SETTING UP LOCAL SYRINGE REPLACEMENT PROGRAMS (SRP) FOR DRUG USE

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In the 1980s, it became clear that an alternative drugs policy was urgently needed in order to halt the AIDS epidemic. Intravenous drug consumers are particularly exposed to the virus, inasmuch as they circulate used needles, on the one hand, and are generally excluded from health and welfare schemes, on the other hand. A bill was therefore passed in 1987 legalizing the sale of syringes by pharmacies, so as to reduce this risk. SRP (syringe replacement programs) were first experimented in 1989, and gained recognition in 1995 following the officialisation, in 1994, of the policy of reducing drug-related risks. These programs are implemented by risk-reduction associations commissioned by the departmental DDASS agencies. Their objective is to approach those most marginalised drug consumers in order to encourage syringe replacement. There are several possible ways of distributing syringes, and places for doing so : from an outreach storefront (such as began to be set up in 1993), a mobile van, a syringe-distributing machine, through contacts on the streets or in the squats or homes of users).

The present study deals with one topical but hardly broached question[1] : that of the setting up of SRP, a complex process that constantly oscillates between two contrasting goals which must nonetheless be combined . the introduction of the project must be acceptable for the local environment (for elected officials, doctors, professional social workers, pharmacists, other associations, the police, users of the city and neighbors), and accessible to drug users (in terms of location, of timing, of the ability of workers to relate to and to maintain a sustained relationship with those most marginalised consumers). We will confine our remarks to the process of achieving acceptability of the SRP. This involves three phases :

I – putting the program on the agenda and having a township agree to it ;

II – persuading elected officials and local partners to accept it ;

III – persuading the neighbourhood to accept it.

The variety of places in which syringe replacement may take place calls for different processes for achieving acceptability. The survey methods used for the present study are of a qualitative nature. They are based on about thirty semi-directive interviews with actors and on the observation of the activities of drug outreach teams in ten-odd townships (*communes*) in the Seine-Saint-Denis *département*.

I – Putting an SRP program on the agenda and having a township agree to it

The DDASS decides where it wishes to have risk-reduction associations go to work. However, it is up to each association to approach towns and propose the implementation of an SRP. The extent to which towns are interested in the program depends on how they deal with drug-related problems. Our study shows municipal handling of these problems to be divided into three types[2], which condition whether the town will put the SRP on its agenda and agree to it.

1°) Health-centred management

In this model, the local officials acknowledge the existence of drug-related problems in the town, and create a committee specialised in the prevention of drug use, generally initiated, supported and presided by a health-councillor. In fact, these health-councillors[3] are often professional health workers and are therefore sensitive to the importance of reducing the risk of HIV and hepatitis transmission among drug addicts. The municipal health centres (MHS) (CMS in French) work hand in hand with the town health and hygiene services (THHS) (SCHS in French), whereas their relations with urban safety and police forces are more spotty. These towns immediately position themselves as interested in obtaining competent advice along with methods and tools appropriate to the local context, and are therefore receptive to any proposal of help in reducing drug-related risks. They are prepared to put the SRP on the agenda before the offer is made, and it is more or less self-evident that they will agree to it. Risk reduction becomes an element of health policy, and the association mandated for the SRP becomes a full-fledged partner of the municipal team.

Occasionally, however, a town may be anxious to benefit from this service, but no-one is offering it, for political or material reasons. There are few risk-reduction associations, and they cannot effectively cover every town in a *département*.

2) Safety-oriented management

In this second model, the municipal team denies the existence of drug problems and points up fear of crime. Drug problems are managed by safety-centred policies, via the local safety contract (LSC), which is set up by the councillor[4] in charge of urban safety, in collaboration with the police forces. Here, municipal health policy is mostly confined to services for the elderly and for young children ; there is no demand for secondary prevention services for drug addicts. No MHS or THHS is to be found. The SRP is slipped onto the agenda by a prevention-minded health-councillor. There is formal acceptance of the proposal to supply a risk-reduction service, then, but in actuality responsibility for it is shunted to the association. The health-councillor "washes his hands" of the problem, so to speak. This means that the association is not a real partner, integrated in the municipal team, and does not receive public backing from the political personnel.

In other towns also stressing a safety-oriented approach to drug use to the detriment of a health and hygiene-centered policy, local officials may categorically refuse the risk-reduction service offered. However, an SRP may be set up in private facilities within the town (neighbourhood centres) without a permit from town hall.

[1] See Daniel KÜBLER's analysis of the conflicts connected with the implementation of drug policies in Swiss cities: KÜBLER (D.), *Politique de la drogue dans les villes suisses entre ordre et santé. Analyse des conflits de mise en oeuvre*, Paris, Harmattan, Collection Logiques sociales, 2000.

[2] These are ideal types. More subtle intermediate types may be found between these archetypes.

[3] We use this term to designate elected officials in charge of developing health policy.

[4] Or by an official mandated by the political personnel.

3) Non-existent management

The third type is exemplified by poor, socially and economically neglected townships suffering from territorial demographic segregation. While local officials are well aware of the existence of drug-related problems, they focus their work on housing problems. And in fact, given the insalubrious conditions and indescribable decay encountered in some buildings, this obviously does constitute a priority. Health policy focuses exclusively on the elderly and young children. No MHS or THHS is to be found. The health-councillor lacks experience in prevention of drug use and leaves it to the risk-reduction association, which functions completely on its own.

All in all, political good will is of paramount importance for the introduction of an SRP, but this is not the only requisite. Acceptance is reinforced when the professionalism of the risk-reduction association is acknowledged by the officials in charge of health.

II – Sensitizing and persuading elected officials and local partners ; constructing an advocacy partnership

Elected officials and local partners must be made aware of the problem and persuaded of the need for an SRP before they come to accept it. This requires work upstream of the actual introduction of the program and during the first months of its functioning, and involves a long period of negotiations.

The first people to convince are the health-councillors. In conclusion of the negotiations, the health-councillors condition the introduction of an SRP on the association's ability to persuade the local partners, the townspeople, and especially the neighbors, to accept it, particularly when the plan is to open a storefront. So, in order to make itself known, to gain recognition and acceptance by the local partners, the risk-reduction association embarks on a sort of obstacle course, organizing meetings to explain to, reassure and convince people, to counter the unavoidable opposition and above all, to reverse what are judged to be "unenlightened" ways of thinking, "to make tolerable what people view as intolerable"[5].

During this phase, the other objective is to create or enter into and enlarge a partnership, so as to create a local relay network that will flank the SRP and serve as a guarantee for it, while possibly doing advocacy work for it. Acceptance of an SRP may in fact be achieved by mobilizing a solid partnership, headed by a pilot team usually composed of the health-councillor, doctors from the MHS and occasionally, THHS officials, as well as the coordinator of the risk-reduction association. Symbolic official recognition by the Administration, via the DDASS is also needed. This gives the SRP political and health legitimacy along with "ennoblement by the State". Conversely, if such a partnership is not organized and constantly galvanized, the acceptability of the program is seriously jeopardized. The construction of a partnership is not confined to the above-mentioned important actors, however : major local non-profit organizations, pharmacists and the police force should be included. Each of these local groups will have a variety of roles to play.

The health-councillors act as the risk-reduction association's Trojan horse within the municipal team. They introduce their colleagues to the idea of setting up an SRP. They are a mediating force between the association and the elected officials, since apparently elected councillors can only be convinced by other councillors. As a secondary benefit of their support, the association may obtain facilities and funding from town hall. In addition, the health-councillors generate a platform for partnerships, by putting the association in contact with other local partners such as street counselors, general practitioners, MHS and THHS, pharmacists and police officers. Last, they are first-rate allies in persuading their constituents. Nonetheless, their backing in itself does not suffice to get an SRP accepted ; health professionals must be actively involved as well.

Physicians are, in fact, powerful actors, often with numerous statuses and roles, including public health physician, health-councillor and/or deputy mayor, in charge of an MHS or a THHS, member of a union and of associations combating AIDS, head of a risk-reduction association, etc. Some combine professional, political and militant statuses, which clearly make them particularly influential. They have considerable leverage with health councillors for putting an SRP on the agenda (especially when the latter are doctors as well), and play a synergetic role with professionals in the drug field. When mobilized, then, they give the councillor the wherewithal to defend the risk-reduction association against its detractors. There is no way of sensitizing officials to risk reduction without their involvement. If the physician, a recognized and socially legitimate specialist, is not convinced of the value of an SRP, how can local officials be persuaded ? Last, the chances of setting up an SRP are much poorer in cities with no MHS. Whatever his "good will", a health-councillor with no experience in fighting drug addiction, no health professionals in an advisory capacity and no backing from an MHS is not armed for action.

The third category of actors from whom consent and backing must be obtained is the other local non-profit organizations, especially the most influential ones such as the tenants' association and the senior citizens' clubs. Once they have been won over, these associations may relay the objectives defended by the risk-reduction association and speak in their behalf.

Pharmacists, although persistently solicited, tend to be reluctant to enter this partnership. Some are surprisingly poorly informed of what risk reduction involves. Others prefer not to have syringe distributor machines on a wall of their pharmacy, and do not participate in used syringe recovery or in supplying people the distributors, even if they are located directly across from the pharmacy.

Preparation for setting up an SRP requires an alliance with the police, to avoid having the work impeded by heavy police presence in places where syringe replacement is operating. Those police superintendents interviewed claim they do not take action in places where syringe replacement is done, and make a clear distinction between repressive work and prevention. The partnership, in this case, may be termed one of mere courtesy. Here too, it is the health-councillors who arrange for the police and the risk-reduction association to meet.

Lastly, an SRP will be more acceptable if actors at the central Administration level are mobilized. Their physical presence at neighborhood meetings gives the approach, occasionally strongly contested by the population, a sort of guarantee and official legitimacy. However, such people hardly ever go to neighborhoods to participate in the task of persuading the population, the elected officials and other partners.

In conclusion, the primary actors in this process are the doctors, especially when they are health-councillors, and heads of MHS. Alliance with the political personnel (via the health councillors) is also essential, however, in that it is the vector of real mobilization and synergy among the local partners, especially the main citizens groups active in the town. These three groups form the core partnership, and the motor behind acceptance of an SRP by the other local partners. Such partnership has a definite impact and occasionally represents a form of advocacy. It is however up to the drug outreach team to organize it.

III – Persuading the population to accept it

Once the first battle has been won, there is a second one in store, requiring that the outreach workers persuade the population. The methods used to do so will depend on the type of syringe distribu-

[5] In the words of the head of one risk-reduction association.

tion and the local context. Methods for gaining acceptance of a storefront or an itinerant van stop are discussed below.

1) Acceptability of a storefront

Everyone agrees that ideally, storefronts should be opened in discreet but well attended locations, either near the city center or at the hub of several towns or *départements*.
However, the idea of setting up a storefront inevitably elicits a negative reaction from the neighboring population. While people agree that something should be done for drug users, it would be best to do it as far away as possible. They are assailed with fears, think it will attract all kinds of drug users to the neighborhood, bring in the dealers, introduce a criminal element, destroy their environment and the image of their neighborhood, force shopkeepers out, submerge their streets with a deluge of contaminated needles. Fear of crime explodes into full force. The first thing to do is to assess the local context, and take it into consideration : this spontaneous opposition is not insurmountable. The following methods of persuasion have been used by those workers on the drug scene whom we met, and by their local partners.
Before setting up the storefront, they orchestrated an informational, explanatory campaign, which consisted of a series of neighborhood meetings between all of the local actors and the residents, so as to reassure them, ask the residents to trust them beforehand, and to agree to the project, in exchange for guarantees that they are serious people and that the operating rules of the storefront will be respected, in a sort of ritual public exchange of commitments. Afterward, they placed prime importance on negotiation and dialogue with residents whenever drug users caused any occasional inconvenience[6], taking the neighbors' complaints into consideration and responding concretely to them (modifying the shop's hours, for example). Through the subtle workings of everyday contacts, by making the storefront a friendly place, open to all, helping both drug users and other people to solve the drug-related problems that arise in the family and neighborhood (through mediation) and picking up the used syringes discarded in public places, the workers managed to legitimate the existence of the storefront and convince people that their presence in the neighborhood was useful. Their professionalism was acknowledged, then, and the storefront finally faded into the landscape. It is nonetheless important to note that however great their effort at persuasion, however effective the political and medical support, relative success at gaining acceptance is always temporary. Last, the methods discussed here are simple examples, among others. The local context is decisive in this respect[7].

2) Acceptability of a mobile van

It seems somewhat easier to get the population to accept some stops for the syringe replacement van than to agree to the opening of a storefront. There are some real difficulties, but they involve somewhat different points.
Given its mobility, the van may travel to those socially and economically neglected neighbourhoods and located within towns with little or no specialised facilities or outreach teams or unequipped with syringe-distributing machines, as well as to those towns in which there is effective political opposition to the setting up of an SRP (in this case, the van must park on a private lot, with the owner's consent). Just as for the setting up a storefront, the residents' reactions and local context must be assessed and taken into consideration. While the methods used to gain acceptance may vary, there are nonetheless some points that do not : authorisation to park in a public or private place must be obtained, stops should be made near areas where the residents are sensitive to the need for secondary prevention of drug addiction, parking must be in places perceived by residents as neutral. Next, conditioned by the local context and physical layout, an alliance with a person serving as mediator between users and the population will be needed, but also, a choice must be made of either playing up the visibility of the van, with its occasional but regularly scheduled nature, to make it a "familiar" feature, having it stop in a discreet place that goes unnoticed, or varying parking places to mollify discontent.

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Ways of making an SRP acceptable vary with the outreach approach used toward drug users, be it a storefront, a van, or work on the streets, and they depend as well on the context – local and geographic, social, economic, and social and health-related aspects along with possible partnerships – and on the political juncture. As shown here, the process of achieving acceptability for an SRP is an ongoing one, which lasts as long as the program itself.
The adoption of an intermediate solution, with a "territorialised" compromise between acceptability for the environment and accessibility for drug users, particularly in the case of a storefront, constitutes the crucial point in this respect. Such an intermediate solution rests on the recognition of and dealing with inventoried needs for the secondary prevention of drug addiction in the area involved, but also on the ability to recognize and take into consideration the difficulties that may arise when a very marginalised group of drug users cohabits with the rest of the population. The point of equilibrium between these two poles may be achieved through negotiations around the various legitimate claims of the different users of the town. This is why the processes and approaches to setting up an SRP cannot be confined within a rigid set of rules ; they depend on trial and error, and consist essentially of experimentation. There is no single model for achieving acceptability for an SRP.

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[6] MARTINEAU (H.), Drug-related nuisances : how the Dutch handle the problem, *Penal Issues*, January 2001, XIV-1 (forthcoming).
[7] Actually, most attempts at setting up a storefront meet up with refusal.