The Normalization of Swiss Drug Policies

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Abstract

The Swiss drug policy strategy has been praised for its innovative pragmatism. It reflects a transformation of the way we look at drugs by focusing on health and by eclipsing the moral background of the drug use context. In this model, help is no longer conditional on the obedience of the person being helped to the norm of the helper. Harm reduction cancels out the norm that defines the different addictions, which makes it possible to broaden the horizon of the intervention to the whole range of behaviors that can be described in terms of addiction. It leads to a global strategy aimed at creating conditions favorable to health as a variable determined by our behavior. Harm reduction introduces the notion of competence, implying the provision of a certain number of framework conditions favoring individual responsibility. The identification of signs of possible psychosocial impairment becomes everyone's business. Addiction policy tends to focus on visibility, reintroducing an ideological valorization of successful behavior, compatible with the economy. Stigmatization is reintroduced in the evaluation of each person's capacity for autonomy, which is unequally distributed.

Keywords: harm reduction, global health, individual autonomy, performance

La normalización de las políticas de drogas suizas

Resumen

La estrategia suiza de política de drogas ha sido elogiada por su pragmatismo innovador. Refleja una transformación de la forma en que vemos las drogas al centrarnos en la salud y eclipsar el trasfondo moral del contexto del consumo de drogas. En este modelo, la ayuda ya no está condicionada a la obediencia de la persona ayudada a la norma del ayudante. La reducción de daños anula la norma que define las distintas adicciones, lo que permite ampliar

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el horizonte de la intervención a todo el abanico de conductas que pueden ser descritas en términos de adicción. Conduce a una estrategia global encaminada a crear condiciones favorables a la salud como variable determinada por nuestro comportamiento. La reducción de daños introduce la noción de competencia, lo que implica la provisión de un cierto número de condiciones marco que favorecen la responsabilidad individual. La identificación de signos de posible deterioro psicosocial se convierte en asunto de todos. La política de adicciones tiende a centrarse en la visibilidad, reintroduciendo una valorización ideológica del comportamiento exitoso, compatible con la economía. Se reintroduce la estigmatización en la evaluación de la capacidad de autonomía de cada persona, que se distribuye de manera desigual.

Palabras clave: harm reduction, global health, individual autonomy, performance

瑞士毒品政策的正常化

摘要

瑞士毒品政策战略因其创新的实用主义而受到赞誉。其通过关注健康并弱化毒品使用情境的道德背景，反映了毒品的看待方式的转变。在此模型中，帮助不再以“被帮助者服从帮助者的规范”为条件。危害的减少抵消了“定义不同成瘾”的规范，这使得“将干预范围扩大到能用成瘾来描述的整个行为范围”一事成为可能。此举导致了一项全球战略，后者旨在创造有利于健康的条件，这是由我们的行为所决定的变量。减少危害引入了能力这一概念，暗示应提供一定数量的、有利于个人责任的框架条件。识别可能的社会心理障碍迹象成为了每个人的职责。成瘾政策倾向于关注可见性，同时重新引入与经济相适应的成功行为的意识形态价值。在评价每个人的自主能力时会重新引入污名化，而这种能力的分布是不均的。

关键词：减少危害，全球健康，个人自主权，表现

The core of Swiss drug policy is characterized by the four-pillar strategy of prevention, harm reduction, repression, and therapy (Boggio et al., 1997). This approach is presented as an example (Beauchesne, 2007), and its success is remarkable: open drug scenes have been dispersed (Kübler, 2000), health problems have been brought under control (Zobel et al., 2004, pp. 13–17), and crime has been reduced (Aebi et al., 1999). The pragmatic method developed in Switzerland succeeds in controlling the most tragic manifestations of a phenomenon with which we must "learn to live" (Ehrenberg, 1996). Although the results are positive overall, it seems necessary to show what this approach leaves in the shade.

The current policy has its origins in the emergence of a moral panic (Cohen, 1972) in the face of the counterculture movement of the 1960s. As illegal drug use became the torch of generational opposition to the order of post-war society, the social reaction adopted a series of essentially repressive measures, overturning the timid prevention already at work and the nascent therapies. In 1975, the 1951 drug law was revised to punish not only trafficking but also consumption (Cesoni et al., 1994, p. 14). In the 1980s, youth movements demanded the occupation of their own spaces, "autonomous centers" on the bangs of state regulations (Roux et al., 1984, p. 204). These places were quickly overrun by problems related to heroin use (Béroud, 1982, p. 8). When they were evacuated by the police or by the occupants themselves, the users found themselves in public spaces, forming "open scenes," notably in Bern, next to the Federal Palace, and in Zurich, in the Platzspitz park.

A strange tolerance then prevailed, with the police trying to circumscribe these activities in the areas where they had taken root. But heroin use was beginning to pose serious health problems: first AIDS, then hepatitis C, particularly affected these vulnerable populations. In 1986, the first injection room was set up in Berne; at the same time, the city of Zurich was developing sterile syringe distribution programmes (Geense et al., 1999, p. 35). Faced with the growing pressure of public opinion in relation to these scenes of distress, initiatives were launched, developing a new model in the field called "survival help." These innovative measures—distribution of syringes, injection rooms, methadone substitution therapy and heroin prescription treatment—were developed by cities facing security and public health problems (Kübler, 2000). On the basis of these initial local experiments, the Confederation launched a coordinated programme of measures in 1994, based on the concept of *harm reduction* as a priority instrument of its drug policy. This orientation puts the emphasis on the health of drug addicts and the prevention of the spread of transmissible diseases. Help is no longer reserved for people who want to end their addiction. This "low-threshold" philosophy is rapidly expanding from health to hygiene and housing (Samitca et al., 2001).

The first dimension of this transformation is axiological: it is no longer a question of tolerating an illegal situation circumscribed to a space, but of provid-

ing a service in the name of health reasons in a context of illegal actions. This model of social action is not introduced without difficulty. While the beginnings were laid in the mid-1980s, it was not until ten years later that needle distribution was accepted nationally (Samitca et al., 2006). After having focused on the repression of trafficking, and then on the repression of consumer-offenders, the priority that emerged was the health aspect. This policy, enshrined in law only in 2011, validates a pragmatic vision in which assistance is no longer conditional on the obedience of the assisted to the caregiver's norm, but on his or her distressing situation.

By inspiring all fields of social action, harm reduction overcomes the normative constraint that defined the different addictions, thus broadening the horizon of intervention. In order to optimize public policies, the different fields of addictions are integrated (Wenger, 2014). To the use of illegal drugs is associated all behaviors that can be described in terms of addiction, involving legal consumer products such as tobacco and alcohol, but also addictions without substances, for example the practice of video games or gambling. This approach is conceptualized in the "cube model," which brings together the four axes of prevention, therapy, harm reduction and repression, taking into account that the appropriate measures vary according to the product and the intensity of consumption (Van der Linde, 2006). Following the recommendations of the WHO (2010), the theme of addictions is associated with the fight against "non-communicable diseases," sweeping away the old moral and quasi-epidemiological conception of a drug that "jumps in the face" of the average person on the street corner. Gradually, measures concerning legal and illegal drugs are being combined with the national prevention program *Diet and Physical Activity*, in a global strategy aimed at creating conditions favorable to health as a variable determined by our behavior and our environment. This linkage fits perfectly with the "cube" model developed in the context of the fight against addictions.

A second dimension linked to this more nuanced understanding of drug use is ontological, since harm reduction enshrines a new approach that can be described as contextual. The product is no longer considered to be the purpose of the action, but the object around which uses are structured (Couteron, 2015). The representation of the drug user is transformed: from a victim of the product, he becomes an actor placed at the center of the institutional system. This perspective introduces the notion of competence, implying a shift in the meaning of intervention: it is no longer an educator who prescribes good practices, but a preventologist who, ideally, makes available a certain number of resources and framework conditions. However, the prevention community rarely has the political means to address the structural conditions of addictive behaviors (Graf, 2012). They focus their strategy on individual responsibility, seeking to strengthen health literacy and inform about the possible consequences of certain behavior patterns. The focus on skills confronts social action with the diversity of the field of intervention.

Faced with the sociological complexity of practices in context, it is the theme of psychological health that emerges as a common axis of work. This orientation is proving to be central to many projects, such as the "How are you?" campaign, set up in 2014 by the Pro Mente Sana Foundation and several cantons (Bern, Lucerne, Schwyz, and Zurich)—see: https://www.comment-vas-tu.ch/. Addiction appears as a response to a life situation that is important to identify early enough. This is the main idea of the so-called "early intervention" measures. The identification of signs of possible psychosocial impairment becomes everyone's business: teachers, social workers, treating physicians, police officers. The program seeks to recognize "red flags." But the difficulty in evaluating its effectiveness (Delgrande Jordan et al., 2021) may be due to the cultural unthinking of the notion of risk. Some potentially problematic behaviors remain valued when they directly benefit the economy or are part of an imaginary of self-improvement, as in the case of stimulant use.

The pragmatism of addiction policy tends to tighten on "visibility management" (Savary, 2014), reintroducing an ideological dimension while abandoning the dynamics of abstinence. Targeted actions to strengthen health skills aim to give people simple paths to "improve both their physical and mental performance" (Salveter, 2017, p. 3). Awareness campaigns spread the message that taking the stairs or eating an apple holds the promise of quality of life. The prevention strategy seeks to normalize not smoking by emphasizing the freedom that comes with a tobacco-free life. Alcohol prevention focuses on drinking control (https://www.mobile-coach.ch). The bottom-up "I'm Talking About Alcohol" campaign encourages everyone to find a personal response.

The cube model was abandoned in 2016, attesting to the merging of different health policy domains into a comprehensive harm reduction-oriented strategy. The guiding idea is that prevention becomes "as natural as brushing your teeth before going to bed" (Salveter, 2017, p. 2). The concept of harm reduction is applied to all daily activity, with the goal of empowering people to control the risks inherent in contemporary life. "Reading along on your smartphone, running five times a week, spending a night at the casino, toasting at an event ... Pleasure, profit, gambling, or social ritual, potentially addictive behaviors belong to the everyday." (Jann et al., 2017). By evacuating the perspective in terms of substance, which supported the moral principle of defilement (Douglas, 1971), the risk of addiction is diluted into everyday rituality. Stigmatization, far from disappearing with the normalization of products deemed evil, is reintroduced: the person suffering from behavioral addictions is still designated as responsible for his or her weakness.

The immaterial nature of the conditions of addiction conceals the irreversible nature of some of the damage: the debts of the compulsive gambler follow the person for life. Harm reduction, by developing the idea of a low-threshold, has made it possible to overcome the obstacle of non-adherence to norms, which posed problems of effectiveness of social action. However, it remains subject to the sur-

rounding normative context, as when people denounce the non-payment of fines for cannabis use, refuse to distribute sterile syringes in certain prisons, or require six months' abstinence before being able to receive treatment. Some of the requirements for getting help are necessary for the proper functioning of the institution, but they run counter to the fundamentally dynamic principle of harm reduction.

The "drug problem" occupies less of the public opinion in Switzerland today, perhaps because it no longer questions the dominant norms head on. We do not care about the difficulties that some people may have in regulating their use of cell phones. By approaching the individual as a whole, this new approach risks losing sight of the always specific character of an addiction. A non-substance related perspective implies that professionals have to abandon certain positions. The risk is that the interdisciplinary exchange will erase the fact that behaviors belong to social registers. Confusing strategy with reality in the field means forgetting that policies do not transform representations of drugs and risks losing sight of the context in which addiction is based. At a time when we are pleading for a pragmatic approach which recognizes the rights of addicts, it is necessary to recall the need to insert it in the concrete fields of social policy, such as family or employment.

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