



emcdda.europa.eu

Social exclusion and reintegration

EMCDDA 2003 selected issue

In EMCDDA 2003 Annual report on the state of the drugs problem in the European Union and Norway

treatment⁽¹⁸⁶⁾. For further information about treatment responses see p. 49.

Social exclusion and reintegration

Definitions and concepts

According to the last survey on 'social precarity and integration'⁽¹⁸⁷⁾, the proportion of the European population at risk of poverty and social exclusion in Europe varies from 9 % to 22 % (European Council, 2001). People are considered to be socially excluded if they 'are prevented from participating fully in economic, social and civil life and/or when their access to income and other resources (personal, family and cultural) is so inadequate as to exclude them from enjoying a standard of living that is regarded as acceptable by the society in which they live' (Gallie and Paugam, 2002).

Social exclusion can thus be defined as a combination of lack of economic resources, social isolation, and limited access to social and civil rights; it is a relative concept within any particular society (CEIES, 1999) and represents a progressive accumulation of social and economic factors over time. Factors that could contribute to social exclusion are problems related to labour, educational and living standards, health, nationality, drug abuse, gender difference and violence (European Council, 2001; National reports, 2002).

Drug use could be viewed as either a consequence or a cause of social exclusion (Carpentier, 2002): drug use can cause a deterioration of living conditions, but, on the other hand, processes of social marginalisation can be a reason for starting drug use. Nevertheless, the relation between drug abuse and social exclusion is not necessarily a causal one, because social exclusion 'does not apply to all drug consumers' (Tomas, 2001).

Taking into account this complexity, it is possible both to analyse drug use among socially excluded populations and study social exclusion among drug addicts (Figure 22).

Drug-use patterns and consequences observed among socially excluded populations

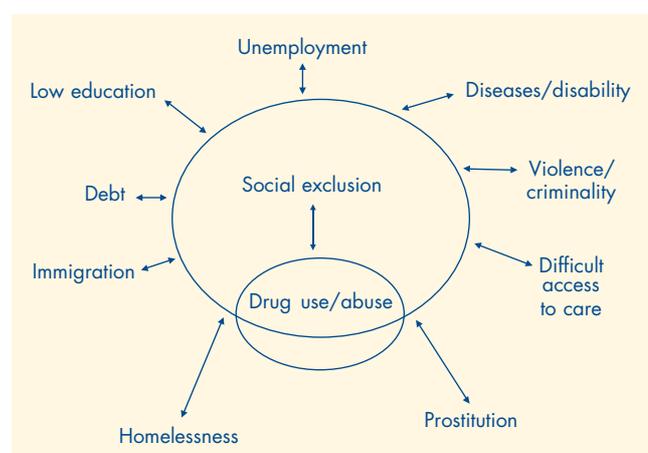
In the literature and research, the following populations are usually considered to be at risk for social exclusion: prisoners, immigrants⁽¹⁸⁸⁾, the homeless, sex workers and vulnerable young people. Bias and methodological

limitations in the presented information on drug use and patterns of use among socially excluded groups have to be considered, because of the lack of information sources and comparable data across Europe.

The association between being prisoner and using drugs has been shown to be quite strong (see also p. 34). A large proportion of prisoners are drug users before being imprisoned, and the reason for their incarceration is often associated with drug use. However, some people follow the opposite course, becoming drug users only after being incarcerated for committing crimes. Studies suggest that between 3 % and 26 % of drug users in European prisons start taking drugs in prison and between 0.4 % and 21 % of incarcerated IDUs first inject while in prison. Drug use within prison is very common: up to 54 % of inmates report using drugs while incarcerated, and up to 34 % report injecting in prison (Stoever, 2001; EMCDDA, 2002a).

The relation between 'black and minority ethnic groups' and drug use is less clear, as little information is available. There is no scientific evidence to suggest that drug use is higher among immigrants than in the general population. However, some studies in specific ethnic minority groups have found a higher proportion of problematic drug users among those groups than among the general population, such as among the Ingrian in Finland (1–2 % of whom are estimated to be drug users, especially heroin users), Kurds in Germany, Gypsies in Spain and several ethnic groups in the Netherlands (Vrieling et al., 2000)⁽¹⁸⁹⁾. The reasons for this could be a combination of socially disadvantageous factors, such as poor command of the local language,

Figure 22: Relationship between social exclusion and drug use



⁽¹⁸⁶⁾ See <http://www.stat-inst.se/article.asp?articleID=87>.

⁽¹⁸⁷⁾ Eurobarometer survey 56.1 (http://europa.eu.int/comm/employment_social/soc-prot/soc-incl/eurobarometer_en.pdf).

⁽¹⁸⁸⁾ According to the EMCDDA (2002b), immigrants are defined as 'black and minority ethnic groups' and include immigrant populations from diverse communities living in EU countries.

⁽¹⁸⁹⁾ Table 19 OL: Distribution of primary addiction problems (alcohol, heroin, cocaine, cannabis and gambling) in the Netherlands among immigrants and native Dutch (online version).

unemployment and housing problems, poor living conditions and lack of economic resources (National reports, 2002).

As regards patterns of drug use, differences are found among ethnic groups. Use of qat is reported only by Somali populations and black Africans while heroin is smoked by immigrants from Surinam and from Bangladesh. And drug use among Gypsies in Spain appears to start at a younger age (by two to three years) than in the native population (Eland and Rigter, 2001; Reinking et al., 2001; Fundación Secretariado General Gitano, 2002).

Homeless people are also reported to be at risk for drug use. Although comparable data across Europe on the relation between homelessness and drug use are not available, specific studies have been conducted in many countries, and drug use is reported as a frequent problem among the homeless (National reports, 2002). Denmark, France, the Netherlands and the United Kingdom report that up to 80 % of homeless people living in shelters are drug dependent; and prevalence rates are even higher among people living on the streets or among homeless people with other social problems. For example, according to a small study carried out in Ireland, 67 % of homeless ex-prisoners are drug dependent (Hickey, 2002). Among the homeless, heroin is the most commonly used drug, followed by cocaine and polydrug use. Other high-risk behaviours, such as injecting drug use and needle sharing, are also reported to be high among homeless people ⁽¹⁹⁰⁾.

Among vulnerable young people, the use of drugs is reported to be frequent; high prevalence is found among children who have experienced family and social problems or problems at school. High prevalence of drug use has been found among the children of drug addicts: rates of lifetime drug use among children whose parents have used drugs in the past year are significantly higher than those found in the 'non-vulnerable' group (lifetime prevalence of 37–49 % compared with 29–39 % among children of non-user parents) ⁽¹⁹¹⁾. Several studies report that children who have suffered sexual or physical abuse within the family have a higher risk of using drugs when adults (Liebschutz et al., 2002). In Portugal, young victims of family abuse and violence are reported to be seven times more likely to use heroin than young people in the general population (Lourenço and Carvalho, 2002). In the United Kingdom,

'young runaways' ⁽¹⁹²⁾ appear to be more likely to misuse drugs. Rates of lifetime drug use are two to eight times higher than in young people who have never run away. The drugs most used are crack, heroin and solvents. Problems at school are another risk factor for taking drugs: a high prevalence of drug use is reported in children not attending school (Amossé et al., 2001), among those attending reform schools (40 % of reform school students in Finland were reported to have had an addiction problem at some time, in 16 % of whom this was related to drugs) (Lehto-Salo et al., 2002) and in those with poor educational grades (13.5 % in Norway) (Vestel et al., 1997).

Among sex workers, drug use is often a motive for prostitution, but could also be a consequence (as is the case for other factors associated with drug use). Drug-use patterns vary depending on whether prostitution comes before or after drug addiction. An Italian qualitative study among street prostitutes found that, when sex workers start to use drugs in order to deal with problems related to prostitution, they mainly use alcohol, tranquillisers or other psychoactive medicines; in contrast, when drug addiction is the main reason for prostitution, heroin is the primary drug used (Calderone et al., 2001).

Research findings or data on other socially excluded groups are less readily available; Denmark reports that among patients of psychiatric services 50–60 % are drug addicts, probably because of the widespread availability of drugs and the fact that such patients are familiar with taking psychoactive medicines (National report, 2002).

Relationship between social exclusion and drug use

More data are available on social conditions among the treated population. Socioeconomic factors related to drug use include low educational levels, early school leaving and drop-out; unemployment, low salaries and difficult jobs; low income and debt; insecurity of accommodation and homelessness; mortality and drug-related diseases; poor access to care; and social stigma (Table 5).

Relevant differences in the social conditions of drug use are found by substance used and drug-use patterns; the worst conditions are found among heroin and opiates users and chronic drug addicts.

⁽¹⁹⁰⁾ The British Home Office reports that in the United Kingdom over one-third of homeless people have injected heroin, and one-fifth have injected crack. In the last month, over 10 % are likely to have used someone else's syringe or passed on their own syringe (Carlen, 1996; Goulden and Sondhi, 2001).

⁽¹⁹¹⁾ According to a survey conducted in England and Wales in 1998–99 among 4 848 young people (Goulden and Sondhi, 2001).

⁽¹⁹²⁾ The Social Exclusion Unit of the British Office of the Deputy Prime Minister defines a 'young person running away' as 'a child or young person under the age of 18 who spends one night or more away from the family home or care without permission, or has been forced to leave by their parents or carers' (Social Exclusion Unit, 2002).

Some 47 % of all clients in treatment in 2001 never went to school or only completed primary school; high rates of early school leaving and drop-out are also frequent among drugs users. Differences are found according to main drug used and by country ⁽¹⁹³⁾: opiates users (in particular heroin users) have the lowest educational level (National reports, 2002).

Because of their precarious social conditions, drug users also have problems related to labour status; unemployment rates are very high compared with the general population (47.4 % among drug clients compared with 8.2 % ⁽¹⁹⁴⁾ in the general population); finding a job is difficult and it is rare for drug addicts to keep a job for long or to progress in a career (DrugScope, 2000) ⁽¹⁹⁵⁾. A precarious labour status can lead to financial problems; drug addicts frequently have low income or no financial resources (32–77 % of clients in treatment survive on social benefits). Debts are also common.

Table 5: Social conditions (education, labour status, housing) of clients in treatment in EU Member States in 2001

Social conditions		Drug users in treatment (valid %) ⁽¹⁾
Education (n = 98 688)	Never went to school/never completed primary school	8.0
	Primary level of education	43.6
Labour status (n = 100 000)	Unemployed	47.4
	Economically inactive	9.6
Housing (n = 41 299)	Unstable accommodation	10.4
	Institutions	7.5

⁽¹⁾ Percentages are calculated on the total number of cases reported under each single item; the total does not sum to 100 % as only the values of interest for this chapter are reported (never went to school, unemployed, etc.); for the complete figures, see Figure 55 OL: Level of education among all clients by country; Figure 56 OL: Labour status among all clients by country; and Figure 57 OL: Living conditions among all clients by country (online version).

Source: Reitox national reports — TDI data 2001.

The living conditions of drug users are often reported to be very poor: 10.4 % of clients live in unstable accommodation and 7.5 % live in an institution. Furthermore, many countries report high homelessness rates (up to 29 %) among drug addicts ⁽¹⁹⁶⁾.

With regard to nationality, characteristics resemble the general population structure ⁽¹⁹⁷⁾; clients are mainly nationals of the country where they request treatment, and the number of clients from other countries (European or non-European) is consistent with the proportion of foreigners in the general population. However, it should be remembered that in some countries registration of clients' nationality/ethnicity is not allowed and consequently such information is not consistently available.

Apart from direct health consequences (see pp. 24 and 28), drug users can find it difficult to access care because of a reluctance to deal with services or poor education, a low degree of acceptance by mainstream medical services and unique health problems for which appropriate services are not available.

Finally, drug users suffer from a negative social image and may face hostility from the general population and public authorities. Research conducted in a prison in Vienna found that drug users may experience violence and abuse from police officers or other public officials (Waidner, 1999).

Social reintegration

Measures to deal with social exclusion among groups with or without drug addiction problems and with the social consequences of drug use/abuse are set out in the European countries and Norway.

On the basis of the European Union drugs strategy (2000–04) (Council of European Union, 2000) and a specific study on social reintegration in the EU and Norway (EMCDDA, 2003b), social reintegration could be defined as 'any integrative efforts for drug users in the community'.

Social reintegration interventions target both current and former problem drug users, ranging from well-functioning 'clean' former addicts and long-term methadone clients to very deprived street addicts. A treatment component, whether medical or psychosocial, is not necessarily required. This also implies that social reintegration does not necessarily take place after treatment but can take place

⁽¹⁹³⁾ Figure 55 OL: Level of education among all clients by country (online version).

⁽¹⁹⁴⁾ Average unemployment rate among the 15 Member States (Eurostat, 2002).

⁽¹⁹⁵⁾ Figure 56 OL: Labour status among all clients by country (online version).

⁽¹⁹⁶⁾ Figure 57 OL: Living conditions among all clients by country (online version).

⁽¹⁹⁷⁾ Figure 58 OL: Clients' nationality by country (online version).

irrespective of prior treatment, being either the final step in a treatment process or a separate and independent post-treatment intervention carried out by non-treatment services with their own goals and means. Social reintegration services do not target problem drug users exclusively but may target all kinds of addicts (including those addicted to alcohol and legal drugs) or even all socially excluded groups (e.g. homeless people and rough sleepers).

A quantitative overview of social reintegration measures in EU Member States is impossible to achieve, as the term 'social reintegration' is not used consistently. Although different services may exist alongside each other, at country level, there are typically general 'provision modes' for social integration:

- targeting all excluded groups with or without addiction problems;
- targeting persons with addiction problems in general;
- targeting explicitly and exclusively problem drug users of illegal drugs (Figure 23) ⁽¹⁹⁸⁾.

It is difficult to quantify the availability of social reintegration services and assess the adequacy of service provision although the evidence would suggest that the number of facilities is probably inadequate. For example, Germany estimates that it needs around 25 000 social reintegration places, whereas the actual number available is roughly 4 000. An employment project in Austria registered twice as many applications as places and had to turn down an average of 15 persons a day.

Social reintegration can be broken down into three main types of interventions: education (which includes training), housing and employment.

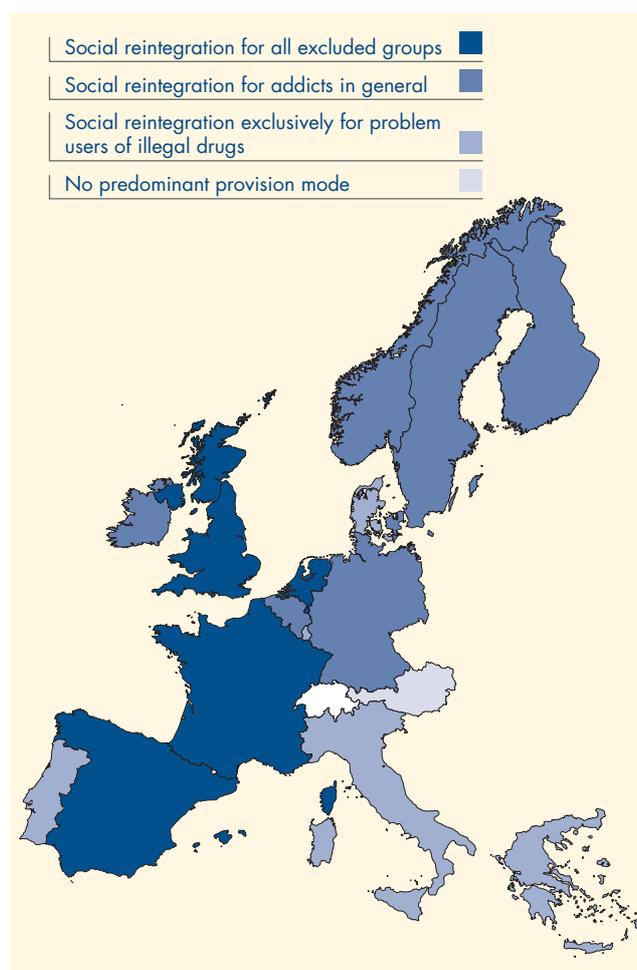
Many drug users have a poor level of education, and many national reports describe a poor relationship between problem drug users and the labour market (Greece (Kavounidi, 1996), Denmark (Stauffacher, 1998), the Netherlands (Uunk and Vrooman, 2001)). Hence, interventions aimed at upgrading academic, technical or practical skills would improve clients' chances in the labour market.

Employment measures can take many different forms, for example providing financial support to companies which employ a drug user in a competitive job, as is reported from Greece. Other measures include setting up employment services, such as the Vienna Job Exchange in Austria, or helping clients to establish their own businesses, as also occurs in Greece as well in Spain under the

auspices of the employment programme 'Self-employment promotion' (this kind of intervention overlaps with education/training).

Finally, providing housing or assistance to find housing aims at bringing some stability into clients' lives. Offering housing can be an intervention in itself but will often be accompanied by psychosocial assistance and some degree of supervision. An example of parallel psychosocial care is Haus am Seespitz in the Tyrol, which runs an open after-care group for clients that meets in housing facilities. In Belgium, 'Habitations protégées' provides both housing and psychiatric care. Research performed in Ireland (Irish national report (Hickey, 2002)) showed that 79 % of female and 76 % of male ex-prisoners indicated that finding suitable housing was their main problem and reason for their social exclusion, suggesting that housing is an important social reintegration intervention.

Figure 23: Main provision modes for social reintegration for problem drug users in the EU and Norway



Source: Reitox national reports.

⁽¹⁹⁸⁾ For more in-depth information and country overviews, see the study 'Social reintegration in the European Union and Norway' (http://www.emcdda.eu.int/multimedia/project_reports/responses/social_reintegration_eu.pdf).