

Histories of Harm Reduction: Illicit Drugs, Tobacco, and Nicotine

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ABSTRACT

This paper traces the different historical routes which the public health concept of "harm reduction" has taken for illicit drugs and for tobacco and nicotine. It locates these different recent histories, not just in degrees of dangerousness or risk, but rather in the ways in which those concepts have been mediated through intervening factors. It identifies institutional and cultural/conceptual planes for discussion. Key issues include different routes of medicalization; the role of differing policy communities; changing cultural and class positioning; and the shifting of boundaries between categories of "substance," "drug," and "medicine." [Translations are provided in the International Abstracts Section of this issue.]

Key words: Harm reduction; Tobacco; Illicit drugs; Policy

INTRODUCTION

Harm reduction has, as a recent feature of policy and practice, been associated with illicit drug use and, within that arena, more specifically with injection as a mode of drug injection (see Note 1). So far, the approach has tended to be substance and technology specific. This paper broadens the compass to take in a cross substance, comparative, as well as an historical approach. It compares the different recent histories of harm reduction for illicit drugs with tobacco and nicotine in the UK. Why are illicit drugs now set within a harm-reduction framework,

while licit tobacco engenders an emphasis on cessation? Different levels of explanation are possible. This paper seeks to locate those disparate postwar histories, not just in the relative "dangerousness" of the substances in question, but rather in the whole complex of their social and cultural positioning. It places particular stress on the different policy alliances and "policy communities" which have developed around illicit drugs and around smoking. This comparative dimension will, it is hoped, develop a more sophisticated understanding of the levers of harm reduction, and also of the nature and conceptualization of public health, both terms which are widely used without historical embedding. Harm reduction has been constructed differently for different substances across time. The experience analyzed here is that of the UK; it is only through serious research on national histories that we can move to more broadly based conclusions for what are both national and international issues.

AIDS AND THE REVIVAL OF HARM REDUCTION IN THE UK

Harm reduction, as has already been discussed, had always been a focus in drug control in Britain since the nineteenth century. Initially, it was harm reduction conceived at the level of the individual consumer or inebriate/addict; the agents of amelioration who were involved were either lay people themselves or, latterly, the medical profession in alliance with the state (Berridge, 1988c). In the 1960s, however, at the time of the drug "epidemic" of that decade, the nature of harm was reconceptualized. The report of the second Brain committee which had enquired into drug addiction laid less emphasis on the reduction of harm to the individual, and more on the danger to society. Addiction was a "socially infectious disease" and the harm to be reduced was to society as a whole.

Harm reduction, in both this social as well as the individual form, went out of favor in many national drug policies in the 1970s and early 80s. Its revival came with the crisis of AIDS. The contemporary history of that recent shift in British drug policy is well known—although perhaps its origin in a Scottish policy document, the McClelland report of 1986, as well as the better known Advisory Council on the Misuse of Drugs (ACMD) Part One Report of 1988, is less prominent. As I have argued in my recent book, the perceived crisis of AIDS served to break an impasse in policy (Berridge, 1996). Not quite at a stroke, two different sets of policy objectives were brought into temporary alliance. The drug "policy community" had long aimed at the prevention of harm as well as outright abstinence. But politicians, the other policy group, held to a rather different set of objectives. AIDS brought a temporary alliance. The prevention of harm, the hierarchy of objectives, needle exchange schemes, harm reduction approaches in drug education—suddenly the flood gates seemed to be open to all types of previously publicly and politically unthinkable approaches.

To a historian used to history of social change, it always seemed that policy and harm reduction might insofar as there was one, was to be a previous situation, but to an extent it does seem to have happened in *ling Drugs Together*, and Home Office the harm-reduction approach (F

Why AIDS brought drug policy was discussed elsewhere. But it is worth noting that it was, of course, important; sudden social change. Drug users, unlike gay men, were not a general population. A crisis always a movement was crucially dependent on a revisionist "policy community" of psychiatrists, social workers, and other professionals, its links with medical and other institutions. This community, a loose coalition of the reduction of harm from drug use. AIDS enabled those objectives to be achieved and of a governmental expert committee mechanisms. A potentially controversial realm of "science" through the contrast can be drawn with similar issue in New York through the rise of science was similar—but the policy was different (Anderson, 1993).

This approach was, both in character and acterized as one of "public health" expressed through the technological means through methadone maintenance. Exclusively, meant treatment, a strategy. *Treatment Effectiveness Review*. The drug policy community brought to conclusions (see Note 2). Despite the scene, few were prepared to challenge. worked suited everyone's interests.

THE HISTORY OF HARM

Let us turn to tobacco, again a rather different recent history of

To a historian used to historical issues such as the role of war and crisis in social change, it always seemed that those alliances and the "golden age" of drug policy and harm reduction might be a temporary one. The "lesson of history," insofar as there was one, was that things might change again—not back to the previous situation, but to an accommodation of different approaches. That indeed does seem to have happened in Britain with the recent policy document, *Tackling Drugs Together*, and Home Office sentencing initiatives serving to modify the harm-reduction approach (Berridge, 1993, 1998b).

Why AIDS brought drug policy into the harm-reduction mode has been discussed elsewhere. But it is worth summarizing issues here. The expansion of risk was, of course, important; suddenly the threat was potentially to the whole population. Drug users, unlike gay men, were a potential conduit for HIV into the general population. A crisis always brings movement in policy. But the direction of movement was crucially dependent on other factors, most notably the existence of a revisionist "policy community" around drugs—comprising leading psychiatrists, social workers, workers in the voluntary sector, and, most important, its links with medical and other civil servants in the Department of Health. This community, a loose coalition, had existing policy objectives, among them the reduction of harm from drug use rather than simple prohibition. The crisis of AIDS enabled those objectives to become policy reality, with the roles of research and of a governmental expert committee, the ACMD, as important facilitating mechanisms. A potentially controversial policy shift was transferred into the realm of "science" through the medium of research and evaluation. Here the contrast can be drawn with similar efforts to make harm reduction a technical issue in New York through the medium of a clinical trial. That effort failed. The science was similar—but the policy alliances and cultural underpinning were quite different (Anderson, 1993).

This approach was, both in the 1960s and in particular in the 1980s, characterized as one of "public health." Harm reduction was a public health strategy, expressed through the technological route of safer injecting, or by pharmacological means through methadone maintenance. Public health also, although not exclusively, meant treatment, a strategy reaffirmed in Britain through the recent *Treatment Effectiveness Review*. According to one experienced drug researcher, the drug policy community breathed a "collective sigh of relief" at the report's conclusions (see Note 2). Despite the wider range of players on the drug policy scene, few were prepared to challenge that conclusion. Arguing that treatment worked suited everyone's interests (Baker, 1996).

THE HISTORY OF HARM REDUCTION FOR TOBACCO

Let us turn to tobacco, again in Britain primarily, and here we can uncover a rather different recent history of harm reduction as a policy objective. The ini-

tial attempts to urge governmental action on smoking in the UK after the publication of the Doll/Hill research on the smoking/lung cancer connection in the 1950s had what was then termed "less harmful" smoking as one among several policy objectives. The 1962 report of the Royal College of Physicians, the first instance of a doctor-led attempt to sum up the nature and policy implications of this epidemiologically discovered "scientific fact," argued that it was unlikely that increased taxation would have a lasting deterrent effect on smoking. Instead, it suggested the imposition of differential taxation so that smokers would shift to safer forms such as pipes and cigars. Those who worried about coming onto some of the antismoking committees because of pipe smoking habits were told not to worry. "Your pipe will certainly not be a disqualification for service on the committee. It is really cigarettes we are after!" (see Note 3). The early campaigners aimed to achieve a change of habit by the use of these less harmful forms, much as the early antidrink movement in the nineteenth century had aimed to eradicate spirit consumption rather than drinking in general.

Harm reduction remained as a policy strategy in the 1970s. The publication of tar and nicotine levels in cigarettes in 1973 for the first time was part of the same strand. The idea was that, given information, people would switch to lower tar brands. But the main impetus of the harm-reduction theme in policymaking at that period was the move to develop the "less harmful" cigarette—sometimes called the "safer cigarette." The tobacco companies worked with an expert governmental committee, the Independent Scientific Committee on Smoking and Health (ISCSH), set up in 1973 under the chairmanship of Robert Hunter, Vice Chancellor of the University of Birmingham. Its main initial area of work was to allow the assessment of various types of tobacco substitutes by an independent body of experts. The model of operation was rather like that of the Committee on the Safety of Drugs, subsequently renamed the Committee on the Safety of Medicines, which had been set up in 1964. The idea was that cooperation over issues such as testing products would produce more progress and greater control, albeit on a voluntary basis (Berridge, 1998a).

For much of the 1970s the committee was occupied with the launch of this new material. And this was accompanied by an interesting and significant—although ultimately unsuccessful—political initiative. In the mid-1970s the new Labour Minister of Health, Dr. David Owen, as part of his general moves against cigarette smoking, proposed to place all tobacco products containing additives under the provisions of the 1968 Medicines Act. This would have meant that tobacco products would have needed the equivalent of "drug safety" licensing from government—this advice would have been given by the Independent Scientific Committee. Owen, speaking on the smoking issue in the Commons in 1976, said (*Hansard*, 1976):

There are I know many people who think that advertising and promotion should be abolished. The idea that advertising and promotion would be absurd to pretend that 19 million people would stop smoking if we advocated stronger use of the pipe. That price is a major factor. The cost of cigarettes but price is quite unacceptable social cost while the rich would continue to smoke desperately is a strategy for the poor who are heavily physically and psychologically dependent. The question is whether the strategy of safer smoking is to compromise or to abolish.

Owen thought that that was not censing, which presumably would be a product. Symbolically and even a politically inspired move to change that of substance to that of drug boundaries were indeed being re-examined in the late 1960s when Britain's drug laws were under revision through the new Misuse of Drugs Act (illicit drugs and tobacco). On the other, the substance of tobacco was tolerated "medicines" camp. It is fascinating to see how things have been—and in fact we will continue to see in the '90s.

But in the event in the 1970s the initiative petered out of the initiative to another post in government. The "safer cigarette." Tobacco products were not on the shelves when they wanted to smoke them. Some success for failing to get marketing and effective health education campaigns which argued that smoking safer than the 39th floor (Health Education Authority), tobacco substitutes were a

There are I know many people who believe that all cigarette advertising should be abolished. They believe and there is some evidence for this that advertising and promotions increase sales. On the other hand it would be absurd to pretend that abolishing advertising would mean that 19m people would stop smoking cigarettes and it would mean that brand switching to safer cigarettes would be more difficult to achieve. Some advocate stronger use of the price mechanism and there is clear evidence that price is a major factor. The Government has increased substantially the cost of cigarettes but pricing cigarettes off the market would have quite unacceptable social consequences in that the poor would suffer while the rich would continue to smoke. What is needed and needed desperately is a strategy for helping the 19m people who do smoke, and are heavily physically and psychologically dependent on cigarettes. . . . The question is whether the industry can be involved in the long term strategy of safer smoking. Some believe that to even talk about safer smoking is to compromise ones stand against all smoking.

Owen thought that was not realistic, and hence his strategy for product licensing, which presumably would ultimately have extended to tobacco itself as a product. Symbolically and even practically, this was an interesting example of a politically inspired move to change the conceptual framework of tobacco—from that of substance to that of drug or rather medicine. This was a time when the boundaries were indeed being redrawn—the Medicines Act had been passed in the late 1960s when Britain's dangerous drugs legislation was also in the process of revision through the new Misuse of Drugs Act. On the one hand, the boundaries between (illicit) drugs and medicines were being more sharply delineated. On the other, the substance of tobacco was potentially being drawn into the regulated "medicines" camp. It is fascinating to speculate on what the outcomes might have been—and in fact we will come back to this issue with nicotine in the 1980s and '90s.

But in the event in the 1970s, the initiative failed for two reasons. One was the petering out of the initiative into voluntary regulation after Owen moved on to another post in government. The other was the abject failure of the "less harmful cigarette." Tobacco products such as New Smoking Material and Cytrel languished on the shelves when they were introduced in the late 1970s. No one wanted to smoke them. Some said this was partly the tobacco companies' fault for failing to get marketing and distribution right. Some pointed the finger at an effective health education campaign by the Health Education Council (HEC), which argued that smoking safer cigarettes was like jumping from the 36th rather than the 39th floor (Health Education Council, 1968–1969). Whatever the reason, tobacco substitutes were a failure.

But new possibilities for harm-reduction approaches were explored in the 1980s and '90s. Two major avenues in the British context was firstly manipulation of tar and nicotine content of cigarettes, and secondly the replacement of cigarette smoking altogether by a different technology—that of nicotine replacement therapy. The tar and nicotine strategy continued throughout the 1970s and '80s. The Hunter Committee's efforts did not go uncriticized. A blistering BMJ editorial criticized its second report, published in 1979, for advocating low tar/low nicotine cigarettes (Hunter Committee, 1979). People smoked to maintain their nicotine levels, so advocating cigarettes like that might actually be more harmful rather than less (Jarvis and Russell, 1980). The committee's third report in 1983 suggested cigarettes with low tar but a proportionately higher level of nicotine to compensate for this effect. At the same time, a large-scale research program was set up with arms-length industry funding, through the Tobacco Products Research Trust, to investigate the effects of modified cigarettes. By the time of its fourth report in 1988, the committee noted that the general trend had been to maintain machine yields of nicotine while reducing those of tar. But ideally it wanted to reduce both—for there was the issue of what it called maintaining habituation in smokers while developing it in new ones (Swann and Froggatt, 1996). Sir Peter Froggatt and Nicholas Wald, chairman and a member of the committee, summed up after a symposium two years previously that on evidence currently available, nicotine yields should be brought down, but the toxicity of cigarettes could be reduced more if nicotine yields were reduced less than those of tar. They recognized dependence as a two-edged sword. It was a reason either to maintain nicotine or to lower it in order to wean people off the habit (Wald and Froggatt, 1989).

Nicotine was also central in the other strand of harm-reduction strategy—that of nicotine replacement therapy (NRT). Here the cooperation was not with the tobacco industry but with the pharmaceutical one (Ferno, 1994). In 1980, nicotine chewing gum was licensed by the Committee on the Safety of Medicines for general use as an antismoking aid, a decision based on the usual grounds of safety and efficacy. But another committee in the drug-regulation structure, the Advisory Committee on Borderline Substances, ruled against its use in NHS prescriptions because of its doubts about the gum's efficacy. NRT was therefore in the odd position of being the only prescription-only medicine not available on the NHS. A doctor who did write an NHS prescription was brought before a disciplinary tribunal. In the 1990s came further change as some nicotine products moved into the over-the-counter (OTC) category which meant that they could be sold under pharmaceutical supervision (*British National Formulary*, 1987–1995). There were still oddities. In 1995, for example, nicotine nasal spray was prescribable—but the prescription had to be approved by the local Family Health Services Authority (FHSA), the GPs local supervisory body. NRT was marketed as

a strategy for stopping smoking reduction possibilities. An ancient central paradox was that people often wanted other unwanted components in the cigarette. Promote purified nicotine, but the cigarette was still there. Strict regulation of the constituents of the cigarette could become a real possibility—but the cigarette was still there. It seemed logical to offer a cigarette with low tar and nicotine, but the cigarette was still there. A compelling objection to recreation was not shown to be harmful.

Here is a continuous history of harm reduction in the arena. So, where is the difference between these initiatives have not been seen as harm reduction for illicit substances since the 1970s by a different approach. The HEC advertising campaign model which came to predominate in advertising controls, and had little to do with harm reduction as far as the political strategy had seen harm reduction as parallel to the change of stance? Criticism on Smoking and Health) Mike Daube as its secretary, any time. The ASH/HEC nexus was: Briefing notes for a meeting in record "need to increase public health. Need for action to prevent harm might otherwise be eliminated public health member of the IS layed second report in 1979 underline. "The only adequate response to this requires measures which (Hunter Committee, 1979b). The reduction initiatives such as the Skoal Bandits in the early 1980s. As a "Skoal Bandits were banned, and it is like it if you raise these issues" the public health aim and prohibition in the 1980s with the "discovery" of the concept of addiction in relation

a strategy for stopping smoking. But some in the smoking field saw wider harm-reduction possibilities. An anonymous *Lancet* editorial in 1991 put the case. The central paradox was that people smoked for nicotine but died from the tar and other unwanted components in the smoke. So why not change strategy? argued the author. Promote purified nicotine products and at the same time impose stringent regulation of the constituents of tobacco smoke—then the elimination of smoking could become a realistic health promotion target. People smoked for nicotine—but the cigarette was essentially a “dirty” drug delivery system. It therefore seemed logical to offer a cleaner product. There was, the author asserted, “no compelling objection to recreational and even addictive use of nicotine provided it was not shown to be harmful to the user and to others” (Anon., 1991).

Here is a continuous history of harm-reduction initiatives in the smoking arena. So, where is the difference with illicit drugs? One key difference has been that these initiatives have not been conceived of as “public health” in the same way as harm reduction for illicit drug use. “Less harmful” or “safer smoking” was opposed since the 1970s by a more prohibitionist turn in the antismoking coalition. The HEC advertising campaign indicated that opposition. The public health model which came to predominate focused on health education, price, and advertising controls, and had little time for the harm-reduction model. This was quite different from the political strategies of the earlier antismoking campaigners, who had seen harm reduction as part of a range of strategies for smoking policy. What led to the change of stance? Crucial events were the establishment of ASH (Action on Smoking and Health) in 1971 and the involvement of the campaigner Mike Daube as its secretary, and the reconstitution of the HEC at around the same time. The ASH/HEC nexus was deeply opposed to safer smoking (Daube, 1979). Briefing notes for a meeting in 1975, for example, taken from the ASH archive, record “need to increase public awareness of limitations of so-called ‘safer’ smoking. Need for action to prevent ‘safer’ smoking from perpetuating a habit which might otherwise be eliminated eventually” (see Note 4). Dr. J. Donald Ball, a public health member of the ISCSH, issued a dissenting memorandum to its delayed second report in 1979 urging greater urgency, but also a different policy line. “The only adequate response to the tobacco-disease problem is preventative; this requires measures which stop people smoking or prevent them starting” (Hunter Committee, 1979b). The public health alliance therefore opposed harm-reduction initiatives such as the low-tar program and products such as Skoal Bandits in the early 1980s. As a long-term smoking researcher commented to me, “Skoal Bandits were banned, although the risk would be less—but people don’t like it if you raise these issues” (see Note 5). Increasingly, prohibition became the public health aim and prohibitionist tendencies initially increased in the late 1980s with the “discovery” of passive smoking and a greater emphasis on the concept of addiction in relation to nicotine (Berridge, forthcoming). These moves

in the British movement paralleled those in the United States, where a cigarette that heated rather than burnt tobacco was lobbied against by public health interests.

WHY DIFFERENT HISTORIES?

So here is the central paradox produced by a cross substance and historical approach. One substance seems to have moved toward a harm-reduction approach in recent years; the other substance seems to be moving away from harm reduction. Both strategies are nevertheless categorized as "public health." Why the difference? How can we explain it? The concluding part of the paper will address this issue and suggest some considerations for the role of such initiatives within broader historical time frames.

Among the explanations we can consider are the following.

The degree of dangerousness of the substance under consideration. None of the substances under consideration here are benign. It might perhaps be argued that tobacco, and nicotine, is potentially more dangerous than heroin and illicit drugs and that therefore moves to eliminate use rather than to reduce harm are rational responses. However, existing historical analyses of the way drug policies have developed has perhaps disabused us of the notion that policies are put in place as rational responses to specific defined degrees of danger from particular substances. So perhaps we can leave aside that drug-centered approach as a major means of explanation. A historical approach would argue rather that the "dangerousness" of substances at particular stages in history is located in a whole range of other intervening issues. "Dangerousness" is culture and time specific.

Perceptions of risk might be a second line to pursue. But here, too, there are difficulties. Both illicit drugs and smoking have recently been perceived as posing a risk to the population as a whole. For drugs, the risk was via AIDS; for smoking, the risk was that of passive smoking, of environmental tobacco smoke (ETS). But the policy response was very different. AIDS brought drug policy into the harm-reduction mode, as discussed above; passive smoking has moved smoking policy further down the prohibitionist route. Control of the workplace and of public spaces, legal action for damages, are on the agenda as never before. Experts universally agree that passive smoking has moved the issue onto a new plane.

The argument here is that we should look not at dangerousness and risk in isolation—but rather at how these issues are mediated through a range of social and moral, political, and economic factors in particular societies. Let us touch on some of these, beginning with institutional and policy issues and moving on to more general cultural and conceptual planes. Firstly the *different roles and routes for medicalization and professional control* for smoking and for illicit drugs.

Drugs, like alcohol, have, since the UK—a specialist medical en changing. But it has still been of determining the nature of policy, of harm reduction in recent poli doctors have undoubtedly been in the treatment model is by no me tine replacement therapy's hist blurred and in some respects, as and OTC NRT, recalls the way established in the last century. A lished, were never that medical psychiatry did not establish itsel demiology have historically play medical "treatment" model is di public health, but this is an admi focused specialty.

This leads to a further point, each substance. By the term "p "policy activists" who have an mechanisms within government health issue, and, as such, it wa approaches which were prom (Webster, 1996). The public he reduction as a public health str adherence to harm reduction as these are differently located peo mainstream. Crucial, too, has t two policy communities. For si tary movement, centered for a ment. For drugs, the voluntary and rehabilitation sector and the cize—the medical system of co Abuse, the coordinating central a different type of organization Prevention Group for smoking. nities into government—the c shows interesting differences. of Drugs (ACMD), the official issues, has broadened its remit whole of the policy arena, the I

Drugs, like alcohol, have, since the 1960s at least, been a psychiatric preserve in the UK—a specialist medical enclave. As I have argued elsewhere, that role is changing. But it has still been of enormous importance in the British context in determining the nature of policy, the focus on clinics, on treatment, the bedrock of harm reduction in recent policy initiatives. What about smoking? Although doctors have undoubtedly been involved in the movement, medical ownership and the treatment model is by no means so securely in place, as the survey of nicotine replacement therapy's history has indicated. Professional ownership is blurred and in some respects, as for example the growing role of the pharmacist and OTC NRT, recalls the way in which pharmaceutical control of opiates was established in the last century. Antismoking clinics, too, where they were established, were never that medical; often it was psychologists who ran them and psychiatry did not establish itself in the smoking area. Chest medicine and epidemiology have historically played important roles—but the relationship to the medical "treatment" model is different. Epidemiology is linked in the UK with public health, but this is an administrative and managerial rather than a treatment-focused specialty.

This leads to a further point, *the different role of the "policy community"* for each substance. By the term "policy community" is meant the wider group of "policy activists" who have an interest in the area, and who link into policy mechanisms within government. Smoking has always been a mainstream public health issue, and, as such, it was well within the change to individual lifestyle approaches which were promoted by prevention documents in the 1970s (Webster, 1996). The public health policy community has little time for harm reduction as a public health strategy, whereas for the drug policy community adherence to harm reduction as a philosophy has been the watchword. For drugs, these are differently located people—social work, probation, not the public health mainstream. Crucial, too, has been the different role of voluntarism within the two policy communities. For smoking this was essentially a centralized voluntary movement, centered for a long while on ASH and with no links into treatment. For drugs, the voluntary sector has historically been part of the treatment and rehabilitation sector and therefore with an interest in—although it might criticize—the medical system of control. SCODA, the Standing Conference on Drug Abuse, the coordinating central organization for the drug-service sector, is rather a different type of organization to advocacy groups like ASH or the Coronary Prevention Group for smoking. The route for policy advice from these communities into government—the classic device of the advisory committee—also shows interesting differences. Whereas the Advisory Committee on the Misuse of Drugs (ACMD), the official committee advising the Home Office on policy issues, has broadened its remit to include a wide range of players and cover the whole of the policy arena, the ISCSH remained a more limited body with a lesser

policy role. Aspects of smoking policy were firmly beyond its remit (see Note 6). The scientists it recruited, while public health specialists, were not, in general, "activists." The newer Standing Committee on Tobacco and Health (SCOTH) has a wider range of public health players.

One could go further in the British context and point to other strategic differences, for example, the *increasing fragmentation of the harm-reduction case for smoking*. On the scientific side of the harm-reduction camp we find on the one hand the ISCSH and its policy of industrial cooperation with the tobacco industry, with another group favoring the pharmaceutical route of nicotine replacement therapy. The "technological fixes" and their translation into policy are less clear. And NRT's role is less medicalized. For drugs, the harm-reduction options—syringe exchange and methadone—have been less contentious and more firmly medicalized.

Moving away from the mechanics of policymaking, a further issue to be considered is the *conceptualization of the substance* itself. Illicit drugs have, with modification, been placed within a clearly defined legal system of regulation for much of this century, a system which was modified in the UK in the 1960s and after—but basically the categorization remained the same. The bout of legislation in the late 1960s, the 1967 Dangerous Drugs Act and the 1968 Medicines Act, made the boundaries if anything clearer between illegal and legal drug, between "drug" and "medicine." But tobacco—and nicotine—have been what the anthropologist Andrew Sherratt calls "peculiar substances," substances which also affect the mind and moods as well as the body but have not—at least until recently—been categorized as drugs (Sherratt, 1995). The recent policy history I have traced here has shown various attempts—David Owen in the 1970s, NRT in the 1980s and '90s—to recategorize. The recent US FDA initiatives over nicotine emphasize that the trend is now toward greater regulation rather than harm reduction. In the United States at least, nicotine is a "drug" with all the historical implications that term has in that society. In Britain the tension between "substance," "drug," and "drug as medicine" remains unresolved, as the situation over the prescription of NRT illustrates. A recent antismoking summit called by the new Labour government was notable for the language of addiction used in relation to nicotine on the illicit drug model—but the Minister for Public Health also used the analogy of the regulation of pharmaceutical drugs during discussion (see Note 7). The blurring of the boundaries continues.

These shifts are part of broader trends within society, in particular the *changing cultural positioning* of tobacco and illicit drug use. It would be unwise to overemphasize the contrasting trends—smoking apparently in decline while drug use is on the increase. The decline for smoking, in Britain at least, is class based, with the middle classes giving up while smoking becomes concentrated among the poorer sections of society (*Social Trends*, 1997). For illicit drugs, research

seems to indicate a broadening but an issue of cultural positioning is link opinion-forming sections of society to the effects of Prohibition drinking in general—it simply isn't drunk before, and whose opinion society rather than just a part of it (is normal behavior are conditioned to explore, by parameters of social opinion formers in the media, against smoking, while it has become smoking seems to be descending to attack habits which are associated

We may perhaps end by asking questions at stake here also? Is there social movements which mean that which social and political change movement began with a harm-reduction opposition to drinking and "the normal life cycle"? With drugs also in nineteenth century when opiate use a stricter regulatory approach, and normalizing the habit in the developing trajectory is not quite so neat. In the case of prohibition for some consumers, paper has indicated, has had a value clearly been important. This leads to the question of industrial interests play. The interest (leaving aside the recent use of methadone) paradoxically made the strategy easier to achieve for drugs.

These are issues with cross-national implications. In the United States, the analysis would be far less entrenched as a policy. In the United States it would make more sense to consider the harm-reduction approach and of conceptualizing one more risk; in Europe, in particular where nicotine is used within the harm reduction rather than the role of the law and of legal regulation. In the United States—but in both countries

seems to indicate a broadening base of use, in particular among the young. The issue of cultural positioning is linked more specifically to positioning among the opinion-forming sections of society. As John Burnham long ago showed in relation to the effects of Prohibition, it was not the case that Prohibition increased drinking in general—it simply increased it among middle-class people who had not drunk before, and whose opinion was seen as representing the whole of society rather than just a part of it (Burnham, 1968–69). Our perceptions of what is normal behavior are conditioned in ways which this paper does not have time to explore, by parameters of social class and by the way these issues are framed by opinion formers in the media. Media and middle-class opinion has moved against smoking, while it has become more tolerant of illicit drugs. But certainly smoking seems to be descending the social scale; and it has always been easier to attack habits which are associated with women and the poor.

We may perhaps end by asking whether there are broader historical developments at stake here also? Is there perhaps a natural life cycle to scientific cum social movements which mean that we are looking at different stages through which social and political change moves? The nineteenth century temperance movement began with a harm-reduction approach, only later moving to outright opposition to drinking and “the trade” and a total abstentionist line. Is this a natural life cycle? With drugs also we can see elements of the same pattern in the nineteenth century when opiate use moved from being a tolerated “bad habit” to a stricter regulatory approach, and, as with smoking, a particular focus on eliminating the habit in the developing world (Berridge, 1988c). But the historical trajectory is not quite so neat. In the UK, harm reduction was established (alongside prohibition for some consumers) as a medicalized policy option and, as this paper has indicated, has had a varying history since. The role of medicine has clearly been important. This leads us also to question the role which the involvement of industrial interests play. Has the lack of a historically strong industrial interest (leaving aside the recent involvement of the pharmaceutical industry and methadone) paradoxically made harm reduction as an historically established strategy easier to achieve for drugs?

These are issues with cross national implications. If we were looking at the United States, the analysis would be different. There, harm reduction for drugs is far less entrenched as a policy. The contrast would be less obvious. In the United States it would make more sense to talk of a coming together of prohibitionist approaches and of conceptual boundaries. A deeply risk-averse society has encompassed one more risk; in Britain, perceptions of risk are differently constructed, in particular where nicotine addiction is concerned. Nicotine still remains within the harm reduction rather than the prohibition camp—but that may change. The role of the law and of legal means has so far been more prominent in the United States—but in both countries the boundaries between different forms of

regulation are being redrawn to reflect the changing nature of these substances, nicotine in particular. Will all substances ultimately emerge under similar, if cross-nationally differentiated, forms of regulation, and under the public health rubric? The historical contingency of harm reduction and of perceptions of risk remains.

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NOTES

1. Although now the terminology applies to other means of taking drugs. Take, for example, the recent London Dance Safety campaign which targeted the use of drugs by clubbers.
2. Interview by V. Berridge with drug researcher, October 1996.
3. Letter from Dr. Tibbs to Dr. Robert Murray about joining the initial ASH Committee (Action on Smoking and Health), 24 August 1970. ASH archive, Box 29, Contemporary Medical Archives Centre (CMAC), Wellcome Institute for the History of Medicine, London.
4. Briefing note for ASH/HEC meeting, 1975(?). ASH archive, Box 19, CMAC, Wellcome Institute.
5. Interview with smoking researcher by V. Berridge, February 1995.
6. Interviews by V. Berridge with members of this committee, 1996-97. All were concerned to make the point that the committee dealt with science rather than advertising and other matters. The replacement committee, the Standing Committee on Tobacco and Health (SCOTH), has a broader remit.
7. Notes taken by V. Berridge during "Dying for a Fag," the antismoking summit, National Film Theatre, London, 14 July 1997.

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