AIDS and drug policy
Revolution or revision?

Are we all the shiny new children of the HIV era – or the inheritors of Victorian values?

by
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AIDS APPEARS TO have caused some radical changes in drug policy in Western Europe, in Australia, and above all in Britain. The general view has been established that the danger of the spread of HIV from drug users into the general population is a greater threat to health than drug use itself. The words and concepts of harm minimisation/reduction are on everyone's lips.

For Britain, some commentators have argued that AIDS changed the direction of drug policy; others have been more cautious.[1,2] In general AIDS has been seen as bringing about a kind of new dawn, a 'new public health' approach integrating drugs into mainstream health policy. The decision to expand needle and syringe exchanges was, said one senior civil servant, of "fundamental importance" – a new departure for drug policy.

But how sharp was the pre- versus post-AIDS division? If you work in a drug agency, how much of what you now do is due to the HIV epidemic? Has drug policy radically changed under the impact of AIDS, or has AIDS simply been used to accelerate existing developments? Do recent changes merely exemplify some long-standing themes and tensions in drug policy?

An analogous issue is the impact of war on social policy. Historians have recently begun to question the view that the Second World War was the only catalyst for radical change, for example in the inauguration of the NHS in Britain.[3] They argue that the wartime national 'consensus' for social change was less than unanimous and that the roots of the NHS can also be found in prewar debates and blueprints for healthcare.

What war did was to enable change to happen more quickly and somewhat

> AIDS has been seen as bringing about a kind of new dawn

differently than might otherwise have been the case. War served to overcome vested interests and opposition to change, but essential continuities with the prewar health service remained.

Like war, AIDS evoked a period of political emergency reaction. In Britain this was at its peak from 1986-7 though, in relation to drugs, it spilled over into 1988 with the Government's reaction to the first *AIDS and Drug Misuse* report from the Advisory Council on the Misuse of Drugs (ACMD). There was the creation of an emergency Cabinet committee on AIDS chaired by the Deputy Prime Minister, William Whitelaw; the 'AIDS week' on television in February 1987, when both networks joined with government to broadcast programmes on the wartime model; the Commons emergency debate in November 1986. Many of the actions of central government in this period had a wartime flavour.[4]

> The growth of concern over drug-related HIV spread in the mid-80s served to lend political acceptability to and extend pre-existing policy trends towards harm minimisation approaches and away from seeing addiction as a medical disease. Paradoxically this public health concern has brought medical services back towards the centre of Britain's response to drug problems. The coalescence of penal and medical approaches has revived the policy characteristics of previous eras.

Before there was AIDS

The impact of AIDS across many policy areas cannot be understood unless we understand something of their 'prehistory'.[5] What was happening in genitourinary medicine, for example, or in health education, before AIDS? The immediate prehistory of drug policy clearly shows that harm minimisation was not a new AIDS-specific policy objective.

Throughout the 1980s there was a growing belief in some circles that reducing harm was a more realistic aim than more rigid and medically based ideas of 'treatment', 'cure' and 'abstinence'. The concept received its best-known public expression in the 1984 ACMD report on *Prevention* which abandoned the traditional division into primary, secondary and tertiary prevention in favour of two basic criteria: "(a) reducing the risk of an individual engaging in drug misuse;
(b) reducing the harm associated with drug misuse".[6]

Such ideas were commonplace, too, in the increasingly important voluntary sector. Accompanying them was a tendency to downplay the 'medical model' of addiction as a disease requiring specialist treatment. This change received official sanction in the 1982 ACMD report on *Treatment and Rehabilitation*, with its emphasis on a multidisciplinary

In the '20s Delevingne of the Home Office (left) looked for a ban on long-term prescribing to addicts. Rolleston's committee (right) fought off the challenge and established doctors' right to prescribe

approach based on drug problem teams and drug advisory committees.

The early and mid-80s also saw the formation of a distinct 'policy community' which embodied these ideas. There was a shift from the previous primarily medical community to one more broadly based. This comprised 'revisionist' doctors in drug services, researchers, drug service workers, leaders in the drug voluntary sector and, most crucially, civil servants in the Department of Health who shared their objectives. Differences there were over implementation, but one policy objective – minimisation of harm from drug use – found general support.

But this policy remained difficult to enunciate publicly; it lacked political acceptability. There remained a yawning gap between the 'political' and 'policy community' views of drugs. So pre-AIDS drug policy in the 1980s had a dual face: a 'political' penal policy with a high public and mass media profile, and a much less public 'in-house' health policy based on a rhetoric of de-medicalisation, community services, and harm minimisation.

AIDS, like war and the NHS, lent political feasibility to this 'in-house' policy. A policy which before could be advanced only slowly, as the unspoken underside of penal policy, 'came out' because of AIDS. As a senior medical officer commented:

"AIDS may be the trigger that brings care for drug users into the mainstream for the first time ... The drug world can come 'in from the cold' through AIDS ... it's a golden opportunity to get it right for the first time."[7]

Research by social scientists was an important legitimating factor – a telling comment on the power of the new policy community. Also important was the willingness of Conservative politicians to push for change. In-house policy became a priority for politicians, too.

What emerged was a liberal consensus – harm minimisation and safer sex rather than prohibition or social segregation. One senior Conservative politician saw drug policy post-AIDS as "increased controlled availability at home and stronger prohibition round the edges".[8] Pragmatism was the order of the day.

So far we've looked just at the immediate prehistory of drug policy before AIDS, but reduction of harm, broadly defined, had been a consistent policy theme even before the 1980s.

The history of harm reduction

In the postwar 1920s a hard line emergency response to drug use was at its height. Numbers of addicts were at their lowest ever but the Home Office (inspired by US example and by its new responsibilities under the 1920 Dangerous Drugs Act) saw the solution as prohibition – stamping out addiction via the courts and a penal response. The medical profession defended its role and with it the disease concept of addiction via the Rolleston Committee of 1924-26.[9] For us, what is significant is that committee's justification of maintenance prescribing:

"When ... every effort possible in the circumstances has been made, and made unsuccessfully, to bring the patient to a condition in which he is independent of the drug, it may ... become justifiable in certain cases to order regularly the minimum dose which has been found necessary, either in order to avoid serious withdrawal symptoms, or to keep the patient in a condition in which he can lead a useful life."[10]

This was a framework in which the minimisation of harm to the individual drug user was paramount, albeit also as a means of allowing them to lead a "useful" (ie, economically productive) life. In this Rolleston followed the tradition of the nineteenth century, when the public health rationale for improving the health of the population invariably had an economic justification.

The 1960s provide a more recent example of the durability of harm minimisation in drug policy. Then the arguments more directly encompassed a social dimension. As would happen with HIV in the 1980s, the 'epidemic' – then addiction itself – led to the language of infectious disease, public health and national crisis. The 1965 Brain Report saw addiction as a "socially infectious condition," a disease which "if allowed to spread unchecked, will become a menace to the community".[11]

The report's proposals – notification and (later dropped) compulsory treatment – were classic public health responses. The rationale of the clinics that emerged from the report was harm minimisation – but, in the 1980s, minimisation of harm to society as much as to the individual drug user. Clinic doctors had to prescribe opiates to undercut the black market, but not so much that the overspill supplied the market and new addicts were created. Treatment was of minor importance compared to the minimisation of social harm. Max Glatt, a psychiatrist involved in the debates over the clinics, recalled:

"Most of us were very averse to prescribe what we thought were killer drugs. But in the end when we were asked to man the new addiction centres, the arguments were that if we didn't prescribe, the black market would take over ... But it's quite wrong to say (as people do nowadays) that we thought at the time this was the *treatment* for drug addiction. It was just a kind of first aid ..."[12]

Clearly the reduction of harm as a justification for formal and informal drug controls is not without its immediate and long-term history, dating back as far as the nineteenth century.[13] But there are also more complex tensions in drug policy – a plethora of conflicting, sometimes interconnecting forces.

Complex policy tensions

The classic overarching paradigm in many analyses has been the conflict between penal and medical forms of control. However, there are, and have been, conflicts between *different forms* of medical control, eg, between aiming to cure the individual versus a form of public health approach focused more on community welfare.

Even 'public health' has not been an unchanging concept. The term conjures up visions of nineteenth century battles against disease and poor living conditions. But medical advances, which assigned specific causes for diseases, meant that directly attacking the bacteria rather than an unhealthy environment became the focus of public health.

Social hygiene, with its emphasis on individual responsibility for health, was

the reformulated public health of the early part of this century. The 'new public health' of the 1970s and '80s, emphasising individual lifestyle and prevention, has to some degree revived social hygiene concerns, although there are also strong efforts to broaden the public health paradigm to encompass questions of inequality and social structure.

'*Public* health' thus contains within itself the seeds of an *individually* focused medical approach. The nineteenth century 'public health' focus stimulated by the urban crisis of industrialisation later gave way to individually focused theories of addiction and disease. In the 1960s change was justified on public health grounds – the control of a potentially epidemic disease – but by the '70s this had shifted to an individually focused abstinence-oriented treatment approach. In drugs, as in other health areas, there has always been an implicit tension between prevention and cure.

Historically, the tension between penal and medical approaches has also been more complex than it would appear. Nineteenth century advocates of inebriety as a disease saw treatment as more humane than prison, but for them the 'medical model' was an argument for compulsory incarceration – a prison under *medical* rather than penal control.

Likewise in the 1920s, the Rolleston committee's defence of humanitarian drug treatment applied only to those middle class addicts doctors were likely to treat. Chlorodyne, a working class tipple, was not even in their terms of reference and opiate use in prisons received a distinctly harsher response from the medical experts; compulsory treatment and cold turkey were considered appropriate.

Most important of all, Rolleston did not mark some autonomous medical 'victory'. Maintenance prescribing operated within a system of domestic and international control in which the perspectives of the Home Office, the justice ministry, were dominant. How that balance of forces operated could easily alter over time.[14]

AIDS and its aftermath in British drug policy have displayed these tensions in all their complexity. While nominally 'normalising' drug use via harm minimisation, the 'non-medical' rhetoric of policy post-AIDS has disguised some clear tendencies towards sustained or even increased medical input, and revived some earlier medical arguments.

The impact of AIDS

AIDS has brought doctors back towards the centre of drugs work through the emphasis on prescribing, the focus on the role of the GPs and the new emphasis on the general health of drug users. Whether this is seen as de- or re-medicalisation depends on your perspective.

The need to attract drug users not normally in contact with services, sanctioned by a range of official reports, has served to elevate the notion of 'treatment', which has resumed its place as an unchallengeable 'good'. AIDS also revived some earlier medical arguments around treatment. The debate over prescribing methadone as a 'bait' to attract users into services to prevent HIV spread mirrored the arguments of the '60s, when prescribing was also used to attract addicts to prevent harm to society.

Increasingly, too, voluntary (non-medical) and statutory (medical) services are being brought into closer relationships and the differences between them blurred, a process hastened by the NHS and community care reforms and owing much to more general trends in health policy.

The response to AIDS exemplified the long-standing policy influence of the medical profession. Doctors in the civil service and medical expert advisers were of key importance. Without their support, the 'new departures' in policy could not have been sustained.

The 'public health' paradigm of post-AIDS drug policy contained within it a strong focus on the individual: health education for individuals, and the idea of the drug user as a 'normal' person responsible for their own actions, were key elements. As with past public health responses, the potential exists for a shift to an individualistic medical response.

Differences between penal and medical approaches have also blurred under the impact of AIDS. HIV's potential impact among prison populations has been the impetus behind the introduction of harm reduction into the probation service, of treatment into prisons, and of penal aspects into treatment and rehabilitation.

These shifts have been part of broader changes in the criminal justice system which have aimed to keep offenders out of prison. The Prison Medical Service is becoming the Prison Health Service; but offenders can now also be 'sentenced' into treatment. The probation service appears to be developing a key 'gatekeeping' role between medical and penal approaches. HIV has emphasised the health aspects of the penal response, but it has also emphasised (as in the nineteenth century, the 1920s and the 1960s) the punitive aspects of the medical.[15]

REFERENCE TO historical precedents was absent from the initial policy debates around AIDS and drug use, despite the long tradition of 'using history' to support particular lines in drug policy.[16] The promotion of existing policy objectives was better served by emphasising their relation to the *new* AIDS situation than to the drug policy past.

But many aspects of policy change did draw on distinct pre-AIDS continuities. War and crisis do lead to change, but long-standing themes also reassert themselves – witness the current revival of the prescribing debate and of forms of 'compulsory treatment'. The complex historical tensions within drug policy have been clearly displayed in the wake of AIDS. Whatever, the future of that policy, it will not escape from its history. ❍

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