How the Law of 1970 Limited Care Responses, More Than Uses

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Abstract

Since the adoption of the 1970 law establishing a prohibition regime on drugs in France, and notably punishing their use, things have changed a lot. The AIDS epidemic in particular has encouraged an approach to social problems in terms of harm reduction. This approach is gradually being extended and is taking various forms (testing, low-risk consumption rooms, user expertise, etc.). As a society without drugs and addiction seems illusory, it seems appropriate to direct regulatory tools towards limiting risks rather than penalizing users.

Keywords: law of 1970, AIDS, harm reduction, users, addictions, regulation

Cómo responde la Ley de 1970 de atención limitada, más que usos

Resumen

Desde la aprobación de la ley de 1970 que establece un régimen de prohibición de las drogas en Francia y, en particular, sanciona su uso, las cosas han cambiado mucho. La epidemia del SIDA en particular ha fomentado un abordaje de los problemas sociales en términos de reducción de daños. Este enfoque se está extendiendo paulatinamente y está tomando diversas formas (testing, salas de consumo de bajo riesgo, experiencia del usuario, etc.). Como una sociedad sin drogas y sin adicciones parece ilusoria, parece apropiado orientar las herramientas regulatorias hacia la limitación de riesgos en lugar de penalizar a los usuarios.

Palabras clave: ley de 1970, SIDA, reducción de daños, usuarios, adicciones, regulación

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1970年禁毒法如何限制（而不是使用）护理响应

摘要

自从法国于1970年采纳禁毒法以建立禁毒制度并特别惩罚毒品使用以来，情况发生了很大变化。艾滋病的流行尤其鼓励从减少危害的角度来解决社会问题。这一措施正在逐步推广，并且存在不同形式（例如检测、低风险毒品消费室、用户专业知识等）。鉴于没有毒品和毒瘾的社会似乎是虚幻的，因此将监管工具用于限制风险而不是惩罚使用者一事似乎是合适的。

关键词：1970年禁毒法，艾滋病，减少危害，使用者，毒瘾，监管

The law of 1970

This law penalizes the use**,** even the private use, of narcotics; drugs are thus made illegal. It therefore establishes a system of prohibition. In an attempt to balance the need for punishment and assistance to the user, it provides for free access to care, guaranteed by anonymity and free of charge. This access would be the result of a triple dynamic: the maturation of "demand" (in reference to psychoanalysis, which was dominant at the time[1]), the exhaustion of "pleasure" (the user must be allowed to reach the end of the product-effect, until he or she tires of it, and then "ask" for help, a theory that Castel would criticize[2]) and penal constraint (the therapeutic injunction[3]). It thus inaugurates a binary approach, between judge and caregiver, which will progressively make people forget the other dimensions of use, hedonic, social, economic, or even public health, in a post-68 and pre-crisis economic context, well recalled by Alexandre Marchant[4] and Vincent Benso.[5]

But the balance was soon lost, and the decrees that followed accentuated the prohibitionist aspect, such as the one of March 13, 1972, which prohibited the anonymous purchase of syringes in pharmacies.

The 1970s and 1980s were marked by a massification of drug use, which became increasingly visible, with the installation of "open scenes" and the resulting increase in delinquency**.** Anne Coppel speaks of "the first heroin groundswell."[6] For many politicians, drug use seems to be less a public health problem than a social issue. Indeed, this use is going to impose itself in the public space:

- **The open** drug dealing and consumption **scenes** in Paris, rue de l'Ouest, Belleville and then the Chalon block, move to the Goutte d'or, Stalingrad, Gare du Nord, and today, Porte de la Chapelle, "crack hill."

- **Petty crime** (thefts, burglaries of pharmacies or private homes, assaults) is growing and is a feature of the news.

These behaviors, although resulting from the lifestyle induced by the penalization of the use, will give rise to responses reinforcing the prohibitionist side:

- Increase in the number of arrests: the number of drug offences (ILS) increased from 10,000 in 1979 to 20,000 in 1982, then 30,000 in 1986 and 150,000 in 2019. Today, the "Amende Forfaitaire Délictuelle" is the result of the same desire to punish the user as directly as possible.

- The debate on the distinction between trafficking and use was revived: users, who often also sell drugs to finance their consumption, were more often assigned the status of "trafficker," in order to better justify incrimination. In 1984, a circular invite to determine whether the status of trafficker does not take precedence over that of user; in 1986, a special incrimination of transfer of drugs for use is created.[7]

Narcotic drugs, which are psychoactive substances with heterogeneous pharmacological characteristics, thus have in common their "illicit" criminal status, which cancels out any space for use. A single objective unites criminal prohibition and medical withdrawal, namely abstinence.

AIDS, harm reduction and self-support

During his 1985–86 election campaign, Jacques Chirac denounced the therapeutic injunction. The gateway to care that it would establish was suspected of favoring a lax response to drug use. Albin Chalandon, appointed Minister of Justice, promised a strict application of the law with the creation of 1,600 places in penitentiary centers focused on detoxification and 2,000 places granted to the association Le Patriarche, a sectarian association imposing abstinence through coercion. The principle of adherence to care and the model of a "group/community" approach (dominant in many countries, but not in France) will be permanently discredited.

But an unforeseen emergency is about to arise: the prevalence of a new virus, HIV, is exploding. Studies carried out in prisons among drug users reveal a worrying situation, with high rates of infected people.[8] As this is an infectious pathology, it is therefore new caregivers who are going to take an interest in it, unaware of addiction and free of any representation about it. Other actors, also outside the field of addiction care, coming from the precariousness and community health, will get involved in the fight against this epidemic, but also against the first effects of economic precariousness which are becoming more and more visible. This time, in the name of public health, these professionals are going to push for a revolution in care practices on 3 axes:

- **Addressing use to reduce risk** through access to appropriate equipment. The exemplary measure will be the provision of clean syringes. Opposition to this measure forms the ideological basis of reactions to each step forward in the fight against drugs: weakening the fight against drugs, trivializing drug use, losing interest in care by allowing users who are too irresponsible and suicidal to change their behavior. But as soon as the decrees of 1987 and 1988 were passed, the results were clear: 52% of the users were using an individual syringe (they had been 70% sharing a year earlier). For the first time, a measure other than a repressive one had the value of a "socialization enterprise."[9]

- **Meet users who are not seeking cessation assistance.** A quarter of needle exchange users are unknown to the health network.[10] This shows the interest of *outreach*, practiced by Médecins du Monde, by Professor Flavigny's "Amitié" teams and by the Abbaye association, renewing the street work of the 1970s. Dr. Jean-Pierre Lhomme fought to impose this minimum meeting threshold,[11] which he called "adapted threshold," as opposed to the expression "low threshold" sometimes used. At the same time, "boutiques" were being set up, such as "La boutique" in Charonne and "Transit" in Marseilles, which provided assistance with everyday life (showering, meals, syringes, etc.) to active drug addicts who were in a precarious situation and did not wish to give up their drug use. This "going towards the user"—through needle exchange buses, outreach work or presence at parties (and not waiting for a request for care) and unconditional reception (without commitment to a course of care), with nevertheless minimal requirements (no violence, respect for the law, no consumption in the structure, no dealing), but without any condition to stop, and users being received even when they are under the influence of drugs—shows that the users are also able to meet on another axis than the prohibition of use. The question of overdoses, which was the first subject of RDR, even before AIDS prevention, is also present.[12]

- **Sharing expertise:** 1992 saw the creation of ASUD (Autosupport des usagers de drogues), the first active users' association. It is committed to the rights of users, and in particular the right to access to substitution treatment (prescribing an opiate with the aim of reducing the use of street heroin), which prohibition had made illegal. As these treatments were prohibited, users diverted to codeine drugs (Neocodion®, 12 million boxes sold in 1994, 80% of which were self-substituted, Nétux®, Codethyline®, etc.). This "misuse" allows them to reduce the withdrawal syndrome and to manage their dependence.

  Addiction medicine was born from the meeting of users' knowledge[13] and the practice of general practitioners who received them (Carpentier,[14] Lhomme, Barsony,[15] Lebeau, Magnin, and many others). From the end of 1993, with the authorization of methadone, until the marketing of Subutex® in February

1996, a series of circulars extended and organized access to substitution drugs which had previously been banned.[16] The results were once again indisputable: in 1999, the number of fatal overdoses fell by 80%, and the rate of new infections fell from 30% to 4% between the beginning of the 1990s and 2001. Finally, arrests for heroin use fell by 67%.[17]

Responses, including medical responses, must therefore take into account the knowledge of users and respect their "comfort zone." A new approach is needed, that of harm reduction (RDR), renewing and extending its historical model.[18] In 2004, harm reduction was incorporated into the health law, and medical and social facilities such as the drug user reception and support centers for harm reduction (CAARUD) were dedicated to it.[19] However, this progress is made under strict medical supervision and within the framework of the fight against transmissible diseases. No mention is made of support for drug use problems and the social dimension is neglected. Thus, drug use continues to be stigmatized and only escapes—in part—the police and the magistrate if the doctor is called in.

Expanding DRR: 2004–2016

This "house arrest under medical conditions" does not allow RDR to fully support users. A new stage will therefore begin, marked by three battles to obtain an "extension of the field of harm reduction":

- ***Testing***[20]: as early as 1995, a different kind of RDR was needed to intervene in raves and other techno parties, and to adapt to their "new" drugs, MDMA, ketamine, speed, LSD, but also cocaine and alcohol. The "teufeurs" created associations such as Techno Plus, Keep Smiling, or Le Tipi, and invented, so to speak, an adapted risk reduction: reassurance, to accompany the "*bad trips*" (bad delirium), *chill-out* zones (to help users to come to their senses), and *testing*, a quick analysis of products, based on colorimetric reactive tests, which allows to inform the user before the act of consumption about the presence or absence of substances. This type of RDR, which falls outside the field of prevention of infectious contamination, will not be accepted by the public authorities in the same way: *testing* will not be included in the RDR reference framework.

- **For alcohol and tobacco**, psychoactive substances not prohibited and whose use is even advertised, it is in fact the fight against cancer that will fortunately move the lines. With the 1991 Évin law, it is the market that is targeted, not the user, with the objective of containing and regulating the supply: protection of minors, prohibitions on use in "shared" places, restrictions on sales and advertising. This will be more successful with tobacco, but the mistrust of vaping shows the difficulty of moving away from a purely medical approach to risks and integrating the expertise of users.[21] In the case of alcohol, risk reduction

will first be carried out by the health authorities. It will mainly target occasional drinking and harmful use. For those users who are still determined to continue drinking, professionals will set up appropriate reception facilities to encourage and assist the practice of self-control.[22]

- **SCMRs (low-risk consumption rooms)**: at the beginning of 2009, the hepatitis C epidemic was on the rise and killing more people than HIV. Faced with the immobility of the authorities, the "Collectif du 19 mai," which includes ASUD, the Fédération Addiction, Act-Up Paris, Safe, Gaïa/Médecins du Monde, SOS Hépatites and salledeconsommation.fr, sets up a real-fake drug consumption room. Oppositions to this tool echoed those formulated against the exchange of syringes, notably the risk of "facilitating use." It took seven years and a visit to the Council of State to verify the consistency of this principle with the prohibition of use, and its inclusion in the 2016 public health law.[23]

A new definition of RDR was therefore adopted in 2016, partly thanks to the mobilization of user and community health associations (Aides, Asud, Act Up) and actors such as Médecins du Monde and the Fédération Addiction. It includes, in particular, three important points:

- It no longer differentiates between the licit and illicit status of the substance.
- It is not limited to the risk of infection: article L3411-8 states that "the policy of risk and harm reduction for drug users aims to prevent health, psychological and social damage, the transmission of infections and death by overdose linked to the use of psychoactive substances or substances classified as narcotics."
- New missions have been added (drug analysis, experimentation of low-risk consumption rooms) and the protection of harm reduction workers from incitement to use in the exercise of their function is guaranteed.

However, this new approach to harm reduction remains focused solely on the prevention of medical complications and induced diseases. The use of drugs is still prohibited, a legacy of the bipolarity between disease and crime of the 1970 law.

Working between justice and medicine? Regulating the market to reduce the risks of objects and substances?

As we celebrate the 50th anniversary of the prohibition established by the 1970 law, and the 30th anniversary of the Évin law, it may be useful to recall three questions which cross the addictions policies.

Can there be drug-free societies?

Thousands of years of use of opiates, hallucinogens, alcohol, cannabis have been attested at different times, in different cultures, without necessarily inducing dra-

matic consequences, these uses being socially contained.

However, more "dramatic" episodes took place in the 19th century, at the time of the rise of global industrial capitalism. "Alcoholism," "opium addiction," "morphinism," and "smoking" will indeed grow while companies are created to produce the incriminated substances and mass consumption develops, in accordance with the standard of the nascent market economy.

The episode of the last decades is contemporary with hyper-consumerism and the appearance of a multitude of technologies and psychoactive products, more and more powerful and available, generating easy and quick profits, but also damages on health and social life. Despite health warnings and repression, this consumerist use is felt as a good way to get well-being and adapt to a stressful context. The prohibition of the product denies the evidence of the social functions of the use of psychoactive substances.

Is our society particularly addictive?

Sociologists, anthropologists, and economists have examined this question, identifying four factors at the crossroads of the major economic, cultural and social evolutions of our globalized world. Christian Ben Lakdhar[24] reformulates the synthesis as follows: "*The first is the weakening of the social bond, and its corollary, individualization, which leads to an erosion of self-control, favorable to addictive behavior. The second is linked to the intensity of the environment and to the consumerist culture: speed, rapidity, permanent change would favor the excitement of desire. The third element consists in the search or the necessity of performance. It pushes the individual to help himself, to equip himself, to equip himself to hold on, to surpass himself or simply to stay in the race. The fourth element on which this addictive society is based is socio-economic: the rise of inequalities and poverty favors the use of psychoactive substances ... The addicted individual, necessarily successful, autonomous, and therefore uncertain, is immersed in a society where everything is a drug, an addiction, and potentially addictive,*" to the point that addictive behaviors have become "*the leading avoidable cause of death*." Prohibition makes the user feel the need for self-control, often in contradiction with the dominant culture.

Is addiction a "transitory disease?"

The dimension of adaptive behavior of addiction, in connection with the collective acculturation to economic and social evolutions, questions its possible dimension of "transitory disease."[25] A transitory disease does not mean imaginary but appearing/disappearing more or less according to the times, the representations and the ecological niches. Based on the work of Vigarello,[26] the period we are currently experiencing can be understood by grasping the changes in our relationship to pain and pleasure. The notion of "well-being" follows the evolution of techniques and work: overwork replaces physical fatigue: "*machine tools ... lighten* the *task of*

the big muscles ... but by the speed of their flow, by the sustained attention that they demand, cause a considerable nervous fatigue ..."[27] The notion of well-being was developed as early as the 1950s[28]; then followed Ehrenberg's notion of "the fatigue of being oneself."[29]

When we look at the recent history of treatments for unhappiness, we see that molecules are regularly proposed to treat these new illnesses, such as depression or *burn-out*. Thus, cocaine "*...mixed with wine*" and "*taken with each meal*" is supposed to bring about rapidly "*the almost complete disappearance of the feeling of dejection and prostration so painful in neurasthenia*."[30] In the 1930s, amphetamines inherited in their turn the mission to fight against fatigue. Today, some people see in CBD the new molecule that would help well-being. And why not, if we remember the success of energy drinks, prohibited then authorized, on the side of the "whiplash." Addiction is about our lifestyles and social relationships and cannot, therefore, be approached from a medical/judicial perspective alone.

Diversify the regulation tools

The current extension of the field of addictions does not result from a disease of our brains, which have suddenly become incapable of control, nor from a "weakness" of the law that should be reinforced, but is the result of transformations of the economic, cultural, and social context that increase the expectations towards the possible objects of addiction and deregulate the control of our consumption behaviors (*Cf* the opioid crisis in the United States). This phase, which began in the 1980s, is showing signs of exhaustion and of a possible new transformation, 40 years later and at a time when the ecological crisis is calling hyper-consumerism into question: a drop in smoking and alcohol use, a change in the status of cannabis.

Taking this sociogenesis into account is also very rich in terms of the evolution of practices. For if the relationship with others and with the world is a factor of use and of their deregulation, it can also participate in their decrease, by a transformation of its social links which would help to get out of tensions and sufferings, to fight loneliness and boredom, to satisfy its need to create, "to be with," to open spaces where to live social relationships which guarantee to each one a "perimeter of sovereignty," of rights, of choice and of autonomy. The law, for its part, should focus less on prohibiting use and penalizing users than on limiting risks (by penalizing certain uses) and helping to control the excesses of the market (regulatory policy). It would thus be consistent with the new paradigms of care.

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