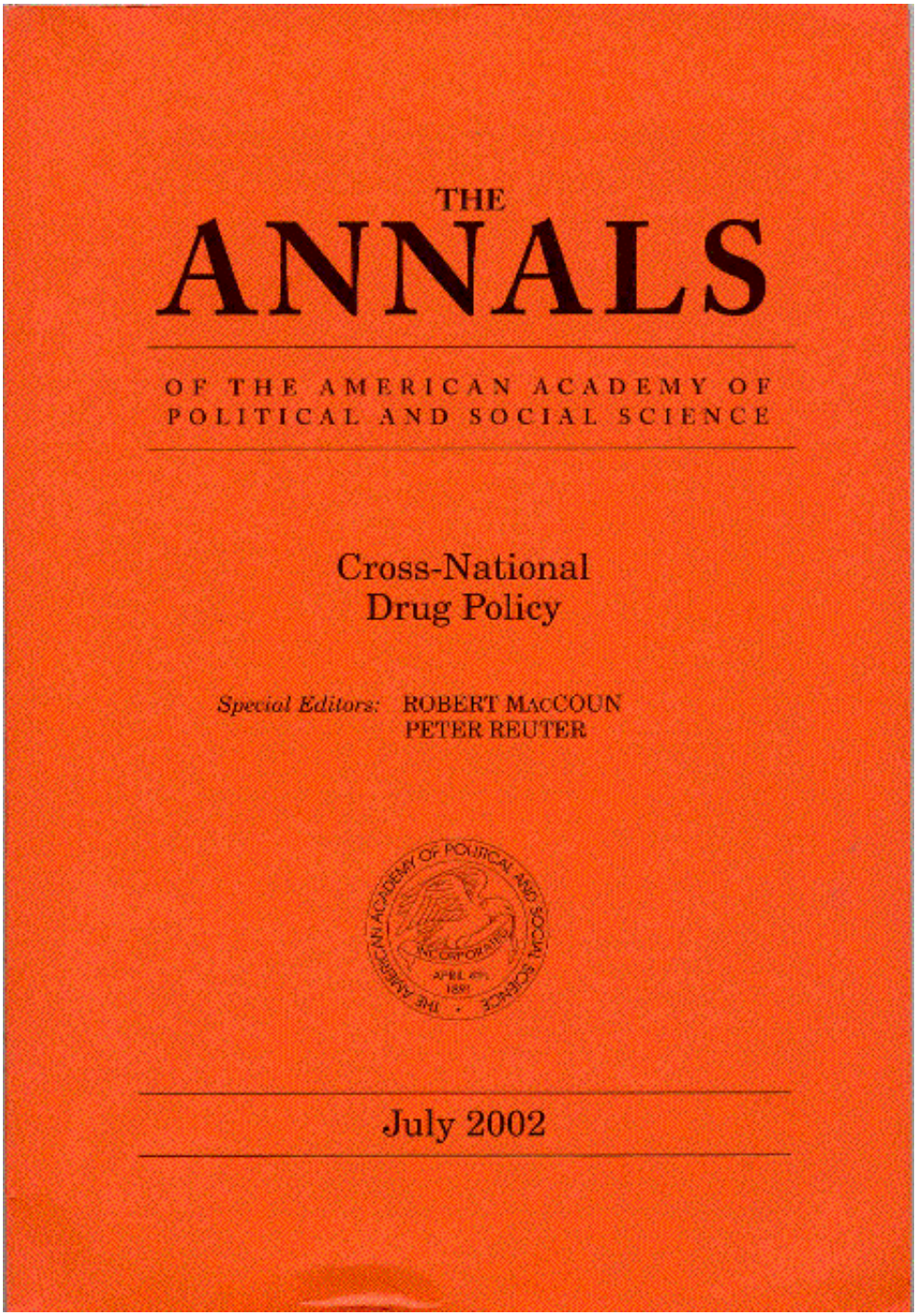
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Policy Paradigms, Ideas, and Interests: The Case of the French Public Health Policy toward Drug Abuse

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ABSTRACT: The goal of this article is to analyze (1) how and why French public policy of care to drug users remained until 1995 a policy primarily curative, devoted only to proven drug addicts, directed toward abstinence, and mobilizing mainly the psychotherapeutic techniques inspired by the psychoanalytical paradigm, whereas the majority of the other European countries, answering to the brutal epidemic of AIDS, had, as of the middle of the eighties, started a palliative policy of risk reduction envisaging, among other measurements, the massive distribution of substitute products such as methadone and (2) how and why France brutally revised its positions, in the middle of the nineties, to adopt a policy of harm reduction and by doing this aligned itself, more or less, with the orientations followed by the other European countries. This analysis led the authors to test some of the political science approaches that stress the role of ideas in policy-making processes.

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NOTE: This article is a rewritten and extended version of two others articles: Bergeron (1999a) and Bergeron (2001). Some of its conclusions were presented at a conference organized by Rosemary Taylor at the Center for European Studies at Harvard University, 26-28 January 2001, titled "Re-Thinking Social Protection: Citizenship and Social Policy in the Global Age."

THE FRENCH PUBLIC HEALTH POLICY TOWARD DRUG ABUSE: A LONG-LASTING EXCEPTION IN EUROPE

The French public health policy toward drug use and drug addiction is known to be very singular in Europe: the choices made by French experts, administrations, and governments to cope with drug consumption were specific to France up to 1995.

Before explaining why French public policy toward drug users was so distinct from that of other European countries, we first want to discuss some concepts that helped us to build our argument. We would like to make clear that there are two ways of understanding the expression "public health policy to cope with drug consumption." Following Gusfield (1981), there exist a causalist strategy for drug health policy and a consequentialist one.

The first strategy (the causalist one) supposes to carry out a policy with a primary aim of providing care for drug addiction: in this case, you need to understand what are the possible causes of drug addiction and as such to carry out programs that care or try to care for addiction. Here again, there are two major possible aims for drug addiction treatment: either (1) abstinence is a main aim, and a set of different therapeutic techniques are available, each of which is based on a specific etiological theory (paradigm)—(a) therapeutic communities based on behavioral psychology; (b) methadone treatment with progressive withdrawal; (c) ambulatory treatments, such as psychotherapies inspired by different kinds of psychology such as psychoanalysis, cognitive psychology, behaviorism, and so forth—or (2) abstinence is not the proper aim for drug addiction treatment, because drug addiction is regarded as essentially caused by biological (and more and more neurobiological) deficiency. Thus, in this perspective, drug addicts should be provided with substitution drugs throughout their lives, as for diabetics. All those curative treatments then typically concern individuals who have already experienced drug addiction for a long time, who do not feel at ease anymore with it, and who desire to withdraw from what they more and more consider to be a dangerous habit.

The second strategy for a public health policy toward drug consumption is the one in which the chief aim is not to provide care for drug addiction, properly speaking, but to take action on the social and medical consequences of drug consumption. It is obvious that drug consumption, especially for heroin, is a risky practice. In this perspective, among other measures (such as needle exchanges, first line aid centers, etc.), methadone treatment could be an appropriate indication. According to many experts and physicians, methadone could not only reduce the progression of the AIDS epidemic (even if this point is still very controversial) but also create the conditions for drug users to seek help with their respective health and social situations. In this perspective, methadone could be provided to an addict who, for example, does not want to kick his or her habit; who, for instance, has to be hospitalized for a long time or who

needs to rest for a while; who needs social aid such as housing, a job, administrative registration, and so forth. In this respect, providing a heroin addict with methadone is more a palliative and preventive than a curative practice. This policy is called harm reduction policy. Of course, those two aims are complementary, but the hierarchy established between them within a public health policy has important consequences, as we will see later on.

What was the French situation in 1994? In 1994, French public policy was principally oriented toward a curative perspective. Its major aim was abstinence, and above all, there was by and large only one kind of therapy developed all over the territory: psychotherapy inspired by psychoanalysis. The two other major curative treatments (therapeutic communities and methadone treatment) were not present in the French health landscape. Moreover, a preventive and palliative harm reduction policy had never been carried out in France, and the international contrast with other European countries was, in this aspect, astonishing. Everywhere else in Europe, from the mid-1980s for Great Britain and Holland and at the very end of the 1980s for Germany, Switzerland, Spain, and in some respects, Italy, a harm reduction policy had been implemented mostly in reaction to the appearance of the AIDS epidemic.[1]

In fact, the shift in French policy occurred in 1995. Slowly, from 1992 on, a group of actors from different origins (hospital physicians concerned with AIDS, members of nongovernmental organizations concerned with social and medical first aid, some drug addicts, some experts, etc.) started to demonstrate against the French public policy's major aims and against the professionals who, up to this time, had been the legitimate experts for the government on drug problems. Given this background, the aim of this article is to answer two main questions: (1) How can we understand the singular French situation? How do we account for the fact that the aims of French public policy remained for so long on a curative perspective with abstinence as the ultimate goal? How can we understand that methadone had never been considered an acceptable and appropriate treatment by French experts whereas it was in almost all other European countries? Put differently, how do we explain the success of a policy (even by the standard of the French experts who were first against the development of methadone) that was not even recognized a few years earlier? and (2) How can we understand the disruptive shift that occurred within the French public policy toward a harm reduction policy?

THE STABILITY OF THE FRENCH PUBLIC POLICY

France has been characterized by a politics that led simple users to prison. Since 1998, things have been changing; both the number of sentences for drug use and the length of jail sentences are decreasing (see Table 1).

We can start our explanation of this singular situation by paying attention to institutional conditions.

TABLE 1
FRANCE DATA: 1999-2000

Number of problematic users	124,000-176,000
Number of substitution treatments	64,500
Number of arrests for consumption	74,633
Number of arrests for street resale	10,874
Sentences for drug use	70,444
Sentences for use and resale	6,530
Number of incarcerated people in the year	700

SOURCE: Observatoire Français des Drogues et des Toxicomanies (1999).

The French health tradition had always utilized, up to the late 1980s, a curative perspective when dealing with public health problems. This is a tradition in which prevention has long been regarded as a secondary aim. As a result, when the French state implemented a health policy toward drug users at the beginning of the 1970s, it did so to favor curative solutions. The French state was less inclined to carry out a preventive and palliative policy to which the recent introduction of methadone treatments is linked. But more fundamentally, we can also argue, to explain the French exception, that the majority of the critical actors and experts on this topic had slowly adopted a certain kind of paradigm to understand drug addiction. This paradigm was, among other references, largely influenced by psychoanalysis. This tradition's major arguments can be summarized as follows: taking actions to care for drug consumption consequences would entail more the implementation of a political will of social control than a therapeutic solution to drug addiction. (These experts, in the 1970s, were strongly influenced by Foucault's thesis, and many of them were very active in the "May 1968" revolution and/or in the French antipsychiatry movement.) Such a policy would have been, according to them, a policy that ignores the suffering "subject" who is hidden by a social stigma. On the contrary, by their logic, curing drug addiction, setting drug addicts free from their habit, would put them in better condition to get jobs, to find housing, and so forth: in one word, to recover a "normal" life since this rehabilitation would be grounded in a nonpsychopathological basis. Concerning methadone, they argued that since drug addiction is the symptom of deep psychological suffering, and since drug addiction is the symptom of psychopathological structures like neurosis, psychosis, or perversion, providing drug addicts with methadone would be providing them with simply another drug. With these two explanations in mind (the curative tradition and the domination of the psychoanalysis paradigm), it seems easy to see how a public policy that was principally curative emerged and for which methadone was morally (argument of social control) and scientifically (psychoanalytical arguments) unacceptable. But these explanations alone are not sufficient: we want to understand why and how the domination of a certain paradigm could have been possible in France.

Conceptualizing our issue in terms of a domination of a certain paradigm—interpretive framework—

(which involves certain aims, a certain hierarchy of those aims, certain instruments and solutions, specific settings of these instruments and solutions) led us to test the political science approaches that stress the role of ideas in policy-making processes.

Following Hall (1993),[2] we identify the groups of critical actors who succeeded in influencing the definition of what should and should not be French policy toward drug users. In other words, we tried to show how certain ideas became legitimate in the field and how some actors, taking advantage of their position on a "broader institutional framework" (Hall 1993, 280)—and convinced that the aims and solutions that derive from the psychoanalysis paradigm were the "right and proper things" to do at that time—succeeded in institutionalizing those ideas "into the standard operating procedures of key organizations and absorbed into the worldviews of those who manage them" (Hall 1997, 184). In this perspective, since the mid-1970s, a "policy network," formed by two major groups of actors, slowly took power in the field (Bergeron 1999b). As in many French public policy studies (see, e.g., Muller 1984, 1989; Setbon 1993), a policy network—in our case a policy community—gathered different kinds of actors sharing a set of common normative and cognitive ideas (involving certain aims, solutions, etc.), took advantage of the centralization of the French state (institutional conditions), and dominated the field. On one hand, a certain kind of professional—most of them psychiatrists—slowly eliminated (during the 1970s) the competition of other experts who tried to promote other aims and solutions (therapeutic communities and methadone treatments) related to other paradigms and how they succeeded in being the legitimate representatives of the field for the French authorities (during the 1980s). On the other hand, a particular governmental agency (Direction Générale de la Santé, which is located in the French Health Ministry) also succeeded in appropriating the policy as far as financing, regulating, and evaluating the policy actions are concerned. Finally, these two groups of actors, civil servants, and professional experts obtained more and more autonomy in managing French public policy and how they struggled to keep actors, such as other agencies (namely, the Direction de l'Action Sociale of the French Health Ministry and the Mission interministérielle à la lutte contre la toxicomanie), other professionals, local authorities, and so forth away from involvement in French policy.

We should also mention that their actions and their monopolistic position in this field were possible because their aims and solutions were respected and were not in contradiction with the more global political and cultural norms (Bergeron 1998, 1999b). Ehrenberg (1993, 1995) showed very well that in France, drug addiction was clearly framed in terms of individual responsibility and that for this reason, most politicians would consider harm reduction policy as if they were "abandoning drug addicts to their addiction" and methadone as a "passive" instrument

of getting out of addiction. With this fact in mind, there existed in France an objective alliance between politicians and psychiatrists inspired by psychoanalysis, who both, for different reasons, rejected consequentialist policy and methadone. But why did anomalous developments (the spread of AIDS and the degradation of the social conditions of many drug addicts) not threaten the French paradigm, whereas they had in other European countries, especially in those that had also implemented a mostly curative policy (Germany or Spain, for instance)?

We use Raymond Boudon (1986, 1990, 1995) who, inspired by Simmel and Weber, suggested taking into account the good reasons that actors have to believe in certain ideas and thus to act as they do (since a lot of actions are caused by beliefs). This perspective is rationalist in that it assumes that action is caused by reasons, whatever those reasons[3] could be: normative, cognitive, utilitarist, and so forth. Rationality[4] could then take the form of cost-benefit considerations in some circumstances but also other forms in other cases: the reasons an actor has to act as he does or to believe what he believes have to be perceived by the actor as strong and are not necessarily instrumental; the actor also endorses ideas because those ideas, to the best of his or her knowledge or normative dispositions, are acceptable. Endorsing a theory is in most cases an action caused by the fact that one sees strong reasons for endorsing it. In this respect, this approach shall not be reduced to the rational choice model, which, to put it briefly, considers individual actions to be essentially instrumental and mostly focuses on a certain kind of reason: personal interests.

To make those reasons comprehensible (in the sense of Weber, *verstehend*), we have to reconstruct the social, normative, and cognitive context in which the actors were situated before 1993. We have, in other words, to understand why certain ideas made sense for them at that time and in their social context. Here again, we shall be succinct: The reasons our experts and actors refused for so long to change French public policy on drugs and, especially, to introduce methadone treatments in France were influenced by two kinds of effects, called by Boudon (1986, 1990, 1995) "positional effect" and "dispositional effect."

The first one—positional effect—is a cognitive perspective. It basically supposes that you see reality according to the position you hold. Our hypothesis is thus: the experts and professionals who were working in therapeutic institutions and who were the legitimate advisors of French authorities concerning drug policy typically did not see, before 1993, drug addicts who presented the social and medical characteristics that convinced other European experts to reconsider their policy's aims and to adopt methadone treatment and harm reduction policies. In other words, they typically saw, during the 1980s and at the beginning of the 1990s, drug addicts who were not in such poor shape regarding health and social conditions. As a matter of fact, when in 1995-1996 methadone was finally provided to many French

addicts, a population of addicts they had not previously encountered suddenly appeared in the treatment centers of those very experts. We cannot here explain why they confronted themselves with a certain kind of addict whose typical characteristics did not disturb their beliefs and were assumable by their paradigm, but we can suggest that it is linked to the way they were organized, the way they recruited patients, the therapeutic practices they used to care for patients, and so forth (Bergeron 1999b). Finally, consistent with the conclusion of the sociology of medicine (see, e.g., Freidson 1970) or of social aid organizations (see, e.g., Lipsky 1980), each field and organization tends to create and select its appropriate client, whose characteristics tend to confirm professional beliefs or at least not jeopardize them.

The second effect—dispositional effect—entails the process by which theories or systems of ideas to which one adheres slowly become a cognitive frame through which reality is interpreted in a specific direction. We can here give the example of a certain kind of drug addict who came in small numbers to the treatment centers during the 1980s and at the beginning of the 1990s could not end their heroin consumption with psychotherapy and underwent repeated detoxification treatments. Those patients are today regarded as one of the first targets for methadone treatment. But in those times, experts and professionals, according to their psychoanalytic point of view, would conclude that those addicts were not motivated enough to stop addiction and to reconsider their past. They would conclude that a "free demand," as psychoanalysts tend to say, had not yet emerged and, therefore, were unsuited for methadone treatment. It is an obvious conclusion that actors tend (but not eternally) to select facts that confirm their beliefs. In this respect, the psychoanalytical paradigm slowly became an institution in the sense of Berger and Luckmann (1966). We can say, following Gusfield (1981), that methadone was at that time an "unthinkable" instrument for experts and civil servants. This fact also suggests that the accumulation of anomalies is not sufficient to threaten a paradigm, that ad hoc hypothesis, as Kuhn ([1962] 1970) showed, is often elaborated to cope with what is not yet perceived as an anomaly. It suggests then that change in ideas is a long-term process that requires several conditions to fully occur (see below).

Finally, policy making from 1970 to 1992-1993 was doubly autonomous: at the top since no contests and exogenous actors could interfere in the policy-making process (a "relatively closed policy network"; Hall 1993, 291) and at the bottom since the legitimate experts for the French government working in therapeutic centers were not in contact with a large part of the population of drug addicts and/or could not see anomalies as real anomalies.

But one must not insist too much solely on cognitive processes. Interest (personal utility) could also be a good reason to believe in certain ideas. That is why, inspired by the theory of organization that was promoted by

terrible consequences for certain kinds of patients (what we call in France *le procès du sang contaminé* has been a traumatic event for French politicians). Those failures made preventive and palliative actions toward patients more legitimate aims in the French medical field. As a result, but later, in the specific field of drug policy, ideas stemming from the harm reduction paradigm, congruent with this more global transformation, slowly became more and more acceptable; such ideas became more "persuasive in themselves, which is to say, at least partially independently of the power of their proponents" (Hall 1997, 185). They had a cognitive and an axiological rationality in this new context. In this respect, an external group of different actors, helped by media that slowly became conduits for their ideas (the daily newspapers and TV), published a lot of reports on anomalous developments and, by doing so, made them visible in the public arena.[6] They presented the French situation as an exception in Europe; and succeeded in convincing politicians—above all the new government formed in 1993 by Edouard Balladur and especially Simone Veil, the freshly named minister of health—that methadone could be a means of stopping the propagation of AIDS and could create the conditions for drug users to seek help on their respective health and social situations.

We can conclude that French policy also "changed, not as a result of autonomous action by the state, but in response to an evolving societal debate that soon became" more or less[7] "bound up with electoral competition" (Hall 1993, 288). The new community policy, taking advantage of the *Sang contanimé* political trauma, succeeded in gaining authority in the field (the new visibility of anomalous developments contributed to undermining the authority of the orthodox experts and of the paradigm they advocated in favor of physicians dealing with AIDS in public hospitals). The development of methadone programs in France was then also (but not only) decided by Simone Veil on the argument that there exists a causal link between development of methadone programs and low prevalence of AIDS in the rest of Europe. But this causality was at that time very controversial and still is today. So to understand how new critical actors succeed in being regarded as authoritative for politicians, one must study not only the scientific debates in which experts in competition produce contradictory experimental proofs (causal link between AIDS prevalence and methadone programs) but also the links existing between the different competing paradigms and the more global institutional and cultural norms and values that also give selectively more legitimacy to certain scientific ideas and less to others. As Hall (1993) put it, one must notice that in this process, "shifts in the locus of authority" are very important:

> Faced with conflicting opinions from the experts, politicians will have to decide whom to regard as authoritative, especially on matters of technical complexity, and the policy community will engage in a contest for authority over the issues at hand. In other words, the movement from one paradigm to another is likely to be

preceded by significant shifts in the locus of authority over policy. (P. 280)

But once again, if you want to understand how "ideas can be persuasive in themselves" (Hall 1997, 185), the Boudon (1986, 1990, 1995) model seems necessary. It helps explain why, for instance, some of the experts of the orthodox paradigm converted to harm reduction before 1993 and then why they started to fight for the introduction of methadone in France. One can see that they were mostly located in a position in which they saw more anomalies (e.g., they were located in poor suburbs outside Paris and big cities) and that they tended to be less cognitively disposed to form ad hoc hypotheses when confronted with these anomalies. Endorsing the harm reduction paradigm was a rational action as far as cognitive and axiological rationalities are concerned. But these actors were also less interested in the social world institutionalized by the former policy. Thus, the reasons they switched to the harm reduction paradigm are clear: it served their personal utilities, of course, but it above all fit with their specific situation; helped them reconceptualize their past experiences through this new cognitive framework of anomalous experiences as real anomalies; offered a new professional identity;[5] helped them feel included in a larger community, backed by a coherent system of ideas that tended to reduce the psychological cost of being deviant; and so forth. Once again, the reasons they changed their ideas concerning how to cope with drug problems made sense for them in their given context and were simultaneously cognitive, normative, and utilitarian ones. This perspective helps explain why almost the whole majority of professionals finally accepted, more or less, the necessity of implementing a harm reduction policy despite their earlier beliefs. At that time, anomalies were made visible for everybody (through the action of media, namely), and a new social world in which it was possible to invest was slowly emerging.

CONCLUSION

Finally, we think that adding such a sociological perspective to ideas-oriented approaches in political science presents two major advantages.

First, it opens the black box of socialization and gives clues to explain how institutionalization takes place. Culturalist perspectives generally assume the fact that widespread beliefs can be well explained by socialization processes: individuals involved in a certain kind of institutional environment are considered to interiorize norms, values, cognitive frames, beliefs, and so forth. To explain why beliefs spread in society, those kinds of perspectives mobilize the concept of interiorization. But labeling a process is not explaining the process. By reconstructing the different kinds of reasons an actor has to believe in certain ideas—ideas that are of course available in a certain social context and at a given time—and at the same moment explaining why those ideas make sense for him or her, you not only explain the phenomenological fact of conviction that actors express toward

certain ideas but also open the black box of socialization, which in this respect turns out not to be so nebulous. Socialization describes the processes by which an idea can make sense, in many different ways, for an actor located in a particular cognitive, normative, and social context. Finally, interiorization (and cognitive frames that could result from this cognitive process) appears much more as a consequence of socialization than as its cause at the individual level.

Second, this approach offers the possibility of recognizing that beliefs and actions of individuals have to be viewed in multiple dimensions. In this perspective, it then appears obvious that the reasons actors have to believe in certain ideas and/or to act as they do could be cognitive, normative, and/or utilitarian ones (material interests, interests in terms of power, interests in terms of preserving a professional identity, interests in gaining legitimacy, etc.). Our study showed that at a certain period of the history of our policy, it was quite difficult for a sociologist to establish that beliefs of individuals determine their interests. We shed light on the fact that in our case, at a certain time, interests could be also (but not only) a good reason for believing and especially for continuing to believe in certain ideas. Finally, in such a perspective, ideas do not appear to be either rationalizations of self-interests or substantial entities, purely persuasive in themselves, endorsed by actors who would not be embedded in a social context.

Notes

1. As a matter of fact, you could, in February 1994, count up to 9,500 drug users provided with methadone treatment in Spain, 17,000 in Great Britain, 15,000 in Italy, 10,000 in Switzerland, and 8,000 in Holland. During the same period in France, only 77 drug users were provided with methadone, whereas the population of heroin users was estimated between 130,000 and 180,000 people. For three years, a deep controversy raged, at the end of which French authorities decided to develop methadone and other substitution treatments and to carry out a harm reduction policy. Today, there are as many as 70,000 drug users provided with substitution treatments in France.

2. We focus on Hall's (1993) theory and try to apply it to this different subject presenting an equal amount of "highly technical issues and a body of specialized knowledge pertaining to them" (p. 291).

3. Of course, those good reasons can lead to false beliefs. Those good reasons are then not "objective" reasons but reasons that make sense for the actor. True and false beliefs, according to Boudon (1986, 1990, 1995), should both be explained by this "cognitivist" approach.

4. Boudon (1986, 1990, 1995) rejected explanations that consider beliefs or actions caused not by reasons such as, for instance, the concept of habitus of Bourdieu (1980) or the "prelogical mentality" of Lévy-Bruhl ([1922] 1960).

5. There exists a huge literature constituting harm reduction—not as a paradigm but as a coherent system of normative and cognitive ideas.

6. A fascinating fact (which confirms the influence of our positional effect) is that during the "normal" period (1980s) and at the beginning of the public controversy in 1992, when TV reported on the dramatic social and medical situations of heroin addicts in Switzerland, for instance, where in the middle of big cities such as Zurich there are very special police-free places (they call them *sciences*) where addicts can get heroin and inject it, the orthodox experts tended to think that they in France succeeded in avoiding such misery.

7. As Hall (1993) observed, elections and formation of new governments are only one of

the different components that make change occur; before 1993, there had been other changes in government in France, which had little impact on the major goals of the policy.

8. Muller (2000) insisted on the fact that a change in *Référentiel* generally has heavy consequences on collective identities, consequences that explain partly the resistance to disruptive, normative, and cognitive changes.

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