**Was the role of addiction psychiatry an accident of history**?

Virginia Berridge

Centre for History in Public Health

LSHTM

Recent changes in addiction services in England, relocated within local government, have entailed the development of the role of third sector providers. Addiction psychiatrists have complained that specialist expertise and training positions have been lost as a result . Addiction psychiatry has been part of the scenery for addiction services for as long as most people now active in the field can remember. But has that always been the case? It’s arguable that the longer history of the occupation contains within it the roots of the current problems.

Psychiatry’s presence in this field was quite a recent development, really after World War Two and especially from the late 1960s. The area of specialism first emerged in the late nineteenth century, dealing with a condition then termed ‘inebriety’. The Society for the Study of Inebriety, founded in 1884( now the Society for the Study of Addiction) promoted the idea that inebriety ( covering both drugs and alcohol but with attention focussed on alcohol) was a medical condition and should be treated by doctors. But most of its members were not psychiatrists ( or alienists in the terminology of the time).They were medical temperance reformers and many came from the field of public health. The Society’s President, Dr Norman Kerr, was a prominent temperance reformer and had been Medical Officer of Health for Marylebone since 1874.

Mental health ideas tended to come from Europe, not from the UK or the US, where inebriety was also a much discussed concept . In Sweden, Magnus Huss provided a description mid century of what he called chronic alcoholism .Later on theories about morphine addiction came from Europe. Levinstein’s *Die Morphiumsucht* was published in the 1870s and developed ideas about morphinomania .The concept of ‘moral insanity’ permeated the European ideas .

In the 1920s and 30s matters began to change. The mental health profession in the UK took a greater interest in ‘ addiction’ but was still part of a very mixed field. Take for example, the membership of the Rolleston committee, the departmental committee on morphine and heroin addiction which reported in 1926, and confirmed what is often called the ‘ British system’ of drug control and treatment. The 9 members of that committee were all medical, 4 practising medical men and 5 government doctors, mostly from within the newly established (1919)Ministry of Health. But mental health as a specialism was not prominent .The key leaders in the formation of policy were Rolleston himself, a former President of the Royal College of Physicians, Professor W .E. Dixon, Professor of Pharmacology at Cambridge, Sir William Willcox, drugs advisor to the Home Office, who was a forensic scientist, and Dr Branthwaite of the Board of Control. There was no mental health majority - nor was there among the witnesses to the committee. Of the 34 witnesses, 24 were doctors, including a group of 4 prison doctors who always took a harsher line. The biggest professional group involved were general practitioners, operating in general through private practice. Some were what have been called ‘ transgressive prescribers’ – mostly in the West End of London where they fed a small addict subculture .But others were from a range of backgrounds and geographical areas, giving prescriptions to users who could not otherwise function.

There was a growing demand for a specialist mental health approach. Private homes offered treatment- including the Norwood Sanatorium Ltd with branches at Beckenham and Rendlesham Hall. But inter war health services otherwise had little provision after the decline of the inebriates acts campaign. Voluntary mental patients were treated at the Maudsley, which opened in 1923, and the 1930 Mental Treatment Act empowered local authorities to open outpatient psychiatric clinics. By 1936 there were 166 of these. The mental health specialism of addiction had begun to emerge by the late 1930s.A committee of the Royal College of Physicians on the subject in the late 1930s had a membership of psychiatrists, but its report never appeared.Professor DK Henderson of the University of Edinburgh, gave the 16th Norman Kerr memorial lecture in 1936 and urged the integration of alcoholism within psychiatry and also the establishment of an integrated mental health service. He wanted to end the artificial distinction between the treatment of psychoses in the County mental hospitals, the old asylums, and the neuroses in the voluntary hospitals, outpatient clinics and private practice.

This is indeed what happened after the war. The period from the 1940s and 1950s through to the 1970s was a period of optimism and change. It can be seen in many ways as the high point of addiction psychiatry.

The role of WHO , established in 1948, was of importance ,with its initial focus on alcohol . Alcoholism was included in the remit of its expert committee on mental health which first met in 1949.A 1951 report from WHO stressed the importance of alcoholism as a disease and as a serious social problem. WHO reports in this period defined alcoholism as a medical problem- the committees were formed of psychiatrists and others and their influence was disseminated down at the national level. Key figures were G.M.Hargreaves ,head of the WHO mental health unit, a British psychiatrist, and E.M.Jellinek who was consultant to WHO from 1950-57.Jellinek had established his reputation in the alcohol field at Yale University and brought with him to WHO the ideas about understanding alcoholism which were emerging in post prohibitionist America. The rebirth of the disease concept of alcoholism accompanied this period of optimism.

The other development was the integration of mental health within the newly established NHS.

For the first decade of its existence, mental health was still under the Board of Control and remained the Cinderella of NHS services .But the Board was abolished after the 1959 Mental Treatment Act and the door opened to the development of specialist approaches to alcoholism treatment. The psychiatrist D. L. Davies first entered the field of alcoholism because it offered a new drug treatment, Antabuse .He gathered round him an influential network of psychiatrists who trained at the Maudsley and the Institute of Psychiatry. Treatment approaches also emphasised the individual’s social situation. It was in fact through different networks –the BMA and Magistrates committee influenced by the specialist service at Warlingham Park operated by the psychiatrist Max Glatt- that specialist treatment for alcoholism found its way onto the policy agenda. Policy moved away towards outpatient care after a few years, again led by the group of psychiatrists and researchers from the Maudsley.

Some psychiatrists began to develop an interest in drugs. This was a gradual process. The membership of the two committees chaired by Sir Russell Brain which examined drug addiction from the late 1950s through to 1964 showed that psychiatric dominance was by no means a foregone conclusion. The first committee was chaired by Brain, a neurologist and former President of the Royal College of Physicians-the Chief Medical Officer had been adamant that he should be in the chair rather than the psychiatrist Sir Aubrey Lewis . Other members included A. Lawrence Abel of the Royal College of Surgeons; D. Dunlop of the Royal College of Physicians; Donald Hudson from the Pharmaceutical Society; A.D.McDonald , a pharmacologist and member of the WHO expert committee; two members from the BMA; and M.A.Partridge from the Royal Medico-Psychological Association, forerunner of the Royal College of Psychiatrists. The committee was certainly not dominated by psychiatrists.

Nevertheless ,its role was crucial in establishing addiction psychiatry at the heart of specialist hospital based services. The reconvening of this committee in the early 1960s and its recommendation of the establishment of specialist treatment centres- the Drug Dependence Units - is a well known story The second Brain Report established the policy of placing drug addiction treatment with the specialist hospital based psychiatrist. It sought to abolish the role of two other groups in the medical profession who covered this area of medical ‘ dirty work’- private practice and the GP. It attracted sharp criticism from Bing Spear, chief drugs inspector at the Home Office, who deplored the ‘psychiatrisation’ of addiction and the ending of the role of the GP. In his view, a few ‘bad apple’ GPs and private practitioners had brought the primary care system into disrepute and there was no need for the new specialist hospital system.

There was little psychiatric unanimity initially about what treatment should be-Dale Beckett who operated the Salter Unit at Cane Hill hospital in Birmingham favoured maintenance, while Thomas Bewley at Tooting Bec argued for transferring addicts to methadone. The Ministry of Health sought advice from those such as Max Glatt with experience of treating alcoholism. But few knew about drug addiction. Bewley told an interviewer from *Addiction* that he became an expert on addiction in 1964 when he had only seen 20 patients. But that was far more than anyone else. ’That was how I became an ‘expert’. I knew little but everyone else knew less’.

The role of psychiatry was embedded through policy influence and also through research. The establishment of the Addiction Research Unit at the Institute of Psychiatry in 1967 enhanced the position of psychiatry ; a stream of research studies underpinned the new approaches .Psychiatrists were dominant on the new policy advisory committees set up at this time. They dominated an MRC committee set up in 1968 to evaluate different methods of treatment for what was now being called drug dependence. They were also heavily represented on the Advisory Council on Drug Dependence(ACDD) set up in 1966 and replaced by the ACMD(Advisory Council on the Misuse of Drugs) under the Misuse of Drugs Act in 1971.The ACDD had a broadly based membership but of the 6 doctors on the committee, half were psychiatrists. The role of psychiatry was established in the 1960s and 70s.

It seemed as if the succeeding decades, the 1980s and 90s were a high point- the coming of HIV reaffirmed the role of medicine and undermined the ‘ war on drugs’ strategy. The subsequent Treatment Effectiveness Review, intended by the health minister Brian Mawhinney, to question the role of treatment, ended up reaffirming it. But in retrospect there were also signs of a changing role for addiction psychiatry. Dependence remained the official , psychiatric, term .But the population approach established for alcohol in the 1970s; and the focus on the whole population risk brought for drugs by HIV, established concepts of harm and risk and a public health approach. A wider range of players gained greater prominence in both fields .The role of the GP revived and specialist GP practitioners dealt with addiction. GPs also became more important in community based approaches for alcohol. Psychiatry began to lose ground, for alcohol, to new professional groupings such as the liver specialists and the A and E consultants who drew attention to problems of binge drinking and cirrhosis which appeared in A and E, and other locations, not through the mental health route .

The role of the voluntary sector changed as well. It had been an important player in the addictions field do many years , but as the subordinate partner of addiction psychiatry. Brain had defined heroin addiction as a social disease and voluntary organisations played an important role . From the late 1960s, rehabilitation facilities had been run by the voluntary sector in the form of therapeutic communities. There was a long tradition of working with the voluntary sector in the alcohol field as well. But what was meant by voluntarism changed. In the 1990s the voluntary sector developed through large organisations run on a business model .The old relationships of partnership and collaboration no longer worked. There was competition for contracts and the move to local government exacerbated tensions, expanding the role of the voluntary sector to make it a lead rather than a subordinate player .

We can see that psychiatry always occupied a field which had its full share of other disciplines and organisations ,and often in partnership with the voluntary sector and other players. The heyday of addiction psychiatry as the dominant group was really quite short- from the late 1960s through to the 1990s. Was addiction psychiatry’s role in England an accident of history? In other countries addictions are not the province of psychiatry in the same way-one can point to the addiction specialist in Australia; or to the role of social workers in some Scandinavian countries. Even in Scotland, there had been little of a role historically for specialist mental health addiction treatment. In the UK there has now been a reordering of relationships under the impact of structural service changes, although the policy role of psychiatry in the drug field remains strong. Change will be ongoing; and we cannot assume that this reordering is the end of the story.

**Further Reading**

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**Conflict of interest**

None .

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