16. Social exclusion and re-integration

16.1 Definition and concepts

a) definitions and concepts used in France

Poverty is a lack of income [63]. A precarious situation, more difficult to define, is the fragility of a situation [64]", and includes the notion of poverty : it can therefore only be measured with reference to the instability of situations and with the consideration of many angles. If the concept of insecurity could be defined, but not measured, this exclusion is very difficult to seed at the first attempt. All research work highlights '*Exclusion is not isolated by a type of "sanitary rope" which will be inserted into society, there is a continuum of situations, a group of positions where relations with the centre has more or less spread*". (ONPES 2001, p. 49)**.**

We generally attribute the origin of the term social exclusion to René Lenoir but Pangam (1996) observed that the notion was already present in the writings in the sixties. "The observers agree on one more point : *Impossibility to define the excluded with the help of a unique criteria*". Weinberg et Ruano-Borbalan (1993).

For the department of employment and solidarity, exclusion is defined as being a group of ruptured mechanisms on the symbolic plan. 'stigmas or negative attributes) and that of the social plan (different ruptures socially linked which incorporates men between them). Exclusion is at times a process, produced by a social cohesion by default, and a condition resulting in insertion default. (Department of employment and solidarity 2002a).

The concept of exclusion is characterised by 3 dimensions :

- the economic sphere : insecurity with regards to employment, chronic resources shortage

- the non-acknowledgement : lack of use of social, civil and political rights ;

- social relations : social and psychological destruction that the economic crisis and the non-rights situation breeds in the individual, the family and social groups.

Social exclusion is therefore spread, and is generally studied in interaction with the other two dimensions.

On the opposite side, insertion is a process that leads a person to find an acknowledged place in society. This can be done in several ways : professional insertion (contact with the work market), social insertion or global insertion (employment, health care, housing, culture, education).

In France, 300 000 people are affected by exclusion (0.4 to 0.5% of the total population, according to HCSP in 1998), 8 to 10% of the population is affected by poverty, (ONPE 2001) and probably 20 to 25% by insecurity (HCSP 1998).

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[63] According to the ONPES. Nevertheless poverty cannot be reduced to a single, monetary factor but also concerns other aspects of daily life: housing, health, education, work and family life. The line between poverty and serious poverty is defined by INSEE.

[64] A precarious situation is the absence of one or several securities, in particular employment, allowing people and families to meet their professional, family and social, obligations and to enjoy their fundamental rights" (Statement from the Economic and Social Council 11/02/1987 in a report by Wresinski J., 1987) ..

Problems put forth or discussed in the country affected by social exclusion/inclusion in relation with drugs.
The HCSP (1998) picks up at several stages in its report the existing interaction between the process of insecurity or exclusion and illicit drug consumption. The behaviour risk and the problematic consumption of drugs generally develops at the same time as the deterioration of a person's self-image and the impression of being socially useless. Depression, anxiety, alcohol and drug use problems increase depending on whether we are dealing with inhabitants of the Ile de France region, housed RMI (social/occupational integration minimum income) claimants or homeless people (Marpsat and Firdion 1998 according to a survey carried out in the Ile de France region by Viviane Kovess)

The report continues by citing the terms "exclusion", "violence", "delinquency" and "drug addiction" as the trait the most frequently associated with the suburbs.
In certain cases, however, and always in precarious areas, the presence of drugs may be a means of economically inserting through the intermediary of a microeconomic traffic, obtaining a status of a psychoeffective acknowledgement. (Jamoulle 2001).

However, notice should be taken that the accompanying risk and the problematic consumption are more spread in an underprivileged background and does not allow for determining if these are consequences of a precarious condition or a cause. Indeed, due to the French action plan against poverty and social exclusion (Department of Employment and Solidarity 2001), the use and consumption of illicit products was not subject to systematic study in this area. The information that we have concerns almost uniquely the consumption and drug traffic of the young people from other districts or the phenomena of alcoholism of the homeless.

In the 1970's, the almost exclusive usage by drug addicts in a specific system is based on the gratuities and the anonymous, and the consequences of this were the aspects of social negligence and kept in the same social exclusion. (Wieviorka 1999). With regards to the fight against the problems connected to drugs, France has in the space of 15 years taken an approach towards individual users recognising that this could be related to social exclusion. The vision of drug addicts as such the excluded could contribute to the implementing of "threshold" structures.

Groups identified as particularly vulnerable regarding the consumption of drugs :

The youth intermittent experimentation with drugs is connected to curiosity, peer pressure, and fashion, as much as the availability of the product and the opportunity to try it. (Hartnoll 2002).

Intense use of drugs, is, in itself, associated to individual and family background and the socio-economic underprivileged status. We also found that often a consumer has mental and delinquent problems.

Risk factors connected to the problematic consumption of drugs

- ✓ Individual characteristics - genetic, metabolism, personality
- ✓ Broken family – family dysfunctionning
- ✓ Weak socio-economic status/social dropout/unemployment
- ✓ Other social and psychological problems – school problems, low self esteem, depression
- ✓ Early use – particularly associated with other school problems
- ✓ Repeatedly exposed to the availability of the products – particularly in vulnerable groups knowing other risk factors
- ✓ Lack of clear and precise information on the health risks

Source : Hartnoll 2002.

From the factors listed in figure 1, a typology of the population most exposed can be done. If we keep the criteria linked to socio-economic situations and underprivileged families, the sub-population is easily recognised: Young people, unemployed, RMI beneficiaries, immigrants or foreigners, no stable address. These groups have been identified as particularly vulnerable in the exclusion process.

We also know that the imprisoned or ex-convict population and prostitutes have a higher level of consumption than the general population.

16.2 Drug use patterns and consequences observed among socially excluded population

It has proven difficult to find information on the illicit drug consumption of the socially excluded : The tendency towards alcohol and tobacco consumption, *a contrario*, is better known in France.

In a study conducted in Paris in 1996, of 838 homeless people, 16% declared to use or to be hooked on drugs for life and 10% in the year. During their whole life, 33.9% have a problem with substance use or are dependant. *L'Observatoire du Samu Social* (1998, 1999) gave out similar numbers : 21% of the people who frequent emergency shelters for nursing care (CHUSI) admitted to taking illicit substances or medication (26% in 1999). On the whole, including the general population, men in a precarious situation appeared more concerned by drug consumption than the women.

In the adult excluded population, the most widely consumed drugs are cocaine (22% in 1998 and 33% in 1999), cannabis (20% and 28% in 1999) and when two substances are associated, it is often cocaine or heroin. (OSS 1998, 1999). Some people declared to have taken Subutex® or methodin. (7% of these people frequent CHUSI).

When comparing the population in general, (ages 12-75) the prevalence to experiment with cocaine is 1.3% and 0.2% for occassional use. Cannabis is placed at the same level for the unstable and general population. (1 French person in 5 or 21% of the 12-75 age group have experimented, but only 7.6% had consumed during the last 12 months. (Beck 2000).
Young people who do not attend school or have no professional training are more at risk that school goers (HCSP 1998). When they are homeless or in an unstable position, consumption of psychoactive substances is more important to them than to other young people: 65% frequently consume cannabis or another illicit drug, yet the general 14-18 age group population experimentation with psychoactive products other than cannabis is less than 5%. (Beck *et al.* 2000).

Cannabis as an illicit substance plays a big part in the young homeless population, its repeated consumption concerns more than half of those questioned. (Amossé *et al.* 2001). This substance is found in the general population where half of the young people in the 14-18 age group declare to have tried it, nevertheless, repeated consumption of illicit substances other than cannabis is very high on the homeless list: (Beck *et al*. 2000). 65% repeatedly at least two illicit substances other than cannabis, 34% at least three.

16.3 Relationship between social exclusion and drug use

Indications of social exclusion in specific drug consumption populations in comparison with the general population

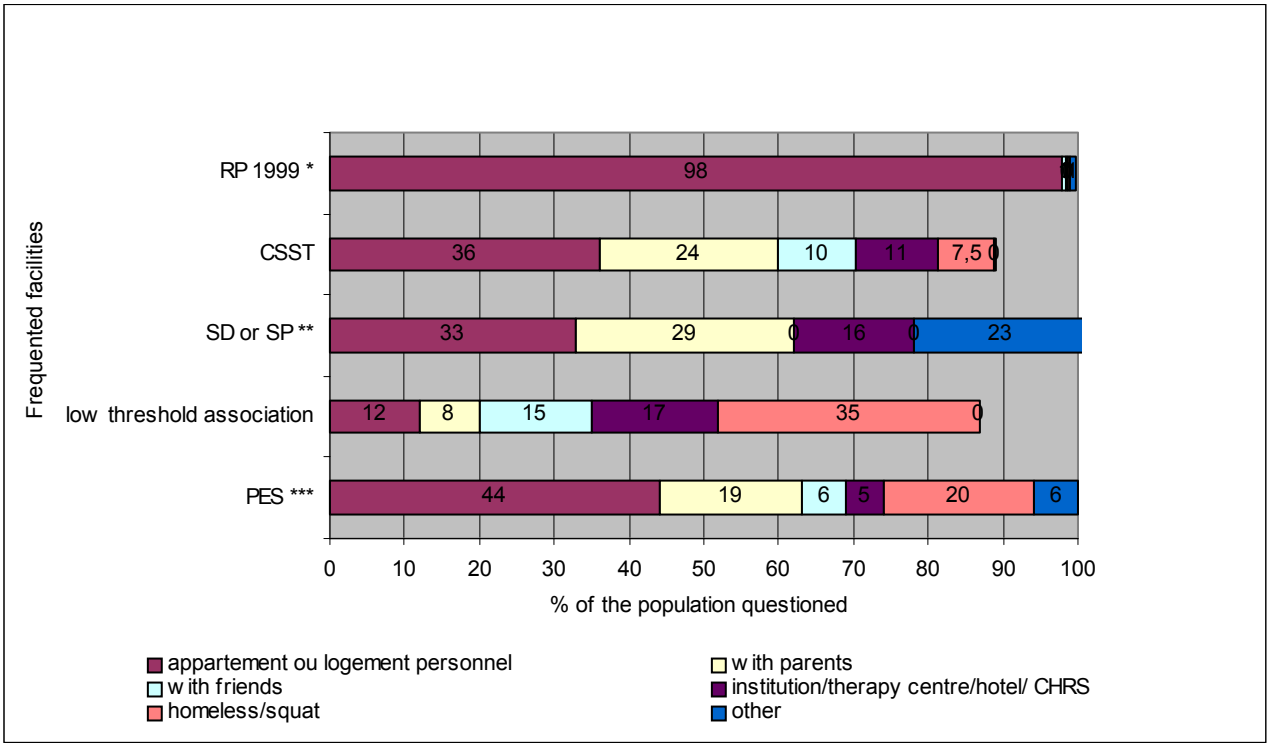
Several surveys conducted for the use of drugs in the lodging structures tell about their economic and social situation. (CEIP, DGS 1999, Facy 1999, IREP 1996, Tellier 2001). The survey methodologies are different (exhaustive or groups, survey place, time, date, structure and questionnaire) but the results boil down to the same. A population of drug users drop outs for whom the health and social conditions have deteriorated (AIDS and Hepatitis epidemics have largely contributed to this deterioration) and so the unstable situation of social exclusion accentuates over the years.

As an example, l'IREP (1996) observed between 1991-1992, a radicalisation of unstable situations: a growth of RMI beneficiaries, begging, sexual work, a change in the market – smaller doses for smaller prices, a phenomena of malnutrition in the "lower-threshold" structures.

The people frequenting the Specialised Drug Addict Treatment Centres (CSST) in 1999 are mainly unemployed. (62% in 1999 according to Tellier 2001). As a comparison the unemployed represent around 4% of the active French population. 31.4% of the cases looked after by the CSST have a revenue from work, 13% receive the DOLE, 33.4% receive the RMI or a handicap allocation (AAH) and 12% are looked after by a third party (DGS 1999), but most of them have medical aid cover. These numbers are much lower in the general population for the age group concerned: 3.3% of the population receive the RMI, 2.1% the AAH.

If almost 68% declare stable housing (independent or with the family), 23% have unstable housing and 7.5% are homeless (DGS 1999) (figure 2).

Comparison of the living conditions of drug users in relation the facilities that they frequent



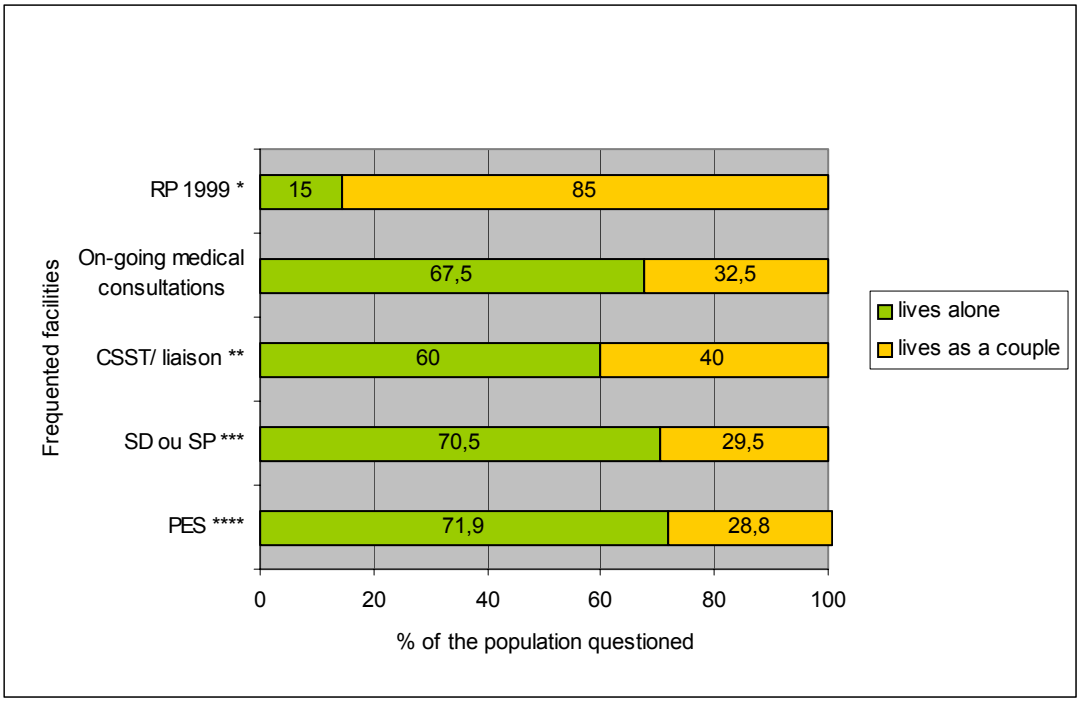
* RP 1999: Census conducted by INSEE in 1999 of the French population for the Ile-de-France region. The heading apartments or personal housing and parents home are put together.

** SD or SP corresponds to homeless or prevention centres (IREP 1996).

**** PES: Programme d'Echange de Seringues [Syringe Exchange Programme] (Emmanueli *et al.* 1999).

About 60% of the patients that are heroin users for more than 18 months treated in CSST are single (35% of the French population declared themselves as single in the 1999 census) less than 40% live together as a couple (figure 3). They rarely live alone (13%), their usual circle is a partner (36%), children (25%), parents (45%), family (29%) or friends (32%) (Facy 1999)

Comparison of the marital situations of drug users in relation to the facilities that they frequent



* RP 1999: Census of the French population in 1999 carried out by INSEE for the Ile de France region. The section named *alone* corresponds to households made up of one person only ; the section named *in a couple* corresponds to households made up of at least 2 people.

** CSST / liaison : data published by OPPIDUM programme (CSST/ liaison team and certain other structures) (CEIP 2000)

*** SD or SP corresponds to homeless and prevention structures (IREP 1996)

****PES: Programme d'Echange de Seringues [Syringe Exchange Programme] (Emmanueli *et al.* 1999).

The people found in so-called "low-level" group homes are generally more marginalized than those who frequent CSSTs (Bello *et al.* 2002, Emmanuelli *et al.* 1999, Espoir Goutte d'Or 2001, Le trait d'Union 2001, OFDT 2000). Most drug users are single, and about 30% live in conditions of "*extreme poverty*"; 50% come from risky living arrangements. Furthermore, 80-90% have no work-related income, and about 30% have no type of social security coverage. At least half, and perhaps more, of these people who frequent "low level" structures receive RMI or AAH: these allocations are potential resources that enable them to receive some type of social security coverage, but the their level of living conditions remains at-risk.

These users are turned into social outcastes because "dependency hinders the formation of social links" (Sida Parole): "psychiatric problems, lack of well-being, chronic instability, inability to form close-knit relationships, loss of any concept of time, and loss of intellectual abilities make their isolation even worse" (Le Trait d'Union). This marginalisation is confirmed by institutions offering treatment that underscore an increase in requests for material and social assistance, which are far more frequent than requests for health care-related assistance (Espoir Goutte d'Or 2001, IREP 1996).

Data published from research on social exclusion (as a risk or a consequence of drug use)

Numerous authors have shown that economic and social difficulties often result in an aggravation of the health, both physical and mental, and by the adoption of risk behaviour (Marpsat et Firdion 1998).

Consumer behaviour in fringe or homeless populations appears, for women as for men, to be strongly linked to the type of their accommodation: the amount of consumers of illicit substances is less in institutionalised, collective housing areas that in « independent » housing (Amossé *et al.* 2001).

10% to 20% of the homeless population is involved in drug use but the problems vary according to certain socio-demographic characteristics, essentially age, income level and the reason for the situation (Kovess et Mangin-Lazarus 1997). Drug use is more frequent amongst young people that have no income (30% of the homeless population of less than 30 years old are involved). These young people, a 1/3 of them fostered in their childhood or in serious conflict with their family have an unstable personality type (impulsive or limited). However, women use drugs much less than men (as in the general population) and people over 55 years old have practically no drug abuse problems.

A comparison has been carried out between homeless people staying in specialised alcohol abuse centres and other people (Facy *et al.* 2001): it showed that twice the amount of homeless people use drugs other than tobacco and alcohol (30% vs. 15%): heroin (3% vs. 1%), cannabis (8 % vs. 3 %) and multiple drugs (8 % vs. 1 %).

Paugam and Clemencon (2002) determined that amongst all the personal difficulties confronted at adult age by the people that go to shelters, centres and homes, 27% describe problems with alcohol, 17% answer problems with drugs, the answer most often given in the same category is problems with health (33%).

To study the workings of breakdowns and the insecurity process, people have been questioned about the difficulties that they encounter. Most often mentioned is a drop in resources or a loss of housing. Drug problems are in 11th position (14%): Drug use, therefore, does not seem to be the most important factor at the root of the breakdown process.

In homeless or unstable situation populations problems of illicit drug abuse are less frequent that the use of alcohol or tobacco. Therefore, we can see that « *the majority of illicit substances are used (heroin, cocaine, poppers, medicaments) and if the prevalence is not higher it is only a question of cost »* (Sida Parole, Laurent El Ghozi).

16.4 Political issues and reintegration programmes

Policies regarding social exclusion problems and their implications for responses to social exclusion

The blueprint law relating to the fight against exclusions, dated 29th July 1998, is a four-pronged approach (Ministry of Employment and Solidarity 2002b):

- to guarantee access to fundamental rights: the right to employment, housing and access to treatment, education, and knowledge;

- to prevent types of exclusion stemming from exclusive assistance logistics in order to make a shift toward prevention: excessive debt counselling and treatment, the keeping of housing arrangements, improving the subsistence means of the most destitute, enabling these groups to exercise their civic rights…;

- to deal with urgent social issues by increasing the effectiveness of responses to these issues. To do this, it has been deemed necessary to reinforce and extend existing social monitoring tools but also to co-ordinate emergency financial assistance mechanisms;

- to better co-ordinate collective actions, shifting from traditional administrative logistics to a sense of individual case management for each person.

Within this framework, the government has introduced three types of operations that enable it to fight, more specifically, against social inequalities with regard to health care. Universal Health Insurance Coverage (CMU in French) guarantees everyone social security health coverage and makes it easier for the most destitute to gain access to supplemental coverage. The second operation, consisting of regional prevention/treatment access programmes (PRAPS) aim to protect people who live in risky situations and who have experienced difficulties in accessing social and health services; this operation means that a specific treatment/prevention offer is being adapted to the needs of every region[65]. The third operation pertains to private and public health care establishments that take part in the public hospital system: ongoing treatment access (PASS) adapted to the needs of those who live in risky situations[66].
Within the context of the application of the law pertaining to the fight against exclusions, mechanisms that help guarantee access to rights, housing, and social reintegration for people in difficult circumstances have been greatly expanded. Drug users have directly benefited from these improvements, but no figures are available for this specific population.

Reintegration-oriented treatment elements found within services specialising in drug addiction

The French case management mechanism comprises a number of structures: CSST, outpatient treatment centres, centres with group housing, therapeutic apartment networks, transitional group homes, group homes for people in urgent circumstances, networks of foster families, treatment centres in penal institutions. Nevertheless, the "*group home/treatment mechanism has, for a long time, benefited from a psychological and medical approach, to the disadvantage of a social approach. It seems that the social and family-related problems of users need to be addressed […] Thus, this does not concern specific rehabilitation and re-integration tools that would be added onto those that already exist but would involve the better use of existing tools."* MILDT 1999 (p. 79 and following pages).

The same document (MILDT 1999) contains recommendations for better risk-reduction policies with regard to the most marginalised users:

- to reinforce and pursue the development of risk-reduction structures and related structures (shops, sleep-in centres, neighbourhood mobile teams,

[65] For the 26 regions, only 4 have given priority status to prevention and case management of dependencies.

[66] They offer treatment or palliative care, monitoring the ongoing nature of treatments following the admission of people in difficult circumstances or their housing and must be able to accommodate people in risky situations, both day and night.

syringe exchange programme [*programme d'échange de seringues,* PES], automatic syringe dispensers);

- to provide a framework for risk-reduction policies by creating specifications that will enable it to be integrated sufficiently within specialised treatment mechanisms and in more general structures that receive marginalised people;

- to define the role and status of former drug users working in risk-reduction structures.

Operations already undertaken since 1999 in the area of group housing, guidance, treatment, and reintegration comprise, notably[67] :

- the creation of 20 hospital liaison teams;

- the development of substitution treatments (improvement in terms of the accessibility and quality of case management)

- risk-reduction (10 shops, 2 "sleep-in", 18 PES, 72 automatic syringe dispensers, 4 neighbourhood mobile teams);

- treatments to drug users in prison;

- training in the area of tobacco withdrawal given to doctors.

As of this writing, 387 out of 1345 organisms (including the associations sector) specialised in drug addiction case management focus on re-integration/rehabilitation[68] (DATIS 2002). Amongst these structures, 40 offer legal assistance, 26 offer group housing, 38 structures offer work rehabilitation programmes, 26 permit one-night stays in hotels, and 354 provide social/educational follow-up services[69]. It must be noted that there are significant regional differences.

Finally, outside those programmes and types of operations established by the MILDT's three-year plan and the national plan for the fight against exclusions, operations may be carried out in the area of rehabilitation/re-integration by means of certain projects established at the community, departmental, or regional level: urban development programmes, large-scale urban development programmes (including the European URBAN project), local security contracts or re-integration programmes [*contrats locaux de sécurité,* CLS or *contrats locaux d'insertion,* CLI], local education contracts [*contrats éducatifs locaux*] (CEL), Health and Citizenship Education Committees [*comités d'éducation à la santé et à la citoyenneté*] (CESC), departmental re-integration programme [*programme départemental d'insertion*] (PDI), departmental prevention programmes [*programmes départementaux de prévention*] (PDP), regional health programmes [*programmes régionaux de santé*] (PRS)…

Programmes de réintégration spécifique concernant les anciens consommateurs de drogues

None

[67] As of 1st June 2002

[68] The other areas of operations may be the following: treatment, prevention and housing. These are not mutually exclusive. As a means of comparison, 690 structures offer treatment, 969 are involved in the area of prevention, 187 focus on therapeutic housing (an operation that does not exclude the others).

[69] There may be several re-integration operations per structure.

Results of the assessment

In 1999, the MILDT (1999) identified three populations for which case management should be built up and reinforced: parents who use drugs and these users' children, adolescents, and incarcerated populations.

For drug addiction and for exclusion, the processes are multidimensional, not only affecting the "excluded," but also a wide variety of population categories still within the bounds of social and institutional categories. At this moment, the latter have only been very slightly affected by risk reduction efforts or other policy-based operations in the fight against drugs.
(Joubert 2000).

16.5 Methodological information

limitations of available data

It must be noted that traditional statistics, including all information that is backed up by figures, have "trouble identifying populations in conditions of poverty and risk. These individuals, much more than others, tend to be ignored by general surveys that aim to describe structures pertaining to society at large and its evolution" (ONPES 2001 p. 43). Furthermore, as we have already seen, the idea of poverty-risk-exclusion does not amount to merely the financial aspect. Hard-to-assess factors of fragility or insecurity must also be taken into consideration. Only a multidimensional approach can allow all the dimensions of risk to be encompassed.
The socio-economic profiles of surveyed drug users have been used to allow us to compile this report. Indeed, there has been no more specific study or research carried out on this topic in France. The prejudices are thus hard to ignore: users outside the substitution programme (Subutex® or methadone) or outside PES are surveyed even less often; reports of operations of associations specialising in the area of drug addiction only allow for very limited analysis.

Main surveys and research

Surveys of excluded or homeless populations[70]: CFI-Pâque, dispositif 16-25 ans: jeunes en insertion (1994) ; Kovess and Mangin-Lazarus (1997); Facy *et al.* (2001) ; Amossé *et al.* (2001); Monitoring Centre for the Social and Medical Welfare of the Homeless (SAMU) in Paris (1998 and 1999); Paugam and Clemencon (2002).

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