PREVENTIVE POLICY FOR DRUG USERS : STRAINED NORMS

***Marie-Danièle BARRÉ**, researcher at the CESDIP, and **Patricia BÉNEC'H-LE ROUX**, associate researcher at the CESDIP, discuss the findings of a study of front line actors of drug-related harm reduction policy*[1].

The drug-related harm reduction policy : a definition

An official instruction issued by the Interdepartmental Mission for the Fight against Drugs and Drug Addiction (the MILDT) and the Interdepartmental Delegation for Urban Affairs (DIV) defines this public health policy as follows: *The policy known as the "drug-related risk reduction" policy, implemented by the administration in the wake of the emergency represented by the epidemic of AIDS ten years ago, consisted at the time of providing drug users with sterilized injection material. It presently designates all of the information, aid and care services offered to consumers of psychoactive substances and especially to users of intravenous drugs, in order to reduce the health and social risks and harm connected with their consumption. The present scheme includes: non-prescription sale of syringes in pharmacies . . ., distributors and/or exchangers of prevention kits..., citizens group syringe replacement programs aimed at reaching the most marginalised users; contact places or "storefronts" providing responses to such basic needs as food and cleanliness, but also first aid and guidance toward health and social services; mobile, community-based teams*[2]... This scheme is sometimes called "front-line" or "lower threshold" because its objectives differ from those of the therapeutic scheme. It basically approaches users upstream of health care through outreach work and makes minimal demands in contacts with users.

« License » and « mandate » as defined by E. Hughes

An occupation consists in part in the implied or explicit license that some people claim and are given to carry out certain activities rather different from those of other people and to do so in exchange for money, goods or services. Generally, if the people in the occupation have any sense of identity and solidarity, they will also claim a mandate *to define (...) proper conduct with respect to the matters concerned in their work*[3].

Research Methods

We began our research by collecting documents, conducting about ten exploratory interviews with key actors in drug-related harm reduction (DrHrDrHr) work and a brief quantitative investigation of the socio-professional characteristics of actors working in DrHr schemes in the Ile-de-France region. However, most of our data are drawn from a qualitative survey of three schemes (a store, a needle-exchange mobile van and another van for methadone distribution operated by *Médecins du Monde*[4]). This investigation consisted of observing the work of front-line outreach actors and conducting thirty-odd semi-directive interviews with these actors, the people who financed and decided DrHr policy, the patrons of the store and professional partners in the health and social arena.

The prevention policy aimed at users of illegal drugs is not concerned with use itself only but, among other things, with the consequences of that use when it is not discontinued. In this perspective, various facets of a DrHr policy have been set up in France over something short of twenty years now. The study discussed in part herein was concerned, firstly, with the actors implementing that policy, and especially those working with the most marginal users, and secondly, with their work. Using the tools developed by sociologist E. Hughes, we have reflected on the definition of the "license" (I) and the mandate (II) of these professionals, thus shedding new light on the stakes presently involved in this government policy.

I – Battles around a license, or from deviance to norm

The license granted to front-line actors covers the right to discuss the way illegal drugs are used without breaking the law[5] which prescribes a 5-year prison term for provocation to use or depicting drug-related offences in a positive light. It also authorizes them to provide preventive material (syringes, sniff kits, condoms and so on) and in some cases to distribute a substitute substance, methadone. More than anything else, this license may be seen as the stake of a series of battles. DrHr policy may be analyzed as an innovative process, a deviation from the norms (1), embodied by actors who have fought for the establishment of a new norm (2). To this day, there are still struggles around defining that policy (3).

1°) *Harm reduction: a deviant activity*

DrHr began clandestinely. It represented a deviance from drug-related health policy grounded in abstinence, but also from penal norms, which punished use. The distribution of clean syringes, begun in the late 1980s[6], was by no means self-evident. In 1993 a daily newspaper reported on the difficulties of the association *Médecins du Monde* as follows: *(...) the latest "*coup de poing*" ("punch") operation took place on January 12th in Paris' Goutte d'Or neighborhood. According to* Médecins du Monde *the police confiscated and 'trampled underfoot' the kits distributed by the association's mobile team, each of which contains two syringes, two condoms and a letter from the ministry of Health*[7]. DrHr was offensive to the professional culture of police and justice system actors, but also to health workers, while official texts testifying to recognition of these new practices by the administration, if not to a reversal of previous norms, had yet to be published. Although militant action had opened the way, it was not until 1994 that the ministry of Health institutionalized the DrHr policy and set up the new scheme[8], indicating a radical change of direction in French drug policy. In 1995, a ruling modified the regulations and authorized the distribution of syringes outside of pharmacies, and in 1999 an official instruction from the ministry of Justice[9] explicitly stated that *arrests for the pure and simple use of drugs in the immediate vicinity of low-threshold agencies*

[1] This paper is the result of a study financed by the MIRE in the framework of a call on « professional dynamics in the health field », launched in 2001.

[2] Official instruction dated January 9, 2001 relative to the inclusion, within urban policies, of the fight against drugs and drug addiction.

[3] HUGHES E.C., 1984, *The Sociological Eye*, Transaction Publishers (USA and UK), 287.

[4] Being the only one extant in the Paris area, the anonymity of the latter cannot be preserved.

[5] Article L3421-4 of the Code of Public Health.

[6] In 1987 the Barzach ruling authorized the non-prescription sale of syringes in pharmacies, the first prevention brochure had been published by AIDES in 1986, the first syringe exchange programs were set up in 1989.

[7] *Libération*, January 20, 1993.

[8] The scheme had been officially presented in 1993, on an experimental basis, in the three-year action plan of the MILDT.

[9] Official instruction dated June 17, 1999.

or of needle exchange places are prohibited and that *irrespective of the place, the simple fact of possessing a syringe should not be viewed as sufficient evidence of law-breaking, susceptible of arrest.*

These deviant, innovative prevention practices were endorsed by militants and professionals who rebelled against the traditional ways of their profession. The mobilization that led to the creation, in 1993, of the collective called "*Limiter la casse*" ("Limit the damage") which supported DrHr, "involved three components: 1) militants of self-support, 2) anti-AIDS militants, 3) actors on the health scene"[10]. These actors had to fight the accredited specialists in care for drug addicts, including most members of the National Association of Drug Abuse Workers (ANIT), which association officially reversed its position in 1994[11]. At the time, the strategy of accepting innovation meant seeking recognition outside the circle of health professionals, which is to say of specialists. In fact, the new policy indicated a struggle for the definition of care for drug users, but also for the bounding and the occupation of professional territories.

Thus, DrHr, a deviant attitude advanced by dissidents, who actually used foreign experiments[12] to support their position, was working toward the establishment of a new norm.

2°) *Harm reduction: a new norm?*

Whereas we cannot really say that the innovation process led to an "inversion of norms", it is true that another norm for action gradually arose alongside of, or rather, superposed on the existing penal and health norms. This trend was recently marked by an important event: the integration in the legislation on public health policy voted on August 9, 2004, of three articles representing acknowledgement of this policy. The first article gives DrHr a legal status, the second establishes a broader vision including social risks alongside of health risks, the former including risks run by users and by society at large, such as crime, as revealed by the parliamentary debates. Lastly, the third article establishes that the State, in exchange for funding guarantees, has a definite right to oversee any action,; here we see institutional legitimacy threatening the freedom of actors to determine the content of their mandate.

The other norms were not abandoned, notwithstanding. The projected revision of the 1970 act – presently dropped, the status quo being preferred – did not include the decriminalization of drug use but rather, its transformation from a moderately serious offence to one susceptible of a fine. Its advocates claimed that this would make punishment more effective, more sure and also more proportionate, by eliminating imprisonment. A prohibitionist conception is retained here. Likewise, DrHr still partakes of the rhetoric of health care, which in turn is supported by the goal of abstinence. The logic of defending individual rights according to which DrHr policy represents the right of "contented drug-users" to be informed, as the association for self-supportive drug users (the ASUD) put it, is out of the question here. Moreover, we note that the Senate investigation committee on national drug policy had refused to hear the self-support associations in spite of their historical role in developing and implementing it.

3) Harm reduction: the issue of definition

While DrHr is unsettling for social and health norms, its true originality resides in its unsettling effect on penal norms. One of its peculiarities lies in its working on the fringes of the law. This transgression, ultimately accepted, organized by an official instruction and presently by a legislative act, is the outcome of the militant work of actors, some of whom now want to extend the framework of DrHr, as has been the case in some other countries.

In particular, we encountered ambivalence toward the distribution of syringes in specially protected places such as storefronts for drug abusers, where the very nature of the problem occasionally confronts people with the need to cope with illegalities. Tolerating unlawful behaviour such as consumption on the grounds is very risky, first of all because actors are not equipped to treat overdoses and secondly because that sort of accident would threaten the very existence of the place. However, out and out refusal of such behaviour may call into question the very meaning of the work done. As one front-line actor says: *we are well aware that there are people who are taking fixes in there, and its against the rules. That shouldn't happen. But sometimes it's better for it to happen here than elsewhere (…) at a pinch, you see, our job is to give syringes to people who come here, and who have the stuff in their pocket (…). "Now, go shoot up in a cellar, or someplace else (…)". That's absolutely incoherent (…). But our role, the way we do things, is also to juggle with the border between (…) you see, what's legal, what's illegal.* To hold up in such an uncomfortable position actors usually adopt a militant stance, challenging the legislation: *"I think one of our roles is to change the 1970 Act, for instance", says one front-line actor, or demanding an "injection room". And the real answer, that would be to be able to open an injection room. That's obvious, but we haven't gotten to that point yet. And as long as we don't have one, we'll be somewhat in the s...* (a citizen's group leader).

To this day, actors working in the front line in risk reduction cannot claim to have a very solid license. In spite of the social legitimacy acquired, mostly owing to recognition of the positive effects of that policy[13], the extent of their license still remains an issue for the administration, the professionals, drug users and militants. Each group has its specific logic and there are many intra-group conflicts. As for the mandate of DrHr actors, its contours are relatively fuzzy.

II - A difficult mandate to define

The content of the mandate of these actors is difficult to delimit: they have to define what discourse to offer at a given time, for a particular person and situation. Being open and non-judgmental, the actor is obliged to set aside the norms of prohibition and abstinence, but how far can he or she go in maintainung what is therefore a subjective vision of norms? The imperative focus on health has completely upset relations to norms and their hierarchy, but the situation is paradoxical: users are not allowed to consume in a store, but they are not allowed to consume elsewhere either, whereas the actor gives them the means to do so. Furthermore, health care continues to be the objective: the health-related norm of seeking abstinence or of reducing consumption, or of using legal substances, must therefore be re-introduced in the relationship at some point. This work, with its constant search for the "lesser evil" for the user, involves translating social (1), health-related (2) and penal (3) norms. The outcome is an uncomfortable mandate (4). Last, the context, located on the fringe of norms, affects the attitudes of both actors and users: use sometimes remains difficult to talk about, even in a needle-exchange mobile van or a storefront. Negotiation around norms is simultaneously necessary and taboo.

1°) *Questioning the social norm*

The actors' relation to norms and the difficulty they experience in fulfilling their mandate is particularly visible in the persistence of taboos surrounding the use of drugs, the way they are used and the ailments connected with them.

[10] COPPEL A., 2002, *Peut-on civiliser les drogues ? De la guerre à la drogue à la réduction des risques*, Paris, La Découverte.

[11] BERGERON H., 1999, *L'État et la toxicomanie, histoire d'une singularité française*, Paris, Presses Universitaires de France.

[12] In the United States, England and Germany among others.

[13] EMMANUELLI J., 2001, Contribution à l'évaluation de la politique de réduction des risques sanitaires chez les usagers de drogues intraveineux, *Tendances*, 12, 1-4.

These taboos apply, firstly, to the actors' useful but always potentially stigmatizing competence, their "guilty knowledge"[14], varying in extent depending on the member of the team. As one front-line actor put it: *Drug use. It both is and isn't a taboo... Among us, there is no tremendous taboo..., if there are people on the team who are users, they aren't in what we call a crippling consumption, or in anything that handicaps them socially, professionally or psychologically... But it's more complicated to defend that in the outside world. Proclaiming that there are people on our team who know pretty much what they are talking about with respect to drug use, and that they didn't learn it all in books, that's still a real problem. Including with respect to our board of directors.* However valuable, then, the knowledge of such users, galvanized as a necessary resource both for establishing ties with patrons of these schemes and for elaborating effective prevention messages, nonetheless continues to be guilty knowledge.

Patrons of the scheme also have taboos. One sometimes has the impression that drug use has more to do with a shared secret than with down-to-earth everyday experience. For instance, some absences at an outing organized by one team were due to an incompatibility between the methadone distribution schedule, to which some participant patrons had to comply, and the appointment for the outing. The team only found out about that afterward, since no-one had discussed it openly. It took all of one actor's sense of humor to take the drama out of this kind of situation: *You have to talk about it. Things can be arranged. We're not in a public day nursery here, we're not talking about some kind of baby food problem*, says one front-line actor.

2°) *Negotiating with the health norm*

To what point should one negotiate with the health norm? Whereas accepting substance use is part of these actors' professional approach, here again, this does not mean that it is necessarily very easy to talk about it. The actors may feel divided between respecting the user's privacy and the need for an intervention when they discover excessive consumption or deterioration of a user's condition: *They find it difficult to talk about their consumption... It isn't easy, in the sense that when he doesn't want to say it, he doesn't want to say it. After that, when it begins to be clear that he's taking too much and is doing himself harm, are we doino our job?... Are we really doing our job when we pretend to believe him? We have to find a middle road...* (a front-line actor).

This accompaniment work so often described by actors rests on each worker's personal negotiation with the health norm. It is more a matter of constructing an ethical position than of referring to an occupational ethic: *It isn't easy for a doctor to do nothing... to allow the person to advance at his own rhythm, and sometimes even to regress* (a front-line actor).

3°) *Little arrangements with the law*

As we have seen, DrHr is faced with the apparent paradox of a policy which requires "little arrangements with the law" in order to exist. And those arrangements are all the easier to ignore inasmuch as implementation of the policy is essentially turned over to the associative sector, whose mandate is sufficiently fuzzy as to dilute responsibilities, in the last analysis. Here we see the public mandating authority's ambiguous position with respect to difficult missions: *It (use) is prohibited. That's part of the rules and regulations of storefronts.*

- But in practice, how do you handle the problem?

- You have to ask Mister X [from the storefront] about that. He doesn't tell me in detail how he handles his[15] *problem.* (an administrative official)

We may advance the classical postulate that the institution organizes a fuzzy space within which each actor can claim to have what Brodeur[16], writing about the tasks assigned to the police, calls "a gray check", as opposed to a "blank check": *The signature and the amounts conceded are both sufficiently imprecise as to give the minister who wrote it ulterior motives to plausibly deny what was actually authorized. However, both are legible enough to assure the police officer who receives the check that he has some leeway in which to manoeuvre, which leeway he too may plausibly assert was explicitly granted.* That "grey check" is obviously a resource for public actors who may thus exonerate themselves from the risks of the action undertaken.

4°) *An uncomfortable mandate*

Nonetheless, acknowledging or accepting drug use should not result in its trivialization, and herein resides all the niceties, if not to say the ambivalence of the DrHr message. Here we have an actor, hired essentially for his competence in dialoguing with users, who has somehow gone over to the other side of the "fence", and has a subtle analysis of his mandate and of the attendant responsibilities. There are mistakes to be avoided, both in the mission consisting of gleaning information and in the mission of giving information. In the exchange through which he learns about substances and how they are used, the actor must not give any hint of what he knows and the other does not know. Last of all, he is in the delicate situation of giving information about better ways of consuming drugs without encouraging their use or giving the impression of agreeing to use. As one front-line actor says: *And the question we will always be faced with is: "OK, is it good?"... – No, it isn't good.... (but) it's what you're looking for...*

In conclusion, we would point out that the recognition of DrHr in the August 9, 2004 public health act raises as many questions as it solves. While the legislators seem to want to buttress the legal license granted to actors to do their job to some extent, on the other hand the question of the content of their mandate remains extremely complex. The latter actually rests on a contradiction: to provide tools for prevention in the framework of deviant behaviour is to grant a degree of legitimacy to that very behavior, whereas at the same time this preventive approach wants to be the first step toward approaching treatment. Nonetheless, this vagueness also leaves some room for manoeuvring for actors who are able to continue to innovate so as to respond to constantly changing situations. In fact, on the one hand a mandate of this sort is necessary if front-line DrHr work is to be done – that is, if actors are to be in a position to negotiate with social, health and penal norms. But on the other hand, this sort of precariousness makes DrHr a space open to negotiation. The outcome is that the license and mandate of the actors we have observed continue to be the object of battles; since DrHr is a policy subjected to strain, the product of a given state of relations between social forces.

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[14] « The lawyer, the policeman, the physician, the reporter, the scientist, the scholar, the diplomat, the private secretary, all of them must have license to get – and in some degree, to keep secret – some order of guilty knowledge. It may be guilty in that it is knowledge that a layman would be obliged to reveal, or in that the withholding of it from the public or from authorities compromises the integrity of the man who so withholds it... ».

[15] Emphasis added.

[16] BRODEUR J.P., 2003, *Les visages de la police: pratiques et perceptions*, Montréal, Presses de l'Université de Montréal.