

Use of illicit drugs and social exclusion: state of knowledge in France

Since the end of the 1990s, poverty, precariousness, exclusion, integration or reintegration have been at the heart of all the social debates. Many surveys have been carried out with homeless populations, people living below the poverty line or the unemployed, with the particular objective of studying the interactions between their living conditions and their state of health. It is in this context that it seemed worthwhile to examine in particular the illicit drug use behaviours of destitute populations and, conversely, the degrees of poverty, precariousness or exclusion of drug users.

Exclusion is hard to measure

The words “poverty”, “exclusion” and “precariousness” have been in current usage for some years. It is appropriate to define them here. Poverty is a clearly established concept: it lies in the insufficiency of means¹. Precariousness is characterised by the fragility of the situations² and encompasses the notion of poverty: it can therefore be measured only in reference to the instability of the situations and from the point of view of multiple dimensions. As for the concept of exclusion it is immediately much harder to define, something emphasised by all the research works.

For the *ministère de l'Emploi et de la Solidarité* [ministry of employment and solidarity] (2002), exclusion is defined as a series of breakdown mechanisms on both the symbolic level (stigmas or negative attributes) and the social relations level (breakdown in various social links which bind people together). Exclusion is both a process, produced by a lack of social cohesion, and a state, the result of a lack of integration.

The concept of exclusion is characterised by three dimensions:

- economic: precariousness as regards employment, chronic or repeated insufficiency of resources;
- non-recognition: the non-exercising of social rights, civil rights, political rights;
- social relations: the social and psychological destructuring caused by economic crisis and no-rights situations among individuals, families or social groups.

Social exclusion is therefore understood as a component of exclusion and is generally studied in interaction with the other two dimensions.

In France, 300,000 people are affected by exclusion (0.4 to 0.5% of the total population, according to the *Haut comité de santé publique* [High-level committee on public health] [HCSP], in 1998, 8 to 10% of the population is affected by poverty (ONPES, 2001) and probably 20 to 25% by precariousness (HCSP, 1998).

¹ Nevertheless, according to the *Observatoire national de la précarité et de l'exclusion sociale* (ONPES) [National observatory for precariousness and social exclusion], poverty cannot be simplified to the sole money-type indicator, but also concerns other aspects of daily life, such as housing, health, training, work and family life.

² “Precariousness is the absence of one or more means of security, particularly employment, which make it possible for people and families to assume their professional, family and social obligations, and enjoy their basic rights” (Opinion of the *Conseil économique et social* [Economic and social committee] of 11 February 1987 in the J. Wresinski report, 1987).

Drug use and increasing precariousness: some populations more exposed than others

In the general French population, experimentation and actual use of illicit drugs are marginal, with the exception of cannabis. It does seem, however, that the general trend is slightly upwards (except for heroin), in particular for cocaine, amphetamines and ecstasy.

The use of illicit drugs affects young people in particular for whom the experimental and intermittent use of drugs is linked to curiosity, mimicry and other group fashions as well as to the availability of the product and the opportuneness of using it. The intensive use of drugs is, itself, associated with individual or family characteristics and with unfavourable socio-economic positions (Hartnoll, 2002).

On several occasions in its report the HCSP (1998) brings up the interaction that exists between the process of increasing precariousness or exclusion and the use of illicit drugs. At-risk behaviours and problematic drug use generally develop at the same time as the feeling of social uselessness and the deterioration of one's self-image, and the worsening of one's state of health both physically and mentally. This information is confirmed by a study carried out in Ile-de-France by Kovess and Mangin-Lazarus (1997) which concluded that depression, anxiety disorders, and problems with alcohol and drug use are observed more often among RMI [*Revenu minimum d'insertion* – guaranteed minimum income] recipients than among the inhabitants of Ile-de-France and even more among homeless people.

The HCSP report continues by citing the terms "exclusion", "violence", "delinquency" and "drug addiction" as the characteristics most frequently associated with the suburbs. In certain cases, however, and always within zones of precariousness, the presence of drugs can be a means of integrating oneself economically through the micro economy of trafficking, and of obtaining status and psycho-affective recognition (Jamouille, 2001).

Nevertheless, noticing that at-risk behaviours and problematic uses are more widespread in disadvantaged settings does not make it possible to determine whether these are the consequence of a state of precariousness or the cause of it. In fact, as is noted in the *Plan d'action français contre la pauvreté et l'exclusion sociale* [French action plan to counter poverty and social exclusion] (2001), the use and consumption of illicit products have not been systematically studied in these settings. The information available concerns almost solely drug use and trafficking among young people in sensitive areas or alcoholisation phenomena among homeless people.

Drug use in excluded populations is not a marginal phenomenon

It has proved difficult to find information on the use of illicit drugs in socially excluded populations: there is, conversely, much more information in France on trends in alcohol and tobacco consumption.

In a study carried out in Paris in 1996 among homeless people (Kovess and Mangin-Lazarus, 1997), 16% said that they had used drugs or had a dependence at least once during their life and 10% during the previous six months. The *Observatoire du Samu social* [Observatory of the medical emergency assistance service] [OSS] puts forward fairly similar figures: in 1998, 21% of the people frequenting the *centres d'hébergement d'urgence pour soins infirmiers* [emergency accommodation centres for nursing care] (CHUSI) admitted taking an illicit substance or medicines (26% in 1999). Men who are in a situation of precariousness appear, as in the general population, to be much more affected by repeated use than women.

In the adult population in situations of major exclusion, the drugs used most³ are cocaine (22%), cannabis (20%), and where two substances are combined, cocaine and

³ Among the people interviewed during their medical consultation at the CHUSI who said that they "take" the drug.

heroin (OSS, 1998) are preferred. Some people also say that they take Subutex[®] or methadone. Within the population who frequent the specialist alcohol centres there are twice as many homeless as other people who use psychoactive products other than tobacco and alcohol (30% as opposed to 15%), including heroin (3% as opposed to 1%), cannabis (8% as opposed to 3%) and other multiple psychoactive products (8% as opposed to 1%).

By way of comparison, in the general population (12-75 year-olds), the prevalence of experimentation with cocaine is 1.3% and 0.2% for at least occasional use. The use of cannabis stands at the same level for the populations in situations of precariousness and the general population (Beck, Legleye and Peretti-Watel, 2001).

The prevalences of use vary according to age, income level and the cause of the homelessness. Use is more frequent among young people with no income (30% of the homeless population aged under 30 is affected). Conversely, people over 55 have practically no abuse problems.

Young people who have dropped out of school or who have no professional training have at-risk behaviours that are more pronounced than in young people who attend school (HCSP, 1998). When they are homeless or in a situation of precariousness, their use of psychoactive substances is greater than that of other young people: 65% frequently use⁴ cannabis or another illicit drug (Amossé *et al.*, 2001) whereas among the 14-18 year-olds in the general population experimentation with psychoactive products other than cannabis remains below 5% in the course of their life (Beck *et al.*, 2000).

Cannabis occupies a central place within the illicit substances among young homeless people, with its repeated use affecting more than half of those surveyed (Amossé *et al.*, 2001). The repeated use of illicit substances other than cannabis is very high among young homeless people, and when they have regularly used an illicit product other than cannabis, it usually proves to be a multiple use (Amossé *et al.*, 2001).

According to Paugam and Clemençon (2002), of the people who go to the reception centres and housing and integration services, 17% cite drug problems as being personal difficulties encountered in adulthood, with health problems (33%) being the response given most often in the same category. In order to study the spiral of breakdowns and the process of increasing precariousness, the individuals were asked about the difficulties they have encountered. Drug problems appear in 11th position (14%): the use of drugs does not therefore seem to be the most important element in the source of the breakdown mechanism.

Estimating social exclusion among drug users

In the 1970s, caring for drug addicts almost exclusively in a specific system, one which was free of charge and anonymous, resulted in the social aspects being overlooked and these very individuals being maintained in a context of social exclusion (Wieviorka, 1999). Thus, in terms of combating drug-related problems, France has, in the space of fifteen years, moved from an individual approach to users and risks to a view that considers the whole problem of risk-taking as a consequence of social exclusion (Joubert, 2000). Viewing drug addicts as being excluded has thus been able to contribute to the setting up of "low-threshold" structures⁵.

Several surveys carried out among drug users in reception structures provide information on their economic and social situation. The research methodologies are different (exhaustive or sampling, place of survey, time, date, structure, questionnaire), but the results do converge: a marginalised population of drug users whose health and social conditions are deteriorating (the AIDS and hepatitis epidemics have contributed largely to this deterioration)

⁴ Have used the product at least 5 times during their life.

⁵ Structures set up within the framework of the risk reduction policy, aimed at active users in situations of precariousness (centres, sleep-ins, syringe exchange programmes, mobile teams, etc.)

and whose situations of precariousness and social exclusion are becoming more acute as the years go by.

As an example, the *Institut de recherche en épidémiologie de la pharmacodépendance* [Research institute for drug addiction and epidemiology] (IREP) observed, between 1991-1992 and 1996, an intensification of the situations of precariousness and homelessness: an increasing proportion of RMI recipients, significant begging activities, growth in the sex trade, changes in the market with single doses being distributed at low cost, and malnutrition phenomena in the “low-threshold” structures.

The people who frequented the specialist drug addiction centres (CSST) in 1999 were mainly unemployed (62%), whereas they represent only 4% of the total French working population. 31% of the users treated in the CSSTs have income from working, 33.4% are recipients of the RMI or the adult disabled allowance (AAH). These figures are very low in the general population for the age brackets in question: 3.3% of the population receives the RMI and 2% the AAH.

Although nearly 68% said that they have stable accommodation (independent or with their family), 23% have precarious accommodation and 7.5% are homeless (table below). The isolation of the users is more pronounced than in the general population: 55% of the patients treated in the CSSTs who have been heroin users for more than 18 months are single whereas more than 35% of the French population said that they were single in the 1999 census, with 32% living as a couple (table opposite).

The so-called “low-threshold” structures take in a more marginalised public, by definition and in practice, than that in the CSSTs (table below). The majority of drug users are single, around 30% live in situations of “extreme poverty” and 50% in a situation of precarious accommodation. Moreover, 80 to 90% do not have any income from work and around 30% do not have any social security cover. Half, or even more, of those who frequent the “low-threshold” structures are recipients of the RMI or the AAH: this is, for example, the case for 53% of those contacted by the “low-threshold” structures within the context of the TREND (*Tendances récentes sur les nouvelles drogues*) [Recent trends in new drugs] surveys.

Comparison of the housing conditions of drug users by structure frequented

[Key to terms used in table]

structures fréquentées	structures frequented
PES	PES
bas seuil associatif	community low-threshold
SD or SP	SD or SP
CSST	CSST
TREND (ASUD)	TREND (ASUD)
RP 1999	1999 census
% de la population enquêtée	% of the population surveyed
chez les parents	with parents
appartement ou logement personnel	apartment or private accommodation
sans domicile/squat	homeless/squat
institution/appartement thérapeutique/hôtel/CHRS	institution/therapeutic apartment/hotel/CHRS [<i>Centre d'hébergement et de réadaptation sociale</i> - Centre for housing and social readjustment]
chez des amis	with friends
autres	other

* 1999 census: data for Ile-de-France drawn from the census of the French population in 1999 carried out by INSEE. The “apartment or private accommodation” and “with parents” headings are mixed together.

** SD or SP corresponds to *Sans domicile* [homeless] or *Structures de prevention* [prevention structures]
 *** PES: *Programme d'échange des seringues* [Syringe exchange programme]

Comparison of the marital status of drug users by structure frequented

[key to table]

structures fréquentées	structures frequented
PES	PES
SD ou SP	SD or SP
CSST/liaison	CSST/liaison
Usagers BHD	BHD users
TREND	TREND
RP 1999	1999 census
% de la population enquêtée	% of the population surveyed
Vit en couple	Lives as a couple
Vit seul	Lives alone

* 1999 census: data for Ile-de-France drawn from the census of the French population in 1999 carried out by INSEE. The "lives alone" heading corresponds to households consisting of a single person; the "lives as a couple" heading corresponds to households consisting of 2 or more people
 ** survey of a population of 779 users undergoing BHD substitution treatment
 *** CSST/liaison: data from the OPPIDIUM programme (CSST/liaison team and some "low-threshold" structures)
 **** SD or SP corresponds to *Sans domicile* or *Structures de prevention*
 ***** PES: *Programme d'échange des seringues*

This survey data has been confirmed by some of the players on the ground. It turns out, in fact, that the users are highly desocialised because "*dependence prevents social bonding*" (AIDS association spokesperson): "*psychiatric problems, malaise, chronic instability, inability to form relationships, loss of the concept of time, and loss of intellectual capacities make the isolation worse*" (the association Le Trait d'union). The marginalisation is also emphasised by the care institutions which observe an increase in requests for material and social assistance, which are much more frequent than the requests for health assistance (Espoir Goutte d'Or, 2001).

Conclusion

It is important to note that classic statistics has "*difficulty in defining the populations in situations of poverty and precariousness. These people, much more than other people, elude general surveys which aim to describe the structures of the whole of society and the changes therein*" (ONPES, 2001, p.43). One can put forward the hypothesis that these populations which elude the surveys are even more desocialised than those the studies do manage to include. Moreover, as we have seen, the notion of "poverty-precariousness-exclusion" does not come down to the financial aspect. It is necessary to take into account the fragility or insecurity factors which are hard to evaluate. Only through a multidimensional approach can the bounds of precariousness be encompassed.

Even though the surveys carried out among the homeless populations have expanded in recent years, only a very small number have asked the interviewees about their behaviour towards illicit drugs. Conversely, the questions on the use of alcohol or tobacco are more frequent, thus providing better information on these subjects. It is certain that among the homeless populations or those in a situation of precariousness problems of illicit drug abuse are less frequent than the at-risk use of alcohol or tobacco. For some people, "*the reason the prevalence is not any higher is solely a question of cost*" (AIDS association spokesperson and Laurent El Ghozi). It can be seen, however, that the majority of illicit substances are used to a greater extent than in the general population (heroin, cocaine,

poppers, medicines, etc.), but the available data is not sufficient to carry out a more exhaustive analysis of at-risk behaviours.

This article is based in part on the socio-economic profiles of the drug users interviewed within the context of occasional and local surveys. No study or research on the living conditions of this population has been carried out at a national level. The biases are therefore not insignificant: the users who are not part of a substitution programme (Subutex® or methadone) or a syringe exchange programme (PES) are surveyed less frequently since the activity reports by the associations involved in drug addiction only give a very localised analysis. Nevertheless, it is clearly apparent that drug users are involved in exclusion processes of varying severity. Within the context of the implementation of the law to counter exclusions (of 29 July 1998), the plans for access to rights, and for reception and social reintegration for people in difficulty have been widely extended and it may be supposed that drug users have benefited directly from these improvements. A detailed assessment does, however, still need to be drawn up.

It is necessary to improve the knowledge on the subject (with, for example, more specific questions during surveys on the living conditions of the users which would cover social, professional and financial areas) in order to gain a better understanding of the extent of the problem and the possible impacts of the measures set up to counter it.

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For further information

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- Interviews were carried out with:

Laurent El Ghozi (Deputy Mayor in charge of health in Nanterre, PRAPS expert);

Spokesperson from the AIDS association (Mr Pino Mitrani);

The association Le Trait d'Union (Mrs Baldet and Mrs Barbot).

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