Are they?, asks Andy Malinowski as he looks at the impact of AIDS on current drug policy development and challenges the view that it has led to a 'radical shift in direction'. This article is an abridged version of an MSc Thesis, which was submitted to Bath University in 1992.

INTRODUCTION

The article will begin by aiming to make sense of history through a brief identification of factors which distinguish one policy phase from another, identification of their interrelatedness and factors leading to their transition. In the process it will ascertain whether identifying and discussing such phases is a useful way of describing and analysing policy changes and whether the pre- and post-AIDS periods of policy development warrant a separate fourth and fifth phase. Secondly, it will discuss whether the policy-making community was ready for AIDS and examine how it responded by analysing related research data. Finally, a summary of the article's conclusions will be presented.

Evidence and research suggest that the first identifiable phase of British drug policy, spanning the period from 1800 to 1914, was essentially characterised by minimum state intervention. It witnessed the growth of professional involvement and controls, which were, underpinned and legitimated by medical concepts. Government intervention led to legislation (1868 Pharmacy Act) designed to curb the availability and use of opium, and was driven largely by the fear of social unrest (Berridge and Edwards, 1987). It seems that the major factor which created the conditions for a transition to a second phase was the First World War. Reports that troops were using cocaine, together with pressure for governmental intervention from the media and medical
professions, led to the establishment of, on the one hand, the 'British System' of medical control and, on the other, a penal framework of national and international controls, enshrined in the Dangerous Drugs Act, 1920. This second phase, which spanned the period up to 1967, is characterised by power struggles between the Department of Health and the Home Office for policy initiative and supremacy, together with a gradual penalisation of non-medical drug use. It was a period which considered 'addiction' to be limited and essentially confined to the respectable middle classes, and therefore a legitimate activity. When evidence began to accumulate in the mid-1960s of a rise in notified addicts, together with the growth of a drugs subculture, the government once again intervened.

The third phase, which spanned the period from 1968 to 1981, witnessed the introduction of the Dangerous Drugs Act 1967, and an alteration in the balance between the medical and penal approach, towards even greater legal controls, professional restrictions and the criminalisation of drug use. The emphasis in drug policy switched from the social control of 'addiction', associated with the second phase, to one of individual and therapeutically oriented treatment. Significantly, this period of policy development saw major changes in the policy community, with the rise of voluntary sector influence at the cost of the medical professions. This third phase can be considered a period when policy makers and clinicians lost their way. The switch away from the social control of drug use and a public health model of service provision was accompanied by little initial and subsequent research. Currently, there exists practically no coordinated evaluation of the clinic system. The introduction of the concept of dependency, which replaced 'addiction', did little but temporarily legitimise a switch towards therapeutic and abstinence-oriented treatment. The fine balance between the social and individual control of drug use, tipped towards the latter, and would not be significantly altered until the early 1980s. The ideological outlook and influence over policy that was enjoyed by the alliance of the voluntary residential sector and consultant psychiatrists, came to an end by the early 1980s.

Looking back over the first three phases, several factors come to prominence: first, the degree of state intervention, as exemplified by increasingly punitive legislation; second, the development of the professional classes and their legitimising body of knowledge; third, the power struggles between two government departments, with punitive responses gradually gaining supremacy in response to changing circumstances; fourth, the class nature of social policy, where because of the fear of social unrest, the development of a drug subculture and 'illegitimate' drug use, greater restrictions and controls were introduced; last, each phase can be said to reflect a particular conceptualisation of nonmedical drug use. Rosenbaum (1985) refers to three models of policy development - namely the medical model, the Reformist and the Libertarian. The first and second phase of British drug policy reflect a 'medical model' of policy, where 'addiction' is seen as a chronic disease. The third phase is clearly characterised by the
'Reformist' model where the concept of disease is replaced by one of dependency, which emphasises social learning and rehabilitation. 'Addiction' was no longer to be seen simply as a chronic and life-threatening activity.

The fourth and fifth phase in British drug policy collectively reflect the pre- and post-AIDS awareness periods, beginning in 1982 and continuing up to the present time. They differ on a number of important points, and therefore warrant being recognised as distinct phases. Both reflect essentially a 'Libertarian' model of policy, which is associated (inter alia) with flexible prescribability. They herald the beginning of an increase in central direction from government in policy formulation, coupled with widespread local autonomy. The fifth phase, however, is explicitly associated with the goal of harm minimisation, underpinned by the concept of 'public health', which was given a new lease of life by the emergence of AIDS.

Returning to the fourth phase, it is characterised by a significant increase in Central Government involvement, in the form of funding and policy development. This compares with the third phase where policy was largely determined by an alliance between the consultants and the residential voluntary sector. Drug policy became politicised and took on a high public and mass media profile. However, it did not become a political issue, in the sense that a remarkable inter-party consensus prevailed. The Government's rhetoric was reflected in their 'war on drugs', and their penal response in further legislation (Drug Trafficking Offences Act 1986). This marked a further de-medicalisation of drug policy, a process which had begun in the 1970s. On the whole, however, there is little empirical research to show how political rhetoric translated into policy and practice. What is clear is that there exists a gap between the 'political' and 'policy community' perspective on policy and practice (Berridge, 1991; Turner, 1991). An example of this is the mass media anti-heroin campaign of 1985-1986, which went ahead despite research and departmental advice that it may prove ineffective or counterproductive (Dorn, 1986). The fourth phase could be considered a period when the policy community finally got its act together. It underwent important changes in its membership and in the process became less dominated by the medical profession. The influence of the voluntary residential sector also began to want as 'street' agencies began to flourish, incorporating a different 'Libertarian' culture, which did not readily embrace abstinence as the prime and only goal of treatment. Accompanying this change was a further reconceptualisation of drug use to the currently dominant and broader concept of 'problem drug taking'. 
THE IMPACT OF AIDS

So what happened in 1986 for it to warrant being considered the beginning of the fifth phase? First, AIDS became an issue for policy makers and practitioners. Second, and consequently, the public health paradigm was rediscovered, which enabled a switch from therapeutically oriented treatment towards the widespread development of harm-minimisation policies. Third, non-medical drug use was recognised as being, diffused to most levels of society, and in some quarters increasingly came to be seen as a normalised or non-deviant behaviour.

In retrospect, it appears that the fifth phase is not a clean break with the past, but is linked historically to inherent ideas, themes and tendencies evident in preceding phases. For example, although the concept and practice of harm minimisation has received a fresh coat of paint in the post-AIDS period, its roots can be traced to principles enshrined in the Rolleston Report (DCMHA, 1926). It seems that policy developments within each phase are influenced retrospectively by what went before and thus by problems as they arise.

This idea that policy formulation associated with the fifth phase is not 'new' and therefore not a radical departure from the past is examined in more detail by an analysis of the research data.

An important question to address at this juncture is how ready was the policy community to respond when AIDS became an issue in 1986-1987? Were the necessary ideas, structures and will in place to allow a development of radical policies?

We recall that the social and political climate in the Spring of 1986 was described by a leading commentator as being highly unsympathetic to the widespread provision of syringe and needles (Stimson, 1990a). Yet in the Autumn of 1986, we read that two senior non-medical civil servants were making encouraging and sympathetic noises to the idea of harm minimisation (Berridge, 1991). One important factor which may explain this shift in opinion is the publication in the Autumn of the McClelland Recommendations - pertaining to Scotland - well ahead of the ACMD's Report which primarily referred to England and Wales. Another facilitating factor, identified by a senior Department of Health civil servant was 'the pre-existing development of Community Services... which enabled a speedier response. Referring to the latter part of the fourth phase and the period following the publication of the seminal ACMD Report (ACMD, 1982), the same civil servant felt that 'fortuitously the fact we'd already shifted on policy...
a fertile seed bed from which we’ve been able to develop’ (Berridge, 1991, p 188). All the seven respondents that 1 interviewed support the suggestion that important ideas and structures were already in place and in various stages of development. For example, Interviewee B, a Regional Consultant Psychiatrist feels that the changes that ‘...were on the boil...‘before AIDS, were initially a response to a feeling that specialist services had lost their way, and subsequently, ’...HIV concentrated people’s minds...‘ and acted as a major catalyst and stimulus to ideas already showing green shoots. This latter point is a theme that appears throughout the research data. The major importance of the Treatment and Rehabilitation Report (ACMD, 1982) in providing the conceptual framework for subsequent policy development is strongly argued by Interviewee D, a senior Department of Health civil servant. Indeed, she refers to the implementation of most of its proposals as itself representing a ‘radical shift’. In her opinion, structures were conceived and developed throughout the early 1980s, which during the fifth phase were to play a central role in facilitating policy formulation, but which at the time took little account of the impending AIDS issue. As she frankly puts it, ‘in ’82 it was there, we knew vaguely about what was going on in the States, but I don’t actually think we put that in any discussion’. Interviewee E, speaking from a National Voluntary Sector perspective, also feels that the timing of when AIDS became an issue, for policy makers and practitioners alike, was crucial in accounting for the rapid development of specialist services in the post-AIDS era. In 1986, due primarily to the government’s central funding initiative, there existed the beginnings of an unprecedented geographical spread of new specialist services. Interviewee E feels that this was a major factor in them being able to accommodate new ideas and practices. For these ‘...services were still young, they were still developing, they got their feet on the ground, still had the enthusiasm for development and change’.

It seems therefore that, in 1986, when AIDS eventually became an issue, certain vital ingredients were in place to allow a subsequent rapid response. Various ideas and proposals were already in place; all that was needed was the will to act and the necessary funding. Had AIDS occurred in phase 3, the policy community may not have been quite as willing and ready to respond.

Research data gathered in carrying out this study shows that all seven interviewees feel that although AIDS was a major factor in subsequent policy development, it has not led to a radical shift in the direction of policy. They all, with perhaps the exception of Interviewee F (a senior civil servant at the Home Office), feel, in various ways, that the policy initiatives identified in
phase 5 were already in the pipeline before AIDS became an issue. Additionally, they consider policy development to resemble a circular or repetitive process. Thus policy is seen as reacting to events as they occur rather than being thought through rationally and pro-actively. Policy is seen as 'adapting to changing circumstances' and in the process regaining a 'balance'. Running through the policy process are certain 'themes' that respond and alter as they collide with external developments. One consultant described it as the 'centre of the response' whereas two others described it as a 'cyclical' and 'wheel view' process, implying that the ingredients stay the same while the mix alters.

Most agreed with the 'policy community' idea of how and who makes policy. One consultant, while acknowledging changes that have take place within the community in the last 10 years, comments that, 'twenty years ago, one could get all the main interested parties in drug services into this room .... like the Liberal Party could all get into one taxi.'

None felt that the 'community' was unrepresentative. As one Consultant put it:

'I think the influences now on drug policies are so much wider and more varied than they used to be that I think this idea that there are just a few people who are somehow calling the shots isn't the case.'

So if the impact of AIDS on drug policies is not considered to have led to a radical departure, what has been its impact and what policy initiatives has it brought to the fore? To answer these questions, we must return briefly to the state of policy development in the mid-1980s and identify what indeed was in the pipeline and what eventually emerged.

Two major issues that the research data identify are the concept of harm minimisation - as exemplified by the provision of injecting equipment and flexible prescribing - and, secondly, the apparent liberalisation of control responses, e.g. police cautioning, referral schemes and sentencing policy.

Taking harm minimisation first, one respondent seems to be genuinely surprised that in some quarters this concept is still considered novel and unprecedented. This may not be surprising, as specialist services expanded rapidly during the 1980s taking in many workers who had little experience or appreciation of the historical context of policy development. It also suggests that
there occurs a partial cultural break in the transmission of ideas, principles and past practices, between phases in policy development.

Interviewee C, who chaired the ACMD during the preparation of the Treatment and Rehabilitation Report (ACMD, 1982) felt that the shift away from abstinence towards preventing 'drug users from creating harm to others and ... themselves', was already in the pipeline, primarily due to the above report. Likewise, Interviewee D feels that the report's proposals of a shift towards community-based services, a move away from specialisation and a growth in the non-residential voluntary sector, were just developing when AIDS became an issue. Although HIV disease was later to speed up the development of these initiatives dramatically, it was 'the issue of a much wider more diverse drug problem, which didn't include AIDS' that was the central impetus to what Interviewee D considers as being 'the more radical shift than the one that took place by about 'ST. Indeed, this plausibly suggests that phase 4 was the one within which far-reaching concepts were developed and ideas forged, whereas phase 5 merely represents a fruition of these ideas.

One respondent, Interviewee E, feels that the concept of harm minimisation received an important endorsement following the Advisory Council's publication on Prevention (ACMD, 1984). The arrival of AIDS, for Interviewee F, had the effect of re-prioritising harm minimisation which would not otherwise have received widespread support, which in the process contributed to 'a shift in emphasis towards a more flexible and pragmatic approach'. The suggestion here is that AIDS helped to overcome deep-seated ideological objections to more flexible and pragmatic treatment responses, away from abstinence-oriented policy. As the above civil servant Respondent puts it,

'I wouldn't say that there has been a profound change in policy. A shift in emphasis, strongly, yes. But there's a much better understanding of the plight of the addict and the benefits of making treatment attracting in the interests of society.'

No longer was the treatment to be confused with attempting to change the behaviour of those who didn't want or deserve change, but could now be costed and quantified in terms of the public good.

Turning to the apparent liberalisation of control responses, the majority of respondents, although acknowledging recent changes in the practices of the police, customs and to a lesser extent the judiciary, feel that the origin of these changes can be traced to the early 1980s.
Interveneres A, a consultant psychiatrist (reported to be the most influential voice within the 'Establishment'), referring to the innovative police diversion schemes in operation in Manchester during the mid-1990s, argues that AIDS had nothing to do with their initial conception, although later they did influence their development. Likewise, the Home Office is said, by Interviewee B, to have been against imprisonment for drug-related offences, favouring instead the 'methadone programmes', which were developing on an ad hoc basis across the country, during the pre-AIDS period. One respondent, a Senior Department of Health civil servant, feels that AIDS did provide justification and an added impetus to noncustodial services. In her opinion:

'AIDS has quickened that up because the government was worried first of all about prison overcrowding, secondly they were, worried --(about) the number of HIV positive people in prison' [in Italy and Spain].

However, it is clear that these changes are local and peripheral to the central thrust of the Government's penal policy. The 'War on Drugs' continues unabated, with the Home Office occupying the lead position in developing a strategic policy framework which is characterised by its punitive outlook. The changes that have taken place in the last 10 years are a reflection of a more pragmatic response to factors such as prison overcrowding and the feared spread of HIV disease among prison inmates. But they appear minor when one compares prison statistics over a 10-year period. In 1980, 735 men were gaol for drug offences, whereas in 1990, this figure rose to 2739, representing 10% of the male prison population. Figures for women are just as disurbing. In 1980, 55 women were gaol for drug offences, whereas in 1990, 303 were imprisoned, representing 33% of the female prison population (Guardian, 1992). Legislative changes have resulted in the Controlled Drugs (Penalties) Act 1985, which increased the maximum penalty for trafficking under the Offences Act, which as a result of Home Office agreements with several countries, allows assets to be confiscated if it can be shown that they are the proceeds of drug trafficking. This policy approach was summed up by one Conservative Politician in 1989, as amounting to 'increased controlled availability at home and stronger prohibition round the edges' (Berridge, 1991, p. 194).

In conclusion, it is suggested that AIDS, rather than forcing a radical break with the past, has merely, dramatically speeded up policy developments already in the pipeline. As Interveneres A puts it, what this clearly shows is themes continuing, being altered, not carrying on with no regard to AIDS, but AIDS just becoming a major influence on a process that continues...
HARM MINIMISATION

A further examination of the research data enables us to address the issue of 'newness' in policy direction, by specifically focusing on two graphic examples of harm minimisation, namely the provision of injecting equipment and flexible prescribing.

This article has briefly discussed the development of prescribing policies and the availability of injecting equipment. We recall that throughout phases 3 and 4, the prescribing of injectable opiate drugs was largely confined to small pockets of long-term injectors, whereas the provision of orally administered methadone was accepted as the most appropriate form of opiate prescription.

The provision of 'flexible prescribing', which here refers to the accessibility, amount and duration of prescription, together with injecting equipment, was patchy and largely determined by individual practitioner and geographical factors. It is argued that the rapid spread of HIV disease in Edinburgh was largely due to the nonavailability of injecting equipment during the early 1980s. Access to prescribed oral preparations of methadone has, until recently, been extremely difficult to acquire in Scotland, especially on a longterm and widespread basis.

Until 1988-1989, dependent drug users in England and Wales would have had a mixed experience in attempting to acquire either an opiate prescription or injecting equipment, which would largely be dependent on where they lived and which generic or specialist service they approached.

Although policy development during the late 1980s regarding harm minimisation has been geographically patchy, ad hoc and reflecting regional differences, there have nevertheless been important changes that have taken place during phase 5, which have resulted in a more widespread and easier access to treatment.

It is now easier to get an opiate prescription, both long and short term. In some parts of Britain, drug users receive oral amphetamine prescriptions, smokable stimulants and opiates and, to a lesser extent, injectable heroin. Injecting equipment is now explicitly available through over 200 'exchange' outlets and numerous pharmacies. So how 'new' are these policy shifts and what part did AIDS play, and would the concern over the spread of hepatitis B have resulted in similar policy changes?
Several interviewees pointed out that injecting equipment was available throughout phases 3 and 4. However, their availability was not an issue according to Interviewee G, an ex-regional organiser of a national drug rehabilitation agency, because, 'for one thing you had more people being prescribed injecting drugs and the means of injecting them, so you weren't so aware of them. People purchased their syringes from chemists'.

We are also reminded by one consultant that 'Drugchnics in the early days ... (gave out) ... syringe and needles, ... (as well as) ... practical advice on injecting technique'. Another consultant, Interviewee B, argues that harm minimisation was on the agenda at the onset of the clinic system in 1967-1968. He tells us that his, 'early experience in clinics '71 onwards was that we handed out needles and syringes and I remember that ... we produced a slide show for users to show the dangers of drug injecting...'

So what is new about current harm-minimisation policy? Primarily, it is the prominence that the concept has acquired during phase 5 and the prime place it has occupied on the policy makers' agenda. As the above consultant put it, even though 'harm minimisation is not a new concept in drug misuse ... (it has) ... clearly gone to the top of the agenda directly because of HIV.'

The majority of respondents feel that harm-minimisation practices would have continued to occupy a low profile had AIDS not occurred. All agree that injecting equipment would not have become as widely available. Interviewee D, a doctor civil servant, feels that despite the prevalence of hepatitis B, a life-threatening infectious disease, syringe and needles would not
have been made available in the form of 'needle exchanges'. As she puts it, 'syringe and needle exchanges, I'm sure were in direct response to AIDS. I don't think that would have come otherwise'.

One explanation of why hepatitis B did not and would have not initiated widespread harm-minimisation policies is that it was seen by policy makers and drug users as being a disease qualitatively different to AIDS. The above respondent claims that hepatitis B was never really taken as seriously by the Department of Health because there was not considered to be, 'a massive escalation of hepatitis B, in the same way we saw a massive increase in HIV. Also, drug users viewed AIDS differently from hepatitis B. In Interviewee D's opinion, they were more prepared to modify their high-risk behaviour in relation to the spread of HIV disease, compared to hepatitis B. This in turn may have influenced policy makers' attitudes to what range of behaviour change was realistically possible. Indeed, she described this preparedness to modify high-risk behaviour as 'surprising', 'fascinating', 'radical', because if you try to talk to people who have been seriously ill, e.g. septicaemia, hepatitis B, endocarditis, because very few died from it, "it was seen as part of the way of life, you accepted that at the same time you went on using drugs. AIDS is different because they do know people are dying, it is a pretty nasty death - I actually think that's the most radical change that's occurred, the attitude of drug users to ill health'.

Another respondent, Interviewee G, feels that unlike hepatitis B, AIDS has led to a focus on good practice. In her opinion, sterile injecting techniques were not on the injecting drug users' agenda in the late 1960s and early 1970s. Consequently,

'We didn't even use to think about it. We had people with abscesses and horrendous sorts of disease, illness related to injecting. It never crossed anybody's mind.'

All the respondents agree that, because of public opinion and professional objection, 'syringe exchange' as an explicit policy initiative would not have come about had it not been for AIDS. This seems a reasonable and accurate observation, especially when one recalls the initial
scepticism in the mid-1980s that greeted those agencies pioneering such schemes. Despite medical justifications such as hepatitis B, Interviewee F, a senior Home Office civil servant, feels injecting equipment provision would at best have been confined to major cities such as London and Manchester—reminiscent of availability during the late 1960s and early 1970s. As he puts it, 'Hepatitis B, that is a good reason in having a needle exchange, but it didn't happen'.

The consensus that was finally reached in the setting up of syringe exchanges in the late 1980s, followed isolated grass roots initiatives, protracted debate and research. However, progress on this issue was not straightforward. As one regional consultant, Interviewee B, puts it,

'I remember in a meeting in 1986, a meeting in the College of Psychiatrists Addiction Group ... we had a debate whether or not syringe and needles should be provided. I was speaking for ---there were very strong views expressed by a range of people ... there was a strong view that it was wrong...

Several respondents identify the Department of Health as being the key actor in helping the practice of syringe exchange to become officially accepted. Two have specifically pointed to the 'positive attitude of the Chief Medical Officer' as being instrumental in its acceptance. Had it not been for this vital endorsement, Interviewee D feels, 'Ministers would have been more chary of the Department actually issuing guidance on implementing needle exchange programmes'. She foresaw possible difficulties might have involved getting Home Office support for such a policy development, and therefore involved them in discussion from a very early stage'.

Nevertheless, drug policy would occasionally develop from the grass roots in a bottom-up fashion, as in the case of a Swindon-based non-statutory agency, which in late 1986, together with five others, in Kingston, Liverpool, Sheffield, Peterborough and Dundee, began to provide syringe and needles, independently and ahead of government guidelines and policy. These developments, which received widespread publicity, had the effect of concentrating and influencing the minds of people who were considering following similar policy initiatives.
Turning to prescribing policy, the picture that emerges is a process that, earlier, was described as resembling a 'wheel view' of policy formulation. Prescribing per se, although initially seen as being central to the clinic system in 1967-1968, became marginalised throughout the 1970s and early 1980s. As Interviewee A puts it, referring to the latter period, 'prescribing was not seen as the big issue - the big issue was seen as the changes people needed to make in their lives to bring about major life changes.'

The coming of AIDS changed this early emphasis of the 1980s on therapy and personal growth, which implicitly embraced abstinence, and carved out a clear role for prescribing, which has harm minimisation as its central goal. However, unlike the development of syringe exchanges, most respondents feel that liberal or flexible prescribing was already in the pipeline, and that AIDS 'gave that apush again'. Interviewee D felt that the pendulum was once again swinging towards more flexible prescribing, following the publication of the report 'Treatment and Rehabilitation' (ACMD, 1982), and the 'Guidelines for Good Clinical Practice' (DHSS, 1984).

Although these latter Guidelines were published by the Department of Health and Social Security, they,

'...weren't the Department of Health's guidelines, they were drawn up by an autonomous medical group at the request of the Department, ...it needn't have done [published them] if it hadn't gone along with them.'

What seems to have happened in 1987-88 is that two distinct forces came together, which were to have a considerable influence on the prescribing debate. The first one was the trend, which began in the early 1980s, towards the 'normalisation' of services. Normalisation in this context means a move towards less specialist agency involvement, where primary health care, the statutory and voluntary sector cooperate in providing a service for drug users, as envisaged in the 'Treatment and Rehabilitation Report'(ACMD, 1982).
The second force was the perceived need for more pragmatic policies in response to the feared spread of HIV. Together, these resulted in policy initiatives being more rapidly implemented, aided by the fact that the bulk of strategic planning had already been carried out during the fourth pre-AIDS phase.

Past arguments for and against prescribing were dusted down, with holders of opposing views adopting familiar ideological positions. This time the boot was on the other foot. Those who opposed a move towards more flexible prescribing had to confront the growing arguments for change. This was evident in doctors' surgeries, drug dependence units, various conferences addressing the issue, and the plethora of articles appearing in specialist journals during the late 1980s. The debate on the role of prescribing was once again open.

Several respondents see the swing towards flexible prescribing as reflecting a process of 'enlightenment', where a public health crisis such as AIDS forces a reevaluation of past policies and practices, and a move towards more rational and informed decision-making. Interviewee E, although remaining unconvinced that prescribing policies during phase 5 have changed radically, feels nevertheless that a more subtle change has taken place. In his opinion, prescribers have become more sophisticated in offering a flexible and low-threshold service. They have developed their skills in making clinical judgements and have,

'...learnt the act of assessing individuals and the range of individuals will have a range of different levels of prescription that they are prescribed.'

However, it is not clear how accurate this view is. Clinicians have always experienced great difficulty in consistently making accurate assessments of drug users' needs, resulting primarily from a lack of training and resources, and from the inherent difficulties in carrying out an assessment. Ideological positions adopted by clinicians further complicate the picture, resulting in wide variations in prescribing policy throughout the UK.

Significantly, several respondents questioned the permanence of policy changes. Interviewee E wonders what would happen to prescribing policy, if the rate of 'notified addicts' to the Home Office were to decline. Another respondent, who chaired the Advisory Council on the Misuse of
Drugs, states that, 'Policy will have to try and adjust to new events that take place. If for instance they discovered a cure for AIDS, and it was reckoned that in five years' time they got rid of AIDS, because of treatment, then you would find that there would be a drift away from the harm prevention approach.'

Such a view suggests that policy changes, which are primarily driven by pragmatic considerations, are at risk of being reversed if conditions change. This would then cause problems for practitioners and drug users alike, who for alternative reasons are committed to harm minimisation.

CONCLUDING REMARKS

This article has briefly discussed drug policy development over several distinct phases and, in the process, confirmed a fourth and identified a new fifth phase. It suggests that the analysis of drug policy development is usefully facilitated by incorporating a 'phase model' of analysis, which identifies various characteristics and their historical interconnectedness.

The research data challenge the view that AIDS has led to a 'radical shift' in the direction of drug policy. Although the period from 1986 warrants a separate phase 5, due specifically to AIDS, it cannot be described as representing a clean break with the past.

Prescribing policy, in the early 1980s, was in a state of flux as a result of a host of previously identified factors. We recall that it was firmly on the policy makers' agenda, if not top priority. Likewise, harm minimisation, in its various expressions, was in the process of becoming rehabilitated, as abstinence increasingly became questioned.

The provision of injecting equipment (needle exchanges) in its widespread and explicit form is the one major policy development that data suggest would not have occurred had it not been for AIDS. However, can this initiative be considered a rupture with the past? The answer is clearly no. The research data remind us that, although injecting equipment availability during phases 3 and 4 (1968-1986) was low key and patchy, there is no reason to believe that this profile of availability would have ceased to continue had AIDS not occurred. Certainly, in areas of high incidence of sharing, there would have been a corresponding increase in related illnesses, such as hepatitis B, as indeed was the case throughout this period. But this, as we see, had little general impact on availability.
Nevertheless, the development of 'syringe exchanges' amounts to a major humanitarian development, and vindicates an assertion that, 'The only instance of AIDS overriding established policy objectives has been in the field of drugs. ...The Government had abandoned its previous stance of augmenting its restrictive and punitive policies on drugs now that AIDS had come to be seen as the greater danger.' Fox et al. (1989, p. 88)

We have noted that drug policy development historically resembles a circular process, which reacts to events as they occur. Fashion and ideas come and go, stimulated as much by external and global factors (e.g. the Crack scare and international agreements) as by internal and domestic ones, such as changes in the policy community and the redistribution of power.

British drug policy over the five phases is, on the whole, characterised by a dual track approach, with the balance and emphasis seemingly alternating between an overtly penal response and one concerned with health and treatment. It would be wrong to conclude that the Department of Health has gradually gained the leading role in policy direction. Certainly, it has become more assertive and outspoken during the post-AIDS period, as its public health role has become clearer. But the Home Office has not relinquished its 'iron fist in a velvet glove' approach. Phases 4 and 5 represent a time when the Home Office tightened its grip on the central thrust and direction of British drug policies, although this may not appear to be the case to the casual observer. Legislation and judicial practice pertaining to this period bear witness to this assertion.

Although phase 5 is associated with significant changes in British drug policy, they do not merit being described as representing a radical break with the past.

Nevertheless, AIDS has had a major impact on the scale and depth of policy formulation and implementation. It has given the wheel of history a momentous push. What the state of policy will be once the wheel stops again will depend on a variety of domestic and international factors. One thing is certain and that is we cannot guarantee that drug policy will not return to a situation where an abstinence orientation, to the exclusion of harm minimisation, once again dominates the policy-makers' agenda.
Drug policy development should not be viewed as a progressive and benevolent process, inexorably benefiting the individual and society. It is not simply the product of experience, wise counsel or of lessons learnt, but the result of a confusing set of factors which are tied to powerful cultural and social forces.

Future progress in drug policy will depend not only on rational considerations of how best to benefit the individual and society, but on making explicit the complex web of attitudes, power and politics which underpin drug policy formulation. A central aim would be the demystification of the policy process itself. Another aim would be the provision of a nationally coordinated training programme for practitioners, in order to avoid regional and district disparities in policy implementation, especially in the interpretation of prescribing policy.

Until this occurs, a balanced and effective drug policy will continue to elude us, reminiscent of past and current economic cycles of boom and bust.

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