NAD

Nordic Studies on Alcohol and Drugs
2018, Vol. 35(2) 93–99

DOI: 10.1177/1455072518765836
journals.sagepub.com/home/nad
SAGE

Framing drug and alcohol use as a public health problem in Britain: Past and present

Alex Mold
London School of Hygiene & Tropical Medicine, UK

Abstract
Recent attempts to approach drug and alcohol problems as a public health issue in the UK and globally have begun to achieve some success. Yet, in historical terms, the idea that the use of psychoactive substances should be regarded as a public health problem is a relatively new one. In the UK, it was only in the latter half of the 20th century that what were termed "public health" approaches to alcohol and drugs began to gain purchase. Moreover, what was meant by a "public health" framing of psychoactive substance use changed over time and between substances. This article examines the development of public health approaches to drugs and alcohol in Britain since the 19th century. It suggests that a public health view of substance use existed alongside, and interacted with, other approaches to drug and alcohol use. To understand the meaning of a "public health" framing of drugs and alcohol we need to locate this in historical and geographical context.

Keywords
alcohol, Britain, drugs, history, public health

In recent years, the notion that illegal drug use should be thought of as a public health problem has started to gain momentum. This can be seen in the UK and at the global level. In April 2016, a United Nations General Assembly Special Session addressed the issue of illegal drugs. The resulting report placed emphasis on public health approaches to dealing with drugs alongside control measures (United Nations Office of Drugs and Crime, 2016). That same year, two

Submitted: 9 February 2018; accepted: 27 February 2018

Corresponding author:
Alex Mold, Centre for History in Public Health, London School of Hygiene & Tropical Medicine, 15–17 Tavistock Place, London, WC1H 9SH, UK.
Email: Alex.Mold@lshtm.ac.uk

leading British public health agencies published a report which argued that drug policy should be reorientated towards improving public health rather than focusing on criminal justice (Royal Society of Public Health & Faculty of Public Health, 2016). In some ways, this could be seen as a shift which brings the approach to illegal drugs closer to that offered to other substances, such as alcohol and tobacco. Both of these products have been dealt with as public health problems for many years, with policies being directed towards both lowering consumption and dealing with the harmful effects of drinking and smoking. Yet, in historical terms, the idea that the use of psychoactive substances should be regarded as a public health problem is a relatively new one. It was only in the latter half of the 20th century that what were termed "public health" approaches to alcohol and drugs began to gain purchase, and, as we will see, the nature of these changed over time.

This article will explore how alcohol and drugs came to be framed as a public health problem in Britain. Beginning in the late 19th century, and moving forward to the present, the article examines the development of public health approaches to drugs and alcohol in Britain. Tobacco smoking will not be considered in detail, as this story is already well known, and the trajectory of smoking as a public health issue is somewhat different (Berridge, 2007). The article will suggest that there was no single "public health" approach to substance use: this can mean different things at different times and in different places. Moreover, public health approaches do not exist in vacuum, they interact with and are shaped by societal, political and economic pressures as well as other approaches to drug and alcohol use. This can also be seen in the persistence of multiple co-existing ways of framing drug and alcohol use. In Britain, medical/psychiatric and penal/criminological approaches have tended to be more dominant, especially for drugs. To illustrate these arguments, the article will present a brief history of how and why drugs and alcohol came to be defined as public health problems. This enables us to examine what a "public health" approach to drugs and alcohol is or was in the British context and how it might differ from other perspectives and other places. Indeed, such an approach can tell us much about past and present ways of dealing with drugs and alcohol in Britain and more widely. In the UK, there is less of a clear "social" response to drug use than in the Nordic countries (Edman & Olsson, n.d.). This speaks to the need to understand substance-use policy in historical and geographical context.

What is "public health"?

Before considering the ways in which drugs and alcohol came to be regarded as a public health problem, it is worth considering what this might mean. Defining "public health" is a difficult enterprise. Christopher Hamlin points out that "Any historian of public health first confronts the problem of definition – health that is truly public. For the history of public health is not merely concerned with change of content, but also with inchoateness of concept" (Hamlin, 2011, p. 411). Jane Lewis argues that the problem of definition is especially acute for public health in more recent times: "While the focus of nineteenth-century public health seems clear, writers have found it hard to describe the content of public health in the twentieth century" (Lewis, 1986, p. 5). In their examination of a series of definitions of public health from the 1920s onwards, Marcel F. Verweij and Angus Dawson found that some of these are very broad and others more narrow. Despite these differences, they suggest that all the definitions of public health had two elements in common. Firstly, public health is about the nature of the health of the public: that is the population, the whole, or the collective. Secondly, all the definitions encompassed interventions or practices that were aimed at protecting the health of the public. These interventions were not primarily those of an individual, but involved some form of group response (Verweij & Dawson, 2007). Public

health, as Dorothy Porter puts it, is concerned with "collective action in relation to the health of populations" (Porter, 1999, p. 4). How, when and why have such ideas been applied to drugs and alcohol in the UK?

Alcohol and drugs in the 19th century

Medical approaches to drugs and alcohol have a long history. The idea that habitual substance use was a disease dates back to at least the 18th century (Levine, 1978; Porter, 1985; Warner, 1994). The language used to describe this condition changed over time and according to place. In Britain, the notion of "inebriety" was dominant throughout much of the 19th century. Although inebriety was principally applied to alcohol, it could encompass other substances too. Towards the end of the century, the terms "alcoholism" and "addiction" began to be used (Berridge, Mold, & Walke, 2014). Coherence around these terms was related to a growing body of medical expertise around chronic substance use. The establishment of the British Society for the Study and Cure of Inebriety in 1884 suggests that a specialist body of knowledge around substance problems was beginning to form by the end of the century. Doctors, principally general physicians, were the leading authority on alcohol problems and, although there were few drug addicts at this time, drug problems too. At the same time, alongside this medical approach there was also a legal or penal system which exerted control over alcohol and those who used it. Alcohol had long been considered a potential threat to public order. In 1898, the introduction of the Inebriates Act permitted the detention of habitual drunkards in government-run Inebriate Reformatories. Such measures were, however, largely intended to deal with problematic individuals rather than addressing a collective issue. Although alcohol consumption could have posed a danger to public health at this time, it was rarely seen in this way. The temperance movement, for instance, did not stress the public health aspects of the alcohol problem. Drinking may have had an impact on industrial production and workplace safety, but alcohol was not framed as a public health problem during the 19th century.

A similar situation existed for psychoactive drugs. Use of substances such as opium and cocaine for recreational purposes was rare. Self-medication with opiate-based preparations was much more common. There was some concern about this practice amongst doctors and public officials, and especially the impact opiate use had on the health of women and children. This led to the introduction of the first piece of legislation to place psychoactive substances under any form of control in the UK, the Pharmacy Act of 1868. This legislation, however, was primarily directed towards controlling opium and other drugs as poisons, and such substances remained freely available and used widely throughout the 19th century (Berridge, 1999). Drugs, like alcohol, were not seen to pose a significant danger to public health.

Drugs and alcohol 1900–1950

In the early 20th century, there was a flurry of interest in drugs and the threat that these posed, but this was not regarded in public health terms. The exposure of cocaine use amongst troops on leave during the First World War, and a handful of high-profile deaths from cocaine overdoses in the immediate aftermath of the war, prompted the introduction of legislation to control psychoactive substances (Kohn, 1992). The Dangerous Drugs Act, 1920, made it an offence to buy or sell substances such as heroin or cocaine without a prescription from a medical practitioner. Yet, once again, this penal system existed alongside medical forms of control. In 1926, the Departmental Committee on Morphine and Heroin Addiction (known as the Rolleston Committee, after its chair Sir Humphry Rolleston) recommended that if all attempts to withdraw drugs from an individual had failed, then he or she could continue to be prescribed the drug on a maintenance basis.

This so-called "British System" offered a medical way of dealing with drugs, but one that was orientated towards the individual, not the wider population (Mold, 2008).

Medical approaches to alcohol in the early part of the 20th century also focused on the individual alcoholic rather than drinking as a public health problem. Collective approaches to alcohol instead focused on the control of the drink trade and the social effects of public drinking. During the First World War, legislation was introduced to restrict pub opening hours and reduce the strength of the drinks served in order to limit the effect of alcohol on the war effort (Nicholls, 2009). In the period after the war, considerable effort went into designing "improved" pubs; spaces, it was believed, that would encourage more "civilised" consumption of alcohol (Gutzke, 2005). Once more, public health concerns were largely absent from these efforts.

Alcohol and drugs 1950s–1970s: Beginnings of a public health approach

In the mid-20th century, alcohol and drug use began to be seen as public health problems. A rise in the number of reported cases of alcoholism during the 1950s prompted increased concern and some new measures, such as the introduction of specialist treatment units (Thom & Berridge, 1995). By the 1960s, other issues surrounding alcohol use started to come into play, such as drink driving (Luckin, 2010). At the same time, there was an increase in alcohol consumption and a rise in associated health problems, such as cirrhosis of the liver. Deaths from liver cirrhosis increased from just over 20 per million in 1950 to more than 40 per million by 1970 (Royal College of Physicians, 1987, p. 24). Partly as a result of the scale of potential damage to health alcohol could cause, it was seen increasingly as a public health problem. However, alcohol was not yet an issue dealt with primarily by public health officials and policymakers. Instead, a distinct "alcohol policy network", consisting of addiction doctors (especially psychiatrists) as well as voluntary organisations and civil servants, pushed alcohol up the public policy agenda (Thom, 1999, p. 110). What helped cement a distinct "public health" approach to alcohol problems was the development of an epidemiological view of drink and its effects. From the 1950s onwards, epidemiological evidence had been crucial to the establishment of a link between smoking and lung cancer (Berridge, 2007; Talley, Kushner, & Sterk, 2004). In the alcohol field, it was the work of Sully Ledermann, a French demographer, that was to prove significant. Ledermann argued that the level of alcohol consumption within a population was related to the extent of alcohol problems within that population. As the total amount of alcohol increased, so too did the number of individuals suffering from alcohol problems. This led Ledermann to suggest that reducing the amount of alcohol consumed by the entire population would result in fewer alcohol-related problems. Although this thesis was controversial in Britain, a population-level approach to alcohol problems attracted the interest of some policymakers and epidemiologists, such as Geoffrey Rose (Rose, 1992). A specific public health view of alcohol was beginning to coalesce, even if policy remained primarily orientated at getting individuals to drink less, rather than targeting population-level drinking (Mold, 2017).

As with alcohol, the development of a public health approach to drugs was partly the result of increased consumption rates, although the number of people using drugs was still very small. When the Rolleston report was published in 1926, addicts were few in number and mostly middle-aged, middle-class, iatrogenic addicts. Little changed for almost 40 years. In 1959, there were just 47 known heroin addicts in the UK, by 1964 this had risen to 328. More importantly, the nature of the addicted population also appeared to have changed. Addicts were younger, and their addiction was often of a

non-therapeutic origin: they had begun taking the drug for recreation, rather than pain relief (Ministry of Health, 1965). These new addicts were thought to pose a threat to public health. Their youth and the fact that they had begun taking drugs recreationally raised the possibility that drug users would form a deviant subculture that would endanger the wider public. The Interdepartmental Committee on Heroin Addiction stated that although addiction was a disease it was also one which, if allowed to spread unchecked, could become a "menace to the community". The committee asserted that heroin addiction was a "socially infectious condition" which required "epidemiological assessment and control" (Ministry of Health, 1965, p. 8). The use of public health language to describe heroin addiction was reinforced by the committee's recommendations which echoed many classic measures put in place to deal with infectious conditions. The committee suggested that incidences of addiction be notified to a central authority; that dedicated treatment centres be established; and that these should have the power to detain addicts compulsorily, if required. Drug addiction was now established as a public health problem.

It was not, however, only a public health problem. Medical and legal approaches to drugs persisted; indeed, these often held more sway. As the consumption of all drugs increased over this period, the legal penalties attached to their use, sale and distribution became more severe. In 1971, the Misuse of Drugs Act introduced a classification system for illegal drugs, and individuals convicted of supplying a Class A drug (such as heroin or cocaine) could face life in prison. At the same time, medical management of addiction continued. The specialist treatment centres set up in the wake of the Interdepartmental Committee's report focused initially on maintaining addicts on drugs in order to prevent the spread of addiction. Over time, however, the clinics moved towards a more interventionist approach. This included prescribing methadone to addicts (rather than heroin) and encouraging them to withdraw from the drug. Addiction doctors became more concerned with treating the individual addict, and especially getting him or her off drugs, than controlling a potential public health problem.

Social approaches to drugs and alcohol? 1980s–present

Priorities in addiction treatment shifted, however, during the 1980s in the wake of HIV/AIDS. The discovery of HIV amongst injecting drug users prompted a change in policy and practice. In 1988, the Advisory Council on the Misuse of Drugs (ACMD) published their report on AIDS and drug use. They asserted that "HIV is a greater threat to public and individual health than drug misuse". The committee recognised that 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" (Advisory Council on the Misuse of Drugs, 1988, p. 17). As a result, the ACMD recommended a series of measures aimed at reducing the harm associated with drug use, rather than concentrating solely on getting addicts off drugs. The notion of "harm reduction" was not a new one. Indeed, the approach had been around for many years, and originated in the voluntary sector. Harm-reduction measures, such as safe injecting rooms and needle exchanges, were pioneered first by voluntary organisations in the Netherlands and emulated in the UK (Mold & Berridge, 2010). Although this was often characterised as a public health response, where the danger posed by AIDS to the community was thought to outstrip the need to get people off drugs, there were elements of a more "social" response too. Drug use was not just a public health danger, it was also a social problem that reflected wider social issues and could only be dealt with effectively by addressing these too.

The direction of travel for alcohol in the latter part of the 20th century was, however,

somewhat different. The "social" came to matter here too, but it figured in a rather different way. The preservation of social order, rather than the recognition of the wider social underpinnings of the issue, was often prioritised. This can be seen in the public and policy reaction to "binge drinking". During the late 1990s and early 2000s, there was a growing amount of popular and political concern about so-called "binge drinking". Although it was often unclear exactly what binge drinking consisted of, attention was directed towards the consumption of alcohol in public by young people (Berridge, Herring, & Thom, 2009). Although alcohol consumption (and alcohol-related harms) were highest amongst older men, a disproportionate amount of emphasis was placed on young women, and the perceived threat to the social order that their drinking posed. Successive government alcohol strategy documents focused on alcohol-related crime and disorder amongst young people rather than attempting to reduce alcohol consumption at the population level (Nicholls, 2009, pp. 233). Public health arguments about the need to lower drinking collectively have not gone away, but, as was the case in the 1970s, are often eclipsed by other sets of concerns and priorities (Gornall, 2014a, 2014b).

Conclusion

The contemporary response to binge drinking in the UK illustrates the ways in which different approaches to drugs and alcohol overlap. As this article has demonstrated, there is nothing particularly new about this development. There have been and continue to be multiple ways of framing drug and alcohol use. These shift over time and place and between different groups of users. Public health approaches exist alongside and interact with medical/psychiatric and penal/criminological ways of dealing with drugs and alcohol. Moreover, wider social, political and economic factors may mean that public health needs are not put to the fore. This can be seen most clearly in relation to population-level arguments about the need to reduce overall consumption of alcohol. Although this thesis has been around for decades, it is unable to achieve much purchase because any attempt to reduce population-level drinking is seen by some as an unfair imposition on "sensible" drinkers, as well as potentially damaging to the alcohol industry.

A deeper problem perhaps surrounds the fact that it is often uncertain what a "public health" approach to drugs and alcohol should consist of. Here again, there has been change over time and between the substances. In the 1960s and 1970s, the concern about drugs revolved around the need to prevent the spread of a socially infectious condition, but in the 1980s, when AIDS was thought to be a greater threat to public health than drug addiction, priorities and policies changed. A "public health" approach to substance use can mean many, perhaps even contradictory, things. Until it is clear whose health is being prioritised, and to what ends, public health will continue to be one amongst many approaches when it comes to dealing with drugs and alcohol.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

This article is based on research conducted as part of a Wellcome Trust New Investigator Award in Medical Humanities. Grant no. WT 100586/Z/12/Z.

References

Advisory Council on the Misuse of Drugs. (1988). *AIDS and drug misuse: Part one*. London, UK: HMSO.

Berridge, V. (1999). *Opium and the people: Opiate use and drug control policy in nineteenth and early twentieth century England*. London, UK: Free Association Books.

Berridge, V. (2007). *Marketing health: Smoking and the discourse of public health in Britain, 1945–2000*. Oxford, UK: Oxford University Press.

Berridge, V., Herring, R., & Thom, B. (2009). Binge drinking: A confused concept and its contemporary history. *Social History of Medicine*, *22*(3), 597–607.

Berridge, V., Mold, A., & Walke, J. (2014). From inebriety to addiction: Terminology and concepts in the UK, 1860–1930. *Social History of Alcohol and Drugs*, *28*(1), 88–106.

Edman, J., & Olsson, B. (n.d.). The Swedish drug problem: Conceptual understanding and problem handling, 1839–2011. *Nordic Studies on Alcohol and Drugs*, *31*(5–6). Retrieved from https://www.academia.edu/9807707/The_Swedish_drug_problem_Conceptual_understanding_and_problem_handling_1839_2011

Gornall, J. (2014a). Under the influence: 1. False dawn for minimum unit pricing. *The BMJ*, *348*, 7435.

Gornall, J. (2014b). Under the influence: 4. Election prospects triumph over public health. *The BMJ*, *348*, 7610.

Gutzke, D. (2005). *Pubs and progressives: Reinventing the public house in England, 1896–1960*. DeKalb, IL: Northern Illinois University Press.

Hamlin, C. (2011). Public health. In M. Jackson (Ed.), *The Oxford handbook of the history of medicine* (pp. 411–428). Oxford, UK: Oxford University Press.

Kohn, M. (1992). *Dope girls: The birth of the British drug underground*. London, UK: Granta Books.

Levine, H. G. (1978). The discovery of addiction: Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol*, *39*, 143–174.

Lewis, J. E. (1986). *What price community medicine? The philosophy, practice and politics of public health since 1919*. Brighton, UK: Wheatsheaf Books.

Luckin, B. (2010). A kind of consensus on the roads? Drink driving policy in Britain 1945–1970. *Twentieth Century British History*, *21*(3), 350–374.

Ministry of Health. (1965). *Drug addiction: Report of the second interdepartmental committee on heroin addiction*. London, UK: HMSO.

Mold, A. (2008). *Heroin: The treatment of addiction in twentieth century Britain*. DeKalb, IL: Northern Illinois University Press.

Mold, A. (2017). "Everybody likes a drink. Nobody likes a drunk": Alcohol, health education and the public in 1970s Britain. *Social History of Medicine*, *30*(3), 612–636.

Mold, A., & Berridge, V. (2010). *Voluntary action and illegal drugs: Health and society in Britain since the 1960s*. Basingstoke, UK: Palgrave Macmillan.

Nicholls, J. (2009). *The politics of alcohol*. Manchester, UK: Manchester University Press.

Porter, D. (1999). *Health, civilization and the state: A history of public health from ancient to modern times*. London, UK: Routledge.

Porter, R. (1985). The drinking man's disease: The pre history of alcoholism in Georgian Britain. *British Journal of Addiction*, *80*, 385–396.

Rose, G. (1992). *The strategy of preventive medicine*. Oxford, UK: Oxford University Press.

Royal College of Physicians. (1987). *A great and growing evil: The medical consequences of alcohol abuse*. London, UK: Tavistock.

Royal Society of Public Health, & Faculty of Public Health. (2016). *Taking a new line on drugs*. London, UK: Royal Society of Public Health.

Talley, C., Kushner, H. I., & Sterk, C. E. (2004). Lung cancer, chronic disease epidemiology, and medicine, 1948–1964. *Journal of the History of Medicine and Allied Sciences*, *59*(3), 329–374.

Thom, B. (1999). *Dealing with drink: Alcohol and social policy in contemporary England*. London, UK & New York, NY: Free Association Books.

Thom, B., & Berridge, V. (1995). "Special units for common problems": The birth of alcohol treatment units in England. *Social History of Medicine*, *8*(1), 75–93.

United Nations Office of Drugs and Crime. (2016). *Outcome of the 2016 Special Session on the World Drug Problem*. Vienna, Austria: UNODC.

Verweij, M. F., & Dawson, A. (2007). The meaning of "public" in "public health". In M. F. Verweij & A. Dawson (Eds.), *Ethics, prevention, and public health* (pp. 13–29). Oxford, UK: Clarendon Press.

Warner, J. (1994). "Resolv'd to drink no more": Addiction as a preindustrial construct. *Journal of Studies on Alcohol*, *55*(6), 685–691.