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WHEN 'DRUGS' BECOME 'DRUGS': ISSUES OF PHARMACEUTICAL ABUSE IN FRANCE FROM THE 1960S TO THE 1990S

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SUMMARY

WHEN 'DRUGS' BECOME 'DRUGS'

Since the 1970s, media frenzies about drug addiction have focused mainly on illicit drugs taken by rebellious or marginalised addicts, relegating iatrogenic drug abuse, and policies and problems linked to psychotropic pharmaceuticals available by prescription or over-the-counter to the shadows. In this article I go beyond the division between illicit drugs and medicines still configuring both public representations and historiography: using archival materials from the 1960s–1990s in France, I highlight some blind spots in drug history. Firstly I demonstrate the role of pharmaceutical abuse in the career of addicts, and then examine regulation policies, which are the dark side, however complementary, of drug policies and prohibition. Finally, I analyse the role of physicians and pharmacists in this control, and discuss the various professional debates relating to the legal supply of psychoactive drugs. In all these issues, the frame of the Cold War context will also be highlighted.

At the turning point of the 1960s–1970s, drug abuse in France became a major concern for public authorities. After a series of teenage

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heroin overdoses in the Summer of 1969 – one being the 'drame de Bandol', the death of a seventeen year old girl from a fatal injection in the toilet of a French Riviera Casino – the media gave the addiction problem a new visibility through the use of the 'epidemic' metaphor. Newspapers talked in sensationalist terms about the 'social plague' or the 'cancer eating the Youth'[1]. Police statistics showed an increase of drug-related crimes (trafficking and the use of) and a doubling of the numbers of addicts in a decade[2]. Echoing the discourse of 'crisis of civilisation' spreading through the media, the Gaullist majority voted for the 1970 Act against drug traffic and abuse, strengthening the prohibitionist logic inherited from the former 1916 Act, which defined the drug user as a victim requiring cure and the trafficker as a criminal deserving of severe condemnation.

The media paid far more attention to illicit drugs than to widely-abused diverted prescription medicines: marijuana and LSD were the subjects of most accusatory discourses during the counter-culture era, in newspapers, magazines and essays. In the 1980s, in a context of economic crisis and unemployment, heroin abuse quickly came to summarise the landscape of drugs. But abuse of prescription drugs or Over-the-Counter (OTC) drugs by addicts – those who considered themselves to be addicts (the 'junkies' or 'les toxs' in French slang) united by the same subculture of frequent drug taking – has been the blind spot of the great public debates, which over the course of thirty years have focused on toughening prohibition, the decriminalisation of 'weed', the actions of police and customs officials, or replacement treatments for heroin addicts. Moreover, the enhancement of public agencies devoted to the fight against illicit traffic (law enforcement by the Interior Ministry, health care supervised by the Health Ministry) has overshadowed those in charge of regulating legal psychotropics (other offices of the Health Ministry), making them, in a way, the 'dark side' of Prohibition. The boundary between the (medical) 'drug' and the (illicit) 'drugs' is however extremely

vague and movable (the English language even uses one word, while the French distinguishes between 'medicament' and 'drogue'): it is merely a juridical frontier, often based and moved on the recommendations of physicians or pharmacists, dividing two substances with similar pharmacological properties[3]. Surprisingly, however, this line has had real consequences on mainstream social representations of the drug problem, while medical or pharmaceutical considerations about the moving of a substance from one world to another usually remain in the shadows. This dark side has only been reconsidered since the 1990s, with the rise of synthetic drugs (ecstasy and derivatives, 'designer drugs', 'research chemicals') blurring, through their production and other aspects, acknowledged boundaries[4].

The relationship between licit and illicit drugs has also been underrepresented in the historiography, which has tended to focus on the suppression of illicit drugs, health care and the prevention of addiction to major drugs such as heroin[5]. Historical works on drug abuse, scarce in the French case, still evoke the issues of pharmaceutical consumption only marginally, focusing instead on the public obsession with illegal products, considering that the medical birth of 'addiction' as a new problem has gradually dissociated this problem from therapeutic 'accidents'[6]. As for the history of (medical) drugs, works have focused on the pharmaceutical industry and governmental regulation of markets, but hardly ever mention the drugs produced and sold illegally[7]. Some studies have started to explore the issues of ambiguous substances regularly passing from one field to another[8], as ongoing projects on the misuses of medication[9]. It is however essential to recall the role of the user, who in this case is an addict who gives new meanings to the use of a substance, beyond the goals appointed by the Marketing Authorisation ('Autorisation de Mise sur le Marché' – AMM), sometimes even discovering new properties.

An attempt to write this history will be made here, using various archival sources: archives from the *Direction générale de la*

Pharmacie et du Médicament, controlled by the Health Ministry, ancestor of the current *Agence Sanitaire de Sécurité Sanitaire des Produits de Santé* (AFSAPS) whose records are unfortunately inaccessible for some periods[10]; printed sources, from official reports to the publications of user groups (such as the peer-support group *Asud*, 1992 – today) without forgetting a few studies about pharmaceuticals addiction; and interviews with former addicts. These materials have enabled me to examine the different uses, logics and issues that have crystallised around pharmaceutical abuse. They will be analysed through the points of view of the various stakeholders: the addicts themselves, public authorities, and finally, professional bodies of physicians and pharmacists who, due to their monopoly on access to these highly sensitive products, occupy a privileged position. This study enables us to reassess the fact that the addicts' subculture has often been considered a simple frontal assault on society. It also allows us to identify some mechanisms of the functioning of public policies regarding drugs and medicines, and shows the socio-professional logics deployed among different health professions. All of this has enabled me to write a rather ignored history, going beyond the partition between the history of illicit drug addiction and the history of medical drugs.

One could object that there is a fourth actor: the pharmaceutical industries which have produced the substances. But as the research presented here is unrelated to laboratory archives, these will be only be evoked at the margins of development[11]. The aforementioned issues will be framed within Cold War history, the main topic of this volume, and several hypotheses relevant to this context will be presented.

From the side of the addicts: a non-existent boundary between drugs and medicines

Rather curiously, the discovery of polydrug addiction associating illicit substances and psychoactive drugs is a recurring element con-

stantly reported as a 'surprise' in some official reports on addiction. A note from the National Institute on Medical Research (INSERM) in May 1969, about the cases of drug poisoning in schools and universities of the Parisian area, reported cases of 'a very inventive pharmacology': hospitalised young people had mixed toxics and alcohol, inhaled various solvents from industrial production and ingested medicinal preparations made with anti-migraine and anorectic drugs (Préludine™ : phenmetrazine), thereby diverting drugs from their medical use[12]. In 1978, the report on drug problems by the Pelletier Committee referred to the consumption of psychotropics coupled with illicit drugs as something new and surprising. A decade later, in 1989, the report by the Trautmann Committee also seemed to discover polysubstance use involving illicit drugs, medications and industrial solvents with surprise[13].

However, despite these recurring 'surprises', polyaddiction, involving manufactured pharmaceuticals by several generations of addicts, is a reality that can be discerned from different sources. Firstly, through the testimonies from autobiographical literature by former and repentant drug users, a genre which was a great success once the 'drug epidemic' had became a popular topic. Guy Champagne, in his autobiography, *J'étais un drogué*, said he regularly bought heroin from his dealer, but also related his successful attempts to obtain Nembutal™ (a synthetic opiate – pentobarbital) from general practitioners (GPs). He also consumed a lot of OTC barbiturates. Similar behaviour is perceptible in the autobiographical 'hippie literature' about travels to Kathmandu. In *Flash ou le grand voyage,* Charles Duchaussois, describing his trip to India and Nepal, talked about heroin and LSD, but also Maxiton™ – a legal amphetamine at that time – provoking euphoriant feelings. In a bestselling investigation edited two times, *Satan qui vous aime beaucoup* (1969, 1972), two journalists, Philippe Alfonsi and Patrick Pesnot, wrote of their interviews with two young girls from Marseilles, who went to Turkey

and Iran, but no further: they were heroin addicts but often used paregoric elixir, an antidiarrheal product stolen from pharmacies, then filtered to extract the opium alkaloids[14]. Fifteen years later, in the bestselling autobiography, *Héroïne, une vie*, the repentant addict, Yves Salgues, narrated his life of opiate dependence: alongside opium and heroin obtained illegally, he also used diverted morphine and suppositories of Eubine™ , melted down to extract the alkaloid[15]. Secondly, this finding is confirmed by archives from the *Direction de la Pharmacie et du Médicament*. The health authority was indeed alerted to the issue by several police reports in the context of the 'drug epidemic'. Observations from 1968–1969 in the Southwest reported that young wandering groups of hippies were combining soft drugs (cannabis), hallucinogens (LSD), and Romilar™ , an antitussive product from the pharmaceutical laboratories of Roche, the sale of which is controlled in France but not in Spain from where the incriminating substances were originating. Of forty young people arrested, in a 1969 case, six admitted regularly taking Romilar™ in very high doses (fifty to sixty pills, swallowed at the same time, causing 'delirious' states of consciousness)[16]. Another example: a minute from the national Gendarmerie of Vaucluse reported the arrest in October 1970 of Alain M. (anonymised), carrying two false medical prescriptions, one bottle of Valium™ (diazepam) and needles. He confessed to injecting himself alternately with morphine and heroin for the past five or six years. Among the minutes, another reported police control highlighted the case of Jean-Marie R. (anonymised), who was carrying needles, tubes of Kinortine™ (a mix of amphetamine and caffeine) and Nembutal™ . He admitted swallowing thirty to forty Kinortine™ tablets at a time, three to four times a day, and two capsules of Nembutal™ once a day[17]. These cases of young people show interesting profiles of polyaddiction, with Valium™ or crushed tablets being injected along the same pattern as heroin.

Finally, published epidemiological studies, generally carried out under the direction of INSERM, enable us to quantitatively assess this phenomenon: unfortunately, these fragmented data prevent us from reconstituting statistical series but they do allow us to evaluate proportions. A questionnaire survey conducted by unit 185 of INSERM between 1976 and 1978 and based on interviews with 226 major illicit drug users treated in health care structures showed that sixty per cent answered yes to the question 'Do you use psychotropic medicine for your addiction?'. In a later survey conducted in 1983 in the Seine Saint Denis department, a population of drugs users described the different drugs they had taken: cannabis (ninety per cent), heroin (eighty per cent), and cocaine (thirty per cent), but also a significant amount of medicines (forty per cent). Another survey the same year was based on the testimonies of pharmacists and physicians working in prisons in the Bordeaux area. To the question 'pharmaceuticals that could imply addictive uses', on the basis of their observations, 248 surveyed physicians answered: Palfium™ (103 quotes), Dolosal™ (péthidine) (fifty-five), Temesta™ (thirty-one), Morphine (twenty-five), Valium™ (twenty-five), Seresta™ (twenty-four), Optalidon™ (twenty-one), Mandrax™ (twenty-one), Tranxène™ (sixteen) and Thymergix™ (fourteen). The 122 pharmacists surveyed answered: Néocodion™ (twenty-seven quotes), Ether (twenty-six), Paregoric Elixir (twenty-two), Temesta™ (twenty), Palfium™ (nineteen), Optalidon™ (fifteen), Tranxène™ (thirteen), Supposédol™ (eleven), Codeine (eight), Valium™ (eight) and Mogadon™ (eight). In addition, to mention a final survey, one conducted in 1985 in the Clermont-Ferrand area with shelters and counselling centres for drug addicts, highlighted that of sixty subjects identifying themselves as 'addicts', fifty-one frequently used 'psychotropic medicines' (eight-five per cent). Among the pharmaceuticals cited were: Néocodion™ (37.25 per cent), Tranxène™ (29.41 per

cent), Valium™ (25.53 per cent), Palfium™ (17.65 per cent), Rohypnol™ (flunitrazepam) (17.65 per cent), Seresta™ (15.69 per cent), Temesta™ (13.73 per cent), Halcion™ (11.76 per cent) and Artane™ (7.84 per cent), it being well known that addicts could use one or several substances in their consumption. For these subjects, the other non-medical associated drugs were alcohol (58.8 per cent), heroin (72.6 per cent), cannabis (58.8 per cent), cocaine (15.7 per cent), LSD (15.7 per cent) and solvents (11.8 per cent). The pharmacological families of these drugs, as established by the 1916 Act[18], are listed in Table B of 'narcotics' (shown here in Table 1), some of them by their commercial names[19]. First are the widely-used opiates, natural or synthetic, then the family of barbiturates, many of which are quite addictive. Then are the amphetamines, many initially prescribed and/or used for weight loss. Then there are the benzodiazepines, often prescribed as hypnotics or anxiolytics, which are also susceptible to abuse. Finally are listed specific products like those initially prescribed for the treatment of Parkinson's disease, but which induce potentially hallucinogenic effects, and finally various other medications.

Opiates: Morphine, Palfium™, Dolosal™, Supposédo™, Fortal™, Eubispasme™, Néocodion™, Paregoric Elixir, Romilar™, Dinalcode…
Barbiturates: Binoctal™, Immenoctal™, Nembutal™, Optalidon™, Supponéryl™, Orténal™, Vespérax™, Sonuctane™…
Amphetamines: Maxiton™, Corydrane™, Tonédron™, Fringanor™, Captagnon™, Dinintel™, Pondynil™, Fenproporex™, Pondéral™, Préludine™, Adiparthrol™…
Benzodiazepins: Rohypnol™, Tranxène™, Valium™, Mogadon™, Halcion™, Temesta™, Seresta™…
Antiparkinsonians: Artane™, Dissipal™…
Others: Mandrax™, Mercalm™…

Table 1. Pharmaceutical products consumed by drug addicts for their addiction.

Combining medicines with illicit drugs is quite common among addicts, therefore, but for what purposes? It is essential to now *qualitatively* assess the role of pharmaceutical drugs in the average addict's career. What is the signification of this consumption? Two important points can be highlighted. Firstly, the overconsumption of pharmaceuticals as an initiation: many addicts were first introduced to drug abuse by their circle of friends through prescribed or OTC substances, such as Maxiton™ . These users often start with pills swallowed in their tens or crushed, then injected, before moving on to illegal substances like heroin. Jimmy K., former heroin addict, was 17 years old in 1970 when he began to take drugs, and thinks that 'this is what has made the riverbed of heroin, when the latter happened, we just finally found the stuff that went further and answered the desires that all these psychoactive drugs had instilled in us'[20]. This kind of testimony is also found frequently in columns of *ASUD*, the journal from the illicit drugs users' association of the same name. Ten and a half million legal amphetamine pills were actually sold by French pharmacies in the year 1970 alone[21]. The most popular products during 'initiations' were legal amphetamines like Maxiton™ , Tonédron™, Kinortine™ or Corydrane™, a mix of amphetamine and aspirin, very easy to access.

This fact is also evidenced by health professionals: In 1971, *Le Moniteur des Pharmacies* emphasised the role of pharmaceuticals as an initiation or a step on the path to addiction:

> *Of 200 addicts hospitalised at Fernand Widal hospital in 1970, fifty per cent were under twenty-one years. Extreme ages were fourteen and thirty years old. The pattern is always the same: a cigarette of cannabis in a party and a few trips with LSD, then intravenous injections of amphetamines, the latter being associated with Secobarbital™ in a later stage. All this leads to intravenous injection of heroin. Homopavine™ is sometimes used but only in periods of transition from one step to another*[22].

A particular dimension emerges among the range of legal amphetamines: weight loss ones like Préludine™ or Adiparthrol™ were very much appreciated when diverted from normal use. Preludine™ was initially overused by young girls to get slim but addicts consumed it for its euphoriant properties. As for Adiparthol™ , a very popular drug until the late-1970s, nicknamed 'Bobol', at high doses it caused what were known as 'love flashes' and collective hallucinations. It is part of the nostalgic memory of many 'speed freaks', mentioned until the 1990s in addict associations' reviews, even though the descent afterwards could sometimes cause episodes of madness, requiring hospitalisation in a psychiatric institution, or even suicide[23].
Another aspect is 'substitution': a sort of self-substitution of prescription-controlled substances by addicts, obtained through the various means mentioned above. Throughout the 1970s and 1980s, the shift of addicts' attention to pharmaceutical opiates can be seen as the result of several factors. The first of these is the temporary drying up of black market heroin. After the dismantling of the *French Connection*, the famous illicit heroin production and trafficking organised by the Corsican mafia in Marseilles, the depletion of the illicit heroin market resulted in an increase in burglaries of Table B opiates from pharmacies: pharmacy robberies between 1973 and 1974 increased by 200 per cent (739 thefts of narcotics/classified products in pharmacies, chemistry wholesale distributors or hospitals for this year). A comment was made by a police representative at the time:

> *We can wonder if the doubling in the number of deaths compared to 1973 is paradoxically an unintended consequence of the relentless struggle we conducted against the heroin trade. It seems clear that this increase is the direct result of uncontrolled consumption of prescription drugs illegally obtained by theft or compliant orders*[24].

At an individual level, this increase may have been the result of a personal strategy due to the loss of a supplying dealer, worries with

the law regarding illicit drug use, especially, for example, after a release from prison, or simply in an attempt to gradually kick the habit of heroin. Indeed the latter dimension can be explained in a context in which the French health care system refused, until the early 1990s, to generalise methadone maintenance, limiting places to around forty in only two sites in Paris, at the hospitals Fernand Widal and Saint Anne. These programs remained experimental from 1972 to 1990, due to a great hostility from the medical profession towards the belief that opiate substitution was a valuable therapy. Over two decades, the field of health care in addiction was indeed dominated by psychiatrists who, headed by Claude Olievenstein at the Marmottan clinic in Paris, imposed a conception of addiction and rehab based on a psychoanalytic approach, without any medication beyond those required for physical weaning[25].

This opposition between supporters of the psychotherapeutic approach and ones of drug treatment support for drug addicts is reminiscent of some famous controversies, such as the Osheroff case, as recalled by historian of antidepressants, David Healy. As doctors did not want to prescribe drugs for the patient, providing him only with health care based on psychotherapy, his condition deteriorated. A misdiagnosis was the cause: the doctors were attempting to cure symptoms of a general depression, when the patient's actual condition was a personality disorder syndrome[26]. A similar problem occurs in the treatment of drug abuse. Indeed, the official definition of drug abuse, as upheld by the World Health Organisation (WHO) and detailed in the Diagnostic and Statistical Manual II (1968) and III (1980), only deals with a simple 'dependence' relationship to narcotics or pharmaceutical substances. It fails to explain determinants and makes the use of drugs for treatment paradoxical. Due to the vacuum left by the classic definition of psychiatry, some psychiatrists have attempted to fill the gap by developing an approach with psychological and socio-cultural concepts, unsuitable

to neurobiological explanations. Through his multiple media interventions, Olievenstein was able to impose himself as an expert recognised by the government, including the General Direction of Health (DGS), at the Ministry of Health. In 1969, while defending his thesis on LSD consumption in the hippie communities on the US Western Coast, he took a stand against the traditional psychiatry he had observed during his internship at Villejuif psychiatric hospital. His addiction theory, using psychoanalytic concepts borrowed from Jacques Lacan's philosophy (in terms of the construction of the patient's identity), matched perfectly with the public debate on substance abuse, which was being perceived as a cultural crisis and a problem resulting from the psychosocial maladjustment of the young[27]. Substitution was therefore banished from the official approach to addiction advocated by experts. This complex setting, combining theoretical discussions, individual power games and socio-professional interests, would be a contributing factor to the separation of illicit drugs and medical drugs in social representations and health care. Although Olievenstein was not as caricatural as many others, and theorised how a substance – whether illicit or licit – became sacralised for an addict as a 'pharmakon', his approach contributed to the creation of new categories and patterns for addiction, radically different from those of the former iatrogenic model. Drug abuse became the plague of contemporary Western civilisation, apparently revealing an idealistic desire from a young generation made desperate by materialist society[28].

Nevertheless, given the impossibility of obtaining synthetic opiates through institutional health care, many addicts resorted to codeine medication in OTC trade from pharmacies, such as Netux™, Tussipax™ and especially Néocodion™, produced by the laboratory Bouchara Recordati and sold from 1957. As laboratory figures demonstrate, sales of the latter literally exploded in the early 1990s, when the problem of diverted consumption was raised.

It is highly likely a major part of this consumption was self-substitution. These misuses were the subject of a public question put to Health Minister, Claude Evin, by a parliamentarian in 1991, instigating the restricting of their sale to a box per day and per person in 1992. However, the actualities are revealed by the testimonies of former drug addicts, who have related their experiences of massive substitution on what they called the 'néo' (ten to twenty pills swallowed at once to cure heroin craving): 'Néocodion™ : OTC in all pharmacies, the rest you all know...Calm craving, warm up. Useful in troubleshooting. Impossible to shoot' (*Asud*, 1992)[29]. The 'néo' is the most famous case of a self-substitution drug, but addicts also liked Rybomunil™, a vaccine against hay fever. This was particularly useful because it was sent with a needle, which could serve for opiate injection, the OTC sale of needles being forbidden in France by a decree from the Health Minister in 1972. Intended to limit heroin use, it was removed fifteen years later in an emergency context; to contain the spread of AIDS among heroin users.

Year	**Néocodion™ boxes sold**
1992	8 748 200
1993	10 000 400
1994	10 833 300
1995	11 996 800
1996	11 246 300

Table 2. Boxes of Néocodion™ sold in France, 1992–1996.

These materials therefore enable us to reconsider traditional conceptions of drug user subcultures. These have certainly regularly been considered to be in direct opposition to the surrounding society and established morals, whether in hippie communities or punk subcultures as expressed in the 1980s in underground magazines

like *Viper* (1981–1984). However, here is drawn the figure of a more socially integrated user, highly attentive to legal supplies of psycho-active substances, even if accessed by subterfuge or theft, developing an alternative knowledge about these substances and ways of using legal mechanisms (the medical prescription) to access them: that is, an expertise of the pharmaceutical universe the ordinary citizen does not have. Moreover these practices blur the boundaries between 'healing and enhancing the mind.' A common opinion is that the generation of the 1950s, facing a new supply of pharmaceuticals (sleeping pills, stimulants), developed a 'culture of a pill for every ill', which the next generation then transposed to illicit products[30]. Actually, the following generation had kept many habits of the previous one and retained its expectation regarding the legal offer of psychoactive pharmaceuticals. This self-medicating behaviour, of psychotropics from licit or illicit markets, is also a form of consumerism. The systematic use of the 'chemical crutch', in its curative or recreational dimension, as the consumption of instant gratification, corresponds to a certain step in the model of liberal democracy (the pursuit of individual freedom) and capitalism (the supply of pharmaceuticals); that is to say, the Western model within the Cold War. This association between drugs and the American way of life was also appreciated by French Communists. Between 1977 and 1981, in the context of Legislative and Presidential election campaigns, the Communist Party engaged itself in an anti-drug fight, denouncing drugs as a capitalist attack on the proletariat. Use of drugs was clearly identified as a plague originating from the US, as illustrated by the comments of communist official, Pierre Zarka: 'The US, which has produced all obscurantisms, the Ku Klux Klan, McCarthyism, racism, political assassinations, mad serial killers, are today producing forty-two million addicts'[31]. Here, however, his condemnation was more of illicit drug use than that of pharmaceuticals.

From the side of the public authorities: the regulation and control of psychoactive drugs, as the dark side of prohibition policy

Public policies about pharmaceutical abuse seem to be overshadowed by those relating to the abuse of illegal drugs, but there are three important policy fields which must be illuminated.

The first aspect of this policy is the tracking of illegal purchases and overprescribing of controlled substances. The responsibility for this lies with the Direction of Pharmacy and Medication, its PH5 office in particular. The tool used for tracking, in force since 1916 and reinforced in 1948 by decree, is the 'counterfoil' book; that is, the use of triplicate records – one copy for the doctor, one for the pharmacist, one remaining in the book, which, once finished, is handed to the health authorities – for every prescription of substances listed in Table B of the 1916 law. The prescription is limited to a maximum of seven days treatment and accounting is required at all levels. This system originated at a time when the main reason for drug abuse was the complacency of many physicians regarding the prescribing of opiates, for their patients or for themselves. Archives of the agency show how this tool worked to track and solve evident cases of drug abuse in the 1960s. To take a few examples: the Guy Pech. (anonymised) file, Paris, 1960: an attending physician who used to steal counterfoil books from colleagues he replaced in Seine et Marne, for his personal use as a Palfium™ addict. Or the Soent. (anonymised) file, Senlis, 1962: a woman addicted to laudanum. Health inspectors noticed oversized prescriptions and investigations highlighted the responsibilities of general practitioners and pharmacists. Or Le. (anonymised) file, Lille, 1962: a woman addicted to Eubine™ suppositories (containing opiate derivatives), apparently obtained these easily with overlapping prescriptions from several practitioners. A final example is to be found in a case in Juvisy, 1963: investigations into a pharmacist who used hydrochloride of

morphine from his stocks for his own consumption and for intoxicating young women to obtain sexual favours[32]. In many cases, the patient profile – generally mature to aged, professionally active or retired, having received or still receiving medical treatment – corresponds with that of an age in which 'iatrogenic addiction' dominated: the late-nineteenth century.

However, records show that this type of control policy continued beyond the '1970 rupture', and the emergence of 'drug epidemics' and apparently polyaddictive uses. The stalking of the convenience prescriber continued, the PH5 office investigating high numbers of prescriptions and/or their overlap. Three 1979 cases in the archives demonstrate this persistence. The Bern. (anonymised) case, Paris 8th: a doctor had prescribed a large number of Table B classified products to imaginary patients and went buying medicines in pharmacies for himself. Over three years, 220 prescriptions forms probably fed this physician addiction. Dr Brav. (anonymised) case, Nogent-sur-Marne: the physician prescribed medication for his drug addict brother and required the pharmacist to deliver the product immediately, despite some overlaps. Dr Chau. (anonymised) case, Paris: the physician prescribed the impressive number of 5920 doses of Dolosal™, Fortal™ and Palfium™ in only two years[33]. Although these profiles, including that of the addicted physician, appear outdated, they still existed at the time of the 'drug epidemic' and its young activist users.

The lack of control of prescriptions can obviously not always be blamed on doctors, as addicts often used deception and false prescriptions. Reports from the regional inspectors of Pharmacy, providing information gathered from various regions forwarded to pharmaceutical unions, inform us about problematic cases of the use of stolen prescription forms from general practitioners, or false prescriptions for barbiturates, neuroleptics or amphetamines by young people:

> *…behaviour and appearance of the customer must of course be a first alert condition, but you should be wary of ordinances indicating only a single drug with dosage figures, when it comes to listed products and poisonous substances from imaginary doctors often domiciled in Paris. These documents are easily recognisable because their header is often printed with artisanal means unrelated to the typography used by professional printers*[34].

The *Direction de la Pharmacie et du Médicament* also reminded pharmacists and physicians of some simple rules as certain provisions of the Public Health Code (R5179 and R5185): the author of a prescription drug listed in A, B, or C Tables, as defined by the 1916 Act, must not only sign the order but also indicate clearly his name and address, and indicate on the sheet the use modalities of the drug. Health authorities also distributed some inquiry notices from the police, as in this example:

> *On Thursday, 23 December, 1971, around 2 PM, an individual appeared at the pharmacy Roux, rue Builiers, at Vernon. He claims to be suffering terribly from the stomach and has to be operated on several days later. He asked the address of a doctor. An employee of the pharmacy led him immediately to Dr Cornette's office. The individual, who writhed in pain, reiterated there that he had surgery within the three forthcoming days by his surgeon and requested the issuance of a sedative, claiming that his doctor usually gave him palfium™. Dr Cornette noted that his client had two operation scars (including a recent one) in the abdomen. He issued an order for six tablets of palfium™…The client said his name was Souj and he was visiting a relative residing in the rue du Sud in Vernon. The doctor notified him that this street did not exist in Vernon, then the individual rectified and cited the rue du Soleil. Shortly after, the patient returned to the pharmacy Roux and presented the ordinance, to which he had added the number one before six, for sixteen tablets instead of the six prescribed. He told the pharmacist that his name was Leduc and he was visiting his remarried mother residing at avenue du Soleil in Vernon. The pharmacist Roux noted that the ordinance had changed and declined to run it. The same day, the same order, fully ironed in felt pen, was presented to the pharmacy Gandolfo in Caillon, where the stranger was able to obtain 16 tablets of palfium™. There are no lady Leduc or Souj on avenue du Soleil in Vernon.*

> *The following reports were provided to us: By Dr Cornette: man of about forty, height about 1m77, thin build, pale, wearing a fur coat, brown-haired…A similar fact was reported recently in Rouen, in a bulletin sent regularly to pharmacists in the region. The palfium™ is a toxic listed on B Table. It is hoped that physicians and pharmacists in the region are now warned against actions of this nature*[35].

Reports such as these, however, disappeared from both the media and historiographical works on addiction from the 1970s onwards. Why has the abuse of these listed substances been consistently overshadowed? Largely this is due to the politicisation of the drug problem: those who exploited it had no interest in publicising this 'iatrogenic model', which, for the most part, implicated members of mainstream society. Instead, public debate focused on a new negative stereotype: the young protester smoking pot who questioned the established order, a few months after the trauma of the May 1968 student riots. In a way, from the 1970 Act onwards, France engaged in its own 'war on drugs', while in the United States in 1971, Nixon was proclaiming drug abuse as the 'public enemy number one'. However, in both cases, the young protestors were the obvious target. During the parliamentary debates to prepare the 1970 Act, the obsession with 'young hairy vagrants of Saint Michel' (one of the main drug scenes in Paris at the time) was blatant, while a number of parliamentarians were pointing out that some dispositions of the Act (such as allowing police to conduct night-time house searches without warrant, eventually removed from the text) could be used as a pretext against leftist activists, the favoured target of the Interior Minister, Raymond Marcellin[36]. Marcellin was also perfectly aware of the danger incarnated by the abuse of pharmaceuticals: 'The indiscriminate use of these drugs present a danger to public health and, in particular, to the youth of our country. This was the case in the past with Maxiton™ and more recently Préludine™' he admitted in an internal letter to his colleague, the Health Minister, Robert Boulin[37]. Nevertheless, pub-

lic statements avoided this dimension. Drug abuse became a symbol of the counter-culture linked with the degradation of morals and a subversion of social order, to the eyes of the parliamentarians and members of the temporary joint ministerial committee co-ordinating anti-drug policy actions, at the Ministry of the Interior, until 1974. But criminalising illegal products associated with criminalised trafficking was far easier than addressing problems associated with legal drugs, despite the fact that a lot of addicts were injecting themselves with as much, if not more, amphetamines than heroin.

But once the agitation of Gaullist politicians about leftist threats had passed, abuse of pharmaceuticals again took centre stage: pharmacy burglaries even became the primary concern of the *Joint Ministerial Commission of Narcotics*, the only administrative body responsible for drug policies, between 1974 and 1978, before heroin from the Middle East or Asia returned to the black market[38]. In the 1980s, however, a new bogeyman appeared: the marginalised junkie living in an urban underworld among Northern African or Sub-Saharan African dealers of illegal-immigrant origin, at a time when heroin use was highly visible in public spaces (like the 'îlot Chalon' neighbourhood in Paris in 1984) or in squats[39]. The spectre of the heroin 'junky', whether based in reality or not, played a useful role in the political dramatisation of social problems – common during electoral periods – while pharmaceutical addiction remained in the shadows. The injecting drug user become the stigmatised junky of the contemporary drug scene, amplifying a social and health catastrophe and extending the ravages of AIDS by sharing needles, before, in turn, crack addicts – as publicly witnessed in 1994 on Stalingrad square in Paris – became the new fixation point of moral panic. Another example of the staging of drug abuse, related to the fear of terrorism following a series of bombings in Paris in 1986: this led to a reformulation of the drugs problem, emphasising alleged links between heroin trafficking in the Middle East and terrorist-financing trafficking rings. The law

of 1987, completing the 1970 Act, increased sentences for trafficking, being inspired by a 1986 law on the prevention of terrorism. This new form of politicisation of drugs – perceiving the addict as a victim or passive accomplice of organised criminals – still contributed to the separation of illicit drug abuse problems from pharmaceutical ones. This is a political boundary, because the restoration of order can be staged only against something that does not fall within the legal and regulated economy, such as real psychotropic drugs.

The second aspect of this policy focuses more specifically on the regulation of psychoactive pharmaceuticals, being the role of the *Commission of Narcotics*, an old interdepartmental administration dating from 1930, and strongly reactivated in the context of preparing the emergency law of 1970, with a 1969 decree establishing a new permanent section. In that period, the enhanced activity of this commission reflects an awareness – as in Marcellin's words – of problems relating to the increasing number of psychotropics produced by laboratories, as treatment centres for drug users were gradually beginning to report the abuse of these substances. The Commission was responsible for advice on exemptions, registrations or changes in referencing the various poisonous substances in the A, B, and C Tables. The Commission intervenes in the pharmaceuticals market through a series of decrees endorsed by the Health Ministry, the Commission having only a consultative role. At the turning point of the 1960s–1970s, these decrees were made by Henri Nargeolet, chief of the PH5 Office, on the advice of the Commission, directed at that time by Jean Mabileau: both were responsible for a huge amount of work on the question of legal amphetamines, for instance.

Although the limitations of the archives allow us only to document the 1960s and 1970s precisely, some features of this policy can be identified, being also limits to the action of the Commission. Firstly, as it was probably unwilling to confront the pharmaceutical industry directly, the Commission did not generally advocate a straightforward

ban, except in the exceptional cases of LSD, produced by the firm Sandoz in 1966 (but always considered a very experimental product), and Corydrane™ from Laboratories Delagrange (more delicate because it was an OTC product), finally removed from the market in 1971. The Commission also placed conditions on the sale of certain pharmaceuticals on prescription (Préludine™ in March 1969), restricting their provision to physicians (solution of Maxiton™ for injection in December 1966, solution of amphetamines for injection in October 1967) or modifying the pharmaceutical preparation at the level of the pharmacy (paregoric elixir becoming only available in its pure form with a prescription for doses over 25g, anything under this amount being mixed with sugar to make the filtering out of opium impossible as any combustion would produce caramel, in November 1969; exemptions for preparations containing opium powder were removed, in January 1971)[40].

Unfortunately this intense regulatory activity did not solve the problem: unable to act on the demand for drugs, it could only translate this to new substances or new ways of accessing former substances, as reported by the *Direction de la Pharmacie et du Médicament* in 1969:

> *Unable to obtain preparations of amphetamines for injection, drug addicts have used tablets of Préludine™, a drug listed in A Table of dangerous substances, but issued on regular prescriptions. Using true or false orders, young addicts accessed the Préludine™, dissolved tablets in water and injected the obtained solution. From a drug to be taken orally for which the therapeutic indication is obesity, drug addicts have thus made an injectable drug used for its exciting action which is only one of its side effects*[41].

At the end of this push to the margins, the black market takes over, with traffic of Préludine™ at that time coming from Spain. But this official statement also demonstrates that control efforts can only occur *a posteriori*, as initial controls jointly carried out between government and laboratories before awarding Market Authorisation can

only be made in regard to the purpose the product was designed for. Psychoactive effects are generally only discovered once the product is being sold, by the addicts themselves.

Moreover, the actions of the Committee are embedded in a set of standards of international origin, including the United Nations (UN) Conventions on Narcotics in 1961 and Psychotropic Substances in 1971. This makes the institution entirely part of the international frame of the contemporary 'war on drugs'. The Commission passes on UN rankings – its representatives take part in the discussions to develop them – and it summarises studies published abroad to determine class changes. As an example, after examining a number of foreign publications, in 1979 the Commission decided not to transfer fenfluramine (the molecule of Pondéral) from Table A to Table C. Case reports of addiction to the product identified in South Africa were unconvincing, given the association of their consumption with other drugs, and many countries consider the molecule to be a relatively harmless weight-loss agent. Nevertheless, after consulting more nuanced reports that discussed its properties as an amphetamine, the Commission considered the substance to primarily act as a low level hallucinogen, and dismissed the demands of French pharmaceutical companies to change the classification of the substance. For them, this change was significant and related to commercial interests: a C Table product is available with a renewable prescription, an A or B Table product is not, consequently limiting sales. In another example from the same year, the Commission responded negatively to a request from the Winthrop laboratory to transfer pentazocine (Fortal™) from Table C to Table B. The laboratory reported cases of stolen pentazocine in pharmacy burglaries and wanted, for insurance reasons, the benefit of security measures for B Table products, to secure their stocks and sold merchandise. Having consulted reports, the Commission decided the thefts were not selective: in many cases addicts were stealing it along with others products, apparently in-

discriminately. On the advice of Professor Lagier, from the national Pharmacovigilance centre, the request was dismissed because pentazocine was taken as an anti-morphine drug and, especially, lists from the WHO and UN Conventions of 1961 and 1971 did not reference the product[42]. These examples also show a third limit to regulation policy: beyond the aspect of a force field between commercial logics from laboratories and public safety worries of the Commission, the desire for greater control of the flows of substances for which there is some public health concern, is permanently addressed in accordance with predefined nomenclatures and the politico-administrative prevalence of advice or a classification on another. The history of this policy during the 1980s can unfortunately not be retraced due to restricted access to records.

Moreover, records concerning these discussions show the occasional 'international' genesis of some decisions and moments when a collective political will can prevail on nomenclatures and make them evolve. The Committee also prepares files of French experts participating in the work of the Council of Europe (sub-committee of the Pharmaceutical Affairs), WHO, and the UN Commission on Narcotic Drugs. Thus, to take one example, in a report in February 1974 about the latest meeting of the UN Commission, the French representative, Charles Vaille, then head of the French Commission, was very interested in debates about the misuse of methaqualone, the molecule of Mandrax. A decision had been made to regulate the use of methaqualone – nicknamed 'qualude' or 'lude' by addicts – in the United States in 1973 and the drug was also used in Southeast Asia. There was therefore widespread opinion in favour of concerted action on the regulation of this molecule. This would take place in France through the decree of 18 May 1974, which included methaqualone in Table B[43]. These are only fragments of an, as yet unknown, politically, socially and economically revealing history of drugs regulation.

But why is this regulatory policy rarely mentioned in discussions about drug policies, when it is so intimately linked to them? Firstly, an effect of administrative sealing has gradually operated. As a simple committee of technical advisors, the Commission could not be the source of a strong political will, however essential when dealing with such a media-sensitive subject as drug abuse. Then, in 1982, the creation of the Interministerial Mission for the Co-ordination of Policies on Drug Abuse (MILT, later becoming MILDT) marginalised the work of Commission. The latter was then refocused on the purely health-related issues of medication abuse, within the future AFSAPS that replaced the former agency in 1993, while MILT became involved with other political developments. In 1985, it came under the authority of the Prime Minister, being associated with an audit of prevention policy and the creation of a new offense, as defined by the law of January 1986, to better target street dealers[44]. In 1986–88, under the rightist Cohabitation Government, it passed under the supervision of the Minister of Justice, Albin Chalandon, to be put at the service of a larger plan against drug abuse, focusing on prevention policy and penitentiary responses[45]. This was intended, according to the statements and correspondence of Prime Minister Jacques Chirac, to create a 'war on drugs' on the US model, and was endorsed by the left – in power between 1988 and 1993 – who enlarged the capacity of MILT, and created a new administration (DGLDT) to strengthen co-operation with foreign agencies, including those in the US. Under the direction of Georgina Dufoix, this led to a major domestic prevention campaign directly inspired by Nancy Reagan's campaign, 'Just Say No'[46]. The desire to imitate the US was extremely strong: an understandable political move in the context of the Cold War blocs.

Moreover, in a third important aspect, regulation policy is directly connected to a set of policies about which governments attempt to communicate as little as possible: that is, the administrative procedures relating

to the system of international control of the production and licit trade of narcotics, for the legal production of opiates by pharmaceutical industries, under the authority of the UN International Board of Control, a legacy from the Interwar League of Nations. For instance, in the global system of legal economy of narcotics, the normal needs of France, as estimated by the UN, oscillated between 200.000 and 240.000 kg for two years in the 1960s. Since 1978, the French need for opium has decreased to 150.000 kg, due to health authority initiatives of that period to produce 'morphine self-sufficiency'. In France, opiate production is mainly in the hands of the Francopia company, a subsidiary of the Sanofi-Aventis laboratory. The PH5 Office is in charge of all these perfectly legal processes[47]. However, there is a certain 'taboo' regarding this matter, for economic, industrial and political reasons, which means it remains in the shadows. This regulation activity is also a legacy from colonial opium monopolies, as in Indochina, where the *Régie de l'Opium* controlled the sale of opium, the Institut Pasteur from Saigon improved opium cultures and the military supervised opium culture and its sale, to finance the Indochina War in the early 1950s[48]. Besides, at a global level, the frame of the 'war on drugs' launched by Nixon in 1971, has almost completely overshadowed the legal aspects of narcotics issues and the functioning of the legal system of international control[49]. In the US, the 'war on drugs' logic had a direct effect on the redefinition of foreign policy (during the presidential campaign in 1968, Nixon promised to address the sources of drugs in other countries), in the context of declining international prestige, and criticism of their role in Vietnam and Chile. In the case of France, this is far less obvious, but France followed its ally when, for instance, Pompidou decided in 1971 to intensify the fight against the *French Connection* through co-operation between French Police and US agents of the Narcotics Office (BNDD), strengthened by a convention signed in February 1971[50]. 'The war on drugs' frame enables the unity of the Western Bloc to be reinforced when disputed by the growing protests of its own youth, but only by targeting

illicit drug rings and not pharmaceutical industries and the legal system of narcotics control. But the legal mechanisms of licit opium trade and transformation also contribute directly to the health sector of Western nations, while countries which produce legal opiates – such as Turkey, a member of NATO – are also strategic allies in the Cold War. It can be assumed that the administrative separation between regulating policy on licit narcotics and law enforcement on illicit products has not been established by chance. It helps combat the epiphenomenon of public concern surrounding drugs consumption while preserving the existing financial, international and strategic equilibrium, even more important in times of Cold War and confrontation between blocs. This also sheds light on why drugs, whether licit or illicit, are never strictly prohibited, but rather controlled. Differences between narcotics and medicines are more related to political logic and administrative distinctions than to any significant difference in psychopharmacological effects. This helps to conceal the proven connections between the legal and illegal narcotics production sectors. US BNDD records from the 1960s, for instance, are full of reports highlighting the diversion of narcotics from legal alkaloid production plants in France: in 1963, for example, American agents suspected that workers at the Sempa factory in the Parisian region were in contact with Corsican traffickers[51]. However, for political and administrative reasons, this kind of connection is never publicly exposed.

From the side of the professional stakeholders: the attitudes of physicians and pharmacists

Controlling the movement of 'legal' substances is not just a matter of administration: it also involves professions, each of which complicates the issue of regulation. Physicians and pharmacists as two professional bodies, often complementary, but also rivals – pharmacists feeling themselves in a position of social inferiority toward physicians, with regard to academic degrees or social recognition – are invested in the issue of pharmaceutical abuse.

Physicians play the role of prescribers, but also of specialists commissioned by public authorities to define a care model in the matter of addiction. But in the 1980s–1990s, these issues revealed logics of rivalry between the public medical sector and GPs. Confronted with the massive public health problem of heroin addiction in these decades, many attending physicians started to practice an informal heroin replacement therapy, superimposed on many addicts' own fairly anarchic efforts at self-substitution. Some physicians prescribed Skenan™ (morphine sulfate), Moskotin™ or, especially from 1987, Temgesic™, which gained its market authorisation that year and could be prescribed with a normal order, without counterfoil books, until 1992. Also that year, REPSUD was created in the Paris area, a network for physicians practicing 'de facto' substitution[52]. By 1985, the profession had already discussed a publication by the Belgian psychiatrist, Marc Reisinger, about his own experiments with the substitution of prescribed Temgésic™ , basically buprenorphine, giving a new therapeutic model[53]. It is difficult to quantify the extent of the prescription of these synthetic opiates in the 1980s–1990s, but this underground substitution only became visible due to the publicity surrounding some controversial cases. These raised ethical and legal issues: could prescribing knowingly psychotropic drugs to addicts be seen as an incentive to addiction? Would substitution be in violation of the law, which defines abstinence as the goal of health care? As an example of these scandals, in 1994, after several months of proceedings, the National Council of Physicians condemned the doctors, Jean Carpentier and Clarisse Boisseau, for the illegal prescription of narcotics and suspended them for a month. This resulted in the petition called 'Qui ne dit mot consent', signed by 280 physicians defending the practice of their colleagues[54]. Another emblematic case, in 1995, was that of Dr Antoine Khouri in the Belleville district of Paris: having gained an understanding of addiction during an internship in Parisian hospitals in the 1980s, where he witnessed the ravages of

Newborn Withdrawal Syndrom (NWS) for babies born to heroin-addicted mothers, he went on to prescribe Temgésic™ , Antalvic™ or ampoules of the injectable form of Palfium™ in a logic of informal substitution to almost 200 regular patients. He was pursued through the courts for the death of nine patients from pulmonary embolism related to unsafe injections; in 1997 he was sentenced to two years in prison and ordered to pay victims' families 1.4 million F (half of the amount to be paid by the pharmacist who sold the Palfium™). This case also revealed the hypocrisy of the departmental council of the National Order of Physicians, who knew how Khouri was using the counterfoil books it gave him, and even approved Khouri's approach in 1993, in response to one of his letters, provided that he did not exceed twenty-five prescriptions per week[55].

Overall, however, these practitioners were obviously strongly criticised by psychiatrists, such as Drs Claude Olievenstein, Francis Curtet and Michel Hautefeuille, and psychoanalysts, like Hugo Freda, who had established themselves as specialists in addiction care. Indeed, for a long time the National Association of Addiction Specialists (*Association Nationale des Intervenants en Toxicomanie* – ANIT, founded in 1982), the main interlocutor of the Health Ministry, expressed its preference for a psychosocial approach to addiction, focusing on the person, not the product, promoting abstinence after weaning and post-cure psychotherapeutic support. ANIT condemned methadone and other opiate substitutes as a form of social control, a mere replacement of one addiction with another: 'By allowing access to wide maintenance programs, the State integrates the group of opiates distributors, competing with the heroin dealers in crime areas', as wrote Dr Nelson Feldman, from Marmottan clinic, in the ANIT publication *Intervention*. Methadone was associated with neurobiological explanations of addiction, so was treated in the same way as synthetic opiates available by prescription. These experts consequently felt compelled to publicly condemn their fellow GPs

in the early 1990s, denouncing the movement that drove people who had become addicted to medications prescribed by some GPs, who were meddling in what did not concern them, to their institutions: '[M]any addicts came to Marmottan to be weaned off Néocodion™ , Antalvic™ , codethyline, Temgesic™ or Palfium™ , products easily available in pharmacies or prescribed for months by general practitioners' (Dr Nelson Feldman)[56]. This position was somewhat hypocritical, as some ex-users testified that Olievenstein, for instance, was not reluctant to prescribe Palfium™ in private consultation[57].

While physicians' attitudes have been analysed in a pioneering sociological work (Bergeron, 1999), the beliefs and behaviours of pharmacists during that period are also well known. They appeared as a more unified profession, trying to impose themselves as the more reliable public actor on the issue, in competition with physicians. Indeed, The National Order of Pharmacists took many initiatives to develop their understanding of the problem of mass drug abuse and pharmaceutical abuse. They have proffered their knowledge in pharmacology matters, as demonstrated by the role of pharmacists within the Narcotics Commission. In February 1971, for instance, its chief, Jean Mabileau, supervised a Conference of the national representative body of pharmacists at the Academy of Pharmacy in Paris. The main goal was to define responses to abnormal uses of prescription drugs and the emergency cases of abscesses, septicaemia, hepatitis and infection-related fevers that resulted from the 'trash way' of injecting. But pharmacists also launched sensationalist campaigns in 1971–1972, on the ravages of drug abuse, such as this tract, distributed and displayed in many pharmacies:

> *Olivier B., nineteen years old, death from drug overdose on 13 January 1971, Annick M., twenty-one years, death from drug overdose on 9 May 1971, Anonymous young girl, seventeen years, death from drug overdose on 10 May 1971, Josette D., twenty-one years, death from drugs on 13 May 1971, Jean B., twenty-two years, death from drugs on 31 May 1971)…pharmacists remind you that today in France there are more than 30,000 drug addicts*[58].

However, a striking point is how the pharmacists appeared to feel themselves underestimated, even to be victims, mere implementers of prescriptions written by physicians, and above all the victims of drug addicts themselves. The upsurge in burglaries and armed robberies of pharmacies was a major problem associated with drug abuse in the 1970–1980s, as shown in Table 3[59].

Crimes	**1979**	**1980**	**1981**	**1982**	**1983**	**1984**	**1985**	**1986**
Pharmacies robberies	920	822	750	926	740	697	551	436
Violent thefts (pharmacists, GPs)	75	32	50	132	53	52	28	77
Narcotics thefts in hospitals	89	92	97	97	130	104	228	142

Table 3. Thefts of narcotics from pharmacies and hospitals in France, 1979–1986.

In support of this victimisation, a dissymmetry can be seen between figures provided by the Ministry of Interior, in Table 4, and those above, from the Federation of Pharmaceutical Trade-Unions, which conducts its own annual survey[60].

Sources of information	**Burglaries 1977**	**Armed attacks 1977**	**Burglaries 1978**	**Armed attacks 1978**	**Burglaries 1979**	**Armed Attacks 1979**
OCRTIS (Police)	642 (total)		1049 (total)		1300 (total)	
Pharmaceutical Unions	1200	112	1538	128	1444	170

Table 4. Burglaries and attacks on pharmacies in France at the end of the 1970s, according to different sources.

Correspondence in the archives of the General Inspection of Pharmacy also displays an emphasis on the problem of aggression during night service: in 1975, presidents of regional trade unions circulated their claims in the media, comparing guardians of night pharmacy to bank cashiers, facing 'molesters more dangerous than any other, drug addicts craving for drugs'[61]. Daytime burglaries could also be quite violent, as seen in this description by a pharmacist attacked in February 1974, in the Parisian suburb of Arcueil:

> *Sir, I have the honour to confirm the armed attack which I suffered on Sunday, 10 February, 1974 at 12h15, during my watch, which I have already reported by phone. Two individuals, aged about nineteen years, broke into the pharmacy while my young preparer was behind the counter and myself in the back room. The first one with a knife, rather disturbing, the No. 2 half masked, nervous, brutal. The No. 1 after throwing my preparer to the ground by applying the knife to her throat and holding her by the hair, tried in vain to open the cash register. Alerted by the screams of my colleague and the sound of his sudden fall on the ground, I was immediately assaulted by the No. 2 that threatened to kill me, to 'shoot me'. He threw me to the ground suddenly and asked for the keys to the toxin cabinet. I yielded to the threat. He tore the phone cables off. Under the surveillance of No. 1 with the knife, we were lying on the floor in the back room, next to the dispensary. Meanwhile, the No. 2 emptied the toxin closet at the back of the second back room. Some customers entered three times, surprised to see us lying on the ground. The No. 1 was hidden from them, threatening us with the knife if we talked! No. 2 then returned, after filling the pockets of his khaki jacket with products listed in B Table. Then he rushed at me with brutality, tearing my glasses off and threatening again 'to shoot me'. He wanted the needles. I showed him the drawers located in the pharmacy. They then fled but without stealing syringes. The three customers had seen all that from outside without reaction. They fled in a blue van. I called the police with my alarm gun. We immediately made an inventory of stolen B Table products. I provided the police with the list of stolen goods, in my complaint. Apparently, the No. 2 was a drug addict in withdrawal, he was terrifying!'*[62].

In these years, pharmacists were therefore attempting to make the protection of pharmacies a major issue and gain guarantees of safety

from public authorities. A response to these claims was contained in the Poniatowsky-Veil Decree from the Interior Ministry and Health Ministry of 1975. Although the text recommended some of the suggestions made by pharmacists (such as protocols: a phone call to be made by the physician to warn the pharmacy before the arrival of a patient, collaboration with local gendarmerie for night patrols), le *Bulletin des Pharmaciens* pointed out that the binding measures (generalisation of alarm devices in pharmacies, storage of classified products in secured metallic closets) were considered too expensive for pharmacists[63].

Nevertheless, pharmacists established themselves as indispensable stakeholders in the fight against addiction. For example, the National Order of Pharmacists with support from the *Direction générale de la Pharmacie et du Médicament*, organised a symposium in Chaillot in March 1972, entitled 'The pharmacist, health and social educator; his responsibility regarding the regulatory texts'. The motion passed after the Congress stated that pharmacists' training gave them adequate expertise in matters of public health, and claimed the right to interpret prescriptions given by doctors and an exemption from certain articles of the Public Health Code, thereby authorising them to deliver classified pharmaceuticals if they believed the client's health depended on it[64]. They also tried to be vigilant actors in restriction enforcement on the ground and, in contradiction with the recommendations of the Chaillot symposium, did not hesitate to refuse to execute a prescription, or at least at certain dosages, presented by 'normal' patients who were not drug addicts but needed opiates for their disease, most often cancer, chronic pain after physical trauma, or other medically valid causes of chronic pain. This is shown by the many letters of complaint in the archives, including this from Verdun, which refers to the political and parliamentary debates in 1975 about the future Veil Act on voluntary interruptions of pregnancy:

> *I had today a prescription from my doctor with the order of two boxes of Palfium™ but the pharmacist...only wanted to give me one. Instead of digressing about abortions, you would be much better served giving the order to pharmacy to execute prescriptions made by attending physicians*

Other examples could be quoted, with most of the complaints concerning Palfium™ , and then Dolosal™ [65]. Finally, in various controversies, pharmacists attempted to have their 'professional responsibility' clause recognised, as shown in their opposition to the decree of 1987 from Health Minister, Michelle Barzach, authorising the OTC sale of syringes: on February 1987, the French Federation of Pharmacy, professing to represent between 17.500 to 21.000 pharmacies, claimed the right of pharmacists to apply the 'conscience clause' and at times decide not to issue a syringe to an addict[66].
The strategies of these professions therefore played a role in the regulation and control of the circulation of psycho-active substances, as well as in the care of drugs addicts. If physicians can appear (unintentionally) as 'dealers', pharmacists who stock drugs often suffer the effects of a criminality typical of the illicit drug economy, even though this is a legal market of legally produced substances. Finally, however, the two professions were reconciled through the implementation of harm reduction policies in the mid-1990s. In 1996, marketing authorisations were awarded by the Ministry of Health for methadone and Subutex™ , allowing physicians to prescribe them to heroin addicts, and pharmacists to deliver them, with the approval of official medical experts. At the heart of this reconciliation between all the stakeholders, we find drug users themselves or field workers (physicians and social workers) applying outreach methods, driving them to adopt a comprehensive approach regarding drug addicts. Substitution was indeed accepted by addiction experts and later the Health Ministry in the pivotal years 1993–1996, after the lobbying of activists, such as Anne Coppel, President of 'Limitez la casse', a harm reduction association founded in 1993, who particularly evoked

the Dutch model – including decentralisation, a refusal of the specialisation logic that separated national experts from local practitioners, and the empowerment of self-help groups of users by acknowledging they knew what was best for themselves – and experiments with opiates prescriptions in the United Kingdom. The debate launched by the book *Drogues, le défi hollandais* by the Belgian philosopher Isabelle Stengers in 1992, contributed to lowering barriers erected by psychiatric experts and legitimising the empowerment of drug user groups, still on the Dutch model[67]. An association of users was therefore created on the model of the Junkie Leages, ASUD. Also in 1992, risk reduction measures involving local municipalities were established (although limited at first by the lack of availability of methadone, thus consisting of programs of 'needle exchange', by bus, local centres or 'steriboxes') including a methadone bus provided by *Médecins du Monde* in 1998. Methadone centres were opened outside hospitals, such as *Clinique Liberté* by the psychiatrist Didier Touzeau and the activist Anne Coppel in Bagneux in 1993, delivering methadone under medical supervision and involving members of ASUD[68].

Given the ambivalent status of substitution products, these harm reduction policies have contributed to lowering the boundaries between legal and illegal drugs. But this blurring of partitions, coupled with the birth of a true public health policy, can also be linked, I hypothesise, with the post-Cold War context. The triumph of the model of liberal democracy placed even more emphasis on individual liberty and civil society, though the empowering of consumers' and citizens' associations. Among these, drug users groups started to be afforded a new and pivotal role in the construction of health policy which directly concerned them. This empowerment retrospectively legitimates the dimension of self-medication and the right to the use of psychotropic drugs, while completely reformulating the debate on the therapeutic use of these drugs.

However, this change has not been entirely comprehensive: the legacy of a great tradition of hostility from experts regarding sub-

stitution treatment is still perceptible. Methadone, due to the former control of its circulation for twenty years (it was produced by the Pharmacy of Paris Hospitals for supplying the only two experimental centres, then produced by the Mayoli-Springer laboratory, then the Bouchara-Recordati laboratory), was initially restricted to prescription by physicians working in specialised addiction centres, and Subutex™ (a newcomer replacing Temgésic™, marketed among health professionals by the laboratory Schering), which can be directly prescribed by GPs, became the main substitution product (in 2001, 12.000 people were on methadone, 85.000 on Subutex™). This asymmetry, which still remains today, is due to the legacy of the former partitioned system between psychiatric experts and GPs on the ground, addicts preferring to go to the latter to be prescribed Subutex™ or Temgesic™, and abandoning specialised centres[69].

In conclusion, this overview has enabled the identification of various stakeholders in the problem of controlling the abuse of manufactured substances. Taking into account the various aforementioned points of view demonstrates how the acknowledged boundary between (illicit) drugs and medicines is malleable, porous and finally, artificial: hence the necessity to reconcile two parallel histories.

Addiction behaviours appear to be more deeply entrenched in society than expected: they not only evolve in a marginal world, but are also related to a perfectly legal supply of industrially-produced substances, however controlled, and are part of a capitalist and liberal society model. Beyond the standards defined in the context of the 'drug war' initiated in the early 1970s, itself inserted in the Cold War context, this smoke curtain should not hide the intransigence of drug control policy or the perverse effects caused by the legal supply of psychoactive pharmaceutical products. At its birth as a medical category in the nineteenth century, drug abuse was essentially iatrogenic: it has remained so under the guise of the new monsters it has engendered in the latter part of the twentieth century.

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facility of Pierrefitte-sur-Seine, in 2014]. Other collections from the National Archives have also been used and will be referenced.

11. This article is based on a current ongoing PhD project: MARCHANT A., *La lutte contre la drogue en France (1965–1995): l'impossible prohibition*, Ecole Normale Supérieure de Cachan (dir. O. Wieviorka). To be defended in 2014.
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17. Minutes from Gendarmerie Nationale (2170, 2177), 1970, National Archives 19900545/1.
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