiction had reduced in recent years so that treatment was now about 'practical management of the physical complications that may accompany drug withdrawal,' facilitating 'family, social, and occupational rehabilitation to take place.'⁶² This was one area of common ground between the two different treatment philosophies; as was the hope by those who offered maintenance that their addict patients would one day achieve a drug-free life. What separated short-term withdrawal and long-term prescription was the priority accorded social functioning

⁶¹ A. Petersen & D. Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage Publications, 1996) pp. 4-5

⁶² Strang, 'Abstinence or abundance', p. 604.

and abstinence. For advocates of rapid withdrawal it was most important for the addict patient to become abstinent from drugs in a short period of time. For supporters of maintenance, social functioning was the primary concern. Only once this had been improved could abstinence be achieved. Conflict, therefore, was about more than the duration of prescription; it was about what treatment should be expected to achieve. This debate went to the very heart of what ‘treatment’ meant within the context of addiction, and in medicine more generally.

Signs of a different approach to addiction in community-based practice and hospital medicine were apparent as early as the late 1960s, a divide that was accentuated by the growth of biographical medicine. In 1967 the *British Medical Journal* published a collection of articles on the proposed centres for the treatment of addiction.⁶³ Comparing the outlook of Bewley, who argued that ‘special centres’ based in hospitals had ‘advantages’ and Chapple, a GP interested in the treatment of addiction who asserted that this was best conducted in the community, is instructive. Bewley noted that the establishment of clinics and co-operation between these would allow for the development of ‘standard practice’ when dealing with addicts.⁶⁴

Chapple, however, asserted that

Institutional treatment has been an almost complete failure...because it has created a situation where the patient finds himself in conflict with his doctors – often forced to relinquish drugs against his will – but also because it fails to face the real problem, which is that of teaching the addict patient to live in society without using drugs.⁶⁵

According to Lart, the gap between these views ‘reflects that between the perceptions of “hospital medicine” and “biographical medicine.”’ The GP’s view was that the

⁶³ ‘Contemporary themes: centres for the treatment of drug addiction’, *British Medical Journal*, (20 May 1967) 498-502.

⁶⁴ Bewley, ‘Advantages of special centres’, *British Medical Journal*, (20 May 1967) 498-499, p. 498.

⁶⁵ P.A.L. Chapple, ‘Treatment in the community’, *British Medical Journal*, (20 May 1967) 500-501, p. 500.

treatment of the addict could only be successfully undertaken in the community, as this would be more accessible to the addict than clinical treatment.⁶⁶

These differing perspectives reflect the greater sensitivity to the social context of illness found in general practice, a trend that continued into the 1970s and 1980s as biographical medicine began to make a more significant impact upon community-based medicine. As seen in Chapter Two, biographical medicine revitalised general practice, but it also brought GPs into further conflict with specialists by providing them with a contrasting view of disease. For the community-based doctor the disease could not be abstracted from the patient, and in turn the patient could not be removed from the social context in which they resided.⁶⁷ In a study based on interviews with, and observations of, GPs during the 1970s sociologists Jeffreys and Sachs found that these doctors were conceptualising their work in a different way to hospital-based consultants. GPs saw their approach as being “holistic, problem-solving and open ended” in contrast to the work of specialists which they saw as ‘narrow, specific and closed.’ Moreover,

In addition to diagnoses based either on physical or on psychological symptoms, they – more often than hospital doctors – needed to take into account as well, social situations. “Ideally in general practice” one doctor reflected, “each patient is recognised as a unique distillation of his physical, psychological and social experiences.” This approach, they suggested, was in contrast to the “ready-made” service provided by hospital consultants. General practice, they claimed, was tailored to the needs of the individual.⁶⁸

This focus on the individual and their social setting was reflected in the kinds of treatment community-based physicians offered addicts. Maintenance focused on the whole addict rather than just on the disease. Doctors who prescribed opioid drugs to addicts over a longer period took into account the situation of the addict and focused

⁶⁶ Lart, *HIV and English Drugs Policy*, p. 60.

⁶⁷ See Markiner, “What is wrong” and “how we know it”, pp. 74-77; Armstrong, ‘The emancipation of biographical medicine’, pp. 5-7.

⁶⁸ Jeffreys & Sachs, *Rethinking General Practice*, p. 50.

on improving their social functioning before ‘curing’ the disease by removing the drug.

The emergence of biographical medicine provided an alternative way of seeing and responding to disease, bringing it into conflict with hospital-based clinical medicine. The existence of this clash can be observed in debates about the treatment of addiction. Examining the arguments of leading protagonists suggests that their views were shaped by their respective positions and the type of medicine practised. Hospital-based DDU consultants saw the disease of addiction and not the addict him or herself. DDU doctors, therefore, largely advocated the rapid withdrawal of drugs from addicts, wanting to cure the patient as quickly as possible by making them abstinent. To achieve this, clinical methods were employed; blood tests, urine tests and physical examinations resulting in the same programme of treatment being prescribed for all. In contrast, the community-based GP or private practitioner saw the patient and their symptoms. This led the community doctor to focus on the experience of addiction; on the social, physical and psychiatric problems that the individual addict faced rather than the ‘disease’ itself. To this end, they advocated the long-term prescription of opioid drugs in order to combat these problems and improve the social functioning of the addict. Attention was paid to the condition of the individual rather than their disease (addiction). It would seem, therefore, that short-term withdrawal represented a hospital based clinical view of disease and its treatment and maintenance represented a community based biographical view. Indeed, biographical medicine’s influence was not limited to general practice. By providing an alternative way of seeing and treating disease away from the disciplinary mechanisms of the hospital, biographical medicine re-invigorated other types of community-based medicine, including those in private practice. The individual

patient had always retained more significance in private practice because, as Porter commented, 'private doctors must, within limits, give patients what they want.'⁶⁹ Private practitioners dependent upon fees for their livelihoods were more amenable to the needs of the patient and not necessarily so concerned with the disease. Such an approach was sanctioned by biographical medicine which placed the patient at the centre of the conceptualisation of disease and its treatment. A divide thus existed between those who treated addicts within the community and those who treated addicts in hospital-based specialist facilities.

As indicated above, caution must be exercised as this divide can be too tightly drawn. There were DDU doctors who maintained addicts, just as there were GPs who practised short-term withdrawal. These positions were not as entrenched as at first may appear, with both methods of treatment sharing some common ground. It is also possible that the treatment approaches of the DDU doctors and the community-based physicians may have been partially influenced by the type of patient they saw, rather than their philosophical outlook. As noted in Chapter One, maintenance was considered an acceptable form of treatment for the middle-aged, middle-class addicts of the 1920s, but not for the younger, recreational addicts of the 1960s and 1970s. If the addicts seen by GPs and private practitioners were more like the addicts of the Rolleston era it would be understandable if these doctors responded to older, middle-class addicts in the same way as their predecessors had done sixty years earlier, with maintenance. Dally repeatedly stated that she treated a different kind of patient to those seen at DDUs. She asserted that her patients were older, employed, middle-class, stable addicts in contrast to the younger, unemployed, chaotic, working-class

⁶⁹ Porter, *The Greatest Benefit to Mankind*, p. 671.

addict more likely to be seen at a DDU.⁷⁰ Confirming this assertion is difficult. Detailed data of patient profiles is not available for a sufficiently large number of private and general practitioners to compare these to the DDUs.⁷¹ Even if a comparison between patient profiles were feasible, it would not be possible to extrapolate how important this was for the individual doctor in making the decision to offer short-term withdrawal or long-term maintenance.

It is also difficult to assess the extent to which community-based physicians treating addicts were influenced by biographical medicine. Though biographical medicine was the ‘dominant ideology’ within the RCGP in this period its adoption in the field was not necessarily so widespread.⁷² Tudor-Hart noted that in 1986 the RCGP had 13,000 members, which was only just over a third of all GPs.⁷³ Tudor-Hart was himself a leading proponent of another ideological approach that influenced general practice: epidemiology.⁷⁴ Here the focus was not on the individual patient as with biographical medicine, but on the pattern of disease within the patient cohort seen in general practice, suggesting a different focus of therapeutic endeavour. Indeed, as seen in Chapter Two, despite changing theoretical outlooks many GPs continued to show little interest in treating addicts, often preferring to refer them on to specialist services. However, those that did treat addicts were often younger doctors who had qualified in the 1970s and 1980s, when biographical medicine was at its most influential.⁷⁵ It is possible, therefore, that these doctors used this approach in

⁷⁰ Dally, *A Doctor's Story*, p. 61.

⁷¹ See Chapter Four, p. 144 for details of age and work record of Dally's patients. A few studies of patients attending DDUs do exist, such as Sheenan & Oppenheimer's 'Why drug users sought help', pp.766-767, but as this was based on only 50 patients attending one clinic it could not be called comprehensive.

⁷² Armstrong, 'The emancipation of biographical medicine', pp. 6-7.

⁷³ Tudor-Hart, *A New Kind of Doctor*, p. 89.

⁷⁴ *Ibid.* pp. 99-107; Markiner, "What is wrong" and "how we know it", pp. 84-87.

⁷⁵ Glanz, 'Views on treatment', p. 544.

their work, enabling them to view the disease of the addict in a different way to their specialist, hospital-based colleagues.

This view accounts for the high degree of conflict over the treatment of addiction. The dispute was rooted not just in intra-professional battles between DDU psychiatrists jealously guarding their speciality from private and general practitioners who threatened their autonomy and status, but also in a deeper conflict concerning opposing philosophies of medicine, disease and its treatment. That is not, however, to deny the significance of addiction in this wider battle. Indeed, the clash between clinical medicine and biographical medicine could only take place in an arena like that of addiction where the field was relatively 'open.' The socio-medico status of the 'problem' of addiction facilitated the emergence of a range of approaches to providing a 'solution.' As no one could agree on what that solution should be, there was no conclusive evidence to 'prove' that any method 'worked.' Judgements about what was the most appropriate method of treatment for addiction therefore came to be based on other elements, such as the position of the doctor and their pre-existing ideas about disease and its treatment. The presence of these alternative views on the treatment of addiction presented a challenge to hospital-based clinicians advocating short-term withdrawal. Yet, DDU psychiatrists were able to counter this challenge by re-iterating the need for a specialist approach to the problems of addiction and confirming rapid withdrawal as the orthodox method of treatment. This was achieved through the production of the *Guidelines* in 1984.

2. The production of the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse, 1983-1984*

2.1 Establishment

In 1982 the ACMD called for ‘an authoritative statement of good practice’ on the treatment of heroin addiction.⁷⁶ This was not a novel recommendation. The Rolleston Committee suggested in 1926 that a ‘Memorandum affording guidance’ would be useful for doctors treating addicts.⁷⁷ However, specific advice from experts on the treatment of addiction was not forthcoming. Guidance for doctors that went beyond what was contained in the committees’ reports did not emerge from Rolleston or either of the incarnations of the Brain Committee.⁷⁸ The call for guidelines expressed in *Treatment and Rehabilitation* met with more success. This was because there was a need for guidelines in the 1980s not felt in previous decades. The involvement of a growing number of doctors in the treatment of addiction with no previous experience of this kind of work meant that many were ‘uncertain about the treatment they should offer’ and, it was argued, would ‘welcome guidance from their colleagues with more experience.’⁷⁹ Crucially, these doctors were treating addicts away from the DDUs. Guidelines on good practice in the treatment of addiction already existed within the clinics. In 1969 an ‘informal’ guide to good practice was drafted by Connell and circulated amongst DDU psychiatrists.⁸⁰ He and Strang asserted that this was ‘not a static code of practice but represented the consensus or prevailing view based on practice and experience as it was accrued.’⁸¹ By the 1980s,

⁷⁶ ACMD, *Treatment and Rehabilitation*, p. 57.

⁷⁷ *Report of the Departmental Committee on Morphine and Heroin Addiction*, p. 26.

⁷⁸ There was a Home Office memorandum on the Dangerous Drugs Act and Regulations and the first Brain Committee report did call for this to be presented in a more readable manner and distributed to all doctors, but this did not take place. See *Departmental Committee on Heroin Addiction*, p. 13 and ACMD, *Treatment and Rehabilitation*, p. 57.

⁷⁹ ACMD, *Treatment and Rehabilitation*, p. 57.

⁸⁰ Connell, ‘Treatment of drug-dependent patients’, 1968-1969.

⁸¹ Strang & Connell, ‘The creation of the clinics’, p. 173.

however, this guidance was becoming increasingly formalised. Bewley outlined guidelines agreed on by consultants in charge of London DDUs in the *British Medical Journal* in 1980 as a way of highlighting the problems faced by the private practitioner who did not necessarily adhere to these.⁸² Connell and Mitcheson expanded upon these four years later in an article that outlined the ‘necessary safeguards when prescribing opioid drugs to addicts.’⁸³ This ‘code of practice’ effectively ensured uniformity on treatment within the London DDUs.⁸⁴ Guidelines on treatment were subsequently required for those doctors who operated outside this system. They were needed as much to determine what was bad practice as to ensure that good practice predominated. The ACMD noted that

the lack of widely known guidelines on the forms that medical treatment of drug misusers should take has meant that dubious practices have escaped the censure they merit. This uncertainty appears to have hampered the effective operation of the disciplinary procedures of both the Misuse of Drugs Act and the General Medical Council.⁸⁵

This had been powerfully demonstrated by the GMC’s case against Dally in 1983. Defining what irresponsible prescription of controlled drugs to addicts consisted of was problematic for both the GMC and Dally, as there was no clear statement of what responsible prescription entailed. Furthermore, this case demonstrated the political as well as the practical need for the development of guidelines on good practice. There was a desire not only to provide advice and assistance to those treating addicts but also to determine who those doctors should be and what treatment they should offer. The creation of a statement of good practice on the treatment of addiction must, therefore, be seen in the context of the wider treatment debate.

⁸² Bewley, ‘Prescribing psychoactive drugs to addicts’, pp. 497-498.

⁸³ Connell & Mitcheson, ‘Necessary safeguards’, p. 768.

⁸⁴ Strang & Connell, ‘The creation of the clinics’, p. 173.

⁸⁵ ACMD, *Treatment and Rehabilitation*, p. 57.

In January 1983 the DHSS convened a conference of representatives from a range of medical bodies and organisations to gauge the response of the profession to *Treatment and Rehabilitation*. The conference agreed with the ACMD's recommendation that a committee of medical experts be established to draw up guidelines on good clinical practice in the treatment of drug dependence. The Chief Medical Officer, Donald Acheson, invited Connell to chair the working group with membership drawn from medical bodies including the GMC, the BMA and the Royal Colleges as well as individuals with expertise in the area.⁸⁶ There were five consultant psychiatrists on the committee, two private psychiatrists, five GPs, and an endocrinologist, Sir Gordon Wolstenholme, a former member of the GMC and sponsor of the Institute for the Study of Drug Dependence (ISDD). The working group also included Professor of Psychiatry W. Kessel, a member of the GMC and former chair of both the Advisory Committee on Alcoholism and the ACMD. The most significant fact about the membership of the committee was, as Mike Ashton noted, that it included individuals from 'both sides of the growing divide between psychiatrists in the drug dependency units and the doctors in private and general practice.'⁸⁷ The DDU doctors were represented by Connell, Bewley and Thorley, the GPs interested in addiction by Banks and Cohen, and the private practitioners by Beckett and Dally. Dally's inclusion might appear surprising given that she had been found guilty of serious professional misconduct, and Bewley did object to her presence for this very reason, but her membership was perhaps indicative of a willingness on the part of the DHSS to hear both sides of the debate.⁸⁸

⁸⁶ Medical Working Group on Drug Dependence, *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, (London: DHSS, 1984) p. 3.

⁸⁷ Ashton, 'Doctors at war, part one', p. 13.

⁸⁸ Dally, *A Doctor's Story*, p. 130; CMAC PP/DAL/B/5/1/2, Letter from Dally to Dr Dorothy Black, DHSS, 26 March 1984.

2.2 Conflict? Discussions of the Medical Working Group on Drug Dependence

The Medical Working Group on Drug Dependence met six times between February and July 1984. They were asked to ‘prepare guidelines of good clinical practice in the treatment of drug dependence for dissemination to the medical profession’ and to ‘consider the feasibility of the extension of licensing restrictions to include all opioid drugs.’⁸⁹ There were four central issues: the role of general and private practitioners in the treatment of addiction, the desirability of requiring doctors to have a license to prescribe any opioid drug to an addict, the nature of the treatment provided to addicts and what constituted irresponsible prescription. On all of these issues there was a considerable diversity of views expressed and a high degree of personal conflict amongst committee members.

Unsurprisingly, the issue of private and general practice involvement provoked some of the most fury. Bewley’s dislike of the treatment of addiction in private practice was well known and in his submission to the committee he asserted that maintenance prescription to addicts in private practice was ‘undesirable,’ citing the experiences of AIDA members and Dally in particular before the GMC as evidence of the problems encountered by ‘single handed doctors who move into this field without training or experience and who can easily be manipulated by addict patients.’⁹⁰ This implied the exclusion of not just private practitioners but general practitioners as well, as not all GPs worked in inter-disciplinary teams like those found at clinics, or had training in this field. Other members of the committee, such as GP Arthur Banks, argued that the large and increasing numbers of addicts meant a

⁸⁹ Medical Working Group on Drug Dependence, *Guidelines*, p. 3.

⁹⁰ CMAC PP/DAL/B/5/1/7, Submission to Medical Working Group on Drug Dependence by Dr Bewley; CMAC PP/DAL/B/5/1/7, ‘Some suggestions for drawing up guidelines on prescribing psychoactive drugs to addicts’, 17 March 1984.

correspondingly 'large number of GPs as well as other services must be persuaded to take part in addict care.'⁹¹

Inextricably linked to the issue of the involvement of the general and private practitioner was the question of licensing. The ACMD recommended in *Treatment and Rehabilitation* that the requirement to possess a license to prescribe heroin and cocaine to an addict-patient be extended to cover all opioid drugs.⁹² This recommendation was clearly based on the advice of DDU consultants like Connell. In 1981 he sent a letter to *The Times* purporting to represent the 'consensus views' of thirteen DDUs and ten voluntary agencies calling for the extension of licensing regulations.⁹³ A similar letter was also sent to the ACMD, a body which Connell sat on and was later to chair.⁹⁴ Spear argued that the London DDU doctors saw the introduction of licenses as a means to both control irresponsible prescription and a way to limit who could actually prescribe for addicts.⁹⁵ Licenses to prescribe heroin were held almost solely by doctors working at DDUs, so the extension of licensing could have led to the complete exclusion of the non-clinic doctor. *Treatment and Rehabilitation* did suggest that the scale of addiction demanded that some doctors outside of DDUs be granted licenses, but recommended that this should only be under the supervision of hospital-based experts.⁹⁶ This, according to Ashton, was a way of ensuring that non-DDU doctors 'toed the line laid down by the clinic psychiatrist.'⁹⁷ Spear went even further, and argued that DDU doctors wanted to use the regulations as a way of eliminating those doctors in private and general practice who continued to

⁹¹ CMAC PP/DAL/B/5/1/7, Submission to Medical Working Group on Drug Dependence by Dr Banks, 'Basic guidelines for good practice in the treatment of drug addiction', 15 March 1984.

⁹² ACMD, *Treatment and Rehabilitation*, p. 59.

⁹³ Letter to *The Times*, (23 January 1981) p. 13.

⁹⁴ Ashton, 'Doctors at war, part one', footnote, p. 15.

⁹⁵ Spear, *Heroin Addiction Care and Control*, p. 282.

⁹⁶ ACMD, *Treatment and Rehabilitation*, p. 59.

⁹⁷ Ashton, 'Doctors at war, part one', p. 13.

prescribe to addicts in a way they thought was inappropriate.⁹⁸ Licensing was, therefore, a critical issue for the Medical Working Group on Drug Dependence and for the treatment of addiction more generally.

The working group contained a number of supporters of the extension of restrictions on the prescription of drugs to addicts including the Chairman, Connell, as well as other psychiatrists such as Maden and Bewley.⁹⁹ Despite the authority of these individuals there were voices raised against licensing. A paper produced by the DHSS and set before the working group outlining potential benefits and drawbacks of the extension of licensing did provide an element of balance to discussions. The paper stated that extending control over opioid drugs could limit ‘injudicious’ prescription of drugs to addicts, thus reducing the over-spill of prescribed drugs onto the black market, protect doctors from ‘importunate’ addicts and encourage the use of more substitute drugs in the treatment of addiction. However, the paper also expressed concern at the restrictions being placed on the clinical freedom of doctors and the possibility that having to apply for a licence might discourage doctors from treating addicts.¹⁰⁰ There were members of the working group who agreed with this view. Banks, in a letter to Dally, said that he had telephoned GPs all over the country to judge their response to licences and found that even those currently treating addicts were reluctant to apply for one, and argued that those that did not want to deal with addicts would have the perfect excuse for not doing so.¹⁰¹ Banks maintained that GPs who were interested in the treatment of addiction could be put off by the bureaucracy

⁹⁸ Spear, *Heroin Addiction Care and Control*, p. 282.

⁹⁹ Connell voiced his support for licensing at meetings of the working group and to the Social Services Committee. See: Social Services Committee, *Misuse of Drugs*, Evidence of Dr Connell, March 1985, p. 126. See also CMAC PP/DAL/B/5/1/7, Submission to the Medical Working Group on Drug Dependence, Dr Maden, ‘Paper on the management of drug addicts in the community’, no date, [1984]. Bewley suggested that the prescription of controlled drugs might be confined to licensed practitioners only in: Bewley, ‘Prescribing psychoactive drugs to addicts’, p. 497.

¹⁰⁰ CMAC PP/DAL/B/5/1/5, DHSS paper, ‘The feasibility of extension of licensing restrictions to all opioid drugs’, 1983.

¹⁰¹ CMAC PP/DAL/B/5/1/2, Letter from Dr Banks to Dally, 28 April 1984.

and form filling required to hold a license.¹⁰² Support for this view came via a letter to the secretary of the working group from Strang, at the Regional Drug Dependence Unit in Manchester. Strang argued that before a scheme was introduced in the North West to encourage GPs to treat addicts they were ‘discriminated against on grounds of diagnosis and sometimes denied access to general medical care as well as drug specialist care’ and he feared this would increase if addicts were only to be treated by licensed practitioners.¹⁰³ Strang also pointed out that restricting prescription of drugs to addicts would place greater demands on an already over-stretched service.¹⁰⁴ Banks too could see no reason why a ban on prescription to addicts by unlicensed doctors would enhance treatment offered to addicts.¹⁰⁵

Despite extensive discussions the committee remained divided on the question of licensing and failed to reach an agreement. At a meeting in June 1984 the secretary and Senior Medical Officer at the DHSS, Dr Dorothy Black, told the group that if necessary they could leave this issue and concentrate on production of the guidelines. This, she explained, was because the ministers concerned ‘regarded the guidelines as the more urgent part of the Group’s terms of reference.’¹⁰⁶ The working group agreed and the guidelines published in October made no mention of licenses. The group did later recommend that licensing restrictions should be extended to all opioid drugs except oral methadone, as did the House of Commons Social Services Committee in 1985.¹⁰⁷ However, civil servants at both the DHSS and the Home Office were concerned about the practicality of monitoring and enforcing the restrictions and the

¹⁰² CMAC PP/DAL/B/5/1/7, Second submission to Medical Working Group on Drug Dependence by Dr Banks, ‘New responses to licensing.’ No date, [1984].

¹⁰³ CMAC PP/DAL/B/5/1/2, Letter from Dr Strang to Dr Black, 10 October 1984.

¹⁰⁴ *Ibid.*

¹⁰⁵ CMAC PP/DAL/B/5/1/2, Letter from Dr Banks to Dally, 28 April 1984.

¹⁰⁶ CMAC PP/DAL//B/5/1/5, Note of meeting of the Medical Working Group on Drug Misuse, 22 June 1984.

¹⁰⁷ House of Commons, *Misuse of Drugs*, p. lvii, p. xxv; Spear, *Heroin Addiction Care and Control*, p. 283.

government decided not to implement this recommendation, stating that they could find no significant advantage to outweigh the risk that some GPs might be deterred from treating addicts by the need for a license.¹⁰⁸

The type of treatment offered to addicts and particularly the role played by the prescription of opioid drugs was another key issue that provoked disagreement within the working group. Bewley, like many of the DDU doctors, argued that if drugs were prescribed to addicts they should be in the form of oral methadone, dispensed on a daily basis.¹⁰⁹ Dally, on the other hand was more prepared to prescribe injectable drugs to her patients and often allowed them to collect their drugs weekly.¹¹⁰ The duration of this prescription to addicts was also a critical matter. Notes of the first meeting of the group recorded ‘There was a consensus that protracted maintenance was no longer acceptable for new patients but might have a continuing use for existing chronic users.’ In addition it was stated that ‘Heroin should not be prescribed to new patients, injectables rarely, the aim should be to use oral liquid preparations if a prescription was deemed necessary.’¹¹¹ Not all members agreed with this; on her copy of the typed notes Dally had placed a question mark by both statements suggesting that she at least did not support the supposed consensus view.¹¹² Though such a mark could be ambiguous and read as a query about a specific point rather than dissent, this is rendered unlikely by Dally’s own comments to the working group on this issue and the highly critical account she presents of their meetings in *A Doctor’s Story*.¹¹³ She argued in her submission to the working group that ‘Addicts vary as

¹⁰⁸ Ashton, ‘Doctors at war’, p. 14; Spear, *Heroin Addiction Care and Control*, p. 283.

¹⁰⁹ CMAC PP/DAL/B/5/1/7, Submission to Medical Working Group on Drug Dependence by Dr Bewley, ‘Some suggestions for drawing up guidelines on prescribing psychoactive drugs to addicts’, 17 March 1984.

¹¹⁰ See Chapter Three, pp. 145-146.

¹¹¹ CMAC PP/DAL/B/5/1/5, Notes of the first meeting of the Medical Working Group on Drug Dependence, 29 February 1984.

¹¹² *Ibid.*

¹¹³ Dally, *A Doctor’s Story*, pp. 127-132.

much as any other group both in personality and in the kind of help they require.’¹¹⁴

This apparently was not the view of other members of the committee who emphasised, according to Dally, that “treatment must be the same for everyone.”¹¹⁵

The production of guidelines on good practice in the treatment of heroin addiction was intended to help determine what bad practice and particularly irresponsible prescription of drugs to addicts comprised. Even here the working group could not agree. Bewley asserted that one way of assessing whether or not a doctor was prescribing irresponsibly was to establish if he or she had ‘special expertise in the treatment of drug dependence’ and if they had the ‘proper’ facilities for treating the patient and for carrying out diagnostic tests.¹¹⁶ This could be taken to mean that doctors treating addicts outside clinics, who did not always have access to these facilities, were acting irresponsibly. Bewley went on to state that responsible treatment would involve more than just prescribing drugs and was swift to condemn ‘liberal’ prescription, a fault he believed was common in private practice.¹¹⁷

Comments such as these led to a high degree of personal conflict between individual members. Dally felt moved to complain to the secretary about Bewley’s attacks on her specifically and private practice more generally. She asserted that the situation was in danger of becoming ‘ugly’ and wanted to prevent the committee from further ‘polarisation.’¹¹⁸ Meetings were undoubtedly heated; the Chairman himself reputedly described them as including ‘near-vituperative exchanges.’¹¹⁹ Infighting and division within the committee worsened when a small number of the working group decided to

¹¹⁴ CMAC PP/DAL/B/5/1/7, Submission to the Medical Working Group on Drug Dependence by Dr Dally, ‘Suggestions for “Guidelines on good practice in the management of drug addiction”’, March 1984.

¹¹⁵ Dally, *A Doctor’s Story*, p. 130.

¹¹⁶ CMAC PP/DAL/B/5/1/7, Submission to Medical Working Group on Drug Dependence by Dr Bewley, ‘Some suggestions for drawing up guidelines on prescribing psychoactive drugs to addicts’, 17 March 1984.

¹¹⁷ *Ibid.*

¹¹⁸ CMAC PP/DAL/B/5/1/2, Letter from Dally to Dr Dorothy Black, DHSS, 26 March 1984.

¹¹⁹ CMAC PP/DAL/B/5/1/2, Letter from Dr Banks to Dr Bewley, 23 March 1984.

write a minority report.¹²⁰ This group of ‘dissidents’ supported, but not, she claims initiated, by Dally agreed not to sign the final report and to create their own instead. According to Dally this was because they felt that the committee were ignoring long-term users and not questioning why the proportion of addicts attending clinics was declining.¹²¹ However, the ‘dissidents’ did not get an opportunity to produce their report as the procedure of the committee was altered (Dally claims by Connell) so that no one would be required to sign the final *Guidelines* making a minority report ‘out of order.’¹²² Thus the working group failed even to agree to disagree.

2.3 Consensus? The report of the Medical Working Group on Drug Dependence

Despite the complete lack of agreement amongst the members of the working group their final report, which constituted the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, asserted that there was an ‘emerging consensus’ amongst doctors involved in the treatment of addicts.¹²³ In a sense this was correct, as a consensus did exist amongst DDU doctors (particularly those who practised in London) about how heroin addiction should be treated, and it was their views that the *Guidelines* largely expressed. The document ignored many of the opinions voiced by the ‘dissident’ faction on the working group. If there was a consensus, it was enforced. A close reading of the *Guidelines* indicates that though they purported to be ‘a flexible framework within which doctors can continue to develop a constructive response to the problem of drug misuse’ they actually put forward a fairly rigid

¹²⁰ These were Dally, Beckett, Banks and Tylden. See CMAC PP/DAL/E/4/20, ‘DHSS working party on the Guidelines’ by Dally, prepared for her lawyers, November 1986.

¹²¹ Dally, *A Doctor’s Story*, p. 130.

¹²² *Ibid*; CMAC PP/DAL/E/4/20, ‘DHSS working party on the Guidelines’ by Dally, prepared for her lawyers, November 1986.

¹²³ Medical Working Group on Drug Dependence, *Guidelines*, p. 4.

regimen that constituted just one side of the debate about the treatment of addiction.¹²⁴

The *Guidelines* stated that ‘All doctors have a responsibility to provide for both the general health needs of drug misusers and their drug related problems’ and it was here that non-specialists should be encouraged to play a major role.¹²⁵ General guidance was given to all doctors who might encounter addicts and more specific advice was included for GPs, psychiatrists, hospital-based staff, police surgeons and prison medical officers. Yet, despite this call to involve a wider range of medical practitioners only a relatively minimal role was afforded the non-specialist doctor by the *Guidelines*. It was noted that certain types of patient were best suited to treatment in general practice. These were young, intermittent drug users who were not physically dependent, stable therapeutic addicts and those individuals who had been using opioid drugs for less than a year and were not regularly injecting. In contrast, patients who were ‘chaotic,’ or on very high doses were not considered suitable for treatment in general practice and it was suggested that those who were ‘physically dependent’ should be referred to the local DDU.¹²⁶ The implication was, therefore, that GPs could treat those who took drugs but not those who were addicted to them. This was reinforced by the guidance on the kind of treatment that should be offered to drug ‘misusers.’ It was recommended that for the type of patient GPs were expected to see (the young, intermittent drug ‘misuser’) the most appropriate and effective form of treatment might be counselling about drug misuse and personal or family problems. If drug ‘misusers’ seen by GPs did require a prescription (and the *Guidelines* stressed

¹²⁴ *Ibid.* CMO’s covering letter.

¹²⁵ *Ibid.* p. 1, p. 4.

¹²⁶ *Ibid.* p. 17, p. 8.

that this was not always the case) this should be given for a short period only, and in an oral form.¹²⁷ Furthermore, it was declared that

a doctor should not undertake to treat drug misusers by long-term prescription of opioids unless in consultation and conjunction with a specialist in a drug treatment clinic or elsewhere who has experience of this approach.¹²⁸

The *Guidelines* were clearly suggesting that GPs should not treat those drug misusers who required long-term prescription; these should be left to the specialists to handle.

As well as making a pronouncement on who should (or should not) treat addicts, the *Guidelines* also expressed a clear view on how they should be treated. They stated that the aim of treatment was to ‘help the individual to deal with the problems causing as well as caused by his drug use, and eventually to become drug-free.’ Treatment, it was asserted, should go beyond the mere prescription of a substitute drug.¹²⁹ Although these were statements that all of those involved in the treatment of addiction would have readily agreed with, the emphasis placed on particular elements indicates the existence of a powerful sub-text in support of clinic-based, short-term withdrawal targeted at abstinence. The practices recommended for use in the treatment of drug ‘misusers’ were those utilised by DDUs. The report stated that doctors should carry out a physical examination of the patient and conduct diagnostic tests to ensure the patient was taking opioid drugs. It championed the use of ‘contracts’ with patients’ agreeing to cut down their drug use by so much by such a date and argued that if drugs were to be prescribed, these should be in an oral form and dispensed on a daily basis.¹³⁰ Doctors like Dally who operated outside the clinics did not always agree with, or adhere to these practices, but there was no suggestion in the report that the value of any of these was a matter for debate. Nor was there any

¹²⁷ *Ibid.* p. 9.

¹²⁸ *Ibid.* p. 7.

¹²⁹ *Ibid.* p. 5.

¹³⁰ *Ibid.* p. 6, p. 7, p.9.

indication in the *Guidelines* that alternative ideas about treatment philosophy or method existed. Maintenance was mentioned, but this term was not explained, nor was the rationale behind it concerning the social functioning of the patient. Moreover, the conditions in which the report suggested maintenance might be used (in conjunction with a specialist at a DDU) made it extremely unlikely that this would take place, as very few DDU doctors supported maintenance for all but a handful of patients. Emphasis throughout the report was on rapid detoxification, preferably within three to six months. Prescription over a longer period than this was ‘too close to a self-perpetuating maintenance type schedule’ and was to be avoided.¹³¹ Once more, clinic practices were presented as orthodoxy. The *Guidelines*, like the committee that produced them, were dominated by the methods and philosophies of the London DDUs.

2.4 The reception of the *Guidelines* and implications raised

Although the *Guidelines* initially excited little interest upon their publication in 1984 they had a significant impact upon the debate over the treatment of addiction. This was recognised by an editorial in the *British Journal of Addiction* in 1985, which argued that ‘[it] is the meaning and implications of this publication [the *Guidelines*]...which repay scrutiny, rather than the dissection of any one line of its sometimes inevitably ambiguous recommendations.’¹³² The journal also expressed surprise ‘that sufficient agreement should have been achieved between the various factions...represented on this committee’ and contended that ‘the committee would still be arguing’ if it had ‘definitively addressed itself’ to questions such as ‘whether injectable drugs still have a place in the treatment of addiction, or whether “long-term

¹³¹ *Ibid.* p. 14, p. 18.

¹³² Editorial, ‘Guidelines of good clinical practice in the treatment of drug misuse’, *British Journal of Addiction*, 80, (1985) 113-114, p. 114.

prescription of opiates” is or is not acceptable practice.’ The report ‘certainly edges up to at least some of these questions, but then tends to retreat.’¹³³

The most serious criticism of the *Guidelines* came from within the working group that produced them. Dally sent a list of critical comments to Black at the DHSS asserting that ‘I cannot believe that [the *Guidelines*] will encourage doctors to help addicts and it will help them only marginally if they already wish to do so.’¹³⁴ A similar critique was also produced and distributed by AIDA, whose members included Beckett, another ‘dissident’ on the working group.¹³⁵ They argued that ‘The “Guidelines” are largely an extension of DDU practice’ but failed to appreciate the difficulties of applying this outside the clinics. AIDA felt that the *Guidelines* were ‘more like a prescription for control than as guidelines for clinical practice’ and did not recognise that ‘addicts differ enormously and need individual attention.’ They were particularly concerned that the needs of long-term addicts were being ignored and there was ‘too much emphasis on control and not enough on caring.’¹³⁶ AIDA, Dally, and Beckett felt that the *Guidelines* did little to encourage the GP to become involved in the treatment of addiction, offered only one side of the treatment debate by advocating DDU treatment philosophies and methods that ignored the needs of the individual, particularly the long-term addict patients that they saw. This kind of criticism of the *Guidelines* stemmed from the position of the doctors in AIDA. Members of AIDA existed by default outside the DDU system and this affected their view of addiction, their practices and treatment philosophy. They criticised the DDU treatment methods which were encapsulated in the *Guidelines* because they

¹³³ *Ibid.* p. 113.

¹³⁴ CMAC PP/DAL/B/5/1/6, Dally’s General Comments on the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* sent to Dr Dorothy Black, DHSS, September 1984.

¹³⁵ Dally, *A Doctor’s Story*, p. 129.

¹³⁶ CMAC PP/DAL/B/4/1/1/8, Association of Independent Doctors in Addiction comments on *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse*, July 1985.

represented a more ‘clinical’ view of addiction that saw the disease not the patient, whereas they practised a more ‘biographical’ approach which stressed the individuality of the patient.

The most significant practical consequence of the publication of the *Guidelines* was the apparent willingness of the GMC to use these as ‘yardstick in disciplining doctors.’¹³⁷ The Council welcomed the *Guidelines*, stating explicitly in their annual report that the PCC would use these in determining cases of irresponsible prescription.¹³⁸ Although the *British Journal of Addiction* felt that the referring to the *Guidelines* in such cases was ‘by no means sinister,’ Spear noted in his annual report that those who did not follow the *Guidelines*, for example by prescribing injectable drugs rather than oral methadone, faced the danger of automatically being regarded as guilty of irresponsible prescription.¹³⁹ The *Guidelines* were rapidly becoming rules. This development was accentuated by the powerful support that the *Guidelines* had from DDU doctors. They were presented as the orthodoxy on treatment. This was significant as this orthodoxy afforded a limited role for the non-clinic based doctor and advocated a form of treatment widely practiced in the DDUs, but not universally supported outside them.

Yet, non-DDU doctors continued to treat addicts despite the apparent dominance of the clinics and short-term withdrawal. The *Guidelines* were clearly not enough on their own to deter the involvement of the non-clinic doctor. A handful of community-based practitioners, like Dally, persisted in offering maintenance treatment to addict patients. This presented a threat to authority of the DDU psychiatrist and the clinical view of addiction, already under attack from external non-

¹³⁷ Ashton, ‘Doctors at war, part two’, p. 16.

¹³⁸ GMC Annual Report, 1985. Quoted in Spear, *Heroin Addiction Care and Control*, p. 289.

¹³⁹ Editorial, ‘Guidelines of good clinical practice’, *British Journal of Addiction*, p.113; Spear quoting his annual report in Spear, *Heroin Addiction Care and Control*, p. 277.

medical bodies as well as those within medicine. To remove this threat and allow DDU psychiatrists to present a unified clinical approach to addiction through rapid withdrawal, the role of the community-based doctor in the treatment of addiction needed to be conscribed and maintenance treatment discredited. This could be achieved by using the *Guidelines* to enforce the supposed ‘consensus’ on treatment. The *Guidelines*, as will be seen in Chapter Five, became a key document in an attempt to eliminate maintenance and the community-based doctor from the treatment of addiction through the GMC’s case against Dally for serious professional misconduct in 1986-1987.

Chapter Five

Withdrawal and Maintenance? Towards Plurality in the Treatment of Heroin Addiction – the GMC versus Dr Ann Dally, 1986-1987

Introduction

In December 1986 Dr Ann Dally appeared before the Professional Conduct Committee (PCC) of the GMC charged with serious professional misconduct with respect to irresponsible prescription of opioid drugs for the second time. This case, like the one three years earlier, was not just about disciplining one doctor but about fighting a wider battle within the treatment of addiction. The issues at stake were, however, slightly different. Whilst the 1983 case was chiefly concerned with the involvement of the private practitioner in the treatment of addiction, the later hearing was much more clearly about dictating what methods should and should not be used to treat addict patients. In the 1986-1987 case maintenance, as well as Dally herself, were on 'trial.' This case was brought within the context of a bitterly contested dispute between those who supported the short-term withdrawal of drugs from addicts, mainly DDU psychiatrists, and those who advocated long-term maintenance, mainly private and general practitioners. As seen in Chapter Four this clash was underlain by a deeper battle between conflicting philosophies of medicine: short-term withdrawal fitted well with hospital-based clinical medicine and maintenance was broadly endorsed by the community-based, individual centred, biographical approach.

This conflict not only formed the backdrop to the Dally case but the hearing itself became an arena in which this dispute was actively contested. A case was brought against Dally not just because of alleged irresponsible prescription of controlled drugs to addict patients but because she represented a group of doctors who advocated the long-term prescription of drugs to addicts, a method that posed a threat

to both clinical medical approaches to disease and its treatment, and the position of this kind of medicine as an authority looking for a key position in the 'war' against drugs. Discrediting Dally, maintenance treatment and the biographical approach to addiction would remove opposition within medicine to short-term withdrawal and the particular view of addiction and disease that underlay this. This was not, however, to be the outcome of the case. Although Dally was found to have prescribed controlled drugs to an addict patient irresponsibly and was subsequently pronounced guilty of serious professional misconduct, this verdict did not represent an outright victory for short-term withdrawal and the clinical view of addiction. The GMC were unable to successfully demonstrate that maintenance treatment alone constituted serious professional misconduct. It was tacitly accepted that a case could be made for the long-term prescription of drugs to addicts. Indeed, this was an approach that was already beginning to find support amongst those who recognised the growing threat to public health posed by HIV and AIDS amongst injecting heroin addicts.

This chapter will examine the origins of the GMC's case against Dally, it explain how this was prosecuted and how it was defended. To establish how far this was a 'political' case about discrediting maintenance and those that supported this, the balance between Dally's actions and the influence of the wider debate in bringing this case needs to be assessed. Dally repeatedly failed to adhere to advice (official and unofficial) on the treatment of addict patients from the Home Office, the GMC and other doctors. She undoubtedly made some questionable decisions about the treatment of individual patients, and one in particular, as will be seen. However, the GMC were more than usually active in investigating Dally's practices and bringing a case against her, suggesting a political agenda. The GMC were traditionally not in favour of anything that could be described as 'social medicine' and were in many

ways the embodiment of the ‘medical establishment’ dominated by clinical medicine.¹ Dally, as a leading proponent of maintenance, offered a form of treatment that did not adhere to these principles. Furthermore, DDU psychiatrists were themselves influential at the GMC and elsewhere within the medical establishment. This influence, whilst not necessarily directly leading to the construction of the Dally case, was a powerful force in creating a climate where any doctor offering maintenance treatment was closely scrutinised.

The case was significant not just because it was driven by a political dynamic but also because it polarised the key issues in the treatment debate. This chapter will reconsider elements of the debate (such as the specialist/generalist and NHS/private divide and the importance of the *Guidelines*) within the context of Dally’s ‘trial’ and its implications. It will also look at how the outcome of this case was determined and assess the importance of the ‘politics’ of the GMC in trying the case and reaching a verdict. The hearing attracted a considerable amount of media coverage in both medical and non-medical circles and the significance of this needs to be evaluated, as much of this also suggested the case had deeper implications. Finally, the ramifications of the cases’ outcome need to be considered. Though Dally was found guilty of serious professional misconduct in respect to her treatment of one individual patient, the GMC were unable to wholly condemn maintenance as a treatment method for addiction. This coincided with an apparent shift in the position of those who advocated the short-term withdrawal treatment of heroin addiction. Some arch supporters of rapid detoxification were beginning to accept that maintenance was of value in the treatment of some addict patients. There was a possibility that plurality

¹ Oswald, ‘Training doctors for the National Health Service’, p. 77.

could exist within the treatment of addiction, as the dominance of short-term withdrawal appeared to weaken.

1. The origins of the case

After her ‘conviction’ for serious professional misconduct as a result of prescribing controlled drugs to an addict in an irresponsible manner in 1983 Dally continued to treat addict patients. She was perfectly at liberty to do so, as she had merely been admonished for her conduct by the GMC. However, the Home Office Drugs Branch and Inspectorate continued to closely monitor her prescription of controlled drugs, as they did with many other doctors involved in the treatment of addiction. Inspection of prescription records and enquires into the administration of drugs to addicts by doctors had taken place since 1922, first by Regional Medical Officers of Health from the Ministry of Health, and later by members of the Home Office’s Drugs Branch Inspectorate.² Dally claimed that throughout the late 1970s and early 1980s Home Office Inspectors visited doctors that treated addicts every year or so to discuss their practice, suggest improvements and issue warnings if needed.³ She also stated that the inspectors who came to see her (often Spear himself) were ‘anxious not to make trouble but to save it’ and were ‘friendly’ and ‘interested’ in her work.⁴

Though these visits may have been routine, Dally’s contact with the Inspectorate increased in the run up to her second appearance before the GMC in 1986-1987. On 26 April 1984 Dally received a visit from Drugs Branch Inspectors John Lawson and John Gerrard.⁵ Although Lawson was keen to assure her that she

² Spear, *Heroin Addiction Care and Control*, pp. 39-41.

³ Dally, *A Doctor’s Story*, p. 70

⁴ *Ibid.* p. 134.

⁵ *Ibid.* pp. 134-135; CMAC PP/DAL/ Box 2 [Where documents cannot be located in the new catalogue the old box system is referred to] Note of interview between John Lawson, John Gerrard and Ann Dally, report by John Gerrard, 26 April 1984.

was not being singled out and was one of a number of doctors to be interviewed, before the official interview began Dally asserts that he told her that the ‘drug dependency establishment’ were trying to ‘make trouble’ and get her charged before a Home Office tribunal.⁶ According to Dally, Lawson said that she would be judged by the standards of the DDUs, and if found wanting could be deprived of her right to prescribe controlled drugs to addicts. This would depend, he said, ‘on how much you [Dally] conform to what the clinic doctors want.’ He advised Dally to ‘pull in her horns’ as these doctors were out to ‘get’ her.⁷ Once the interview proper got underway Lawson cautioned Dally that the Home Office would use this to determine whether or not she should be brought before a tribunal and anything she said could also be passed on to the GMC.⁸ Lawson asked Dally about her prescription of injectable drugs to patients. She told him that many addicts found orally administered methadone made them nauseous and that it was better to prescribe a preparation designed for injection to patient who was going to inject regardless, and would otherwise buy illegal drugs.⁹ Dally also assured Lawson that she always checked to see if a new patient had been notified to the Home Office and made sure that the addict was working and could afford her fees.¹⁰ Lawson commented that the number of patients she saw was on the high side, but Dally countered that she rejected more than she accepted and had taken on no new patients that month. Lawson told Dally that the Inspectorate would consider her prescription and decide whether or not this should be referred to a tribunal, and the interview ended.¹¹

⁶ Dally, *A Doctor's Story*, p. 134.

⁷ *Ibid.* p. 134.

⁸ *Ibid.* p.134; CMAC PP/DAL/ Box 2, Note of interview between John Lawson, John Gerrard and Ann Dally, report by John Gerrard, 26 April 1984.

⁹ CMAC PP/DAL/ Box 2 Note of interview between John Lawson, John Gerrard and Ann Dally, report by John Gerrard, 26 April 1984.

¹⁰ *Ibid.*

¹¹ Dally, *A Doctor's Story*, p. 134.

In May 1984 Dally wrote to Spear complaining about the clinics and their policies, particularly about the lack of a relationship between the patient and the doctor who treated them. She also stated that she had changed her own prescription policy by speeding up the transition of patients from injectable to oral methadone. She told Spear that she felt she was being forced out of the treatment of addiction and intended to retire within the following year.¹² Spear replied in June, responding to her letter and informing her of the outcome of Lawson and Gerrard's visit. Spear told Dally that the Home Office believed her prescription of controlled drugs to addicts could be considered 'irresponsible' within the meaning of the Misuse of Drugs Act (1971) and that details of this might be referred to a tribunal or to the GMC. However, as Dally proposed to make changes to her practice, they did not think this necessary at present, although they would continue to monitor the situation. Spear reminded Dally of

the need for extreme caution in prescribing controlled drugs to persons who may be drug addicts or misusers. A doctor who is prepared to accept and prescribe to such persons may well unwittingly become an important source of drugs circulating in the illicit market.¹³

The Home Office remained concerned about aspects of Dally's prescribing and she received another visit from the Drugs Inspectorate on 3 December 1985. The interview was conducted by Inspector Donald McIntosh.¹⁴ McIntosh had information on 189 addict patients of Dally's, 134 of which were receiving prescriptions for controlled drugs. He asked Dally in detail about a number of them, particularly those who were unemployed, lived at a distance from London, or were receiving large doses. McIntosh was concerned that those who were out of work would be unable to pay Dally's fee without resorting to selling some of their prescription and that those

¹² CMAC PP/DAL/ Box 4, Letter from Ann Dally to HB Spear, 4 May 1984.

¹³ CMAC PP/DAL/ Box 2, Letter from HB Spear to Dally, 5 June 1984.

¹⁴ CMAC PP/DAL/ Box 2, Interview between Senior Inspector D. McIntosh, Home Office Drugs Branch and A. Dally, 3 December 1985; Dally, *A Doctor's Story*, pp. 147-149.

who lived a long way away could not effectively be ‘controlled.’ He stated that although the Home Office were ‘in no doubt that you [Dally] are genuinely motivated in treating addicts’ he felt that by prescribing large doses of opioid drugs she did not encourage her patients to stop taking these and simply perpetuated their condition.¹⁵ Dally defended her actions by arguing that there were no facilities for long-term addicts and that she did her best to ensure that her patients eventually came off drugs. McIntosh reminded Dally that she had said she would retire during 1985, and Dally assured him that she was in a ‘transitional’ stage to retirement but in the meantime needed an income of £75,000 to cover overheads.¹⁶ This statement became significant during the GMC’s case against her for serious professional misconduct as Dally admitted that half her patient list (and so half her income) was made up of addicts. At the end of the interview McIntosh told Dally that the Home Office would consider whether or not there was a case to answer before a tribunal.

In February 1986 Spear himself came to see Dally. He told her that lawyers working for the Home Office thought there was enough evidence of irresponsible prescription to bring Dally to tribunal. According to Dally, Spear also said that he could prevent this if she agreed to make radical changes and close down her addict practice as fast as possible. Dally agreed.¹⁷ In March 1986 she wrote to Spear telling him that she would make arrangements for all her addict patients to be treated elsewhere within three months.¹⁸ Spear wrote back stating that ‘the arrangements you propose are quite acceptable to us.’¹⁹ During this period Dally asserted that she found

¹⁵ CMAC PP/DAL/ Box 2, Interview between Senior Inspector D. McIntosh, Home Office Drugs Branch and A Dally, 3 December 1985

¹⁶ *Ibid*

¹⁷ Dally, *A Doctor’s Story*, p. 149.

¹⁸ CMAC PP/DAL/ Box 7, Letter from Ann Dally to HB Spear, 4 March 1986.

¹⁹ CMAC PP/DAL/ Box 7, Letter from HB Spear to Ann Dally, 11 March 1986.

it hard to discharge addict patients, as she could not find suitable facilities for them.²⁰ Spear later wrote to Dally in an unofficial capacity, stating that he did not think McIntosh would ‘descend’ on her within three months if she had not given up treating addicts altogether, and that he would tell McIntosh about the difficulties she was experiencing.²¹ Perhaps as a result of Spear’s protection Dally did not face a Home Office tribunal. However, the Drugs Inspectorate passed on information about Dally’s prescription of controlled drugs to the GMC, who did decide to take action against her in September 1986.

On 2 September Dally received a letter from the Registrar at the GMC alleging that she had abused her position as a medical practitioner on two separate grounds. The first charge was that she had issued ‘in return for fees, numerous prescriptions for methadone hydrochloride in an irresponsible manner.’ The second related to one patient in particular, a man Dally called ‘Khalid’ in her book. Again, it was alleged that she had prescribed for Khalid in an irresponsible manner and furthermore, had failed to conduct a ‘conscientious and sufficient physical examination,’ to have monitored his progress inadequately and that she discharged him without making proper arrangements for his ongoing treatment.²² Khalid had been a patient of Dally’s since 1982. He was a self-employed roofer who had been addicted to heroin for 11 years when he first saw Dally.²³ Dally prescribed Khalid injectable methadone on a slowly reducing basis, so that by 1985 he had cut his drug intake by around a half, something she regarded as ‘a good result.’²⁴ In addition to his drug addiction, Dally believed Khalid was experiencing marital problems,

²⁰ Dally, *A Doctor’s Story*, p. 149.

²¹ CMAC PP/DAL/ Box 2, Letter from HB Spear to Ann Dally, Spring/Summer 1986.

²² CMAC PP/DAL/E/4/22, Letter from the GMC to Ann Dally 2 September 1986.

²³ Dally, *A Doctor’s Story*, p. 146; CMAC PP/DAL/E/4/17, PCC Hearing 1986-1987, 10 December 1986, p. 2.

²⁴ Dally, *A Doctor’s Story*, p. 146.

asserting that when she first began to treat him he had left his wife and was living with his mother.²⁵ In 1983 Dally received a telephone call from Khalid's wife alleging that her husband was currently unemployed and was selling methadone ampoules prescribed by Dally.²⁶ Mrs Khalid refused to visit Dally and as she had seen no evidence to indicate that Khalid was either out of work or selling his script she regarded this as a symptom of the couple's relationship difficulties. In September 1985 Mrs Khalid sent Dally an unemployment slip to prove that her husband was not working. Dally disregarded this, as the slip was over a year old and 'it would not be beyond Khalid to draw unemployment benefit while he was working, which was none of my business.'²⁷ Mrs Khalid called Dally again, alleging that her husband was selling drugs and that his addiction was getting worse. Dally felt that this was unlikely, as Khalid had recently requested a reduction in his dose. She asked Mrs Khalid to come and speak to her in person, but she refused. Some time later Dally received a solicitor's letter setting out what Mrs Khalid had alleged.²⁸ Dally became concerned and asked for advice from the Medical Defence Union (MDU), who told her to discharge Khalid immediately. At her next consultation with Khalid in December 1985 Dally showed him the solicitor's letter, and told him that she would not be able to resume treatment until the matter was sorted out. She told him to go to his GP to see what help he or she could give him. Dally wrote in Khalid's notes that she had discharged him, but she did not write a discharge letter to Khalid's GP. She argued that she did not want 'to write a discharge letter only to find that Khalid and his wife returned in a week or two and I would have to write another letter.'²⁹ Khalid

²⁵ *Ibid.* p. 146.

²⁶ *Ibid.* p. 146; CMAC PP/DAL/E/4/17, PCC Hearing 1986-1987, 10 December 1986, p. 26.

²⁷ Dally, *A Doctor's Story*, p. 146.

²⁸ *Ibid.* p. 147.

²⁹ *Ibid.* p. 147. See also CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 26 January 1987, pp. 72-73.

went to his GP, who referred him to a DDU. Khalid did not go the clinic, and turned instead to the black market. He was arrested for selling heroin a few weeks later.³⁰

The GMC's charges were based on information received from the Home Office. Much of this had come from the Inspector's interviews with Dally, but the information on Khalid came from Dally herself. She knew that Spear liked to be informed of interesting cases so she sent him copies of the correspondence with Mrs Khalid's solicitors. Dally thought that this was then passed on to someone interested in 'damaging' her.³¹ Indeed, Dally saw the whole case as part of a conspiracy to impose a particular method of treatment for addiction and to stop her and other 'independent' doctors from treating addicts. She had long maintained that the addiction treatment was being controlled by a powerful clique of London based DDU consultants.³² This group, led, she argued, by Connell and comprising, among others, of Bewley, Ghodse and Mitcheson, sought to impose their system of treatment even if it was 'failing.'³³ This (according to Dally) was to be achieved in two ways. The first was to get 'themselves elected to every powerful committee that is in any way relevant to the problem and then, with the power gained, [impose] an orthodoxy.'³⁴ The second was to eliminate the 'independent' doctor from the treatment of addiction, either through the Home Office tribunals or the GMC's Professional Conduct Committee (PCC).³⁵ Dally told her defence team that the DDU consultant group built the case against her and were using the GMC to remove her from the field.³⁶ She argued that:

³⁰ Dally, *A Doctor's Story*, p. 147.

³¹ *Ibid.* p. 147.

³² CMAC PP/DAL/B/4/2/5, 'Some problems in the treatment of heroin addiction' by Dally, May 1984.

³³ *Ibid.*; CMAC PP/DAL/E/4/20, 'The drug clinic consultant group' by Dally, prepared for her lawyers, 18 October 1986.

³⁴ CMAC PP/DAL/B/4/2/5 'Some problems in the treatment of heroin addiction' by Ann Dally, May 1984.

³⁵ *Ibid.*; CMAC PP/DAL/E/4/20, 'The drug clinic consultant group'.

³⁶ CMAC PP/DAL/E/4/20, 'The drug clinic consultant group'.

Strongly influenced by the Connell-Bewley faction, the GMC has got itself into a power game which few of its members understand or are even aware of... They do not realise they are being used for political ends by a particular group of doctors.³⁷

Dally felt that ‘everyone at the GMC who has any connection with drug dependency is either Connell’s stooge or his disciple on the subject.’³⁸ She stated in the diary she wrote during the ‘trial’ in 1986-1987 that she had heard that the GMC’s solicitors, Waterhouse, had been instructed to look for ‘dirt’ on her so that a case could be brought.³⁹

There is evidence to suggest that this was not simply paranoia. Dr David Marjot, a former NHS DDU consultant and ally of Dally’s told her that a private detective working for the GMC had telephoned him asking for the names of addict patients to check if any of Dally’s patients were also receiving prescriptions from him (a practice known as ‘double-scripting’).⁴⁰ Dally’s defence team and an interested freelance journalist chased this lead up and found that the GMC had indeed employed a private detective called Dave Kingham, a former policeman who had worked for the drugs squad inspecting pharmacists records.⁴¹ Although the GMC were not acting outside their remit by bringing in the services of a private detective they were perhaps acting contrary to their usual stance.⁴² The Merrison Committee had recommended in 1975 that the GMC set up an investigation unit to examine alleged instances of serious professional misconduct, but the proposal was rejected by the GMC who felt

³⁷ CMAC PP/DAL/E/4/20, ‘Politics and the GMC’, by Dally, for her lawyers, 15 October 1986

³⁸ CMAC PP/DAL/E/4/20, ‘The drug clinic consultant group’.

³⁹ CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 2 September 1986, p. 2

⁴⁰ *Ibid.* 20 November 1986, p. 70

⁴¹ The journalist was Nick Davies. He is still interested in drug issues. For references to his part in Dally’s case see *Ibid.* 24 October 1986, p. 17; 22 November 1986, p. 70. The private detective is named in *Ibid.* 7 December 1986, p. 105. Ed Vulliamy also commented on the use of a private detective in the Dally case in an article in the *Guardian*, 26 January 1987, p. 17.

⁴² Dally discussed how the GMC was able to initiate and investigate cases using private detectives in a letter to the *British Medical Journal*. See A. Dally, Letter, ‘Investigating the GMC’, *British Medical Journal*, 298, (3 June 1989) p. 1518.

that this was not part of their role.⁴³ Likewise, the circumstances in which the case was brought, whilst not unprecedented, were perhaps unusual. The GMC called doctors to answer charges of serious professional misconduct either as a result of a reported criminal conviction or when a complaint was made about a doctors' conduct. This might come from other doctors, officials or members of the public.⁴⁴ In Dally's case no specific complaint was made about her; information was passed on to the GMC by the Home Office about her prescription of controlled drugs. This was probably fairly common with cases of suspected irresponsible prescription, but it helped to fuel Dally's notion that she was being 'persecuted' by the GMC itself rather than facing charges as the result of an individual complaint.⁴⁵

This notion of persecution and the allied belief that there was a conspiracy between DDU consultants and the GMC to besmirch Dally's reputation and stop her treating addicts requires careful consideration. The 'evidence' for the existence of this conspiracy was predominately based on hearsay and comes from material found in the Dally's papers, largely her own writing on the subject, rather than any independent, corroborative source. Moreover, it was clearly vital for Dally to locate her case in a bigger battle. She needed to show that she was not guilty of serious professional misconduct and pointing to a wider conspiracy to 'get' the independent doctor shifted focus from her own behaviour. Yet, there was much that could have brought Dally to the attention of the GMC without a 'conspiracy.' At a meeting of the GMC in May 1985 the Professional Standards Committee directed doctors to consider three issues when prescribing to addicts. These were: firstly, not to ignore

⁴³ Stacey, *Regulating British Medicine*, p. 57, p. 62.

⁴⁴ *Ibid.* p. 150.

⁴⁵ Whilst there are figures indicating what proportion of charges of serious professional misconduct were based on suspected irresponsible prescription, there are no corresponding figures indicating the origin of these charges. But, as these cases relied on detailed knowledge of prescription practices it is likely many came from information passed on by the Home Office.

warnings from the Home Office or the police about the effects of prescribing in some areas; secondly, that it was inadvisable to prescribe to patients who lived a long distance from their surgery, especially when there were other facilities available, and thirdly, the danger that prescribing privately to an addict without sufficient funds would lead to him or her to sell part of that prescription to a third party.⁴⁶ Dally, it could be argued, ignored all three of these warnings. As well as disregarding general advice she also failed to recognise the seriousness of the cautionary words spoken by Home Office Drug Inspectors directly to her in both an official and an unofficial capacity. The Home Office nearly took her to tribunal; this was prevented only by her promise to change her treatment policies and to gradually retire altogether within three months, a promise she did not keep. However, the fact that Dally's behaviour was hardly blameless does not negate the significance of the case. It does seem likely that there was a concerted effort, in her words, to 'get' Dally and other independent doctors who were treating addicts contrary to DDU policy. Moreover, regardless of whether or not there was a 'conspiracy' surrounding the case it clearly had wider political implications. To make an evaluation of these, a detailed examination of the hearing and its ramifications is required.

2. Maintenance and the treatment debate in the Dally case

The Professional Conduct Committee (PCC) hearing of the Dally case began on 9 December 1986 chaired by Professor Duthie, professor of surgery at the University of Wales.⁴⁷ Dally faced the same charges made in the GMC's letter of September; firstly, that she had abused her position as a medical practitioner by prescribing methadone irresponsibly and secondly, she had failed to examine a patient ('Khalid')

⁴⁶ GMC Annual Report, 1985. Quoted in Spear, *Heroin Addiction Care and Control*, p. 289.

⁴⁷ A full transcript of the hearing can be found in CMAC, PP/DAL/E/4/17, Transcripts of the case 1986-1987.

adequately, not monitored his progress effectively or made arrangements for his ongoing care once discharged.⁴⁸ These two charges were representative of the two factors at work in the Dally case: Dally's own faulty practices in dealing with specific patients and the more general political campaign against maintenance treatment.

Both these elements can be detected in the conduct of the case from its outset and throughout. Timothy Preston, QC (appearing on behalf of the GMC) argued in his opening statement that a doctor embarking on a course of long-term prescription to an addict patient needed to take elementary precautions, precautions not taken by Dally.⁴⁹ This could be observed in five areas. Firstly, Dally treated so many addicts that it was beyond her capacity to treat them all conscientiously or properly.⁵⁰ Information passed to the GMC from the Home Office showed that Dally had treated 189 addict patients between March and October 1985, but this figure did not include temporary patients, and no-one, not even Dally herself, had an accurate idea of the precise number seen.⁵¹ Secondly, Preston argued that Dally treated patients who could not have been expected to afford her fees and the other costs involved in private treatment without recourse to crime, particularly the sale of prescribed drugs.⁵² Khalid himself had admitted selling methadone prescribed by Dally.⁵³ Thirdly, it was asserted that Dally prescribed excessively large amounts of methadone on single prescriptions, that seeing patients on a weekly or fortnightly basis did not amount to a sufficient level of supervision.⁵⁴ Fourthly, Preston felt Dally prescribed for patients who lived too far away from her surgery and in areas where there were already

⁴⁸ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 9 December 1986, p. 1.

⁴⁹ *Ibid.* p. 21.

⁵⁰ *Ibid.* p. 21.

⁵¹ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 2.

⁵² CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 9 December 1986, p. 21.

⁵³ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 10 December 1986, p. 7.

⁵⁴ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, p. 21; CMAC PP/DAL/E/4/17 PCC Hearing, 1986-1987, 30 January 1987, p. 4.

adequate NHS facilities.⁵⁵ Finally, it was argued that Dally had made no attempt to reduce the doses prescribed to her addict patients and had not followed the guidelines which she helped to produce.⁵⁶ Preston noted that only half of the 189 patients treated between March and October 1985 had their dose reduced.⁵⁷ This caused him to question whether Dally was simply selling prescriptions rather than ‘properly treating patients.’⁵⁸

Dally’s irresponsible prescription to addict patients was exemplified, according to Preston, by her treatment of Khalid.⁵⁹ Preston maintained that when Dally took Khalid on as a patient she gave him a ‘perfunctory’ examination and did not test his urine for the presence of opioid drugs, but still issued him with a prescription for a week’s supply of methadone ampoules.⁶⁰ Preston stated Khalid claimed that he never spent more than five or ten minutes in Dally’s surgery and

the “treatment”, in inverted commas, rarely amounted to anything more than the respondent saying to him, “How are you today?” writing out his prescription and handing over the cash. During all this period [Khalid] was unemployed and living on social security.⁶¹

If Khalid’s evidence was correct, then, Preston argued, he was not properly treated.⁶² Khalid was later ‘summarily dismissed’ by Dally after the ‘apparently unwelcome intervention of his wife and the solicitor’s letter,’ and without proper arrangements being made for his ongoing care.⁶³ Thus, Preston asserted, Dally was clearly acting irresponsibly towards one specific patient and to all her addict patients in general.

The political ramifications of the Dally case were immediately apparent to all those involved in the hearing. In both his opening and closing statements Preston

⁵⁵ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 9 December 1986, p. 21.

⁵⁶ *Ibid.* p. 21.

⁵⁷ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 6.

⁵⁸ *Ibid.* p. 6.

⁵⁹ *Ibid.* p. 8.

⁶⁰ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 10 December 1986, p. 1.

⁶¹ *Ibid.* p. 1.

⁶² CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 8.

⁶³ *Ibid.* p. 8.

commented on the significance of the case. At the beginning of the hearing he noted that ‘there may be more than one school of thought as to whether it is medically...or socially, advisable to prescribe long term maintenance doses to addicts’ and he would ‘deprecate any attempt to turn this inquiry into a political debate.’⁶⁴ However, Preston’s presentation of the GMC’s case to the PCC was itself ‘political’ and took a clear stance within this debate. In his final words to the committee Preston stated that whilst he accepted that long-term maintenance might be necessary for some patients it was ‘very much a second best solution to an individual patient’s problem.’⁶⁵ The ‘best’ solution, presumably, was short-term withdrawal. Just as Preston tried to deny the political elements of the case Dally’s defence was contingent on proving that she was not at fault, but was instead the victim of a conflict over the treatment of addiction. Dally’s barrister, William Gage, argued in his closing statement that ‘Dr Dally has had the misfortune to get caught up in the backwash of a medical dispute in the particular field in which she practices. It is our submission that that dispute lies at the heart of the charge against her.’⁶⁶ Dally’s case was based around the assertion that there was not one correct way of treating addicts: there were a number of different ways. Gage stated that ‘Nobody can be dogmatic as to precisely what is right for the individual. It is our case that there is a place for her [Dally’s] type of treatment in the spectrum.’⁶⁷ Indeed, he found there to be a substantial body of opinion that supported Dally’s methods, the existence of which demonstrated that she was not guilty of irresponsible prescription.⁶⁸

⁶⁴ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 9 December 1986, p. 21.

⁶⁵ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 1.

⁶⁶ *Ibid.* p. 9.

⁶⁷ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 26 January 1987, p. 47.

⁶⁸ This will be discussed in greater detail below. CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 11.

On a more detailed level, Gage refuted each of the five allegations made by Preston about Dally's treatment of addict patients. Firstly, he asserted that Dally did not treat too many addicts and she worked hard to provide appropriate care for her patients. He argued that there were simply not enough facilities for the treatment of addiction and she offered a valuable service.⁶⁹ Secondly, Gage explained that Dally made every effort to see that her patients could afford her fee, but some would inevitably 'slip through the net.'⁷⁰ Thirdly, he argued that Dally did not prescribe excessively, and that with long-term addicts it might be necessary to go above the 80mg daily limit set by the *Guidelines*. It was essential to treat each patient as an individual and not to reduce their dose to a level that they could not tolerate, or else they would turn to the black market.⁷¹ Fourthly, Gage noted that no attempt had been made to define how far away from Dally's surgery patients had to live to be considered too far away. Again, he argued there were insufficient treatment facilities available in some areas for some addicts.⁷² Finally, Gage dealt with the allegation that Dally made no attempt to reduce the dose prescribed to many of her addict patients. He stated it was Dally's belief that halting prescription of opioid drugs to a long-term addict too rapidly was to risk relapse and the purchase of illegal drugs.⁷³ Gage also argued Dally's treatment of Khalid was not indicative of irresponsible prescription. He noted that Dally had achieved a reduction in Khalid's daily dose from seven ampoules of injectable methadone and 50ml of methadone linctus to four ampoules and 25ml of linctus.⁷⁴ Furthermore, Dally had every reason to believe

⁶⁹ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 26 January 1987, p. 44.

⁷⁰ *Ibid.* p. 44.

⁷¹ *Ibid.* pp. 44-45.

⁷² *Ibid.* p. 45.

⁷³ *Ibid.* p. 45.

⁷⁴ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 21.

Khalid was employed as he had done some building work for her daughter.⁷⁵ Gage felt that when it came to discharging Khalid, Dally was in a position where she could not win. She had been advised by the MDU to discharge him and if she had gone on treating Khalid she would have been asked why she had continued to do so. It was Gage's submission that Dally had done 'everything she properly and conscientiously should.'⁷⁶ He concluded that she was doing nothing worse than treating long-term addicts. Dally was not simply selling prescriptions, but providing 'a good deal more' in the way of treatment to her patients.⁷⁷

Considering how the two charges in the Dally case were dealt with allows for an assessment to be made as to the relationship between the factors that were instrumental in bringing the case and deciding its outcome: Dally's apparent failings and the more general campaign against maintenance. Khalid stated that when he was first referred to Dally she did not conduct a physical examination of him, or conduct blood or urine tests for the presence of drugs, but she did examine his arms for needle marks.⁷⁸ He asserted that though he saw her for half an hour initially, most of his consultations lasted 'for ten minutes, give or take five minutes.'⁷⁹ These meetings were weekly, until the last six months of his treatment when he could no longer afford to see her so regularly, so he asked to come fortnightly instead.⁸⁰ Khalid told the PCC that Dally prescribed injectable methadone for him and admitted under cross-examination that she did achieve a reduction in his dose over the time he was in her care.⁸¹ But, the 'prosecution' raised serious questions were about the nature of the

⁷⁵ *Ibid.* pp. 21-22. See also: CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 29 January 1987, pp. 68-70; Dally, *A Doctor's Story*, pp. 214-215.

⁷⁶ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 23.

⁷⁷ *Ibid.* p. 23.

⁷⁸ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 10 December 1986, p. 4, p. 18.

⁷⁹ *Ibid.* p. 6, p. 10.

⁸⁰ *Ibid.* p. 5.

⁸¹ *Ibid.* p. 5, p. 18.

treatment Dally provided. Preston asked Khalid: ‘During the two and a half years or so that you were seeing Dr Dally, did you ever receive from her anything that could be described as treatment, other than being handed a prescription for methadone?’ Khalid replied: ‘Not really, no.’⁸² Dally’s treatment of Khalid also appeared unsuccessful when compared to the apparent success of the clinic he was attending at the time of the hearing in getting him off drugs. Khalid told the committee that he had been going to a DDU for five weeks and was completely abstinent.⁸³

Serious questions were also raised about how Khalid could afford to pay for private treatment. He admitted that though he had been in work when he first went to see Dally, he had been unemployed and drawing benefit since 1983. Sessions with Dally cost £30 each and Khalid told the PCC that his prescription charges could be as much as £33 and averaged £25. As he was only receiving £72 a week in unemployment benefit Khalid said he was forced to sell some of his ampoules of methadone for around £5 each.⁸⁴ Dally, it seemed, was unwittingly supplying the ‘grey’ market with drugs, something that was of great concern to many DDU doctors (see Chapter Three). It was hardly surprising, therefore, that the PCC judged the second charge levelled against Dally, irresponsible prescription to Khalid, to have been proven. Indeed, the impression that Khalid was something of a ‘dodgy’ patient was confirmed by the fact that since he had left Dally’s care he had been arrested and was to stand trial for attempted possession of heroin.⁸⁵

Yet, the eight-day hearing was about more than Dally’s failings with respect to one individual. Through the examination of the other, more general charge, the case brought many of the key issues in the treatment debate into sharp focus. There was a

⁸² *Ibid.* p. 8.

⁸³ *Ibid.* p. 21.

⁸⁴ *Ibid.* p. 7. See CMAC PP/DAL/E/4/12, Statement of Annette Lingham, 20 November 1986 for the prices of Dally’s treatment sessions.

⁸⁵ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 10 December 1986, p. 16.

recurrence of interest in who should be responsible for the treatment of the addict. Concern was expressed by two expert witnesses for the ‘prosecution’ about the vulnerability of the single-handed practitioner when dealing with addict patients.⁸⁶ Dr Farrington, consultant psychiatrist at Lady Chichester Hospital, Hove, felt that doctors working alone could easily be manipulated.⁸⁷ Dr Fleming, director of Wessex regional drug dependence services, agreed. In addition, he felt that there was a limitation to the services that a single-handed practitioner could provide to the addict when compared to the multi-disciplinary teams found in DDU’s.⁸⁸ The Dally case was also used to question once more the place of the private practitioner in the treatment of addiction. Many of the same problems with the payment of fees by addict patients raised in the 1983 case were reconsidered. McIntosh told the committee that concern about how some of Dally’s patients were raising money to pay her fees underlay his line of questioning in his interview with her in December 1985. He felt that ‘somebody without sufficient legitimate income would be compelled to sell part of his prescription or resort to other criminal activity in order to finance his consultation and dispensing fees.’⁸⁹ This had clearly been the case with Khalid. The committee also heard about the separate financial issue of how much money Dally earned from her addict practice. Much was made of Dally’s remark made during the Home Office interview about needing an income of £75,000 to cover overheads. McIntosh told the hearing that he thought this was a ‘curious thing’ to say and that it gave him ‘slight pause for concern as to whether the doctor was motivated by financial reasons for continuing to treat [addict] patients.’⁹⁰ However, McIntosh admitted that he thought

⁸⁶ Technically, as the GMC was not a court of law Preston and his team were not the ‘prosecution,’ nor were Gage and his associates the ‘defence,’ but it is convenient short-hand used to refer to each side.

⁸⁷ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 11 December 1986, p. 42.

⁸⁸ *Ibid.* p. 61.

⁸⁹ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 9 December 1986, p. 76.

⁹⁰ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 9 December 1986, p. 90.

Dally was acting in a genuine manner and was prescribing to patients in what she believed to be their best interests.⁹¹ Dally claimed that the comment about needing £75,000 was taken out of context. She stated that this represented the costs for the whole practice which she shared with her ex-husband Dr Peter Dally.⁹² She argued that she could have maintained her level of income by treating more general psychiatric patients and fewer addicts if she had only been concerned about making money. She said that she continued to treat addict patients because she could not just abandon them and force them onto the 'street.'⁹³

During the hearing questions were raised about Dally's suitability for treating addicts that fed into broader debates about the position of the generalist and the specialist in this field. McIntosh stated that the Home Office Drugs Branch had always regarded Dally as a general practitioner with a special interest in the treatment of drug addiction.⁹⁴ Dally on the other hand, told the committee that she described herself as a psychiatrist, not as a GP, despite her lack of formal training.⁹⁵ This was significant, as the *Guidelines* recommended different practices for psychiatrists and GPs when dealing with addicts. Moreover, Farrington told the committee that the *Guidelines* were of limited use to someone like himself with a good deal of experience in treating addicts. It was not, he said, a document to which he referred to regularly.⁹⁶ The implication was that an individual with expertise in the field could disregard some of the *Guidelines'* recommendations, something Dally frequently did. However, the *Guidelines* were a crucial document referred to throughout the hearing as being representative of 'standard' treatment for drug addiction. Preston argued

⁹¹ *Ibid.* pp. 55-56; p. 90.

⁹² CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, p. 63.

⁹³ *Ibid.* pp. 63-64.

⁹⁴ *Ibid.* p. 59.

⁹⁵ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, pp. 15-16.

⁹⁶ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 11 December 1986, p. 57.

that Dally ‘breached, or at any rate ignored’ many of the recommendations made in the *Guidelines*.⁹⁷ He compared Dally’s practice to that outlined in the *Guidelines*. Preston noted that doctors were advised not to undertake the long-term prescription of opioid drugs to addicts unless in conjunction with a specialist at a DDU. Dally countered that the *Guidelines* stated that it did not have to be a DDU specialist, but could also be someone who had experience in the area. She felt she had considerable experience and thus considered herself to be a specialist.⁹⁸ Preston also used the *Guidelines* to suggest that Dally did not follow accepted practice. He pointed out that the *Guidelines* recommended conducting a physical examination of the patient, something Dally did not always do. Dally argued that as her patients were sent to her on referral it was not necessary to carry out an examination as this should have been done by the referring physician.⁹⁹ She claimed that she conformed to the *Guidelines* as far as possible, but that they did not provide for the type of patient she saw: the long-term addict.¹⁰⁰ Other doctors who gave evidence to the PCC were also critical of the *Guidelines*. Dally’s friend and supporter Dr Marjot told the committee that he did not agree with every word of the *Guidelines* and felt that they were of use to some GPs, but of less value to those working within the field. He too felt they did not address the problem of the long-term addict.¹⁰¹ Beckett also thought that the *Guidelines* were intended for those without experience of treating addiction, and was in agreement with Marjot and Dally that they failed to deal with the chronically addicted patient.¹⁰² However, it was Marks who presented the most damning condemnation of the *Guidelines*. He told the committee that he referred to them as

⁹⁷ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, p. 42.

⁹⁸ *Ibid.* pp. 43-44.

⁹⁹ *Ibid.* p. 43.

¹⁰⁰ *Ibid.* p. 42.

¹⁰¹ *Ibid.* pp. 87-89.

¹⁰² CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 28 January 1987, p. 11.

the ‘misguidelines.’ He argued they deserved this sobriquet because whilst they claimed to present guidance on good clinical practice they did not deal with maintenance, the implication being that maintenance was not good practice. He strongly disagreed with this, branding it a ‘false inference.’¹⁰³

Indeed, Marks’ evidence on the subject of maintenance was crucial for Dally and the wider debate as he helped to establish that this was an accepted method of treatment, albeit practised by a minority of doctors working with addicts. Marks freely admitted to prescribing to addicts on a maintenance basis. He asserted that addicts who were determined to take drugs would continue to do so. The choice was not, he said, ‘between getting those drugs [on prescription] and not getting drugs at all; it is between not getting these injections or injecting street rubbish.’¹⁰⁴ Marks believed that maintenance itself was not ‘treatment,’ it was a way of keeping the patient healthy and in contact with the appropriate services until they were prepared to stop taking drugs altogether.¹⁰⁵ Dally’s defence team presented other doctors who agreed with maintenance and criticised rapid withdrawal. Beckett stated that there was nothing wrong with prescribing to an addict over a long period of time, indeed he argued ‘in fact it might be thought wrong not to.’¹⁰⁶ Short-term withdrawal might result in abstinence but the addict too often returned to drugs. He believed that addicts could lead perfectly ‘normal’ lives whilst being prescribed opioid drugs.¹⁰⁷ Beckett also argued that there was no one method that could be applied to the treatment of addiction, as did Marjot.¹⁰⁸ Marjot asserted that whilst the aim in

¹⁰³ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 29 January 1987, p. 20.

¹⁰⁴ *Ibid.* p. 16.

¹⁰⁵ *Ibid.* p. 30.

¹⁰⁶ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 28 January 1987, p. 7.

¹⁰⁷ *Ibid.* p. 8.

¹⁰⁸ *Ibid.* p. 3; CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, p. 86

treating addicts was for them to eventually be drug-free, prescription was sometimes 'the least worst option.'¹⁰⁹

Dally presented her treatment of addicts to the PCC in this light, defending her own practices through a defence of maintenance. She asserted that her philosophy was 'To improve their [the addict's] general health and social situation and to help them reduce their drug need, with the hope that they would eventually become drug free.' This treatment was designed to help the addict patient hold down a job and maintain a normal family life.¹¹⁰ She argued that the patients she treated were older, long-term addicts that 'had been addicted for so long that there was not any question of getting them off quickly.'¹¹¹ Dally felt that there was not one single method available for treating addict patients, rather that 'one has to deal with the patient according to that patient; it is a very individual matter.'¹¹² This meant trying to 'assess each person as an individual and to decide the right treatment for that particular person and to carry it out, modifying it as circumstances change, aiming always at being drug-free in the end.'¹¹³ Dally's general treatment philosophy and methodology thus fitted into a pattern of individual centred maintenance designed to improve social functioning, with the ultimate goal of abstinence, but not necessarily in a short, fixed period of time.

In contrast to this view, the drug addiction experts presented by the 'prosecution' were largely advocates of short-term withdrawal. Farrington told the committee about the practices adopted in his clinic. The goal of treatment, he asserted, was for the patient to become abstinent from drugs. He did not believe that any addict had a long term need for opiate drugs. Most patients were offered a

¹⁰⁹ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, p. 86.

¹¹⁰ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 26 January 1987, p. 52.

¹¹¹ *Ibid.* p. 49.

¹¹² *Ibid.* p. 65.

¹¹³ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, p. 15.

‘prescription contract’ aimed at getting them off methadone in between four and six months.¹¹⁴ However, Farrington did admit to prescribing to a small number of addicts (ten out of 112) on a long-term basis. These were what he termed ‘stable’ addicts, older and less problematic than the rest of the patients he saw.¹¹⁵ Fleming also prescribed on a long-term basis to a handful of patients. He treated between five and ten stable addicts who were employed, in good relationships and mostly in their late thirties or early forties.¹¹⁶ He conceded that for these patients there might be a case for allowing them to continue to take injectable drugs on prescription.¹¹⁷ However, he also stated that he had not prescribed injectable drugs to an addict in eleven years. He estimated that he had prescribed drugs in any form to only a third of his patients; the remainder received counselling. Prescription, he believed was a minor part of treatment.¹¹⁸ So, despite the tacit admission that there might be a case for long-term prescription to a small number of addict patients the evidence of both Fleming and Farrington was broadly supportive of rapid withdrawal. It is intriguing to note they were the only medical witnesses called by the ‘prosecution.’ None of the London DDU doctors gave evidence. This is surprising, as they were widely recognised to be the leading experts in the field and were the strongest advocates of short-term prescription. Dally actually wanted Connell and Bewley to appear as witnesses so that they would be forced to justify their policies. She believed under cross-examination the fallacy of these would be exposed.¹¹⁹ It is unclear why they, or any of the other London DDU consultants, were not asked by the GMC to give evidence.

¹¹⁴ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 11 December 1986, p. 45.

¹¹⁵ *Ibid.* p. 51

¹¹⁶ *Ibid.* p. 71.

¹¹⁷ *Ibid.* p. 75.

¹¹⁸ *Ibid.* pp. 64-65.

¹¹⁹ CMAC PP/DAL/E/4/20, ‘The drug clinic consultant group’; CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 22 November 1986; CMAC PP/DAL/E/4/20, No. of points Dally wishes to raise: Connell and Bewley as witnesses, 25 November 1986.

It is appealing to suggest that perhaps they were too close to the case. Whilst they may not have deliberately orchestrated the hearing it was obvious that they had much to gain by forcing a doctor like Dally out of practice. Being seen to be so directly involved in its outcome would have exposed the political motives of this group of clinicians. Nonetheless, these political dimensions were widely recognised as being vital in determining the course of the case and particularly its outcome.

3. Reaching a verdict: the politics of the GMC

The conduct of the PCC during the hearing indicated that the GMC did not take a neutral view of Dally's case or the treatment debate that underlay it. The GMC were prepared to bend their own rules on patient confidentiality to ensure that the case continued. On the second day of the hearing the cross-examination of the mother of a former patient of Dally's led to a complex legal debate about the use of patient records.¹²⁰ The GMC's 'Blue Book' permitted the disclosure of information gleaned from medical records without the consent of the patient if the doctor was directed to do so by a judge or other officer of the court.¹²¹ Both counsels in the Dally case were using patient records without necessarily having the approval of each individual. The Legal Assessor determined that as the PCC was not a court, the confidentiality ruling should apply, and the chairman ruled that evidence of agreement or attempts to obtain agreement should be provided before any patient's notes were used.¹²² However, on the fourth day of the hearing, after a six-week adjournment for Christmas, the committee reconsidered the issue, and the ruling was reversed.¹²³ It was decided that evidence based on medical records could be heard without the consent of the patient

¹²⁰ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 10 December 1986, pp. 65-70.

¹²¹ Smith, *Medical Discipline*, p. 61.

¹²² *Ibid.* p. 61; CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 11 December 1986, pp. 14-16, p. 1; Dally, *A Doctor's Story*, pp. 178-80.

¹²³ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 26 January 1987, pp. 1-7

concerned as long as they were not identified in public.¹²⁴ The rules on confidentiality did not apply, the Chairman explained, because it was ‘in the public interest’ for confidential information to be used as evidence in this case.¹²⁵ This ruling provoked the resignation of one of the committee members, Dr Michael O’Donnell. O’Donnell felt that the ruling was ‘at odds with my understanding of the position and purpose of this Council.’¹²⁶ O’Donnell devoted his column in the *British Medical Journal* a few weeks later to attacking the committee’s decision. He argued that the committee had got themselves into a procedural mess because of the way the charges were framed and as a result were ‘bending the rules to suit our own convenience.’¹²⁷ O’Donnell noted that the GMC’s Blue Book stated confidential information could be disclosed on rare occasions if it was in the public interest to do so, in circumstances such as the investigation by the police of a serious crime. According to O’Donnell these were not applicable in this case: ‘The GMC’s post hoc explanation reads like a desperate attempt to excuse what, at the time, I thought was inexcusable. I still do.’¹²⁸

The admissibility or otherwise of patient records was not a crucial issue in determining the actual outcome of Dally’s case. The ‘prosecution’ were able to refer to them to condemn her actions, but she was also able to use her notes to defend these. It was the decision to allow the use of confidential information without prior consent and the justification made by the committee for this that was more significant. Patient confidentiality is a central tenet of medical practice, and has been since Antiquity. It is a principle that the GMC are supposed to defend; divulging confidential

¹²⁴ *Ibid.* pp. 1-7; Smith, *Medical Discipline*, p. 61

¹²⁵ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 26 January 1987, pp. 1-7.

¹²⁶ *Ibid.*

¹²⁷ As the first charge levelled against Dally involved around 200 patients getting consent from each of these would have been difficult. M. O’Donnell, ‘One Man’s Burden’, *British Medical Journal*, 294, (14 February 1987) p. 451.

¹²⁸ *Ibid.* p. 451.

information about a patient can itself constitute serious professional misconduct.¹²⁹

The fact that the PCC were prepared to disregard this indicates the seriousness with which the case was viewed. Without evidence based on patient records the case would have failed; neither ‘prosecution’ nor ‘defence’ would have been able to sustain an argument. The hearing would have had to be adjourned until consent from every patient could be obtained, or quashed completely. The PCC clearly wanted the hearing to continue, even at the cost of ignoring the ‘sacred principle.’¹³⁰

It is tempting to suggest that elements within the PCC and the GMC as a whole wanted the hearing to continue because they sought to convict Dally of serious professional misconduct and use the case to deter other practitioners who might be tempted to offer maintenance treatment to addict patients. Between March 1986 and January 1987 Russell Smith observed PCC hearings for a doctoral thesis, and later book, on the self-regulation of medicine.¹³¹ Having witnessed the Dally case he felt it raised a number of important issues about the operation of medical discipline. Smith noted that a problem occurred in determining what constituted serious professional misconduct in a field such as the treatment of addiction where medical opinion was divided.¹³² There was, he argued, a potential risk that ‘Committee members adjudicating upon a particular case could be chosen expressly because of the views they entertain of a given theory of treatment, thus resulting in a biased tribunal.’¹³³ Although Smith thought such a case to be ‘extreme’ and ‘unlikely’ and could find no evidence to suggest that this had ever taken place, it can be argued that questions directed at witnesses by members of the PCC during Dally’s hearing revealed a

¹²⁹ GMC, *Professional Conduct and Discipline: Fitness to Prescribe* (the ‘Blue Book’); Stacey, *Regulating British Medicine*, p. 151.

¹³⁰ O’Donnell, ‘One man’s burden’, p. 451.

¹³¹ Smith, *Medical Discipline*, p. 18.

¹³² *Ibid.* p. 39.

¹³³ *Ibid.* p. 39

certain degree of antipathy towards her methods.¹³⁴ The questions asked by one member of the committee in particular, Dr Henry Ashworth, a retired GP from Manchester, betrayed a personal disapproval of maintenance. Ashworth asked Khalid about his attitude towards treatment immediately after his discharge from Dally's care. He said: 'Would it be fair to say that at the time your thoughts were only really in terms of getting drugs?' Khalid agreed. Ashworth went on 'And you were not really satisfied with any sort of treatment that did not supply you with drugs, because that was your aim, was it not?' Khalid replied 'Yes it was.' Ashworth concluded by saying 'Now that you see there is some other kind of treatment. Is that true?' Khalid agreed.¹³⁵ Ashworth was clearly using his opportunity to ask witnesses questions to put his own views about drug addicts, addiction and its treatment. Ashworth said to 'Miss B' a former addict patient of Dally's: 'Madam, for years you have been a member of that dark, dreary, unhappy culture, the drug scene. Do I gather Dr Dally's name is well known in your culture?' Miss B replied 'It is renowned.' Ashworth continued 'Do I understand that it is renowned because she maintains you and makes no effort to reduce or refer you to any detoxification centres?' Miss B replied 'Yes.'¹³⁶ The chairman did object to this as a leading question, but Ashworth had made his point, just as he had obviously already decided that by prescribing for patients on a maintenance basis Dally was not providing treatment. This was evident in the questions Ashworth directed at Dally herself. Ashworth asked what 'stimulus' there was for her patients to come off drugs if she 'prescribe[d] for them according to their demands?' Dally replied 'As I do not prescribe according to their demands I cannot answer that question.' Ashworth said: 'There is a difference, is there, between

¹³⁴ *Ibid.* p. 78; p. 39.

¹³⁵ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 10 December 1986, pp. 21-23.

¹³⁶ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 11 December 1986, pp. 40-41.

your type of prescribing and prescribing on demand?’ Dally replied ‘Yes, a very great difference.’¹³⁷

Dally devoted much attention to the conduct of Ashworth and other members of the PCC in her diary and autobiography. She and her lawyers even considered making it the subject of her appeal. Dally felt that Ashworth’s line of questioning was ‘hostile’ and ‘sarcastic.’¹³⁸ She reported that her supporters observed that Ashworth and other committee members, such as Dr Scott and Reverend Smith, affected ‘mutual despair’ when Dally’s barrister made an argument in her defence and smiled and nodded when a point went against her.¹³⁹ Ashworth and Scott were both members of the PCC that had found Dally guilty of serious professional misconduct in 1983.¹⁴⁰ It is impossible to say if they were deliberately selected for the later committee because of their views on Dally’s methods or maintenance treatment generally, but this is not implausible. Dally’s friend, the writer George Mikes, told her that O’Donnell had told him that the GMC had decided to find Dally guilty of serious professional misconduct and strike her off the register of licensed medical practitioners before the ‘defence’ had even been heard.¹⁴¹ This is, of course, hearsay, but it does indicate that the verdict in the Dally case may not have been reached by reliance upon the evidence presented alone.

The hearing finally concluded on 30 January 1987. The committee found that the second charge against Dally (her treatment of Khalid) had been proven to their satisfaction, but there was insufficient evidence to support the first, more general

¹³⁷ CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 27 January 1987, p. 75.

¹³⁸ Dally, *A Doctor’s Story*, pp. 207-208.

¹³⁹ *Ibid.* p. 181.

¹⁴⁰ *Ibid.* p. 181.

¹⁴¹ CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 7 February 1987. Dally also refers to the incident in *A Doctor’s Story*, p. 220, but without using O’Donnell’s name.

charge.¹⁴² The PCC believed that the second charge alone did constitute serious professional misconduct. The Chairman stated that as a result of this finding and Dally's 'blatant failure to heed the warning issued' at her 'previous appearance before the Committee in 1983 in relation to similar matters' her continued registration was made conditional on her not prescribing or possessing any controlled drugs for a period of 14 months.¹⁴³ Given the PCC's findings in other similar cases this could be considered a fairly lenient punishment. Between 1983 and 1989 47 cases of non bona-fide prescription of controlled drugs came before the PCC. Of these, five were found not guilty. In 15 cases the doctor's name was erased from the register, in 11 cases the doctor was admonished, in 8 cases the doctor was suspended for a fixed period, 4 cases were adjourned and in 4 cases the doctor's registration, like Dally's, was subjected to future conditions.¹⁴⁴ Whether this was a 'fair' verdict is another matter. Diana Brahams, barrister and legal correspondent for the *Lancet*, produced a detailed analysis of the case.¹⁴⁵ She noted that Home Office inspectors were convinced that Dally was well motivated and believed she was acting in the best interest of her patients. Brahams conceded that whilst Dally may not have been vigilant enough in respect of a single patient (Khalid) 'and for this she can be criticised' it was 'difficult to see what will be gained by forbidding her from prescribing in the area if the alternatives (supplies of impure drugs, dirty needles and the wave of crime committed to pay for supplies of street heroin) are worse.'¹⁴⁶ The

¹⁴² CMAC PP/DAL/E/4/17, PCC Hearing, 1986-1987, 30 January 1987, p. 26.

¹⁴³ *Ibid.* p. 31.

¹⁴⁴ Stacey, *Regulating British Medicine*, p. 164.

¹⁴⁵ D. Brahams, ' "Serious professional misconduct" in relation to private treatment of drug dependence', *Lancet*, (7 February 1987) 340-341.

¹⁴⁶ *Ibid.* p. 341.

‘street addict’ she argued was a danger to ‘himself’ and to the ‘community at large.’ Had the ‘medical establishment’ Brahams concluded, ‘got its priorities right?’¹⁴⁷

Questions were raised by both Brahams and Smith about the way in which the treatment Dally offered had been interpreted as being ‘irresponsible’ and, therefore, constituting serious professional misconduct. Brahams argued that ‘treatment which is medically respectable cannot at the same time be irresponsible.’¹⁴⁸ As a ‘respectable body of medical opinion’ approved of Dally’s treatment methods she could not be considered to be guilty of irresponsible practice.¹⁴⁹ Smith was of a similar opinion. He argued a doctor should not face a misconduct hearing merely because they had adopted a ‘practice of medicine which, while having its opponents, is none the less justifiable as one manner of treatment.’¹⁵⁰ In the Dally case

one was left with the unhappy situation of a doctor having her conduct adjudicated and its undesirability declared, presumably for the benefit of the whole medical community in knowing what was acceptable conduct in the eyes of the GMC, when she had merely been following one school of thought which had its own substantial body of advocates.¹⁵¹

The PCC were clearly not only judging one doctor’s conduct but also the suitability of maintenance as a form of treatment for heroin addiction.

In this sense, the conviction of Dally on the lesser of the two charges represented a partial failure for those who wished to see maintenance utterly discredited. Dally felt that the GMC had ‘been unable to condemn my method of treatment’ although they ‘ensured that no one would be tempted to follow it.’¹⁵² This was a broadly accurate assessment. Whilst Dally’s treatment of Khalid was exposed as being somewhat slipshod she was able to demonstrate that her general methods and

¹⁴⁷ *Ibid.* p. 341.

¹⁴⁸ *Ibid.* p. 341.

¹⁴⁹ *Ibid.* pp. 340-341.

¹⁵⁰ Smith, *Medical Discipline*, p. 72.

¹⁵¹ *Ibid.* p. 71.

¹⁵² CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 31 January 1987; Dally, *A Doctor’s Story*, p. 216.

philosophy were acceptable as a form of treatment by offering a successful defence of maintenance. The GMC were able to denounce the practitioner, but not the practice. Even those doctors who had appeared for the ‘prosecution’ conceded that some addict patients might require long-term prescription. Marks’ powerful testimony on the benefits of this was particularly important, both as an endorsement of Dally’s methods and maintenance treatment more generally. Though the verdict effectively compelled Dally to retire from the treatment of addiction and other doctors mindful of their careers may well have followed suit, maintenance treatment persisted, and was even strengthened as a result.

4. The aftermath

The Dally case was important not just because it polarised many of the issues in the treatment debate, but also because it brought these issues into the centre-field. Media coverage of the case helped to expose its political significance, highlighting the medical dispute at its core and raising questions about the most appropriate way to handle the burgeoning drug ‘problem.’ Letters in support of Dally and denouncing the PCC’s verdict appeared in the medical press.¹⁵³ Beckett, writing in the *Lancet*, hoped that the GMC would begin to question the treatment offered to long-term addicts as a result of the case.¹⁵⁴ Orthopaedic surgeon and father of an addict patient of Dally’s, Patrick Monahan, wrote to both the *Lancet* and the *British Medical Journal*, arguing that Dally’s treatment by the profession had fallen short of expected standards. He asserted that ‘impartiality, untarnished by prejudice, must be re-

¹⁵³ See particularly, *Lancet*, (28 February 1987), pp. 509-510 and *British Medical Journal*, 294, (28 February 1987), pp. 573-574.

¹⁵⁴ H.D. Beckett, Letter, ‘Treatment of drug addiction’, *Lancet*, (28 February 1987), p. 509.

established in all matters related to drug abuse.’¹⁵⁵ Others were keen to highlight the more general implications the Dally case raised. Writing in the *BMJ* Marjot argued the case demonstrated a need for reform of the GMC that acted as ‘prosecutor, judge, jury and executioner.’ Or else, ‘no doctor will be safe if he or she offends medical orthodoxy.’¹⁵⁶ Not all voices expressed disgust with the PCC’s decision. In a carefully worded letter Connell attacked Brahams’ assertion that what was medically respectable should not be considered irresponsible. Connell argued there were many types of treatment that whilst universally accepted could, nonetheless, be practised irresponsibly.¹⁵⁷ Connell may have had a point, but his argument ignored the more significant issue that Brahams tried to raise: in the Dally case a particular *type* of treatment in and of itself was being held up as irresponsible, irrespective of the way it was practised.

Despite Connell’s attempt at diminishing the political significance of the case its importance was widely recognised outside medical circles. Indeed, Dally’s case received a range of coverage from sources as diverse as the BBC’s *Panorama* to *Cosmopolitan* magazine. The broadsheet newspapers reported daily proceedings of the hearing throughout the case, initially picking out only the most negative and sensational details.¹⁵⁸ As the hearing continued and the ‘defence’ was presented more analytical pieces began to appear. Despite Dally’s fears that the left-wing press would be uninterested in the case because it concerned private practice, some of the most sympathetic coverage came from the *Guardian* and the *Observer*.¹⁵⁹ On the eve of

¹⁵⁵ P. Monahan, Letter, ‘Treatment of drug addiction’, *Ibid.* pp. 509-510. See also P. Monahan, Letter, ‘Dally, O’Donnell and the GMC’, *British Medical Journal*, 294, (28 February 1987), p. 574.

¹⁵⁶ D.H. Marjot, Letter, ‘Dally, O’Donnell and the GMC’, *Ibid.* pp. 574-575.

¹⁵⁷ P. Connell, Letter, ‘Treatment of drug addiction’, *Lancet*, (28 February 1987), p. 510.

¹⁵⁸ See, for example, *The Times*, 10 December 1986, p. 3, *The Times*, 11 December 1986, p. 3, *The Times*, 12 December 1986, p. 7, *The Times*, 28 January 1987, p. 3, *The Independent*, 10 December 1986, p. 2, *The Independent*, 11 December 1986, p. 3.

¹⁵⁹ CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 2 February 1987.

the hearing an article by Arnold Trebach was published in the *Guardian*. Trebach argued that ‘they’ (the GMC, the Royal College of Psychiatrists and the Home Office) were ‘after’ Dally again. He believed that prominent people within the medical establishment wished to impose their orthodoxy on the treatment of addiction. Dally was being pursued as a result of her criticism of these policies and also because she was in private practice.¹⁶⁰ Carmel Fitzsimons, writing in the *Observer*, noted that the case raised questions about the best way to treat heroin addiction. She interviewed Dally during the six-week break in the hearing, publicising her views on the treatment of addiction and her ‘battle’ with the ‘drug-dependency establishment.’¹⁶¹ Another favourable piece appeared in the *Guardian* once the hearing resumed in January 1987. Ed Vulliamy highlighted a number of key points about the case; that it was a ‘test’ of the ‘medical establishment’s’ view that maintenance was inappropriate, that the GMC’s lawyers had employed a private detective to investigate Dally’s prescription and also that the GMC had threatened the BBC with an injunction over the content of a *Panorama* programme about the case.¹⁶² Dally was approached by John Ware, the producer of *Panorama* in November 1986, about making a programme on her case and the issues that surrounded it.¹⁶³ When the GMC found out about the documentary they tried to get a High Court injunction to ban its transmission.¹⁶⁴ After watching the programme, the GMC’s lawyers felt they would not win an injunction and the case was dropped.¹⁶⁵ Nonetheless, Dally asserted that considerable changes were made to the programme before it was broadcast as a result of pressure from the GMC.

¹⁶⁰ A. Trebach, *The Guardian*, 3 December 1986, p. 13.

¹⁶¹ C. Fitzsimons, *The Observer*, 25 January 1987, p. 6.

¹⁶² E. Vulliamy, *The Guardian*, 26 January 1987, p. 17.

¹⁶³ CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 13 November 1986; Dally, *A Doctor’s Story*, p. 164.

¹⁶⁴ CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 3 December 1987; Dally, *A Doctor’s Story*, pp. 168-169.

¹⁶⁵ Dally, *A Doctor’s Story*, p. 170.

She stated that film of addicts leading a ‘normal’ life was cut. An interview with Connell was omitted after he withdrew his consent for it to be used. There was no mention of the threatened injunction and the alterations made as a result.¹⁶⁶ The programme did, however, heighten the profile of the Dally case and the debate over the treatment of addiction, bringing the issues to a wider audience.

Many other observers of the Dally case drew parallels with that of obstetrician Wendy Savage who had faced disciplinary action as a result of her unorthodox views about childbirth. Savage too had faced opposition from the medical establishment, although she won her case and retained her job. She offered advice to Dally throughout the case, wrote a supportive article in the *Guardian* at the time of Dally’s (unsuccessful) appeal, and later contributed a foreword to Dally’s autobiography pointing out the similarities in their cases.¹⁶⁷ One of these was clearly their gender, an issue dealt with by Miranda Ingram in *Cosmopolitan* magazine. Ingram speculated that authority punished dissident women more heavily. She drew parallels between Dally’s case and that of Savage, noting that:

Both are women, strong-minded and outspoken. And both are guilty of essentially the same crime...[they] have, by their methods, challenged the status quo of one of the most conservative professions in this country. Worse still, they have caused the profession to score two home [sic.] goals since its efforts to disgrace them inadvertently inspired public debate about the very issue it wished to ignore.¹⁶⁸

Comparisons were also made about the way evidence was accumulated against Dally and Savage. In both cases no complaint was received about the doctor’s behaviour; instead their medical records were scrutinised by officials looking specifically for

¹⁶⁶ *Ibid.* pp. 171-173; CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 7 December, 8 December.

¹⁶⁷ Dally, *A Doctor’s Story*, pp. xiii-xv, pp. 160-161, p. 173, p. 184, p. 237, pp. 239-242; W. Savage, *The Guardian*, 3 June 1987, p.

¹⁶⁸ CMAC PP/DAL/E/4/1, Articles and newspaper cuttings, 1974-1987, M. Ingram, ‘Why women doctors are in the dock’, *Cosmopolitan*, (August 1987) pp. 8-10.

information that might lead to a charge being brought.¹⁶⁹ Marjot coined a new verb to describe this process: ‘to be Savaged.’¹⁷⁰

Through coverage of the Dally case in a wide range of media the issues at the heart of the treatment debate were brought to a non-medical audience. Within medicine, there was a gradual reconsideration of the role of maintenance in the treatment of heroin addiction. This was partly as a result of the Dally case and the publicity it generated. In a commentary on the case the legal correspondent for the *British Medical Journal*, Clare Dyer, observed that ‘the move to curb Dr Dally’s prescribing comes at a time when the threat of acquired immune deficiency syndrome [AIDS] is giving new fuel to the debate over prescribing policy for drug addicts.’ Dyer noted that an argument was being made that flexible prescription would bring more addicts into clinics, and through this contact the risk of HIV infection and its transmission to the ‘general population’ could be reduced.¹⁷¹ Concern about incidences of HIV and AIDS amongst heroin addicts was growing in the immediate aftermath of the Dally case. This prompted a re-examination of the position of long-term prescription of opioid drugs to addicts. The impact of HIV and AIDS upon drug addiction treatment policy will be considered in more detail in the Conclusion, but it is worth noting that medical opinion appeared to be changing towards maintenance quite apart from the issue of AIDS. At a conference of the Royal College of Psychiatrists a few months after the Dally case concluded Marks proposed a motion in support of the long-term prescription of opioid drugs to addicts. Although the vote went against the motion (38 opposed, 29 in favour and 9 abstentions) it was indicative

¹⁶⁹ A. Dally, ‘Dally’s defence’, *New Society*, 25 September 1987, 20-21, p. 21.

¹⁷⁰ Marjot, ‘Dally, O’Donnell and the GMC’, p. 573. He also used this term in an interview with BBC Radio Four’s programme *File on Four*, broadcast 24 September 1987. A transcript of this programme and an audio copy of the broadcast are available at CMAC PP/DAL/B/4/2/11, ‘Long term drug addicts’, *File on Four*, 1987.

¹⁷¹ C. Dyer, ‘Dr Ann Dally’s continued brushes with the GMC’, *British Medical Journal*, 295, (26 September 1987) p. 774.

of a gradual shift in opinion.¹⁷² Even some of the strongest advocates for short-term withdrawal were forced to change their stance. In a televised debate on the treatment of addiction in March 1987 Connell agreed that maintenance should be re-examined as a possible form of treatment for addiction.¹⁷³ In May, he announced the *Guidelines* would be revised to reconsider the position of long-term prescription to addicts, especially in the light of the problems presented by HIV and AIDS.¹⁷⁴ An editorial in the *Lancet* that same month was staunchly in favour of the long-term prescription of opioids to addicts. A number of arguments were made for maintenance, including the futility of expecting a rapid ‘cure’ to addiction and the problems arising from the illicit trade in drugs, such as rising crime.¹⁷⁵ *Drug Scenes*, a special report on drugs and drug dependence by the Royal College of Psychiatrists also published in 1987, discussed maintenance as a method of treatment in an even-handed manner. The report asserted that ‘it is not a question of whether methadone maintenance is in some intrinsic sense “good” or “bad” but whether it is likely to be the best option for a particular patient in particular circumstances.’¹⁷⁶ Maintenance, it seemed, was being ‘brought in from the cold.’¹⁷⁷

Whilst it is impossible to quantify the impact of the Dally case on this thawing of attitudes, it did help to create a climate where a reconsideration of the long-term prescription of opioids to addicts was possible. The case had been brought by advocates of short-term withdrawal and the clinical method in order to discredit maintenance and the more ‘social’ approach to disease this represented. Given the

¹⁷² CMAC PP/DAL/E/4/18, Personal account of the case by Dally, 1986-87, 28 March 1987.

¹⁷³ *Ibid.*; MacGregor, ‘Choices for policy and practice’, p. 194.

¹⁷⁴ A. Veitch, *The Guardian*, 6 May 1987; P. Wallin, *Today*, 6 May 1987; L. Fraser, *Mail on Sunday*, 19 May 1987, p. 5; ‘AIDS prompts drug services review’, *Druglink*, July/August 1987.

¹⁷⁵ ‘Editorial - Management of drug addicts: hostility, humanity and pragmatism’, *Lancet*, (9 May 1987) 1068-1069, p. 1069.

¹⁷⁶ Royal College of Psychiatrists, *Drug Scenes: A Report on Drugs and Drug Dependence by the Royal College of Psychiatrists*, (London: Royal College of Psychiatrists, 1987) pp. 188-189.

¹⁷⁷ This will be discussed in greater detail in the conclusion in relation to the impact of HIV and AIDS on drug policy.

power of both clinical medicine at a general level and the supporters of rapid withdrawal within the medical establishment it is all the more surprising that a wholesale condemnation of maintenance was not produced. Indeed, the Dally case represented something of a minor victory for the supporters of the long-term prescription of opioids to addicts. This was part of, and in a small way helped to cause, a rapprochement towards maintenance as a form of treatment for heroin addiction.

To assess why maintenance ‘won,’ it is necessary to return to the fluctuating relationship between the medical and the social in determining the response to heroin addiction. Changes taking place in broader drugs policy fed into the specific approach to heroin. Initiatives such as *Tackling Drug Misuse* placed greater emphasis on crime and the social problems caused by drug use. The range of agencies involved in drug issues expanded still further, representing a move away from purely medically dominated approaches into what Berridge has called the ‘new policy community.’¹⁷⁸ Within this, clinicians needed to prove that they retained a distinct and crucial role. This could be achieved by addressing the primary concerns of this policy community, such as the social problems arising from drug use. Maintenance appeared to offer if not a solution, at least a potential way to alleviate some of these by placing individuals rather than their disease at the centre of treatment. The ‘triumph’ of maintenance in the dispute over drug addiction treatment does not, therefore, necessarily represent the victory of community-based biographical medicine over hospital-based clinical medicine, but is more indicative of the continued adaptability of medicine in applying itself to ‘social problems.’ The conflict between competing styles of medicine was less significant than medicine’s conflicts with outside forces.

¹⁷⁸ Berridge, ‘AIDS and British drug policy: continuity or change?’, p. 141.

It is ironic then, that to retain its role in addiction, as in other areas, 'medicine' became ever more 'social.'

Conclusion

Epilogue: Drug Policy, AIDS and Beyond

Debates about the treatment of heroin addiction shifted in focus from 1987 onwards as it became apparent that HIV, and with it the possibility of developing full-blown AIDS, could spread between intravenous drug users sharing injecting equipment. HIV and AIDS posed very real challenges to addiction treatment policy in the late 1980s, forcing a re-examination of previously rejected approaches as well as the adoption of seemingly novel initiatives.¹ The ACMD's assertion that AIDS was a greater threat to public health than drug misuse meant that prevention of the spread of HIV amongst intravenous drug users was accorded more importance than curing them of their addiction.² Those who had previously been staunchly opposed to the long-term prescription of drugs to addicts, such as John Strang, reconsidered their position.³ Needle exchanges, providing addicts with clean needles and syringes in return for used ones, sprang up all over England and Scotland, initially as pilot schemes, and later as part of the established 'harm minimisation' response to drug use.⁴ It is questionable, however, if these developments constituted an entirely 'new' direction for addiction treatment policy. Virginia Berridge has pointed to the existence of important continuities with the past, such that 'despite the apparent revolution in the rhetoric of drug policy achieved by AIDS, many aspects of post

¹ For an account of the many challenges posed by HIV and AIDS see, for example, J. Strang & G.V. Stimson, 'The impacts of HIV: forcing the process of change' in J. Strang & G.V. Stimson, (eds.) *AIDS and Drug Misuse: The Challenge For Policy and Practice in the 1990s* (London & New York: Routledge, 1990) pp. 3-4.

² ACMD, *AIDS and Drug Misuse: Part One* (London: HMSO, 1988), p. 1, p. 17, p. 75.

³ J. Strang, 'The roles of prescribing' in Strang & Stimson, *AIDS and Drug Misuse*, pp. 142-152.

⁴ G.V. Stimson, M.C. Donoghone, R. Lart & K. Dolan, 'Distributing sterile needles and syringes to people who inject drugs: the syringe exchange experiment', in Strang & Stimson, *AIDS and Drug Misuse*, pp. 222-231; Lart, *HIV and English Drug Policy*, pp. 85-89; Berridge, 'AIDS and British drug policy: continuity or change?', pp. 149-151.

AIDS policy were inherent in drug policy in the 1980s.’⁵ Gerry Stimson asserts that ‘new’ ideas about how to deal with heroin addiction in the wake of AIDS had their roots in earlier work, that change was ‘perhaps a matter of emphasis and direction, rather than abrupt rupture with the recent past.’⁶ Susanne MacGregor has also expressed doubts as to whether AIDS prompted the development of a distinct phase of drug policy, suggesting there was more a modification of existing practices.⁷

Indeed, there are startling parallels between debates about the treatment of addiction after AIDS and those of the pre-AIDS era that have formed the basis of this thesis. Examining the impact of AIDS on drug policy is a useful tool for reflecting back on earlier issues. This conclusion, therefore, will use AIDS to do three things. First, it will consider how the discovery of HIV and AIDS amongst intravenous drug users impacted upon the way drug addiction was seen and responded to, especially through the paradigm of public health. It is argued that relating addiction to public health was not a new occurrence, that concern about the dangers posed to collective as well as individual health was a concept that had informed drug policy since at least the 1960s. Second, this conclusion will assess how far the recognition of AIDS as a greater threat to public health than drug use led to real change in drug addiction treatment policy. It is suggested that there were strong echoes of past debates, given new impetus by the threat of AIDS. Finally, there will be an attempt to take the ‘long view’ to determine whether there was continuity or change in drug addiction policy over the period examined by this thesis. Questions about continuity or change post-AIDS can equally be applied to the pre-AIDS period and even to the present day.

⁵ Berridge, ‘AIDS and British drug policy: continuity or change?’, p. 152. For an earlier version of this article see V. Berridge, ‘AIDS and British drug policy: history repeats itself?’ in Whyne & Bean (eds.) *Policing and Prescribing*, 176-199.

⁶ G.V. Stimson, ‘Revising policy and practice: new ideas about the drugs problem’ in Strang & Stimson, *AIDS and Drug Misuse*, p. 129.

⁷ MacGregor, ‘Choices for policy and practice’, p. 197.

Considering the influence of AIDS on drug addiction treatment policy thus allows for reflection on the key issues dealt with by this thesis and places these in their contemporary context.

1. A greater threat? AIDS, drugs and public health

The identification of AIDS as a disease in its own right is usually dated to a report on the deaths of five young, previously healthy, homosexual men in Los Angeles from pneumocystis pneumonia, a condition found almost exclusively in people with defective immune systems, published by the Centers for Disease Control in June 1981.⁸ The *Lancet* reported the first British case in the same year, in which another previously healthy homosexual male succumbed to pneumocystis pneumonia.⁹ As these early cases were all gay men it was thought that there was a link between male homosexual activity and immunodeficiency, and the condition became known as GRID (Gay-Related Immuno-Deficiency).¹⁰ In the subsequent months there were reports of immunodeficiency related diseases in heterosexuals too, particularly in haemophiliacs, those who had recently received blood transfusions and intravenous drug users. GRID no longer seemed an appropriate label and the condition was renamed AIDS (Acquired Immune Deficiency Syndrome) at a conference in Washington D.C. in 1982.¹¹ In 1983 and 1984 the virus HIV (Human Immunodeficiency Virus) was identified as the putative agent responsible for causing

⁸ P.A. Treichler, 'AIDS, gender and biomedical discourse' in E. Fee & D.M. Fox (eds.) *AIDS: The Burdens of History*, (Berkeley, Los Angeles & London: University of California Press, 1988) p. 197; G.M. Oppenheimer, 'In the eye of the storm: the epidemiological construction of AIDS' in Fee & Fox (eds.) *AIDS: The Burdens of History*, p. 270; R. Shilts, *And The Band Played On: Politics, People and the AIDS Epidemic* (New York: St Martins Press, 1987) pp. 53-112.

⁹ V. Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford: Oxford University Press, 1996) p. 15.

¹⁰ *Ibid.* p. 28; Treichler, 'AIDS, gender and biomedical discourse', p. 198.

¹¹ Treichler, 'AIDS, gender and biomedical discourse', p. 198.

AIDS.¹² HIV was passed on through blood and blood products, through sexual intercourse or from mother to child during pregnancy. Though there was evidence from as early as 1983 that the virus could spread through heterosexual as well as homosexual sex, the issue of HIV/AIDS in heterosexuals was largely ignored in Britain until 1985, when the possibility of the spread of AIDS amongst intravenous drug users was first seriously considered.¹³ By 1986, it was clear that this possibility was rapidly becoming a reality. A study of injecting drug users in Edinburgh found that 50 per cent of the sample tested had HIV.¹⁴ GP Roy Robertson, whose patients had formed the sample group, called for the widespread availability of syringes and a less 'punitive approach towards drug control' to prevent the deaths of large numbers of intravenous drug users.¹⁵

Robertson's pleas, and those of others, fell initially on stony ground. Ministers at the Scottish Home and Health Department felt that needle exchanges would condone and even encourage drug use, as well as being prohibitively expensive.¹⁶ They did, however, concede that the problem required further investigation and a committee was convened to provide advice on HIV and drug use. The committee, chaired by the regional director of the Blood Transfusion Service Dr D.B. McClelland, reported in 1986.¹⁷ McClelland's central recommendation was that the threat of the spread of HIV to the general population from intravenous drug users justified a 'harm minimisation' approach; that those addicts who could not or would

¹² Berridge, *AIDS in the UK*, pp. 45-46.

¹³ Treichler, 'AIDS, gender and biomedical discourse' pp. 192-195; Berridge, *AIDS in the UK*, pp. 90-91.

¹⁴ Berridge, *AIDS in the UK*, p. 92; Berridge, 'AIDS and British drug policy', p. 143; R. Robertson, 'The Edinburgh epidemic: a case study', in Strang & Stimson, *AIDS and Drug Misuse*, pp. 95-107; Lart, *HIV and English Drug Policy*, p. 83.

¹⁵ Berridge, *AIDS in the UK*, p. 93.

¹⁶ *Ibid.* p. 93.

¹⁷ Scottish Home and Health Department, *HIV Infection in Scotland: Report of the Scottish Committee on HIV Infection and Intravenous Drug Misuse*, (Edinburgh: Scottish Home and Health Department, 1986).

not abstain from intravenous drug use should be brought into contact with treatment services in order to prevent them from spreading HIV. Ernst Buning (a psychologist involved in harm minimisation programmes in Amsterdam) stated that the rationale behind harm minimisation was that 'If it is not possible to cure drug users, one should at least try to minimise the harm that is being done both to them and the wider social environment.'¹⁸ The implications of harm minimisation for drug policy will be discussed in greater detail below, but it is important to note that the McClelland report led not only to the establishment of pilot schemes to test the value of needle exchanges, but also foreshadowed the later findings of the ACMD investigation into AIDS and drug use.¹⁹

In the wake of the McClelland report and amid increasing signs of the spread of HIV amongst intravenous drug users the ACMD decided in May 1987 that a working group should be set up to consider the implications of HIV and AIDS for drug services.²⁰ The working group were to report on measures which should be taken to 'help combat the spread of HIV infection,' concentrating particularly on how 'drug misusers' could be brought into contact with treatment services 'with a view to preventing or minimising unsafe injecting and other harmful behaviour.'²¹ The group, chaired by Ruth Runciman of the Citizens Advice Bureau, met for four months, hearing evidence from those in the drug 'misuse' and AIDS fields and were ready to report in the autumn of 1987, but government reticence meant the final report was not published until March 1988.²² The Runciman committee's most important

¹⁸ E. Buning, 'The role of harm reduction programmes in curbing the spread of HIV by drug injectors' in Strang & Stimson, *AIDS and Drug Misuse*, 143-161, p. 154.

¹⁹ Lart, *HIV and English Drug Policy*, pp. 87-89; Berridge, 'AIDS and British drug policy', p. 143; Berridge, *AIDS in the UK*, p. 120.

²⁰ ACMD, *AIDS and Drug Misuse: Part One*, p. 5.

²¹ *Ibid.* p. 82.

²² The significance of the membership of the ACMD working group will be discussed in greater detail below. *Ibid.* p. 5; Berridge, *AIDS in the UK*, p. 221; Berridge, 'AIDS and British drug policy', p. 144.

and oft repeated conclusion was that ‘HIV is a greater threat to public and individual health than drug misuse.’²³ This led them to recommend, as had the McClelland committee, that services concentrating on harm minimisation should take precedence. Not all intravenous drug users would stop injecting, ‘We must therefore be prepared to work with those who continue to misuse drugs to help them reduce the risks involved in doing so, above all the risk of acquiring or spreading HIV.’²⁴

Stimson has argued that this outlook reflected a ‘new public health paradigm of drug problems’ that:

HIV has simplified the debate. Rather than seeing drug use as a metaphorical disease, there is now a real medical problem associated with drug use. All can agree that this is a major health problem for people who inject drugs, their sexual partners and their children.²⁵

HIV and AIDS did reiterate the potential danger posed by drug use to collective health but, as this thesis has shown, it is misleading to refer to the public health paradigm as a ‘new’ way to view drug addiction. By describing heroin addiction as a ‘socially infectious condition’ the second Brain report (published in 1965) was drawing on contemporary notions of public health, of the social as well as the individual body.²⁶ Notions of public health and drug use clearly pre-dated the Runciman report. Parallels between the 1960s and the post-AIDS era were drawn by, among others, Alan Glanz of the ARU in 1988.²⁷ Glanz asserted that ‘Drugs policy in Britain has entered a new phase and returned to an old phase. The public health

²³ ACMD, *AIDS and Drug Misuse: Part One*, p. 1, p. 17, p. 75.

²⁴ *Ibid.* p. 17.

²⁵ Stimson, ‘Revising policy and practice’, p. 125, p. 124.

²⁶ *Drug Addiction: The Second Report of the Interdepartmental Committee*, p. 8. For further discussion of this issue See Chapter One, p. 52; A. Mold, ‘The “British System” of heroin addiction treatment and the opening of the Drug Dependence Units, 1965-1970’, *Social History of Medicine*, (forthcoming, December 2004).

²⁷ Berridge also cites an observer who drew parallels between Brain and Runciman. See Berridge, ‘AIDS and British drug policy’, p. 148.

imperative has re-asserted itself in the face of the AIDS emergency.²⁸ Berridge has also pointed to the public health aspects of the Brain report, noting that ‘The remedies suggested by Brain – including notification and compulsory treatment – were classic public health responses.’²⁹ Public health has, she argues, formed a dimension to drug policy since the nineteenth century, that the attention paid to opium adulteration, infant doping and working-class opiate use reflected concerns about collective health.³⁰ There was clearly nothing ‘new’ about a public health understanding of drug use in the late 1980s.

Examining the nature of this response in more detail does, however, suggest some differences with past understandings, even if the framework in which these were located was not entirely novel. Public health was not a static collection of concepts and approaches and this is exemplified in its interaction with drug policy. The public health of the 1960s focused on sickness within the social body, on the relationship between individuals as a source of disease. Epidemiology came to the fore as a way of observing the pattern of disease and predicting where this might occur next. This was reflected in Brain’s understanding of addiction as a ‘socially infectious condition’ that required ‘epidemiological assessment and control.’³¹ By the late 1980s understandings of public health had moved away from relationships between individuals and began to centre on the behaviour of the individual. In this ‘new public health,’ according to Petersen and Lupton, ‘Individuals are expected to take responsibility for the care of their bodies and to limit their potential harm to others through taking up various preventive actions.’³² Here the concept of risk is central;

²⁸ A. Glanz, ‘Drug misuse and AIDS prevention: policy on the right track’, *British Journal of Addiction*, 83, (1988) 1237-1239, p. 1237.

²⁹ Berridge, ‘AIDS and British drug policy’, p. 148.

³⁰ *Ibid.* p. 149; Berridge, *Opium and the People*, pp. 75-109.

³¹ *Drug Addiction: The Second Report of the Interdepartmental Committee*, p. 8.

³² Petersen & Lupton, *The New Public Health*, p. ix.

‘risky’ activities such as smoking, drinking and taking drugs must be prevented to preserve the health of the individual and the community. If risky behaviours cannot be altered, then the damage they cause must be controlled and reduced. This is clearly the philosophy that underpinned the recommendations of the McClelland and Runciman reports: if injecting drug use could not be halted then the danger it posed should be minimised. Harm minimisation was a rationale rooted in the ‘new public health.’

Changes in the public health paradigm allowed for the creation of the concept of harm minimisation, but there were specific reasons as to why this was applied to drug ‘misuse’ in the late 1980s. Recognition of the potential damage that addiction could cause to society was also nothing new; this had been documented by Brain in the 1960s and recognised to a greater or lesser extent by all of those involved in the treatment of addiction from this point on. The ‘discovery’ of HIV and AIDS amongst intravenous drug users did, however, add another important dimension to this danger. AIDS was unquestionably a killer: of the 671 British cases reported in 1987 605 died before April 1995. Of the total 10,693 people diagnosed with AIDS between 1982 and 1994 7,346 are known to have died before April 1995.³³ The threat AIDS posed to individual and collective health seemed to far outweigh that of drug addiction.

2. A new response? Heroin addiction treatment post-AIDS

Establishing AIDS as the greater threat had significant implications for drug addiction treatment, not least as a result of the desire to work towards two not always mutually agreeable goals: the prevention and treatment of HIV and the prevention and treatment of drug ‘misuse.’ However, it is questionable how far heroin addiction

³³ Figures taken from Berridge, *AIDS in the UK*, p. 338.

treatment after 1987 differed from the pre-AIDS era. This section will consider two key aspects of drug policy to demonstrate that though AIDS brought about change it was within the confines of existing initiatives and coterminous with the general direction of policy. Firstly, it will examine the role of medicine in the response to heroin addiction post-AIDS, looking particularly at the involvement of specialists and generalists, revisiting the key debates over who should treat the addict discussed in Chapter Two and Chapter Three. Secondly, this section will consider how the concept of harm minimisation effected the treatment offered to addicts, the philosophy behind treatment and the place of the prescription of drugs to addicts. This allows a reconsideration of issues discussed in Chapters Four and Five and returns to the central problem of reconciling the ‘medical’ with the ‘social’ in approaches to addiction.

2.1 The role of medicine

The ‘discovery’ of HIV amongst intravenous drug users resulted in the continued expansion of the drug ‘policy community.’ The role of non-medical agencies in drug policy had gradually increased since the 1960s, when Brain’s definition of addiction as a social disease brought a wider range of actors into the arena. In the 1980s, this trend appeared to pick up speed, as the drug taker became ‘normalised.’³⁴ The ACMD, in *Treatment and Rehabilitation*, called for the ‘development of a range of services to help those with problems arising from the misuse of drugs,’ the Central Funding Initiative (CFI) pumped £17.5 million into community-based services between 1983 and 1987 in a direct attempt to shift focus from hospital-based treatment provision and civil servants actively encouraged a more ‘bottom-up’

³⁴ For a discussion of the normalisation of drug use see Chapter Two, p. 128. See also V. Berridge, ‘Historical issues’ in MacGregor, (ed.) *Drugs in British Society*, 20-35, pp. 21-25; Strang, ‘A model service’, p. 147.

approach, bringing voluntary agencies, former drug users and even current drug users into the ‘policy community.’³⁵ According to drug and alcohol expert Jerome Jaffe medicine no longer sat ‘at the top of the table.’³⁶ On one level, AIDS seemed to reinforce this drift away from the medical. Emphasis was placed less on curing the addict of their addiction and more on reducing the harm that this could pose to the individual and society. As harm minimisation became the orthodoxy those who had often existed outside the mainstream ‘policy community,’ such as voluntary organisations and user groups, were admitted to the fold.³⁷

However, the proliferation of bodies and individuals involved in drug policy both before and after AIDS must not be over-emphasised. As this thesis has shown, medicine, and within this hospital-based clinical psychiatry, retained a powerful, and even dominant, role in shaping policy towards drug addiction. Through their positions as consultant psychiatrists at leading London teaching hospitals DDU doctors were able to acquire expert status in dealing with the problems of the addict. This claim to expertise undermined the position of the community-based generalist treating addicts and at the same time afforded the specialist a greater role in the shaping of drug policy. Leading DDU doctors were expert advisors to the Ministry of Health and later the DHSS on drug issues, members of drug advisory bodies such as the ACMD and other powerful medical organisations like the Royal College of

³⁵ ACMD, *Treatment and Rehabilitation*, p. 2; Berridge, ‘AIDS and British drug policy’, pp. 141-142. For a more thorough exploration of the impact of the CFI see MacGregor, ‘Choices for policy and practice’, pp. 182-186; S. MacGregor, ‘Promoting new services: the Central Funding Initiative and other mechanisms’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 259-269; S. MacGregor, B. Ettore, & R. Coomber, *Summary of the First Phase of Research: An Assessment of the Central Funding Initiative on Services for the Treatment and Rehabilitation of Drug Misusers* (London: Birkbeck College, 1987).

³⁶ J. Jaffe in 1986 Okey Lecture to the Institute of Psychiatry, quoted in Berridge, ‘AIDS and drug policy’, p. 143. A similar argument about the displacement of medicine as the central authority on drug problems was also made by Gerry Stimson in ‘British drug policies in the 1980s: a preliminary analysis and suggestions for research’, pp. 477-488.

³⁷ The origins of ‘harm minimisation’ within the voluntary sector will be dealt with in more detail below. See particularly, G.V. Stimson, ‘Minimising harm from drug use’ in Strang & Gossop, *Heroin Addiction and Drug Policy*, 248-258.

Psychiatrists and the GMC. This allowed consultant psychiatrists' unparalleled opportunities to shape and direct drug policy, often to the exclusion of community-based physicians, whether in private or general practice.

There is evidence to suggest that this influence continued to be felt in the post-AIDS era despite a 're-medicalisation' of drugs that might have threatened the position of the psychiatrist. AIDS and HIV presented a number of clearly 'medical' problems for infected drug users and those treating them. AIDS could result in a range of other diseases: respiratory conditions such as pneumonia and tuberculosis, neurological disorders and dementia, gastrointestinal diseases and bacterial infections, problems with liver functioning and skin conditions.³⁸ According to Stimson, this resulted in a partial 're-medicalisation' of drug addiction treatment, as psychiatrists had to relearn physical medicine in order to conduct examinations for signs of HIV and AIDS related conditions.³⁹ Berridge also notes the revival of 'medical' involvement in drug addiction as a result of AIDS, pointing to the greater emphasis placed on the general health of the drug user.⁴⁰

The complications presented by HIV and AIDS to the treatment of addiction did not, however, prevent psychiatrists from continuing to take a leading role in the drug 'policy community.' Of the thirteen members of the ACMD working group on AIDS and drug 'misuse' only six were from a non-medical background. Of the remaining seven doctors four were psychiatrists, the largest single group.⁴¹ A parallel can clearly be drawn here with the earlier ACMD report *Treatment and Rehabilitation*, when four of the seven doctors on the working group were

³⁸ These are just some of the conditions associated with HIV and AIDS. For a more detailed account of these and how they affected drug users in particular see R. Brettle, M. Farrell & J. Strang, 'Clinical features of HIV infection and AIDS in drug takers', in Strang & Stimson, *AIDS and Drug Misuse*, 38-53 and M. Riccio & D. Hawkins, 'Neuropsychiatric complications of HIV infection' in *Ibid.* 54-63.

³⁹ Stimson, 'Rethinking policy and practice', pp. 128-129.

⁴⁰ Berridge, 'AIDS and British drug policy', p. 147.

⁴¹ ACMD, *AIDS and Drug Misuse: Part One*, p. 81.

psychiatrists.⁴² Further evidence to suggest that psychiatry remained central to the formulation of the response to drug addiction can be found by examining the nature of this response more closely. The Runicman report stressed that GPs and ‘other generic professions’ should play a greater role in the treatment of addiction.⁴³ The working group argued that the advent of HIV made it ‘essential that all GPs should provide care and advice for drug misusing patients to help them move away from behaviour which may result in them acquiring and spreading the virus.’⁴⁴ However, the part GPs were expected to play in the treatment of addiction was constrained. It was recommended that GPs should be equipped to deal with short-term detoxifications and medium-term withdrawal regimes. Furthermore, it was suggested that these be undertaken in co-operation with the Community Drug Teams (usually headed by a psychiatrist) and specialists, at either the district or regional level, were to deal with more ‘difficult’ cases, that is, those involving non-reducing long-term prescriptions or the use of injectable drugs.⁴⁵ Once more, there were echoes with the recent past. *Treatment and Rehabilitation* (1982) and the *Guidelines* (1984) similarly suggested a limited role for the generalist: supervision of GPs treating addicts by specialists and limitations to their prescription of drugs to addicts.⁴⁶ It would appear that AIDS had done nothing to diminish the importance of the clinical psychiatrist in drug policy.

2.2 Harm minimisation

The continued dominance of the psychiatrist meant that the actual treatment of heroin addiction altered little in the wake of AIDS. This is all the more surprising given the

⁴² ACMD, *Treatment and Rehabilitation*, pp. 87-88. See Chapter Two, pp. 117-118.

⁴³ ACMD, *AIDS and Drug Misuse: Part One*, p. 1.

⁴⁴ *Ibid.* p. 30.

⁴⁵ *Ibid.* pp. 49-50.

⁴⁶ ACMD, *Treatment and Rehabilitation*, p. 56; Medical Working Group on Drug Dependence, *Guidelines*, p. 17, p. 8. For an elaboration of the recommendations of both of these reports with respect to GP involvement and prescription see Chapter Two, pp. 115-124 and Chapter Four, pp. 206-221.

apparent conflict between a harm minimisation approach to drug use and the goals of addiction treatment. Harm minimisation gained widespread acceptance because AIDS was established as the greater threat to public and individual health. Bringing the drug user into contact with services in order to prevent them from spreading HIV was more important than stopping them from using drugs altogether. This implied a prioritisation not just of public over individual health, but of the prevention and treatment of HIV over the prevention and treatment of drug addiction.⁴⁷ It could be supposed, therefore, that this philosophy was at variance with abstinence-orientated treatment services. Yet, harm minimisation did not result in the abandonment of long-standing clinical objectives; abstinence remained the focus of treatment for addiction. These two seemingly conflicting concepts were brought together through the development of a 'hierarchy of goals.' The Runciman report recommended that 'services need to adopt a hierarchy of goals in dealing with drug misusers' and that 'the following goals will all reduce the risk to the individual and to others: a) becoming drug free, b) switching from injection to oral use, c) avoiding sharing equipment.' They concluded 'Services should therefore strongly encourage drug misusers towards a goal of abstinence, but for drug misusers who are not immediately motivated to give up, goals (b) and (c) will be more realistic for the time being.'⁴⁸

This approach was not, however, entirely new. John Marks offered treatment based around a set of structured goals at the Liverpool DDU from 1986 onwards.⁴⁹

Ann Dally similarly claimed that treating addiction was about priorities, stabilising the addict, before switching from injectable to oral drugs, reducing the dose when the

⁴⁷ Stimson and Buning both suggested that a choice needed to be made as to which was the higher priority, the fight against HIV or the fight against drugs. See Stimson, 'Revising policy and practice', p. 126; Buning, 'The role of harm reduction programmes', p. 161.

⁴⁸ ACMD, *AIDS and Drug Misuse: Part One*, p. 37.

⁴⁹ CMAC PP/DAL/B/4/2/8, Fazey, 'The evaluation of Liverpool Drug Dependency Clinic', pp. 29-30. See Chapter Four, pp. 197-199.

addict was ready and finally reaching abstinence.⁵⁰ Indeed, the entire concept of harm minimisation clearly predated HIV and AIDS. Stimson has argued that British drug policies have contained elements of harm minimisation since the publication of the Rolleston report in 1926.⁵¹ By suggesting that the addict could be prescribed the drug of their addiction when all other attempts to remove the drug had failed, the Rolleston report was recommending a course of action that reduced harm to the addict.⁵² Another source of ideas about harm minimisation, according to Stimson, was the drug ‘underground’ of the late 1960s and 1970s. He notes that the drug using subculture of this period produced numerous books and manuals on how to use and enjoy drugs whilst limiting their potentially damaging effects.⁵³ This was the philosophy of many voluntary organisations interested in drug issues, such as Release. Release was set up in 1967 initially to provide legal advice to young people arrested for drug offences, but its work rapidly widened to deal with a range of drug-related problems.⁵⁴ Their approach, disseminated through numerous publications, talks and active casework was to encourage those using drugs to do so in a manner that reduced the possible dangers. This was epitomised in the establishment of a telephone drug information service in 1975, designed to ‘prevent physical and psychological damage resulting from the use and abuse of licit and illicit drugs, adulterated or otherwise’ by

⁵⁰ Dally, *A Doctor's Story*, pp. 78-79. See Chapter Two, p. 142 and Chapter Four, p. 198.

⁵¹ Stimson, ‘Minimising harm from drug use’, p. 250.

⁵² Ministry of Health, *Departmental Committee on Morphine and Heroin Addiction*, pp. 9-13. See Chapter One, pp. 49-50.

⁵³ Stimson, ‘Minimising harm from drug use’, pp. 251-252.

⁵⁴ There is an extensive archive of papers relating to Release at the Modern Records Centre, University of Warwick. For early statements of Release’s purpose, see for example: MSS.171/3/12/12, The purpose of Release, July 1967. For a more comprehensive account of the work of Release see sociologist Jeremy d’Agapeyeff’s report on the organisation, MSS.171/5/1/2 Release: A progress report, 1972. For a published account of the origins and early work of Release by its founders see C. Coon & R. Harris, *The Release Report on Drug Offenders and the Law* (London: Sphere Books, 1969). Secondary sources which deal with Release include: J. Green, *All Dressed Up: The Sixties and the Counter-Culture* (London: Jonathan Cape, 1998), pp. 190-191 and A. Marwick, *The Sixties* (Oxford: Oxford University Press, 1998), pp. 788-789. Jonathon Green presents interviews with many of leading figures involved with Release, including Coon and Harris, in J. Green, *Days in the Life: Voices From the English Underground, 1961-1971* (London: Pimlico, 2nd edn., 1998). Release also have an excellent and recently updated website that details their history. See <http://www.release.org.uk>.

providing 'objective, non-hysterical information' to drug users.⁵⁵ Moreover, voluntary organisations were not the only place where harm minimisation objectives were practised. The stated purpose of the DDUs in 1968 was to treat the addict at the same time as preventing the development of the black market, a clear attempt to reduce the potential damage resulting from heroin use.

Though there was nothing new about harm minimisation, there was something different about its adoption in the post AIDS era. Crucially, there was a shift in the intended beneficiary of harm minimisation. The harm minimisation of Rolleston and Release was designed to protect the individual user; the harm minimisation of Runciman was intended to protect the entire community. Of course, this was not 'new' either, since by sanctioning the prescription of heroin to addicts at DDUs in the late 1960s the Ministry of Health had been clearly thinking of the benefit to society in preventing the development of a black market rather than the health of the addict. What was different about the harm minimisation of the AIDS era was the appearance of consensus that it enjoyed, even within clinical psychiatry. As Stimson has indicated, harm minimisation had not always been widely accepted. He asserts that reducing harm from drug use was a minority point of view throughout most of the 1970s and 1980s, found in the 'underground,' but rarely in clinical practice.⁵⁶ The DDUs of this era did not retain their harm-reducing outlook, switching to 'confrontational' methods of treatment such as prescribing addicts rapidly reducing doses of oral methadone in an effort to cure them of their addiction, rather than offering them heroin in order to prevent the development of a black market.⁵⁷ DDUs pursued abstinence-orientated programmes aimed at getting the addict off drugs as quickly as possible.

⁵⁵ MSS.171/3/44/1, The Release Drug Hotline, draft press release, 1975.

⁵⁶ Stimson, 'Minimising harm from drug use', p. 253.

⁵⁷ See Chapter One, pp. 58-59.

AIDS prompted a re-evaluation of these policies. The Runicman report identified two 'wider purposes' for the prescription of drugs to addicts to assist in the containment of the spread of HIV: firstly, 'attracting more drug users to services and keeping them in contact', and secondly, 'facilitating change away from HIV risk practices.'⁵⁸ The working group noted there was evidence to suggest that 'a prescribing function in a drug service can be successful in attracting some drug misusers who would not otherwise approach services.' This was important because 'drug misusers in contact with prescribing agencies are less likely to share injecting equipment.' The group concluded that 'prescribing can be a useful tool in helping to change the behaviour of some drug misusers either towards abstinence or towards intermediate goals such as a reduction in injecting or sharing.'⁵⁹ A more flexible approach to prescribing was thus legitimated.

As seen in Chapter Four and Chapter Five, this was not solely as a result of HIV and AIDS. A similar approach had long been adopted by a number of doctors involved in the treatment of addiction, mainly outside the DDUs. Despite repeated attacks from those who advocated short-term withdrawal (mainly doctors inside the DDUs) this approach did not disappear during the late 1970s and early 1980s, and there is evidence to suggest that maintenance was enjoying something of a renaissance even before AIDS began to make significant inroads into policy formulation. The inability of the GMC to wholly condemn maintenance in the Dally case in 1986-1987, the public concession by Connell that long-term prescription required reconsideration, the narrow loss of a vote in favour of maintenance at the 1987 Royal College of Psychiatrists conference, followed by the suggestion in the College's report, *Drug Scenes*, that this might be an acceptable method of treatment

⁵⁸ ACMD, *AIDS and Drug Misuse: Part One*, p. 47, p. 48.

⁵⁹ *Ibid.* pp. 47-48.

for some addicts, all point to a gradual acceptance that long-term prescription needed re-evaluation.⁶⁰ According to the *Lancet* ‘all the arguments for a review would hold even if AIDS had never existed...a return to some form of controlled availability, which exercises control over inevitable use by rendering alternative methods uneconomic, is not a retrograde step – on the contrary...it is the only feasible way forward.’⁶¹ AIDS, therefore, added impetus to a pre-existing drift towards the reconsideration of long-term prescription.

Examining the response of a leading DDU consultant to AIDS and the prescribing issue does, however, highlight tensions between this and existing ideas and debates. John Strang, a DDU consultant psychiatrist who had been opposed to the long-term prescription of drugs to addicts, pointed to a number of roles for prescribing in the light of HIV. Strang stated that prescribing could be used for ‘relief of withdrawal’, as ‘bait to capture the drug taker,’ as ‘adhesive to improve retention’ or as a ‘promoter of change.’⁶² This could be seen as a retreat from the abstinence orientated policies he had pursued in his Manchester DDU.⁶³ Yet, allusions to more negative consequences of prescription suggest the extent of change was limited. Strang also noted that prescription might ‘obstruct change’ and there was a danger of prescription becoming the ‘end state,’ where the user would be indefinitely maintained on an opioid drug.⁶⁴ Strang’s position was that prescribing might have its uses but it must not lead to maintenance. Maintenance should be replaced with ‘a

⁶⁰ See Chapter Five, pp. 258-259.

⁶¹ ‘Editorial – Management of drug addicts: hostility, humanity and pragmatism’, *Lancet*, (9 May 1987) 1068-1069.

⁶² Strang, ‘The roles of prescribing’, pp. 144-146.

⁶³ See Chapter Four, p. 186; Strang, ‘Abstinence or abundance – what goal?’, p. 604.

⁶⁴ Strang, ‘The roles of prescribing’, pp. 147-148.

more active approach which sought to identify a series of intermediate goals...so as to encourage appropriate changes in behaviour.’⁶⁵

Long-term prescription, it seems, did not become the widespread method of treatment offered by DDUs despite its perceived benefits in terms of preventing the spread of HIV. Steve Cranfield, Charlotte Feinmann, Ewan Ferlie and Cathy Walter, a group of researchers from a range of backgrounds including clinical psychiatry, argue that the DDUs were largely resistant to change. AIDS forced a re-evaluation of maintenance but this remained ‘highly controversial and difficult for established centres to accept.’⁶⁶ Cranfield and his colleagues assert that there were few changes in DDU prescription policies in the wake of AIDS, with the only exceptions being those patients who were HIV positive. They note that the traditional autonomy of the DDUs was threatened by the apparent need to collaborate with a range of services as a result of the threat posed by AIDS. Cranfield and his colleagues observed the drug treatment services in one District Health Authority and found that there was open hostility and rivalry between staff at the DDU and those running the needle exchange, such that needle exchange staff stopped referring patients to the DDU, sending them to local GPs instead.⁶⁷ This led the researchers to argue that though DDUs remain central to the response to drugs in the wake of AIDS ‘Like other psychiatric institutions, they sometimes resist attempts to move towards a community-based approach.’⁶⁸

The reason for this resistance can be related to the central divide between hospital and community, between clinical and biographical and between the medical and the social at the heart of debates about the treatment of addiction. Clinical

⁶⁵ *Ibid.* p. 149.

⁶⁶ S. Cranfield, C. Feinmann, E. Ferlie & C. Walter, ‘HIV and drugs services – the challenge of change’ in Strang & Gossop, *Heroin Addiction and British Policy*, 322-330, p. 322.

⁶⁷ *Ibid.* p. 326.

⁶⁸ *Ibid.* p. 323.

psychiatrists working at DDUs often saw and responded to disease in a particular way. As a result of their location within hospitals and their adoption of clinical methods DDU doctors largely emphasised the cure of addiction. Maintenance was seen as merely perpetuating the disease. Though there might be benefits to society by prescribing to the addict in order to prevent them from spreading HIV, this did nothing to cure them of their addiction. As Strang noted:

If the drug addict is on a slippery slope from which the only escape route is complete abstinence, then discussions of reducing dose, cutting back on injecting or moderating the extent of use will merely encourage the drug taker to consider unrealistic options.⁶⁹

This contrasted with the view of many community-based physicians involved in the treatment of addiction. As a result of paying greater attention to the patient rather than the disease these doctors frequently placed more emphasis on intermediate goals, of improving the patients' social functioning before working towards abstinence. For this reason, community-based practitioners frequently offered long-term prescription to addict patients. This brought them into conflict with the DDUs because they offered an alternative view of addiction and subsequently an alternative way of treating this.

Far from closing the divide between the hospital and the community HIV and AIDS may actually have served to separate the two spheres even further. The relative danger of HIV compared to drug addiction suggested that a community-based approach, stressing intermediate goals and in tune with harm minimisation, was a more appropriate response than the abstinence-orientated, hospital-based, clinical method. In order to retain a role in the treatment of addiction DDUs needed to adopt elements of the community-based, harm-minimisation approach, at least in principle. As Cranfield and his colleagues indicate, however, the extent to which this effected

⁶⁹ Strang, 'The roles of prescribing', p. 146.

real change in clinical practice is more questionable. It seems likely that the divide between the clinical and the biographical approach to addiction, between the medical and the social, persisted beyond 1987, beyond AIDS, and is still present today.

3. Continuity or change? Heroin addiction treatment policy past and present

3.1 Past

The limited extent of change in the practical treatment of addiction in the wake of AIDS suggests there are a number of significant continuities within drug addiction policy. The hospital/community and public/private divide, the dominance of clinical psychiatry and the understanding of addiction within a public health context were common to both the pre-AIDS and post-AIDS periods. An explanation for this continuity lies in the endlessly dynamic relationship between the medical and the social. The dual conception of addiction as both medical disease and social problem resulted in a series of tensions manifested in conflict over the treatment of this condition. These took two forms: firstly, debates over who was best suited to deal with the problem and secondly, debates about what this response should comprise. Examining the nature of these debates revealed a deeper conflict between differing types of medicine and medical practitioner. There was clearly a conflict not just between medicine and other groups over who was able to deal with the problem of addiction, but also within medicine: between specialists and generalists, and between state provided and private care.

This conflict was rooted in a clash of medical philosophies. NHS hospital-based specialist clinical psychiatrists often saw addiction as a disease to be cured, whereas community-based generalists (whether in private or general practice) were more concerned with ameliorating the patient's experience of addiction, with

lessening the negative consequences of this condition for the individual and society. The hospital-based, specialist approach could thus be characterised as more ‘medical,’ and the community-based, generalist approach as more ‘social.’ A battle between these groups was fought out in the pages of medical journals and in the 1983 Dally case, which seemed to caution against the involvement of the private, non-DDU doctor in the treatment of addiction. Yet, the most bitterly contested area in which this conflict was to be found was over the actual methods used to treat the addict. To most clinical psychiatrists short-term withdrawal of the drug from the addict was the preferred method of treatment, whereas for many community-based doctors involved in the treatment of addiction maintenance, or long-term prescription, was an acceptable approach. Here again there was an apparent medical and social divide, as short-term withdrawal could be regarded as a more ‘medical’ approach because of its stress on removing the drug from the addict, and maintenance could be seen as a more ‘social’ approach, because of its emphasis on the social functioning of the addict.

Such a characterisation does, however, draw the distinction between the medical and the social too starkly. The unity between these two seemingly distinct forces should not be underplayed. There is evidence to suggest that the medical and the social worked together as well as in opposition throughout this period to shape and define the response to heroin addiction. No better expression of the conflation between the medical and the social can be found than in Brain’s description of addiction as a ‘socially infectious condition.’ This recognition of the danger posed by heroin addiction to individual and collective well-being located the condition firmly within the framework of public health, itself a project which unites medical and social goals. As indicated above, changing understandings of addiction reflected shifts in

understandings of public health, but the concern for individual and social health remained.

However, as this thesis has indicated, reconciling these two objectives and formulating a response that treated the disease of addiction and resolved the social problems associated with this was problematic. The clearest example of the difficulties encountered and conflicts generated by this dual target was the issue of prescription of drugs to addicts. The supposed benefits and drawbacks of maintenance had divided the medical community since before the Rolleston report, but the re-definition of addiction as a social disease in the late 1960s added a new dimension to the debate. It was suggested that prescribing heroin to addicts might prevent the development of a black market and the spread of the disease of addiction within society. DDUs established by the Ministry of Health in 1968 were set up along these lines, again combining the medical and the social by providing treatment at the same time as offering heroin on prescription to compete with illicit supplies. Many clinical psychiatrists tasked with the running of these clinics disliked maintenance, and felt this perpetuated the disease of addiction instead of curing it. Over the next decade the DDUs gradually switched heroin addicts from prescriptions of injectable heroin to injectable methadone, and eventually to oral methadone in rapidly reducing doses, as this was felt to be a more therapeutic and, therefore, 'medical' approach more likely to result in the 'cure' of the addict. This contrasted with the treatment offered to addicts by many community-based doctors, who continued to see maintenance as a way of lessening the problems associated with addiction for the addict and for society by improving the addicts' social situation, their work, their relationships, their general health and so on before withdrawing from the drug. This issue polarised the drug addiction treatment community, seen most clearly in the

1986-1987 Dally case where the arguments for and against the long-term prescription of drugs to addicts were played out in the disciplinary hearing of a leading advocate of maintenance.

There are inevitably limitations to any work on an area as large as drug policy. The Dally case was not the only significant event during this period; many aspects of the field remain under-explored. More work is needed in a number of areas. It would be instructive, for example, to investigate more thoroughly the view of the DDU psychiatrists. Further research examining their justification for the switch to methadone and short-term, abstinence orientated withdrawal would complement the in-depth analysis presented here of the arguments put forward in favour of maintenance. Moving away from a specifically doctor-focused account could also prove enlightening. Looking more closely at the expanding 'policy community' around drugs and the relative roles of politicians, civil servants, social scientists, voluntary workers and those in criminal justice and their changing ability to shape policy over time might challenge a specifically 'medical' view of this field.

But, by concentrating on treatment this thesis has been able to lay bare the debates that directed a central aspect of drug policy over the years from Brain to the impact of HIV/AIDS. Its potential usefulness, however, is not just limited to the history of heroin addiction treatment policy. The disputes between NHS doctors and private practitioners, between generalists and specialists and between supporters of short-term withdrawal and advocates of maintenance illustrate long-running, more general conflicts within medical practice. Yet, medicine was not necessarily dominant. This thesis has shown the important degree to which 'social' factors were bound up with supposedly 'medical' approaches to addiction in this period, thus questioning the comprehensiveness of the medicalisation of social problems. A

‘social’ dimension to addiction clearly persisted despite the strongly ‘medical’ efforts introduced to deal with this. Work such as this can help contribute to broader discussion by providing examples of these processes in action.

3.2 Present

Moreover, as drug use and the problems associated with this endure, historical research can inform current debate. Conflicts over the key issues highlighted in this thesis continue. The prescription of drugs to addicts remains contentious, though there does seem to be more support for maintenance for a very limited number of addicts. A softening of hard-line attitudes can be detected in the advice given to doctors on the clinical management of drug addicts. The first edition of the *Guidelines of Good Clinical Practice in the Treatment of Drug Misuse* published in 1984 strongly suggested that long-term prescription of drugs to addicts was inappropriate and should only be offered by doctors working at or with a DDU.⁷⁰ The 1991 edition of the *Guidelines* indicated ‘There is at least a small proportion of patients for whom this [maintenance] is a helpful approach’ though this was ‘a specialised form of treatment best provided by, or in consultation with, a specialist drug misuse service.’⁷¹ The most recent incarnation of the *Guidelines*, published in 1999, state that

Methadone maintenance treatment, incorporating psychosocial interventions, can enable patients to achieve stability, reduce their drug misuse and improve health. For these reasons, such treatment should form an important part of drug misuse services.⁷²

⁷⁰ See Chapter Four, pp. 215-218.

⁷¹ Department of Health, *Drug Misuse and Dependence: Guidelines on Clinical Management*, (London: HMSO, 1991), p. 22.

⁷² Department of Health, *Drug Misuse and Dependence: Guidelines on Clinical Management* (London: HMSO, 1999), Executive Summary, p. 4.

This might suggest that maintenance has achieved some degree of mainstream acceptance. But, as the 1999 *Guidelines* aimed to present ‘the pros and cons of some controversial issues such as maintenance and injectable prescribing’ it is likely that support for this method is far from universal.⁷³

Indeed, renewed interest in the prescription of heroin to addicts has exposed continued divisions within the medical profession and the wider ‘policy community’ over addiction treatment. In December 2001 the Association of Chief Police Officers (ACPO) called for the wider prescription of heroin to heroin addicts and the establishment of ‘shooting galleries’ where addicts could inject under medical supervision.⁷⁴ This followed Home Secretary David Blunkett’s submission to the House of Commons Home Affairs Select Committee that there should be a five-fold increase in the number of addicts prescribed heroin to around 1,500.⁷⁵ Yet, not all evidence to the Home Affairs Committee was supportive of the measure. Claire Gerada, representing the RCGP, told the committee that there was ‘no added value’ to be gained from GPs prescribing heroin to addicts as the drug has a low therapeutic index (the difference between a safe dose and a toxic dose) and could easily result in overdose in the inexperienced user. Furthermore, she noted that heroin prescription was prohibitively expensive, costing £10,000-£15,000 a year compared with £2,000 a year for methadone.⁷⁶ However, other GPs were in favour of increased prescription of heroin to addicts. General Practitioner Ian Guy argued that heroin should be prescribed more often and that GPs should be licensed to do so, as did GP Chris Ford,

⁷³ *Ibid.* p. 4.

⁷⁴ *The Observer*, 9 December 2001, p. 2; *The Independent*, 10 December 2001, p. 10.

⁷⁵ *The Observer*, 9 December 2001, p. 2; Drugscope News, 31 January 2001, http://www.drugscope.org.uk/news_item.asp?a=1&intlD=679. For a study on the role of heroin prescribing in drug addiction treatment before this change of policy see N. Meterbian, W. Shanahan & G.V. Stimson, ‘Heroin prescribing in the United Kingdom: an overview’, *European Addiction Research*, 2, (1996), 194-200.

⁷⁶ Drugscope News, 31 January 2001, http://www.drugscope.org.uk/news_item.asp?a=1&intlD=679; *The Guardian*, 15 January 2001, <http://www.guardian.co.uk/Archive/Article/0,4273,4335607,00.html>.

chair of the Methadone Alliance.⁷⁷ Voluntary agencies such as the drug campaign group Transform and the charity Drugscope were also in favour of the measure.⁷⁸ The Home Affairs Committee were largely in agreement and their report published in May 2002 called for a trial programme of supervised heroin prescription to addicts and the establishment of safe-injecting rooms, or ‘shooting galleries.’⁷⁹ According to the *Observer*, heroin was to be available on the NHS for addicts.⁸⁰ This apparent sanction of the wider prescription of heroin to addicts did not receive universal approval; Les Vasey, a former police officer and chair of a drug rehabilitation clinic, told the BBC the proposal was ‘tantamount to the NHS giving out alcohol to alcoholics.’⁸¹

The impact of these measures on treatment services seems to have been more equivocal than the headlines would suggest. The National Treatment Agency (NTA) conducted an investigation into the potential roles for injectable heroin and injectable methadone in the treatment of addiction in 2002, publishing their findings in May 2003.⁸² They recommended that the ‘prescribing of injectable substitute opioid drugs for maintenance may be beneficial for a minority of heroin misusers.’⁸³ However, the NTA were clear that injectable maintenance prescription should only be undertaken in certain circumstances and very much as a last resort. This was emphasised by the report’s presentation of a summary of their key recommendations. They asserted that

⁷⁷ Drugscope News, 31 January 2001, http://www.drugscope.org.uk/news_item.asp?a=1&intlD=679; *The Guardian*, 22 May 2002, p. 4.

⁷⁸ Drugscope News, 31 January 2001, http://www.drugscope.org.uk/news_item.asp?a=1&intlD=679; *The Observer*, 19 May 2002, p. 1; BBC News Online, 19 May 2002 http://news.bbc.co.uk/1/hi/english/uk_politics/newsid_1996000/1996327.stm.

⁷⁹ *The Observer*, 19 May 2002, p. 1; BBC News Online, 19 May 2002, http://news.bbc.co.uk/1/hi/english/uk_politics/newsid_1996000/1996327.stm; *Guardian*, 22 May 2002, p. 4, p. 18, p. 19; *The Independent*, 22 May 2002, p. 1, p. 8.

⁸⁰ *The Observer*, 19 May 2002, p. 1.

⁸¹ BBC News Online, 19 May 2002, http://news.bbc.co.uk/1/hi/english/uk_politics/newsid_1996000/1996327.stm.

⁸² National Treatment Agency, *Injectable Heroin (and Injectable Methadone) Potential Roles in Drug Treatment*, (London: NTA, 2003). The NTA were created in 2001 to increase the availability, capacity and effectiveness of treatment for drug misuse.

⁸³ *Ibid.* Executive Summary, p. 1.

‘optimised oral methadone maintenance should be the maintenance treatment for the majority of heroin users’ and ‘injectable heroin and methadone treatments should only be considered for the minority of patients who are genuinely unresponsive to an optimised oral maintenance response.’⁸⁴ Furthermore, the NTA’s enquiry revealed that doctors were increasingly reluctant to prescribe and there had actually been a reduction in injectable prescribing in ‘both absolute terms and as a proportion of overall opioid substitute treatments.’⁸⁵ It would appear that injectable maintenance remains a divisive issue.

Other debates highlighted by this thesis show little sign of abating. Home Office proposals to extend the licensing system for the prescription of heroin to addict patients to all controlled drugs except oral methadone have provoked a resurgence of conflict over licensing and the wider issue of who should and who should not be involved in the treatment of addiction.⁸⁶ In a letter to *Druglink* in January 2001, a group of GPs and consultant psychiatrists asserted that these proposals were being introduced to curb the prescribing habits of a few private doctors practising in London. The authors felt that licensing would ‘deter doctors from working in this area. This was exactly why a similar licensing proposal was rejected in 1984.’⁸⁷ An editorial written by some of the same authors also appeared in the *British Medical Journal*. Here too, similar arguments were made as had existed fifteen years previously. It was suggested that ‘The proposals...convey a negative message about drug misuse treatment, reinforcing the disinclination of generalists to prescribe for

⁸⁴ *Ibid.* p. 4.

⁸⁵ *Ibid.* p. 4.

⁸⁶ Home Office, *Changes to the Misuse of Drugs Legislation: Licensing of Controlled Drugs Prescribed in the Treatment of Addiction*, (London: Home Office, 2000).

⁸⁷ B. Beaumont, T. Carnwarth, W. Clee, C. Ford, M. Gabbay, R. Robertson, D. Rumball & T. Waller, ‘Alternatives to licensing doctors’, letter to *Druglink*, January/February 2001, p. 9.

drug misusers.’⁸⁸ This article provoked two letters. Andrew Byrne, a GP in Australia, was critical of the editorial. Byrne contended that ‘self-regulation has apparently failed to encourage British doctors to follow the advice on supervision and dose levels.’⁸⁹ The second letter was from Arnold Trebach, professor of jurisprudence, commentator on heroin addiction and advocate of maintenance treatment. Trebach restated many of his earlier arguments about the virtues of the ‘British System’ and attacked the ‘drug misuse establishment’ and the GMC for its ‘persecution’ of doctors who abided by the ‘British System.’ He asserted that:

The planned extension of the licensing system to all controlled drugs would be an illness masquerading as cure. Stricter controls signal the death knell for a humanitarian and efficacious system of addiction prevention and treatment. The GMC has a duty to keep that tragedy from happening. Yet it almost seems intent on creating it.⁹⁰

Trebach’s words were strongly reminiscent of statements he made (in public and in private) in support of Ann Dally at the time of her second GMC PCC hearing.⁹¹

Indeed, the echoes between past and present debates continue. In February 2004 a case came before the GMC that once more places maintenance prescription and the treatment of addiction in private practice on ‘trial.’ Seven doctors working at the private drug addiction treatment clinic the Stapleford Centre have been accused of serious professional misconduct in relation to the irresponsible prescription of drugs to addict patients. The doctors are alleged to have failed to assess patients properly and acted irresponsibly with respect to the type, quantity and combination of drugs

⁸⁸ M. Gabbay, T. Carnwarth, C. Ford and D. Zador, ‘Editorial: Reducing deaths among drug misusers: tighter controls on drug prescribing are not the answer’, *British Medical Journal*, 322, (31 March 2001) 749-750.

⁸⁹ A. Byrne, ‘Standard of care in Britain was not addressed’ letter to *British Medical Journal*, 323, (1 September 2001) p. 513.

⁹⁰ A. Trebach, ‘General Medical Council may be destroying the British system’, letter to the *British Medical Journal*, 323, (1 September 2001) pp. 512-513.

⁹¹ See, for example, CMAC PP/DAL/E/4/12, Statement by Arnold Trebach, 10 December 1986; CMAC PP/DAL/E/4/21, Letter from Arnold Trebach to Dally, 5 October 1986.

prescribed.⁹² One addict treated by the centre's founder, Dr Colin Brewer, died in September 2001 after being sent home with a 'DIY home detox' kit. The patient choked on his own vomit after taking a combination of drugs prescribed by Brewer. It has been suggested the patient's mother was not told that additional drugs prescribed were to be taken instead of, not as well as, the original prescription.⁹³ The hearing has been adjourned until September 2004 due to the ill health of Brewer, but it is clear there are important parallels with the Dally case regardless of its outcome.⁹⁴ There is even a direct link between the two cases: Brewer was asked to take on Dally's patients by the Home Office in 1987 when she was no longer able to prescribe to addicts.⁹⁵

It is clear that the conflict between the private and public sectors over the treatment of heroin addiction and between those who support maintenance and those who advocate withdrawal is being fought once again in the chambers of the GMC. The Stapleford Centre is reported to have offered maintenance prescriptions of both heroin and methadone to addicts who felt unable to come off drugs. According to the *Guardian* 'the technique is legal but tends to be resisted in the public sector, where the preference is for drugs such as methadone to be used on a short term basis to wean the patient off illegal substances.'⁹⁶ Owen Dyer, writing in the *British Medical Journal*, noted that 'Heroin maintenance programmes have frequently been rejected

⁹² *The Guardian*, 23 February 2004, <http://society.guardian.co.uk/print/0,3858,4864876-106536,00.html>; *The Guardian*, 24 February, p. 5; *The Independent*, 24 February 2004, p. 19; *The Times*, 24 February 2004, <http://www.timesonline.co.uk/printFriendly/0,,1-2-1012962-1,00.html>; O. Dyer, 'Seven doctors accused of over-prescribing heroin', *British Medical Journal*, 328, (28 February 2004) p. 483.

⁹³ *The Independent*, 24 February 2004, p. 19; *The Guardian*, 24 February, p. 5.

⁹⁴ Dyer, 'Seven doctors accused of over-prescribing heroin', p. 483; 'Illness halts doctors' drug clinic hearing', 26 February 2004, Surrey Online, http://www.surreyonline.co.uk/content_objectid=13991426_method=full=siteid=50101_headline=-Illness-halts-doctors-.

⁹⁵ Dyer, 'Seven doctors accused of over-prescribing heroin' p. 483; Dally, *A Doctor's Story*, p. 263.

⁹⁶ *The Guardian*, 24 February 2004, p. 5.

by NHS clinics, who prefer to wean patients off the drug.’⁹⁷ Indeed, the significance of the Stapleford case has been widely recognised. The *Guardian* reported that the enquiry was to ‘centre on conflicting schools of opinion regarding the prescription of drugs to recovering addicts.’⁹⁸ The *Independent* noted that the outcome of the case ‘may determine the future direction of drug addiction treatment’ and that it would ‘ask profound questions of the liberal school of heroin treatment.’⁹⁹ The *Times* stated that the hearing is ‘seen as a test case for the treatment of addiction in Britain’ and that it represented ‘a showdown between rival schools of thought on the treatment of drug addicts.’¹⁰⁰

It has been suggested that the Stapleford case is being used to remove the private practitioner from the treatment of addiction. Nick Davies (the journalist who assisted Dally during her disciplinary hearing in 1986-1987) quotes a source close to the Home Office as saying “They have been talking about getting rid of every private doctor who prescribes for heroin users.”¹⁰¹ This was also the argument made about the Dally hearings in 1983 and 1986-1987. Parallels between the cases abound. The alleged origin of the charge in the Stapleford case, as in the Dally case, reinforces the notion that this is a ‘political’ trial. Davies states that Home Office inspectors combed through records of chemists’ dispensing to Stapleford patients looking for breaches in the rules in order to bring a case against doctors at the clinic.¹⁰² Though the *British Medical Journal* reports that the charges ‘seem to have originated after routine monitoring by the Home Office Drugs Inspectorate’ the suspicion remains that

⁹⁷ Dyer, ‘Seven doctors accused of over-prescribing heroin’ p. 483.

⁹⁸ *The Guardian*, 23 February 2004, <http://society.guardian.co.uk/print/0,3858,4864876-106536,00.html>.

⁹⁹ *The Independent*, 24 February 2004, p. 19.

¹⁰⁰ *The Times*, 24 February 2004, <http://www.timesonline.co.uk/printFriendly/0,,1-2-1012962-1,00.html>.

¹⁰¹ N. Davies, ‘Doctors at top drugs clinic face charges’, *The Guardian*, 16 February 2004, <http://www.guardian.co.uk/print/0,3858,4859388-103690,00.html>.

¹⁰² *Ibid.*

the case has been deliberately brought in order to make a statement about maintenance prescription and the private treatment of heroin addiction.¹⁰³ The same was said of the Dally case.

A number of conclusions can be drawn from the obvious parallels that the Stapleford case raises with both the Dally case specifically and the wider issues considered in this thesis. It is clear that the 1983 and 1986-1987 GMC cases against Dally did not issue an unequivocal and lasting warning about the dangers of private practice and maintenance as seen by the 'drug dependency establishment' of clinical psychiatrists. A new generation of medical practitioners need to be reminded of the apparent appropriateness of the clinical approach to addiction and the authority of the psychiatrist in dealing with this problem. In turn, this would suggest that the conflicts between specialist and generalist, between public and private and between withdrawal and maintenance are far from over. This is because the deeper conflict between the medical and the social has not, and perhaps cannot, be resolved. There is no neat conclusion. What this thesis has done, however, is point to the origins of the central debates within drug addiction treatment. And by understanding the roots of policy and practice we are better equipped to deal with current and future developments.

¹⁰³ Dyer, 'Seven doctors accused of over-prescribing heroin' p. 483.

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