

Chapter 4

WHO expert committees and key concepts for drugs, alcohol, and tobacco, 1949–2013

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4.1 Introduction to the WHO expert committees and key concepts for drugs, alcohol, and tobacco

While other historical chapters of this book have studied national and regional situations, this chapter provides an international perspective by examining the role of the World Health Organization (WHO) and its expert committees in disseminating concepts around addiction in relation to illicit drugs, alcohol, and tobacco from 1949 to 2013. Three time periods are surveyed: 1949–1963, when intense discussion of concepts and terminology in relation to drugs and alcohol occurred and the substances were discussed as separate issues; 1964–1989, when the concept of dependence emerged, ushering in the potential for a combined approach to the substances, and also when discussion of tobacco arose; and the 1990s onwards, when a more sustained combined approach to the substances developed and the WHO exercised its constitutional powers to establish an international convention on tobacco. Major questions considered in this chapter include:

- ❑ What were the concepts discussed in relation to illicit drugs, alcohol, and tobacco?
- ❑ What terms were used and how were they defined?
- ❑ What were the similarities and differences in terminology across the substances?
- ❑ How were the expert committees situated within the WHO, and where did responsibility lie for each substance?
- ❑ What was the impact of the professional composition of committees?
- ❑ How did the terminology used in expert committee reports compare to that of the International Classification of Diseases (ICD), the standard diagnostic tool for epidemiology?
- ❑ How did the terminology used in expert committee reports compare to that used in conventions and for health management and clinical purposes?

Review of the WHO expert committees demonstrates considerable engagement with concepts and terminology, and the importance of the WHO in establishing and shifting the conceptual boundaries between these substances. It highlights increasing linkages between the three substances under consideration; a more combined approach to research and treatment, but differences in control; early involvement with the problems of substance use and earlier discussion of tobacco than has generally been indicated in the existing literature; and the problems involved in the creation of standardized definitions at the international level. Box 4.1 provides a list of acronyms pertinent to this chapter.

Box 4.1 Key acronyms used in relation to the WHO expert committees and key concepts for drugs, alcohol, and tobacco, 1949–2013

ADS: Alcohol-Dependence Syndrome

ARD: Alcohol-Related Disability

ECAPD: Expert Committee on Addiction-Producing Drugs

ECDD: Expert Committee on Drug Dependence

ECDLPA: Expert Committee on Drugs Liable to Produce Addiction

ECDPD: Expert Committee on Dependence-Producing Drugs

FCTC: Framework Convention on Tobacco Control

ICD: International Classification of Diseases

PSA: Programme on Substance Abuse

SACTob: Scientific Advisory Committee on Tobacco Product Regulation

TFI: Tobacco Free Initiative

TobReg: WHO Study Group on Tobacco Product Regulation

UN: United Nations

WHA: World Health Assembly

WHO: World Health Organization

4.2 Historiography: role of the WHO, expert committees, and concepts and terminology around addiction in relation to drugs, alcohol, and tobacco

A literature review was carried out on secondary material on the WHO and illicit drugs, alcohol, and tobacco. This included topics on the history of the WHO, the development of international control mechanisms, WHO expert committees, and other relevant mechanisms such as the ICD and UN Conventions. Much literature on the WHO has concentrated on its role in combatting infectious diseases. Health promotion and public health has also been discussed; since the 1970s there has been interest in international substance control, both illicit drugs and alcohol. The mechanism of the expert committee has been examined demonstrating its importance in the development of concepts, terminology, and definitions. Bruun et al. (1975) examined expert committees on drugs and alcohol and highlighted their significance in the development of key concepts; the importance of a committee's composition, policy imperatives, and outputs. Room (1981) has written extensively on this topic, focusing on alcohol and drugs. His analysis demonstrated the fluctuating focus of committees and major turning points, such as the

1992 ECDD (Room, 1997). Room uncovered significant shifts in terminology; for example, the transition from 'habit' and 'addiction' to 'dependence', and from 'alcoholism' to 'alcohol-related problems' (Room, 2005; Room & Babor, 2005; Selvaggio, 1984). He also considered the development of alcohol and drug categories in instruments such as the ICD, revealing its relationship with the WHO, problems of cross-cultural applicability of terms such as 'dependence', differentials between lay and technical understandings, and cross-drug applicability of terms (Room, 1984, 1997, 1998).

Edwards (2007), reviewing the WHO's 1977 report on alcohol-related disabilities, highlighted the lack of commonly accepted terminology as an obstacle to research and policy. His work emphasized the shift to 'disability' as the preferred term to describe the social burden resulting from disease. The changes in the WHO structure—for example, the Programme on Substance Abuse (PSA) which sought to bring a combined approach to substance abuse in the 1990s—has also attracted commentary (Babor, 2003; Grant, 1993). Work has largely considered these substances separately.

Tobacco has not been considered in relation to drugs and alcohol. Little has been said about expert committee discussion of tobacco despite its inclusion in WHO discussions from 1970. The Framework Convention on Tobacco Control (FCTC) in 2005 is noteworthy. Taylor and Bettcher (2000) analyzed the development of international health law. Collin et al. (2002) discussed the FCTC in the context of accelerating globalization. Civil society contributions to the negotiation process proved important for tobacco (Mamudu & Glant, 2009); Yach and Bettcher (2000) demonstrated that the tobacco industry increasingly attempted to influence agencies such as the WHO. Likewise Weishaar et al. (2012) have pointed to the transnational tobacco corporations' efforts to undermine the FCTC. The applicability of the framework to other substances has been the focus of a number of works (Jernigan et al., 2000; Lien & Deland, 2011; Room & Babor, 2005). A final aspect of the literature is that it is generally written by non-historians, many employed or connected to the WHO. Although this has the advantage of insider knowledge, it tends to lack context and to be allied to an activist perspective (Moser, 1980; Yach & Monteiro, 2011; see also the conversations with Mackay, 2013; Moser, 1984; and Room, 2012).

The existing literature has demonstrated the importance of expert committees, but it has largely reviewed the substances individually and tends to concentrate on drugs and alcohol, not tobacco. Tobacco has been studied but with a greater focus on the development of the FCTC rather than its longer history at the WHO. As noted, the literature has largely been written by those with connections to the WHO rather than by historians. In this chapter we consider the three substances together under the umbrella of 'concepts of addiction'. We examine the relationship between concepts and terminology across these three substances, and extend their consideration from the involvement of the WHO in 1949 through 2013.

4.3 Methodology: the WHO expert committees, Technical Report Series, and WHO archives

As well as the literature review summarized earlier, the research examined printed reports and archival material. Examination of original printed material focused upon the Technical Report Series, which published findings of the expert committees; reports on illicit drugs, alcohol, and tobacco were reviewed. Other primary material included WHO Conventions,

texts of which were surveyed for pertinent terms. Terms used in the ICD in relation to drugs, alcohol, and tobacco were reviewed. Although rarely utilized, we surveyed material held in the WHO archives in Geneva. Unfortunately, the archive does not hold minutes of meetings, but it does hold other relevant documentation, such as correspondence between committee members.

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

WHO expert committees are the highest official advisory bodies to the Director-General of WHO and member states. They are established by the WHO World Health Assembly (WHA) and each committee makes recommendations on a subject of interest to the WHO. Members are chosen from WHO expert advisory panels, temporary advisers, representatives from international organizations, nongovernmental organizations, and professional associations. The ECDD has been one of the most active committees, meeting every two years since it was established in 1949 (undergoing various title alterations). It has played a central role in the international drug control system, making recommendations to the United Nations Commission on Narcotic Drugs on control measures. In contrast, alcohol and tobacco committees, not needing to make scheduling decisions in relation to international conventions, have met less frequently, often in response to a WHA resolution calling for research on a particular area of emerging interest.

This chapter splits the expert committee discussions into three time periods: 1949–1963, when intense discussion of concepts and terminology in relation to drugs and alcohol occurred, and the substances were discussed as separate issues; 1964–1989, when the concept of ‘dependence’ emerged and ushered in the potential for a combined approach to the substances, and when discussion of tobacco arose; and the 1990s onwards, when a more sustained combined approach to the substances developed, and the WHO exercised its constitutional powers to establish an international convention on tobacco. Drug committees were more active than alcohol and tobacco committees. Between 1949 and 1963, terminology was a crucial factor in discussions (see [Table 4.1](#)). In relation to illicit drugs, the main term used was ‘habit-forming’; the first committee established in 1949 was named the Expert Committee on Habit-Forming Drugs. Members were pharmacologists/chemists, and discussions centred on the status of various substances in relation to the conventions on controlled drugs (WHO, 1949).

[Please insert Table. 4.1 here.](#)

But attention turned to a new term—‘addiction’—and in 1950 the committee renamed the Expert Committee on Drugs Liable to Produce Addiction (ECDLPA). Attempts were made to differentiate between the two terms. A ‘habit-forming’ drug was described as ‘one which is, or may be, taken repeatedly without the production of all of the characteristics outlined in the definition of addiction and which is not generally considered to be detrimental to the individual and to society.’ The term referred mainly to ‘psychic dependence’, whereas ‘drug addiction’—which implied both ‘psychic’ and ‘physical’ dependence—was preferred by the committee. Addiction was defined as ‘a state of periodic or chronic intoxication, detrimental to the individual and the society, produced by the repeated consumption of a

drug (natural or synthetic) . . . a psychic (psychological) and sometimes a physical dependence on the effects of the drug'. 'Dependence,' a term that would become prominent in the 1960s, was mentioned but not defined. The committee decided that 'habit-forming' should be eliminated from all texts, and urged governments to consider medical research on 'drug addiction'.

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

Discussion of alcohol focused more on the condition of 'alcoholism', taking a more medical approach. The first expert committee, the WHO Expert Committee on Mental Health's Alcoholism Subcommittee of 1951, focused on conceptual discussion of 'alcoholism' (WHO, 1951). Its membership mainly psychiatrists, it was chaired by Dr G.A.R. Lundquist, assistant professor of psychiatry at Langbro Hospital, Stockholm. The secretariat included Prof. E.M. Jellinek, a WHO consultant on alcohol and dean of the Yale Institute of Alcohol Studies; much of the historical literature has focused on his work on alcoholism. The subcommittee made clear that 'alcoholism' was a disease and a social problem in which public health services should play a significant role in prevention and treatment.

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

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

<EXT>excessive drinkers whose dependence upon alcohol . . . shows a noticeable mental disturbance or an interference with their bodily and mental health, their inter-personal

relations and their smooth social and economic functions. . . . They therefore require treatment. (WHO, 1952b)</EXT>

The position of alcohol in relation to other drugs became increasingly important, especially as the term 'addiction' became dominant in relation to illicit drugs. An Expert Committee on Alcohol was created and reported in 1954 (WHO, 1954). The composition of the alcohol committee differed from that of the previous committees on 'alcoholism'; it comprised mainly pharmacologists and physiologists (later committees also had a wider range of disciplines). The committee was chaired by Dr Lundsgaard, professor of physiology at the University of Copenhagen, and included professors of pharmacology such as Dr L. Goldberg from Stockholm and Dr J. Mardones from Santiago, Chile, an associate professor of medicine from Stanford University, and L.D. MacLeod from the Burden Neurological Institute, Bristol. They discussed broader ramifications—etiological, epidemiological, sociological, and anthropological—as opposed to purely pharmacological or clinical concerns.

The committee drew on the work of the 1950 ECDLPA, which added to the confusion, because alcohol and 'alcoholism' could not easily be fitted into the definition of 'drug addiction'. Alcohol was placed in a category of its own, one intermediate between 'addiction-producing' and 'habit-forming'. Concepts pertaining to the pharmacological position of alcohol remained unclear; for instance, the term 'tolerance to alcohol' was seen as causing misunderstandings. A distinction was deemed necessary between 'tolerance' related to addiction-producing drugs of the morphine type and 'tolerance' associated with alcohol. 'Withdrawal symptoms' also proved contentious, as in the alcohol field, the term 'withdrawal symptoms' was used, whereas the term 'abstinence syndrome' was used in the case of drug addiction of the morphine type. Thus the committee was unable to match the definitions between alcohol and illicit drug terminology. The separate category for alcohol was necessitated by the difficulty of drawing a line between the presence and absence of addiction-producing properties (WHO, 1954). The subcommittee pressed for a further meeting incorporating both clinicians and experimental workers to attempt further clarification.

This borderline position of alcohol remained important for the Expert Committee on Alcohol and Alcoholism which met in 1955 (WHO, 1955). Jellinek and Wolff had left; a changing membership drew together pharmacologists, physiologists, psychiatrists, and members from both the Mental Health and the ECDLPA. Its mandate was to clarify basic concepts related to alcohol and the features of the problem in different countries. The committee reiterated the importance of 'alcoholism' as a medical problem in order to involve public health services. However, this was proving difficult due to inadequately defined terminology.

The introduction of the concept of 'problems of alcohol' or 'problem use' forced a broader consideration of the problem. This shift away from 'alcoholism' was important because it was 'excessive drinking' rather than 'alcoholism' which was a major problem for most countries. One approach was to cease using the term 'craving' and adopt 'physical dependence'. Though the 1955 committee acknowledged recent evidence which indicated a closer resemblance between responses to the withdrawal of alcohol and opiates, it

concluded that there was no justification for a change in the position on alcohol. Instead, the preferred concept became the 'problems of alcohol', of which 'alcoholism' was just one aspect.

'Addiction' continued to pose problems for illicit drugs, and the renamed Expert Committee on Addiction-Producing Drugs (ECAPD) revisited the issue (WHO, 1957). Its membership began to broaden. Significantly, the committee included Dr L. Goldberg, who sat on the 1954 Expert Committee on Alcohol, and for the first time included a psychiatrist, Dr Pernambuco Filho, University of Rio, Brazil. The distinction between 'addiction' and 'habit-forming' remained problematic. The committee was forced to refine the previous definitions, as follows:

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

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

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

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

In sum, during this period both drug and alcohol committees were active. Tobacco was not considered at this point. Drugs and alcohol were considered by separate committees, but

concepts and terms were important areas of discussion for both committees. Drug committees initially were made up mostly of pharmacologists, but later were slightly widened to include other disciplines, notably the occasional inclusion of a psychiatrist and one member who had also sat on the alcohol committee. This period saw a shift from the term 'habit-forming' to 'addiction', though the term remained problematic. Drug committees had been established to provide advice in relation to pre-existing international drug control treaties, so the focus was on the substance, though there was a slight shift to consider the problems of use—for example, consideration of the 'addict' by the end of this period.

In contrast, there were no international treaties for alcohol control. Hence the WHO began with health concerns over the condition, not the 'drug'. Committees on alcoholism began as largely psychiatric-based and focused on the condition 'chronic drinking' and later 'alcoholism'. Later committees, which included pharmacologists, physiologists, and psychiatrists, considered 'alcohol' and the 'problems of alcohol use' and 'excessive drinking' rather than just 'alcoholism'. Although some similarities were drawn with illicit drugs, significantly, alcohol was deemed to occupy an intermediate position. Furthermore, in contrast with drug committees, alcohol committees began with an interest in prevention and rehabilitation and an acknowledgement of the significance of cultural differences in alcohol use.

4.5 The rise of 'dependence', tobacco, and the prevention of problems associated with substance use, 1964–1989

During the period 1964–1989, the concept of 'dependence' developed and opened the way for a combined approach to the substances. Though the 1971 UN Psychotropic Drugs Convention led to a focus on scheduling requirements rather than drug terminology and interest in alcohol declined by the 1980s, some influential reports emerged. These reports emphasized the concept of a medical rather than a penal approach, the threat to the community as well as the individual, and the need for prevention of both drug and alcohol 'related problems' rather than a narrow focus on supply. Additionally, during this period tobacco entered the WHO's consciousness as a serious global public health threat (Table 4.2).

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

<EXT>a state arising from repeated administration of a drug on a periodic or continuous basis. Its characteristics will vary with the agent involved and this must be made clear by designating a particular type of drug dependence in each specific case. (WHO, 1964) p9,

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Specific types of drug dependence were elucidated; for example, drug dependence of the morphine type. Crucially, 'dependence' was not linked to any type of control. The 1965 committee was renamed the Expert Committee on Dependence-Producing Drugs (ECDPD) (WHO, 1965).

But 'dependence' had flaws. Criticisms were made of the vagueness of the term, cross-cultural applicability, and cross-drug applicability. Furthermore, it created conflicts with the ICD. The section which covered drug addiction in the ICD contained a diverse list of terms, which the committee argued were not necessarily addiction-producing drugs in a pharmacological or legal sense. The report therefore recommended that 'drug dependence' be taken into account by the ICD.

There was added pressure for clarity when the committee's mandate was broadened in 1966 and again in 1969: from the determination of the control status of drugs to other aspects of 'drug dependence' and 'abuse' (WHO, 1969). The committee's name was also altered to Expert Committee on Drug Dependence (ECDD) in 1969. In addition to pharmacologists, membership of the ECDD was widened to include Dr A. Wikler, professor of psychiatry and pharmacology, University of Kentucky, and Dr P.H. Connell, a psychiatrist at the Bethlem and Maudsley Hospital, London. This shifting membership resulted in a shift towards the condition rather than a strict focus on the drug. 'Drug abuse' was defined as 'persistent or sporadic excessive drug use inconsistent with . . . acceptable medical practice.' 'Drug abuse' was deemed convenient on the grounds that there was no universally accepted term. By 1975 the term 'abuse' would be dropped by the WHO due to its stigmatizing connotations (Kramer & Cameron, 1975), though it remained in the ICD until 1992.

These developments meant that the split between alcohol and illicit drugs was harder to sustain. The WHO wanted to encourage authorities to look at 'alcohol and alcoholism and use and abuse of drugs together'. Although a more combined approach had been sought by the Expert Committee on Mental Health, this was more in relation to research (and to a lesser extent with treatment and education), as opposed to control measures (WHO, 1967b).

The increasingly combined approach to drugs and alcohol was reflected in the 1967 Expert Committee on Mental Health Services for the Prevention and Treatment of Dependence on Alcohol and Other Drugs (WHO, 1967a). This committee was chaired by Dr K. Evang, Director-General, Health Services of Norway, and consisted of sociologists, psychiatrists, neuropsychiatrists, and a pharmacologist. It also included representatives from the UN narcotic drug organizations, such as Mr A. Lande, secretary to the Permanent Central Narcotics Board, as well as those from the alcohol field, including Mr H.D. Archibald, director of the Alcoholism and Drug Addiction Research Foundation, Toronto, Canada. The

broader disciplinary backgrounds reflected the committee's mandate, which was to consider the establishment of services for the prevention and treatment of 'dependence' on both alcohol and other drugs.

The rationale to combine the approaches was persuasive. The concept of 'dependence' brought the concepts around the differing substances closer together. The committee noted the similarities in causation and treatment, and the fact that drugs were themselves often used in combination. Research from the alcoholism field was also viewed as relevant to controlled drugs, and it was accepted that, although attitudes towards 'alcoholism' had shifted towards the therapeutic, this had not happened to the same extent with controlled drugs.

Tobacco, when it surfaced as an issue for the WHO, did so within a different framework: public health. A 1970 report of the Director-General, based on the work of Charles Fletcher and Daniel Horn (1970), leading anti-smoking campaigners, sought to establish the problem as worthy of consideration by the WHO by referring to the links to diseases such as lung cancer, as well as the increasing uptake of smoking, especially by women. The report led the WHO to affirm the hazards of smoking and to ban smoking in its own meetings. The concept of 'less hazardous smoking' arose, alluding to the development of 'less hazardous' cigarettes and methods of smoking. Other methods such as filters were also considered, and the report called for research on the effects on health of modifications in the constituents of cigarettes. A follow-up report in 1971 focused on potential methods of control (WHO, 1971). Legislation was considered important; for example, in enacting measures to encourage smokers to stop. The 'less hazardous cigarette' remained an option and differential taxation favouring the use of 'less harmful cigarettes' was discussed. Any economic losses from reduced tobacco revenue were expected to be offset by a healthier population. By the early 1970s, tobacco would enter discussions of the drug committees.

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

The 1973 committee reflected the rise of the public health population approach; it consisted of a wider range of disciplines, with epidemiologists and sociologists joining the pharmacologists and psychiatrists. This led to further refinements around the concept of 'dependence' with a focus upon 'dependence-producing drugs and more interest in the problems surrounding the use of such drugs' (WHO, 1973). 'Dependence' in itself was not

necessarily considered harmful—in a broad sense, it could include tea and coffee—whereas drugs, such as alcohol, cannabis, and opiates, resulted in individual, public health, and social problems.

Thus by 1974 there was a shift in focus to prevention of the problems associated with drug use. The committee was chaired by Dr B.S. Brown, Director of the National Institute of Mental Health, Department of Health, Education, and Welfare, USA, and included several members of the UN Division on Narcotic Drugs, including Dr O.J. Braenden, and members of the International Council on Alcohol and Addiction. Dr H. Halbach, a professor of pharmacology at the University of Munich, was invited to consider what was known about preventing problems associated with the use of psychoactive, dependence-producing drugs. This shift meant that alcohol gained a higher profile because it was deemed more of a problem than many illicit drugs. Tobacco—the most widespread form of drug dependence—was also drawn into discussion. However, tobacco was excluded from pre-review (the preliminary stage to decide whether a substance should undergo a fully documented or critical review which might lead to the scheduling of a psychoactive substance) on the grounds that its psychotoxic effects were slight compared to other drugs (WHO, 1974).

Yet tobacco warranted its own expert committee (WHO, 1970). Following a 1974 resolution requesting that an expert group be convened, the Expert Committee on Smoking and its Effects on Health was created. It met in 1975 to summarize evidence on the harmful effects of smoking and to propose actions to discourage smoking. Hence, tobacco was isolated from committees concerned with illicit drugs; smoking entered the expert committee's realm from a public health perspective. This was reflected in its membership, which was mainly social medicine and public health experts, cardiologists, and policymakers (WHO, 1975b). It was chaired by Sir George Godber, the UK Chief Medical Officer, with Dr Sujoy B. Roy, professor and head of Department of Cardiology at the All-India Institute of Medical Sciences, New Delhi, acting as the rapporteur. Its members included Dr F. Beske, professor of social medicine and public health, Secretary of State, Ministry of Social Affairs, Kiel, Germany. Charles Fletcher acted as a temporary adviser. This committee reviewed the state of knowledge since Fletcher and Horn's 1970 report and reviewed the gamut of potential control measures, including warning notices, prohibition in certain public places, and protection of the rights of 'non-smokers', as well as quality control and education. Some terms used were similar to those adopted for alcohol and drugs, including 'psychic dependence' and 'withdrawal'. Although drug terminology had moved away from 'habit' or 'habitation' early on, the phrase 'smoking habit' was widely used in reports. Few terms were defined. In relation to nicotine, the term 'dependence' was adopted: 'Chronic use of nicotine produce dependence and . . . or some people the disturbing nicotine withdrawal syndrome . . . contributes to the difficulty of giving up.' Thus the issue of 'withdrawal', developed in drug and alcohol committees, was picked up for tobacco, but differences were also identified: social reinforcement and 'dependence' were thought to develop faster with tobacco than with other drugs such as alcohol.

At the same time, the effects of smoking were accepted as extending beyond the individual user. What would become known later as 'passive smoking' was discussed as 'involuntary

exposure to smoke.' The report noted potential damage to non-smokers: 'the non-smoker exposed to the side stream and mainstream of smokers in enclosed, ill-ventilated spaces such as cars and small offices may be exposed to harmful concentrations of smoke.' This threat to the wider community boosted the need for stricter control measures. Furthermore, by protecting the non-smoker it was hoped to reduce opportunities for smoking.

Threat to the wider community was an important concept for all these substances. This was especially true with alcohol. As discussed by Room (1984), work during this time focused on alcohol's impact on the community beyond the individual drinker. The question of 'alcohol disabilities' was discussed by a WHO Steering Group between 1973 and 1975, resulting in a broader focus than the 'alcoholic'. 'Alcohol-related disabilities' and later 'alcohol-related problems' became the focus at the WHO. The emphasis on 'disability' rather than disease was intended to draw attention to the need to reduce the consequences on the family and society, as well as the individual. Although concrete definitions were not deemed possible, a loose definition was the following:

<EXT>Alcohol-Related Disability is deemed to exist when there is impairment in the physical, mental or social functioning of an individual of some nature that it may be reasonably inferred that it is part of the causal nexus determining that disability. (Edwards et al., 1977)</EXT>

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

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

To summarize, although the 1971 Psychotropic Convention came into force during this period and there was less discussion of concepts around illicit drugs as the committees became more involved in technical discussion over scheduling, there were significant developments. There were major changes to the drug committees' composition, with pharmacologists being joined by epidemiologists, sociologists, and those working in the alcohol field. There was also a shift in how the problems were conceptualized. 'Addiction'

was replaced by 'dependence' and 'dependence-producing drugs', a move which brought potential for a more combined approach to the substances. As such, alcohol became an issue as it could be seen as a 'dependence-producing drug'.

Another important change was a shift in interest to not just the prevention of drug use but the limitation of problems once drug use had occurred. There were limited reports on alcohol, but, significantly, concepts developed around 'alcohol-related disabilities' and 'alcohol-related harm'. Importantly, smoking emerged as a public health problem and warranted the establishment of its own expert committee. Membership of the committee was broad both in geographical location and disciplines but with a medical/public health emphasis. The focus was on the elimination of smoking, though the idea of the 'less hazardous cigarette' emerged, and calls began for WHO to exercise its constitutional powers for an international legal approach to tobacco control.

4.6 A combined approach? the Programme on Substance Abuse and the Framework Convention on Tobacco Control, 1990–2013

The period from 1990 to 2013 is characterized by a more sustained combined approach to substance use. This was reflected in changes to the WHO structure, with the creation of the Division of Mental Health and the Prevention of Substance Abuse's Programme on Substance Abuse (PSA). This period is also marked by the development of global strategies for tobacco control, most notably the Framework Convention on Tobacco Control, which represented the first time the WHO had exercised its constitutional powers (Table 4.3).

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Mounting pressure for a combined approach to drugs and alcohol was built into the structure of the WHO in the 1990s. The WHO's global strategy of 'health for all by the year 2000' led in 1990 to the creation of a new programme, the PSA, designed to prevent and control alcohol and drug abuse. This resulted in alcohol and drugs being briefly separated from the mental health division. Expert committees began to review the substances together. The Expert Committee on Health Promotion in the Workplace reviewed approaches to health promotion as a means of preventing both alcohol and drug problems. Alcohol and drug-related problems were defined as being applicable to any of the adverse accompaniments of drinking or drug-taking, and they could be related to either an individual drinker or to society (WHO, 1993b).

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

warranted its inclusion in their discussions, thereby further expanding the committee's mandate.

In redefining the role of the committee, concepts and terminology occupied an important place. Many of the terms from the previous reports remained valid, but with new research findings there were important subtle shifts. 'Harmful use'—'a pattern of psychoactive drug use that causes damage to health, either mental or physical. . . . Harmful use of drugs by an individual often has adverse effects on the drug user's family, the community and society'—replaced the term 'abuse', which was deemed ambiguous (WHO, 1993a, p. 6). However, it was recognized that the term 'drug abuse' had entered numerous national laws and international conventions, so 'abuse' remained in operation.

'Dependence' remained dominant. The committee decided to follow the ICD-10 diagnostic guidelines and not make a distinction between 'physical dependence' and 'psychic dependence' in order to avoid clinical misunderstandings (WHO, 1993a, p. 5). However, there was a shift towards 'problems' or 'disabilities related to drug use', of which 'dependence' was just one. Further review of the term 'dependence-producing drug' drew nicotine and tobacco into consideration. The level of dosage of a drug now also came into prominence: 'A state of dependence is not necessarily harmful in itself, but it may lead to self-administration of the drug at dosage levels that produce deleterious physical or behavioural changes constituting public health and social problems' (WHO, 1993a, p. 6).

Research had led to a reconceptualization of alcohol consumption levels as a continuum and to an understanding that alcohol-related problems were related to consumption patterns. This was now seen as applicable to all substances, resulting in a change in focus on those with 'less heavy patterns of use' (WHO, 1993a, p. 4). Thus concepts and terminology around levels of consumption were becoming important.

Discussion of 'harm minimization', 'harm reduction', or the 'preventing of problems associated with the use of psychoactive dependence-producing drugs' now explicitly appeared in texts; the committee highlighted the value of harm reduction as opposed to the potential of psychoactive drugs for encouraging drug use (WHO, 1993a, p. 3).

Common approaches were brought together when another reorganization took place in 1995. At that time the Programme on Substance Abuse was amalgamated with the Division of Mental Health to create the Division of Mental Health and Prevention of Substance Abuse (WHO, 1997). Significantly, this division was involved with all psychoactive substances, licit or illicit, including tobacco, alcohol, and illicit drugs.

The 1995 ECDD reflected these changes, acknowledging that although different legal approaches existed for drugs, alcohol, and tobacco, there were significant similarities in treatment options. Consequently, the committee sought treatments that could be used across the three substances. Treatment and rehabilitation were meant to include 'comprehensive identification, assistance, healthcare, and social integration.' Consistent with growing interest in 'human rights' in relation to controlled drugs, inherent in the definition was the idea that all users should be treated 'with humanity and respect' (WHO, 1995a).

In 2000, the Department of Substance Abuse was merged with the Department of Mental Health to create the Department of Mental Health and Substance Abuse, under the Non-Communicable Disease and Mental Health cluster, thus bringing together common approaches to the management of mental health and substance use disorders.

Amendments were seen as essential given the adverse attitudes towards drug users; the committee pressed for an update to the WHO (1994) Lexicon of Alcohol and Drug Terms, a tool for clinicians, administrators, and researchers, which had been established .

Tobacco had proved awkward for the ECDD. Although approaches to research and treatment had drawn substances closer together, approaches to control took a different track. The existing conventions were not deemed appropriate for regulating tobacco, because the only option would be prohibition, which was not viable. The idea of an alternative global mechanism for tobacco control was formalized in 1995 at the World Health Assembly (WHO, 1995b). By 1997 the PSA had a section specifically for tobacco—Tobacco or Health—and the development of an international framework was an important element of its strategy. It published Guidelines for Controlling and Monitoring the Tobacco Epidemic, advocating long-term, comprehensive tobacco control policies (WHO, 1998).

In 1998, after Gro Harlem Brundtland, a physician herself, became director-general of the WHO, tobacco control activities were set within a new structure. The Tobacco Free Initiative (TFI), run by Dr Derek Yach, aimed to raise the profile of tobacco control. Its role was to initiate a process to develop a framework convention that would permit member states to adopt a comprehensive tobacco control policy dealing with aspects of tobacco control that transcended national boundaries. While tobacco had been rejected for pre-review in 1996 by the ECDD, by 1999 this decision was reversed because of new evidence of greater liability for abuse (WHO, 1999a). In 2000, the WHO Framework Convention on Tobacco Control (FCTC) was adopted by the WHA, becoming the first international treaty negotiated under the auspices of the WHO (2003b); it came into force in 2005.

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

Engagement with definitions emerged via a new body. The Scientific Advisory Committee on Tobacco Product Regulation (SACTob) was established in 2000 with the objective to advise WHO on the most effective, evidence-based means to fill regulatory gaps in tobacco control and thus achieve a coordinated regulatory framework. In 2003 this advisory committee was formulized into a study group, and it became known as the WHO Study Group on Tobacco Product Regulation (TobReg). Its report of 2006–2008 considered product regulation, including cigarette contents. ‘Dependence’ was used as a synonym for ‘addiction’; beginning in 2012, the term ‘addiction’ was dropped. Reflecting a focus on the consumer, the term ‘attractiveness’ crept in, a phrase that did not appear for drugs or alcohol. Reports noted that cigarettes were exempt from health and safety standards; the aim of the WHO FCTC was to lay the ground for future regulation of contents. Whereas the

concept of a 'safe cigarette' had earlier been rejected, 'harm-reduction' methods were again a feature. A detailed explanation of 'harm reduction' based on other organizations' definitions was provided, but the study group pointed out that any such action 'must not undermine prevention, cessation and reduction of exposure to second-hand smoke and, ideally, should support them' (WHO, 2007b).

The approach to alcohol followed that taken for tobacco rather than for 'illicit' drugs. The coordinated global public health approach became a feature of alcohol policy, which focused on reducing the problems of consumption. In 2001, Gro Harlem Brundtland spoke publicly on alcohol issues for the first time, and a WHO Alcohol Policy Strategic Advisory Committee was established. A WHO resolution in 2005 called for evidence-based strategies to reduce alcohol-related harm (WHO, 2005). The 2007 WHO Expert Committee on Problems Related to Alcohol Consumption pressed the WHO to develop a global action plan to reduce the harmful effects of consumption. The committee argued for clear definitions of alcohol-related terms, particularly in the area of policy.

Definitions reflected this altered focus; for example 'alcohol-related harm' and 'problems related to alcohol consumption' were seen as equivalent terms encompassing a wide variety of health and social problems at the individual and societal level (WHO, 2007a). Although 'harmful use' was in the ICD-10, the WHO expert committee argued for a broader understanding, one related to the public health aims of the WHO, in which the 'risk of harm' now appeared as a part of 'alcohol-related harm'. Distinctions, however, were drawn, and problems with the term 'harm reduction' in relation to alcohol noted (WHO, 2007a).

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

'Dependence' was again accepted with respect to alcohol. Significantly, the committee noted that if alcohol had been considered under the 1971 convention, it would have qualified for scheduling, as it constituted a public health and social problem (WHO, 2007a). However, as with tobacco, it was not considered practical to include alcohol in current conventions. Instead, by 2008 the WHO had drafted a global strategy which included national actions, such as policies for drunk driving, while at the international level priority areas included public health advocacy and partnership, as well as the production and dissemination of knowledge (WHO, 2010).

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

creation of the FCTC. Alcohol policy was reinvigorated with a focus on ‘alcohol-related harm’ and pressure for a global policy in light of developments in tobacco control.

4.7 Conclusion: the development and role of the WHO expert committees in ‘concepts of addiction’ for drugs, alcohol, and tobacco

This review of the WHO expert committees on illicit drugs, alcohol, and tobacco reveals attempts at the difficult task of standardization of terms around ‘concepts of addiction’, the development of an increasingly combined approach to these substances, moves to bring tobacco and alcohol into a public health agenda over which the WHO has control, and attempts to influence the illicit drug agenda.

WHO expert committees were very active in changing concepts and definitions around ‘addiction’. The term ‘habit-forming’, and its replacement, ‘addiction,’ quickly proved unsatisfactory, especially in light of their links to control measures, as well as ‘borderline’ substances which could not be defined by either term. ‘Addiction’ was replaced by the concept of ‘dependence’ and a focus on ‘dependence-producing drugs’.

The shift to ‘dependence’ highlighted similarities between illicit and licit substances. For example, alcohol became an issue, as it could be seen as a ‘dependence-producing drug’. This opened the door to a more combined approach to the substances, at least in relation to research and treatment, although less so for control. A major change was a shift in interest not only to prevention of substance use but the limitation of problems or ‘disabilities’ once such use had occurred. Further refinement led to concepts around levels of consumption; for example, an increasing concern with ‘excessive drinking’ rather than a focus on ‘alcoholism’.

A term that appeared in discussions for all these substances—although it proved contentious—was ‘harm reduction’. This was interesting in the case of tobacco, for which there was emphasis on the concept of ‘elimination’. However, even though elimination was impractical, concern remained for those unwilling or unable to quit; thus the concept of ‘harm reduction’ had to be considered. The balance between ‘harm reduction’ and ‘elimination’ proved difficult, as evidenced by the issue of ‘less hazardous’ or ‘safer’ cigarettes. Recently, it has led to much debate over e-cigarettes. Finally, although tobacco discussions largely drew on terms already established for alcohol and drugs, they also brought new terms such as ‘consumer attractiveness’ into the discussion.

Changing scientific disciplines within the committee system have played an important role in the development of concepts and terms. Early drug committees dominated by pharmacologists focused on the substance, whereas alcohol committees, initially dominated by psychiatrists, concentrated on the medical condition. Broadening the professional disciplinary base to include pharmacologists, psychiatrists, sociologists, and clinicians, and cross-fertilization between the committees, led to greater interest in treatment and rehabilitation and eventually in combined approaches. In contrast, tobacco committees had a medical/public health composition and focus from the start.

The organizational structure of the WHO has also been important. Alcohol and drugs were both placed under mental health but were initially considered by separate committees.

Increasingly, however, linkages brought research and potential treatment options closer together. Nevertheless, approaches to control have differed. Control was a given for illicit drugs, with international mechanisms and conventions established within a penal framework developed prior to the creation of the WHO. But this was not the case for alcohol and tobacco. Alcohol committees increasingly sought to emphasize the medical aspects of the problem to ensure a public health-oriented approach. In contrast, tobacco, seen as an epidemic, even pandemic, entered WHO's consciousness as a public health issue, and one with added impetus due to the threat to the non-smoker. Tobacco's position in relation to the other substances is interesting. Initially considered separately, it was later incorporated into the PSA. Later still it began to follow its own track, leading to the formation of the FCTC whereby the WHO set the precedent for a convention under its own auspices. Alcohol became the only one of the three substances without some form of international control mechanism. WHO began to press for alcohol to be dealt with as a global public health issue and drew inspiration from the tobacco convention.

WHO committees did not operate in isolation. Differences existed between committees, conventions, diagnostic tools, and common usage of terms. In addition, there were time lags between committee discussions and changes to diagnostic mechanisms such as the ICD. For example, the WHO committees pressed the ICD to include 'dependence'. The committees might also be at odds with other organizations such as the American Psychiatric Association, which wanted to reinstate 'addiction' in the 2006 edition of its Diagnostic and Statistical Manual. While the ICD-11 has retained 'dependence', the psychiatric association proposed to replace it with 'substance use disorder'.

Finally, terminology is not fixed. Rather, it is in constant flux, due to changing scientific understanding, evolving drugs, and new delivery methods. Ever-changing policy imperatives, cultural differences, and attempting to meet the needs of different actors contribute to the mix. Thus the debates are ongoing around dosage, 'intoxication', and levels of use. The current debate concerning 'heavy use over time' as a replacement for the concepts discussed in relation to addiction (Rehm, 2013) suggests that the WHO and its expert committees will continue to play an important role.

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Table 4.1 Major WHO expert committee reports, 1949–1963

Date	Committee	Output	Substance	Major shifts in terminology
1949	Expert Committee on Habit-Forming Drugs	[First report]	Drugs	Habit-forming; habituation
1950	Expert Committee on Drugs Liable to Produce Addiction	Second report	Drugs	Addiction
1951	Expert Committee on Mental Health Alcoholism Subcommittee	First report	Alcohol	Alcoholism; chronic alcoholism; addictive drinking
1952a	Expert Committee on Drugs Liable to Produce Addiction	Third report	Drugs	
1952b	Expert Committee on Mental Health Alcoholism Subcommittee	Second report	Alcohol	Alcoholism; excessive drinkers
1954a	Expert Committee on Alcohol	First report	Alcohol	Alcohol intermediate between habit-forming and addiction-producing

1955a	Expert Committee on Alcohol and Alcoholism	'Alcohol and Alcoholism: Report of an Expert Committee'	Alcohol	Excessive drinking rather than alcoholism; problems of alcohol use or problem use, of which alcoholism is one aspect
1956	Expert Committee on Drugs Liable to Produce Addiction	Sixth report [of a meeting held in Geneva, 24-29 October 1955]	Drugs	
1957	Expert Committee on Addiction-Producing Drugs	Seventh report	Drugs	Addiction-producing drugs
1958	Expert Committee on Addiction-Producing Drugs	Eighth report	Drugs	Interest in treatment for the 'addict'
1959	Expert Committee on Addiction-Producing Drugs	Ninth report	Drugs	
1960	Expert Committee on Addiction-Producing Drugs	Tenth report	Drugs	
1961	Expert Committee on Addiction-Producing Drugs	Eleventh report	Drugs	Medical control of addicts
1961	Convention	UN Single Convention on Narcotic Drugs	Drugs	

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Table 4.2 Major WHO expert committees reports, 1964–1989

Date	Committee	Output	Substance	Major shifts in terminology
1964	Expert Committee on Addiction-Producing Drugs	Twelfth report	Drugs	Dependence; drug abuse
1965	Expert Committee on Dependence-Producing Drugs	Fourteenth report	Drugs	Dependence-producing drugs
1966	Expert Committee on Dependence-Producing Drugs	Fifteenth report	Drugs	
1967	Expert Committee on Mental Health	Fourteenth report [of a meeting held in Geneva, 4–10 October 1966]	Alcohol and drugs	

1969	Expert Committee on Drug Dependence	Sixteenth report	Drugs	
1970	Expert Committee on Drug Dependence	Eighteenth report	Drugs	Psychotropic drugs and the qualifying term 'dependence-producing'
1970		C.M. Fletcher and D. Horn, 'Smoking and Health'	Tobacco	Less hazardous smoking/cigarette
1973	Expert Committee on Drug Dependence	Nineteenth report	Drugs	
1974	Expert Committee on Drug Dependence	Twentieth report	Drugs, alcohol, and tobacco	Problems associated with the use of psychoactive, dependence-producing drugs; includes alcohol and tobacco but tobacco excluded from pre-review

1975	Expert Committee \ on Smoking and its Effects on Health	Smoking and its Effets on Health Meeting: Report	Tobacco	Psychic dependence and withdrawal; smoking habit; dependence adopted in relation to nicotine; involuntary exposure to smoke
1979	Expert Committee on Smoking Control	'Controlling the Smoking Epidemic'	Tobacco	Elimination; rejection of the safe cigarette
1980	Expert Committee on Problems Related to Alcohol Consumption.	Meeting (1979) in Geneva	Alcohol	Alcohol-related disabilities; alcohol dependence syndrome Problems related to alcohol consumption
1983	Expert Committee, Smoking Control Strategies in Developing Countries	Report	Tobacco	

1985	Expert Committee on Drug Dependence	Twenty-second report	Drugs	
1987	Expert Committee on Drug Dependence	Twenty-third report	Drugs	
1988	Expert Committee on Drug Dependence	Twenty-fourth report	Drugs	
1989	Expert Committee on Drug Dependence	Twenty-fifth report	Drugs	
1989	Expert Committee on Drug Dependence	Twenty-sixth report	Drugs	

Table 4.3 Major WHO expert committee reports, 1990–2013

Date	Committee	Output	Substance	Major shifts in terminology/focus
1991	Expert Committee on Drug Dependence	Twenty-seventh report	Drugs	
1993a	Expert Committee on Drug Dependence	Twenty-eighth report	Drugs	Harmful use to replace abuse; dependence; disabilities or problems related to drug use of which 'dependence' was just one factor; alcohol

				consumption and levels of use; e.g. less heavy patterns of use; harm minimization
1993b	Expert Committee on Health Promotion in the Workplace	'Alcohol and Drug Abuse'	Drugs and Alcohol	
1995a	Expert Committee on Drug Dependence	Twenty-ninth report	Drugs	Different legal approaches to control but similarities of treatment options for drugs, alcohol, and tobacco
1999a	Expert Committee on Drug Dependence	Thirty-first report	Drugs	Tobacco included for pre-review
2000	Expert Committee on Drug Dependence		Drugs	
2001	Expert Committee on Drug Dependence	Thirty-second report		

2003a	Expert Committee on Drug Dependence	Thirty-third report	Drugs	
2006	Expert Committee on Drug Dependence	Thirty-fourth report	Drugs	
2006	Study Group on Tobacco Product Regulation	Meeting in Kobe, Japan, 28–30 June Scientific basis of tobacco product regulation	Tobacco	Attractiveness; harm reduction; dependence used as a synonym for addiction
2006	Expert Committee on Problems Related to Alcohol Consumption	[First report]	Alcohol	
2007a	Expert Committee on Problems Related to Alcohol Consumption	Second report	Alcohol	Alcohol-related harm; problems related to alcohol consumption; risk of harm; intoxication

